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**CROSSING THE RUBICON: THE IMPACT OF THE
AFFORDABLE CARE ACT ON THE CONTENT OF
INSURANCE COVERAGE FOR PERSONS
WITH DISABILITIES**

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I. INTRODUCTION

The Patient Protection and Affordable Care Act,¹ as amended by the Health Care and Education Reconciliation Act² (hereinafter referred to collectively as the “Affordable Care Act” or “PPACA”), has been heralded³ as the most important set of changes to American health insurance since the 1965 enactment of Medicare⁴ and Medicaid.⁵ Building on the public and private health insurance coverage systems in existence at the time of pas-

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 25 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.) [hereinafter PPACA].

2. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (to be codified as amended in scattered sections of 20 U.S.C., 26 U.S.C., and 42 U.S.C.). For ease of reference, PPACA as used here will include the Amendments made by the Reconciliation Act.

3. See President Barack Obama, Remarks at the Signing of the Patient Protection and Affordable Care Act (Mar. 23, 2010), *available at* <http://www.whitehouse.gov/the-press-office/remarks-president-and-vice-president-signing-health-insurance-reform-bill>.

4. Health Insurance for the Aged (Medicare) Act, Pub. L. No. 89-97, §§ 101-02, 79 Stat. 286, 290-332 (1965) (codified as amended at 42 U.S.C. §§ 426, 1395-1395ll).

sage,⁶ the PPACA nonetheless makes sweeping reforms with an eye toward achieving near-universal health insurance coverage by 2019.⁷ Coverage reforms, the most important of which take effect January 1, 2014, intend to eliminate Medicaid's historic exclusion of low-income adults who are neither pregnant, disabled, nor extremely poor parents of minor children.⁸ Other PPACA reforms have as their goal to improve the scope and quality of coverage in the individual health insurance market as well as in the group health benefit markets, whether fully insured or self-insured.⁹ In addition, the PPACA establishes state health insurance exchanges, which are scheduled to become operational by January 1, 2014,¹⁰ and whose purpose is to make quality and affordable coverage accessible to individuals and small

5. Medicaid Act, Pub. L. No. 89-97, §§ 1901-05, 79 Stat. 286, 343-53 (1965) (codified as amended at 42 U.S.C. §§ 1396-1396d).

6. Christine Eibner, Peter S. Hussey & Federico Girosi, *The Effects of the Affordable Care Act on Workers' Health Insurance Coverage*, 363 NEW ENG. J. MED. 1393, 1393 (2010). As of 2009, non-elderly Americans derived their coverage as follows: Medicaid and the Children's Health Insurance Program (CHIP) (17%); other public insurance (3%); employer-sponsored insurance (57%); and individually purchased private health insurance coverage (5%). Some 19% of all persons were uninsured that year. Of this number, an estimated 81% were citizens or lawfully present in the U.S. See *Kaiser State Health Facts: Nonelderly (0-64)*, THE HENRY J. KAISER FAMILY FOUND., <http://www.statehealthfacts.org/comparebar.jsp?cat=3&ind=126> (last visited June 9, 2010); see also THE HENRY J. KAISER FAMILY FOUND., *THE UNINSURED: A PRIMER, KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE* (2010), <http://www.kff.org/uninsured/upload/7451-06.pdf>.

7. The Congressional Budget Office (CBO) estimates that by 2019, the number of non-elderly uninsured individuals would be reduced by 32 million. The number of non-elderly individuals without insurance would thus decrease to 23 million, approximately one-third of whom are unauthorized immigrants. Put differently, by 2019 the percentage of legal, non-elderly individuals with health insurance would increase to 94%. See Letter from Douglas Elmendorf, Director, Cong. Budget Office, to Nancy Pelosi, Speaker of the House, U.S. House of Representatives 9 (Mar. 20, 2010), available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

8. PPACA, Pub. L. No. 111-148, §§ 2001(a)(1)(C), 2002(a), 124 Stat. 119, 150-51, 158-59 (2010). See generally DAVID G. SMITH & JUDITH D. MOORE, *MEDICAID POLITICS AND POLICY: 1967-2007* (2008); ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* (2003).

9. See PPACA §§ 1001, 1201, 124 Stat. at 130-38, 154-61. These provisions are applied to Employee Retirement Income Security Act-governed health plans, including self-insured plans by § 1563. Examples of reforms include barring the use of pre-existing condition exclusions, excessive waiting periods, elimination of annual and lifetime limits on coverage, comprehensive coverage of certain preventive services, coverage of routine health care furnished as part of clinical trials, and a prohibition against rescissions. *Id.*

10. *Id.* § 1311(b)(1), 124 Stat. at 173.

employer groups.¹¹ Finally, the PPACA makes improvements in Medicare coverage¹² and payment structures,¹³ seeks to stimulate greater efficiencies and higher quality in health care delivery,¹⁴ and addresses challenges in population health,¹⁵ health care access,¹⁶ long-term care,¹⁷ and the health workforce.¹⁸

This Article focuses on one particular slice of the Act, namely, the provision that establishes federal standards for coverage of “essential health benefits” in the state-regulated individual and small group health insurance markets. Historically, regulation of the content of coverage within these two markets has been the virtually exclusive purview of state insurance law.¹⁹

11. *Id.* § 1311, 124 Stat. at 173–81. For a general overview of health insurance exchanges, see TIMOTHY STOLTZFUS JOST, THE COMMONWEALTH FUND, PUBL'N NO. 1426, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: KEY POLICY ISSUES (2010), http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf.

12. *See* PPACA §§ 3001–08, 124 Stat. 353–78.

13. *See id.* §§ 3131–43, 124 Stat. at 427–42.

14. *See, e.g., id.* § 3022, 124 Stat. at 395–99 (shared savings arrangements through accountable care organizations); *id.* § 3201, 124 Stat. at 442–54 (Center for Medicare and Medicaid Innovation); *id.* §§ 3011–3015, 124 Stat. at 378–89 (National Strategy to Improve Health Care Quality).

15. *Id.* §§ 4001–4402, 124 Stat. at 538–88.

16. *See, e.g., id.* § 10503, 124 Stat. at 1004 (Community Health Centers and National Health Service Corps Fund); *id.* § 10801, 124 Stat. at 1015.

17. *See, e.g., id.* § 10202, 124 Stat. at 923–27 (incentives to offer home and community-based long-term care services).

18. *Id.* §§ 10501–10609, 124 Stat. at 993–1015.

19. The federal government has not been without a presence in the state-regulated individual and group health insurance markets, as laws such as the Public Health Service Act standards for coverage enacted through the Health Insurance Portability and Accountability Act, the Mental Health Parity Act, and other laws discussed in this Article indicate. At the same time, states historically have borne the vast responsibility for the content and structure of health insurance products sold in the group and individual markets. *See Metro. Life Ins. Co. v Massachusetts*, 471 U.S. 724 (1985); THE HENRY J. KAISER FAMILY FOUND., HOW PRIVATE HEALTH COVERAGE WORKS: A PRIMER, 2008 UPDATE 8–20 (2008), <http://www.kff.org/insurance/upload/7766.pdf>. For an analysis of the economic effects of state health insurance mandates on the cost of individual coverage, see MICHAEL J. NEW, HERITAGE FOUND., THE EFFECT OF STATE REGULATIONS ON HEALTH INSURANCE PREMIUMS: A REVISED ANALYSIS (2006), available at <http://www.heritage.org/research/reports/2006/07/the-effect-of-state-regulations-on-health-insurance-premiums-a-revised-analysis> (follow “Download PDF” hyperlink). The study, which not surprisingly, finds a significant impact of mandates in the individual market, focuses on mandated benefits, health plan liability laws, laws regulating direct access to specialists, and laws addressing provider due process. In the author’s view, the concept of a mandate extends well beyond the benefit, coverage design, and utilization management and reaches matters of fair process for members and providers and

Because small group plans are only rarely self-insured²⁰ and thus only rarely exempt from state insurance regulatory law under Employee Retirement Income Security Act (ERISA)²¹ preemption principles, it is state law that has been the dominant force in shaping the individual and small group markets. The aim of the essential health benefit statute is no less than to extend the impact of the PPACA beyond the threshold issue of access to *any* coverage, and to introduce a federally uniform meaning to the concept of coverage, at least in the individual and small group markets, with a particular focus on the integrity of such coverage for persons with disabilities and serious health conditions.

How the essential health benefit provision ultimately might affect the structure, scope, and content of coverage within markets that the statute does not affect—larger group health markets whether fully insured or self-insured—we cannot yet know. It may be that the corporations that sell health benefit services products will over time, adapt the types of reforms required for those markets that the essential health benefit provisions affect. Nor can we know at this point how the essential health benefit provision will affect underlying state laws regulating the content of health insurance in the individual and small group markets, since federal regulations delineating the precise relationship between the federal statute and existing state benefit mandates had not arisen as of the time of this writing. At the same time, the essential benefit statute reaches beyond earlier state benefit

plan liability for injuries caused by negligent or willful misconduct. *But see* Jonathan Gruber, *State-Mandated Benefits and Employer-Provided Health Insurance*, 55 J. PUB. ECON. 433, 433 (1994) (finding that state benefit mandates have no effect on the rate of coverage in the group health insurance market because the mandates memorialize, rather than compel, insurer behavior in the market. Put another way, by the time a group health mandate makes its political way onto the books of a state's insurance code, insurers are providing the benefit anyhow.).

20. See AGENCY FOR HEALTHCARE RESEARCH & QUALITY, PERCENT OF PRIVATE-SECTOR ESTABLISHMENTS THAT OFFER HEALTH INSURANCE THAT SELF-INSURE AT LEAST ONE PLAN BY FIRM SIZE AND STATE: UNITED STATES, 2009 (2009), http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2009/tia2a.pdf.

21. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 U.S.C. and 29 U.S.C.). ERISA preempts state laws that relate to employee health benefit plans but saves state laws that regulate insurance. *Id.* § 514, 88 Stat. at 897. State laws saved under ERISA preemption principles encompass laws that regulate benefit design structure as well as the application of benefit design to plan participants and beneficiaries. See *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 366 (2002); *Metro. Life Ins. Co.*, 471 U.S. at 746.

mandates, with aims to broadly address the fundamental problem of benefit and coverage design structures that result in discrimination against persons with disabilities, rather than through the more traditional approach found in existing state laws of specific treatment and benefit mandates.²²

As used in this Article, in most instances, the term “discrimination” does not convey the concept of invidious treatment of individuals with disabilities;²³ rather, it describes generally how the insurance industry—with society’s blessing—has been able to expose certain populations to higher financial risks because of their underlying health conditions, using strategies related to both the design and administration of their products.²⁴ Indeed, discrimination against persons with disabilities in the context of health insurance coverage, through practices that utilize disability status to determine financial risk, has long been normative practice in the health insurance industry. The essential health benefits statute and its anti-discrimination provision can alter this experience for persons with disabilities.

This Article begins in Part II with a description of the types of insurance practices that discriminate against persons with disabilities, including a discussion of the reach of existing laws addressing discrimination in insurance content and coverage. Part II considers both public and private health insurance in this regard. Part III analyzes the essential benefits statute in the fuller PPACA context, and explores the implications of the statute’s terms in light of the body of law on which it builds. Part IV discusses the implications of the law for the health insurance markets that exist alongside those that the essential health benefit statute touches.

22. See COUNCIL FOR AFFORDABLE HEALTH INS., <http://www.cahi.org/index.asp> (last visited June 9, 2011) (website regularly publishes newsletters on the latest state insurance mandates).

23. We say “in most instances” because, as discussed below, there are circumstances under which discrimination in the design and administration of health insurance can in fact constitute a civil rights law violation.

24. See SARA ROSENBAUM, THE O’NEILL INST. FOR NAT’L & GLOBAL HEALTH LAW, GEORGETOWN UNIV., INSURANCE DISCRIMINATION ON THE BASIS OF HEALTH STATUS: AN OVERVIEW OF DISCRIMINATION PRACTICES, FEDERAL LAW, AND FEDERAL REFORM OPTIONS 1 (2009), <http://www.law.georgetown.edu/oneillinstitute/national-health-law/legal-solutions-in-health-reform/Papers/Discrimination.pdf>.

II. SETTING THE CONTEXT: DISCRIMINATION IN INSURANCE COVERAGE AGAINST PERSONS WITH DISABILITIES

A. *Historical Health Insurance Access and Coverage Discrimination*

Discrimination against persons with disabilities (and other individuals insurance companies considered “uninsurable” or “bad risks,” such as the poor, the elderly, and those with chronic illnesses) has been a historic problem in both the access to and content of health insurance. This discrimination arose, in large measure, out of the country’s failure to enact a single, national health insurance program. In the absence of universal coverage premised on a social insurance model (as in the case of other wealthy industrialized nations), the private insurance industry entered the market incentivized by lucrative tax policies allowing the exclusion from employee income of employers’ contribution to insurance coverage arrangements.²⁵ Insurance coverage thus became tied to work, thereby excluding those whose health conditions precluded employment.²⁶ Moreover, insurers pursued benefit designs calculated to cover costs associated with working populations who did not experience serious and chronic physical and mental health conditions that precluded work. As described by a leading authority on the topic of discrimination against persons with disabilities in health insurance and health care:

Private health insurers engage in risk-classification practices as part of their competitive strategies for capturing profitable segments of the health insurance market while avoiding unprofitable segments. Rather than segmenting the market by product and competing based on product price and quality, however, health insurers tend to segment the market by customer—competing in their efforts to sell policies to those customers considered likely to be profitable and to avoid customers who can be predicted to be unprofitable.²⁷

The U.S. approach to health insurance coverage thus started to adhere closely to market principles, in which those who are in relatively poor health are more likely to be uninsured or underinsured, and where government programs exist only for populations who lay beyond the reaches of the private market, such as

25. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 334 (1982); David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 *NEW ENG. J. MED.* 82, 83 (2006).

26. Deborah Stone, *Protect the Sick: Health Insurance Reform in One Easy Lesson*, 36 *J.L. MED. & ETHICS* 652, 652–53 (2008).

27. Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 *U. KAN. L. REV.* 73, 82 (2005) (footnote omitted).

the old, poor, sick, and disabled. For example, Congress created Medicare for the elderly, and Medicaid evolved to address the needs of the poor and those with high health bills rendered indigent.²⁸

Furthering both this private market approach and the resulting discrimination against individuals with poor health risks is a system in which insurers and health benefit services corporations sell third-party-administered products primarily to large, employed groups or healthy smaller groups, giving insurers the advantage of large risk pools and/or relatively healthy self-selected groups.²⁹

Health insurance products, including, for purposes of this Article, products sold to self-insured groups, are contracts of risk; in order to avoid the problems of adverse selection (enrollment by the sickest populations) and moral hazard (over-use of covered services), health insurers developed techniques for discriminating among and against higher health risks.³⁰ Health insurance companies developed a variety of techniques at the initial enrollment phase as well as through benefit and coverage design and plan administration to classify and, in some cases, to completely avoid risk. For some individuals deemed “uninsurable” by an insurer—for example, those with an existing costly medical condition, or perhaps just the risk factors for such a condition—the result can be complete rejection of their application for insurance coverage.³¹ Alternatively, an insurer might permit enrollment in the insurance product but impose exclusions or waiting periods for pre-existing conditions.

Perhaps most challenging to high-risk individuals’ efforts to obtain affordable, meaningful insurance coverage is insurers’ use of “actuarial rating,” or medical underwriting. Actuarial rating is a system of pricing insurance premiums based on an individual’s likelihood of utilizing covered medical care. Insurers determine this likelihood by analyzing a person’s risk factors, family history, and personal medical history,³² and charge higher premiums for individuals whose characteristics pose higher financial risks. In some cases, premium rates effectively price high-risk individuals out of the insurance market. Medical underwriting has its

28. See SMITH & MOORE, *supra* note 8, at 21–40 (2008); STARR, *supra* note 25, at 368–78.

29. See ROSENBAUM, *supra* note 24, at 5.

30. See TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 189–91 (2007).

31. This type of absolute bar to enrollment is most common in the individual insurance market (as opposed to large and small group markets).

32. See Stone, *supra* note 26, at 653.

strongest presence in the individual market, but has also been a practice in the group market, although the guaranteed issue and renewal requirements of the Health Insurance Portability and Accountability Act of 1996 curbed this to some extent.³³

Actuarial rating leads to a rather perverse system of financing health care services, in which those who most need care are those least likely to become insured, and thus the least likely to be able to afford the care. Individuals already sick are at risk of exclusion from the private insurance market altogether; those people who are relatively less healthy face the prospect of higher premiums and high cost-sharing, making insurance potentially unaffordable; and those who show risk markers for future illness also face higher premiums and the risk of unaffordable insurance.³⁴ Particularly invidious were insurer classifications based on immutable characteristics such as race, national origin, or gender. For example, African Americans historically have been subject to exclusion from the insurance market and higher premiums,³⁵ and women traditionally have faced higher health insurance premiums than men based on actuarial data that portray a pattern of relatively high health care utilization at certain stages of their lives.³⁶

Beyond barring enrollment in a health plan altogether and using actuarial rating to shield themselves from high utilizers of covered services, insurers have developed many other risk-shielding strategies and tools that apply after the point of enrollment. In the next section, we describe how these strategies and tools are used to discriminate against high-risk individuals, including persons with disabilities. In Part II.C below, we discuss how existing law permits the use of these risk-shielding tools and thus the resulting discrimination.

B. *Health Insurance Design and Administration Techniques That May Produce Discriminatory Effects Against Persons With Disabilities*

Prior to the enactment of the PPACA, the law did little to curb disability discrimination in the design and administration of

33. See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, §§ 101-102, 110 Stat. 1936, 1955-78 (codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.) (amending both the Public Health Service Act and ERISA to reach group health insurance plans whether insured or fully insured).

34. Stone, *supra* note 26, at 654.

35. Crossley, *supra* note 27, at 85-87.

36. ROSENBAUM, *supra* note 24, at 4; see also Robert Pear, *Women Buying Health Policies Pay a Penalty*, N.Y. TIMES, Oct. 30, 2008, at A23.

health insurance, even where it proscribed conduct that limits disabled individuals' ability to gain health insurance itself. As a result, insurers and health plan administrators have been free to devise techniques that limit their financial exposure to claims of coverage for costly benefits and services. These techniques show up in the standard design of health plan products sold to groups and individuals.

Insurers generally utilize two broad approaches to managing their financial risk, each of which encompasses several specific techniques.³⁷ The first approach relates to the initial design of their covered benefits and services. For example, a health benefit plan might contain outright coverage exclusions, such that coverage for a particular treatment or service is never available to a health plan member, regardless of the peculiar characteristics or needs of the individual seeking coverage. An example would be the total exclusion of speech therapy, or speech therapy whose defined purpose is to restore speech, which precludes its availability to persons who need therapy to develop speech or to maintain the ability to speak or avert the loss of speaking skills.³⁸ Another example would be use of a definition of "medical necessity" that limits the scope of what can be considered necessary, and therefore covered, to treatments and services that aid in recovery of lost functioning.³⁹

Benefit design techniques might also include financial strategies such as patient cost-sharing incentives that penalize the use of costly treatments; for example, very high cost-sharing for the use of expensive drugs that have no therapeutic equivalent regardless of the patient's underlying need for care. Similarly, insurers might employ physician incentive plans that encourage providers to avoid costly patients by rewarding physicians for limiting resource use, without adjusting for patient characteristics.⁴⁰ Broad design parameters of an insurance policy apply equally to all individuals enrolled in the plan⁴¹ and effectively amount to

37. See RAND E. ROSENBLATT, SYLVIA A. LAW & SARA ROSENBAUM, *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 139–42 (1997).

38. *Bedrick v. Travelers Ins. Co.*, 93 F.3d 149 (4th Cir. 1996).

39. Sara Rosenbaum & Paul Wise, *Crossing the Medicaid-Private Insurance Divide: The Case of EPSDT*, 26 *HEALTH AFF.* 382, 386 (2007).

40. See Bruce Landon et al., *Creating a Parsimonious Typology of Physician Financial Incentives*, 9 *HEALTH SERVICES & OUTCOMES RES. METHODOLOGY* 219 (2009) (demonstrating that one survey of the physicians shows a far greater likelihood that physicians will report incentives to decrease rather than increase use of resources (75% versus 25%)).

41. Decisions about how to initially design a health insurance policy are considered "macro" decisions, given their universal application to all members of a particular health plan.

fixed limitations and exclusions over the kind and amount of medical care for which the insurer will pay.⁴²

The second broad approach insurers use to limit their financial exposure to medical care claims is employed after a plan has been designed and sold to consumers, when insurers aim to manage how individual beneficiaries use the benefits the plan actually covers.⁴³ Examples of utilization management practices, as they are called, include insurers' decisions about whether to approve coverage at all given their interpretation of the terms of their plans; to approve partial coverage of a claim based on whether the proposed treatment is, in their view, appropriate; and to determine whether a proposed service is medically necessary.⁴⁴

1. Coverage Design Techniques

Outright Exclusions and Limitations: As noted above, the use of explicit exclusions and limitations—particularly for conditions or treatments that are costly and chronic—in the initial design of an insurance plan is one of the most obvious and most prevalent types of design strategies aimed at limiting insurers' financial risk. These exclusions and limitations take several forms, all of which have relevance in the context of disability discrimination. *Across-the-board* coverage exclusions and limitations are of course common, in which specific services or procedures go uncovered (or uncovered to a certain extent) in all cases. For example, a plan could exclude treatments for AIDS-related conditions altogether⁴⁵ or limit occupational therapy visits to no more than 30 annually. *Treatment- or procedure-based* limitations attach when, for example, otherwise-covered speech therapy might face exclusion when the purpose of the proposed treatment is to restore speech to previous levels, but when the health plan member seeking coverage was so young as to never have begun speaking in the first instance.⁴⁶ Finally, coverage exclusions and limitations may be *purpose-based*. Insurers utilize purpose-based limitations to shield themselves from financial responsibility in the case of treatments and services that happen to have value for the claimant—for

42. See *Kenseth v. Dean Health Plan, Inc.*, 610 F.3d 452 (7th Cir. 2010).

43. ROSENBLATT ET AL., *supra* note 37, at 140–41 (referring to these utilization management practices as “micro” techniques for their application to plan members on a case-by-case basis as individuals seek coverage for services specific to their needs and medical conditions).

44. *Id.*

45. *Doe v. Mut. of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999).

46. *Bedrick v. Travelers Ins. Co.*, 93 F.3d 149, 149 (4th Cir. 1996).

example, in an educational or social sphere—above and beyond pure clinical value.⁴⁷

Embedded Treatment Guidelines: Treatment guidelines (or clinical practice guidelines, practice parameters, clinical protocols, etc.) are systematic, sometimes evidence-based statements developed to assist clinical decision-making given a certain medical scenario or constellation of patient symptoms.⁴⁸ Insurers and health plans also use them, however, to inform coverage decision-making. In instances where plan creators do not incorporate the guidelines into the health plan terms at the moment of design, plan administrators use treatment guidelines merely to aid their decisions about whether to cover a proposed treatment, since the guidelines are not dispositive. Where plan creators *do* directly write treatment guidelines into a health plan's coverage provisions, the outcome is very different; because the guidelines in these circumstances become part of the actual terms of coverage, they have the effect of delineating the full scope of coverage, thus eliminating the possibility that an individual could receive coverage for a service that the treatment guidelines do not contemplate.⁴⁹

Benefit Definitions: Even assuming in theory that an insurer elected not to include any explicit exclusions in its health policies, plan benefits could still be severely limited through the use of restrictive definitions pertaining to covered benefit classes, services, and "medical necessity." For example, restricting the definition of speech therapy to "therapy needed to restore speech to prior levels" has the effect of excluding from coverage therapy that is potentially beneficial but nonetheless disallowed in the case of a patient for whom a prior level of speech cannot be fully restored, such as for a patient with muscular dystrophy seeking therapy to prevent further deterioration of his speech. Similarly, a plan's medical necessity definition can function in a variety of ways with the effect of limiting benefits and services for people with disabilities, including a construction that permits coverage only in the event that an impairment results from "illness, injury or disease."

47. This type of exclusion can be triggered, for example, in the case of a child with developmental disabilities who is receiving physical therapy that both has not just clinical value, but social value expected to result in overall improvement in the child's health and functioning. *See Mondry v. American Family Mut. Ins. Co.*, 557 F.3d 781 (7th Cir. 2009).

48. *See, e.g.,* INST. OF MED., CLINICAL PRACTICE GUIDELINES: DIRECTIONS FOR A NEW PROGRAM 38 (Marilyn J. Field & Kathleen N. Lohr eds., 1990).

49. *See Mondry*, 557 F.3d 781; *Jones v. Kodak Med. Assistance Plan*, 169 F.3d 1287 (10th Cir. 1999).

Cost-sharing: Cost-sharing—whether in the form of deductibles, copayments, or coinsurance—is another technique insurers use to limit their own financial exposure to claims of coverage and to shift the risk to policyholders. As with outright coverage exclusions, cost-sharing can apply across-the-board or only to specific conditions or treatments. Plans sometimes also “tier” their cost-sharing responsibilities as a way of driving patients to use certain providers that, in the view of the insurer, are more “efficient” in the provision of treatments and services.⁵⁰ The tiering amounts to the assigning of relatively higher or lower cost-sharing of one type or another to benefits and services, say, for example, to the selection of either generic or brand-name prescription drugs.⁵¹ Because cost-sharing must occur at the point of receiving a medical service or product, it has been shown to discourage low-income sick people from seeking care.⁵² In this way, cost-sharing may be a more effective technique than actuarial rating for discriminating against people in poor health.⁵³

Physician Network Size and Composition: Because the size and composition of both primary and specialty physician networks affect patient utilization of services, network size and composition affect an insurer’s financial risk. While insurers will sometimes exclude physicians altogether from networks as a way of steering patients away from their services, insurers and health plans more recently have sought blunter, more value-based approaches to incentivizing the use of higher quality physicians, including the utilization of provider tiers.⁵⁴ Network tiering subjects some physicians’ services to higher cost-sharing, with the lowest cost-sharing reserved for health professionals whose treatment outcomes the insurer views as reflecting both efficiency and high quality. Physician tiering, and the cost-sharing associated with it, may or may not account for those providers who treat patients with enhanced health needs.

Provider Payments: Finally, insurers also use various incentives to help manage provider use of resources,⁵⁵ and thus their own

50. A. Mark Fendrick et al., *Applying Value-Based Insurance Design to Low-Value Health Services*, 29 HEALTH AFF. 2017, 2017–21 (2010).

51. See, e.g., *Saltzman v. Independence Blue Cross*, 384 F. App’x 107, 109 (3d Cir. 2010).

52. Stone, *supra* note 26, at 655.

53. *Id.*

54. See Anne B. Claiborne et al., *Legal Impediments to Implementing Value-Based Purchasing in Healthcare*, 35 AM. J.L. & MED. 442, 481 (2009); Ellen Nakashima, *Doctors Rated But Can’t Get a Second Opinion; Inaccurate Data About Physicians’ Performance Can Harm Reputations*, WASH. POST, July 25, 2007, at A1.

55. See *Pegram v. Herdrich*, 530 U.S. 211, 219 (2000); *Shea v. Esensten*, 107 F.3d 625, 627 (8th Cir. 1997).

financial risk. Incentives include end-of-year bonuses, share-savings plans, and case management fees. Incentive arrangements may or may not take into account a provider's patient mix, including whether a provider has many patients with enhanced health needs.

2. Utilization Management Techniques

Prospective and Concurrent Review. The second broad approach insurers use to limit their financial exposure to medical care claims is the management of patients' utilization of services that the health plan covers, applying the terms and definitions embedded in the coverage documents to individual cases whose factual issues might place the patient either within or outside of coverage. Prospective and concurrent reviews are processes designed to control unnecessary utilization or overuse of covered services through, respectively, advance or simultaneous consideration of the medical necessity of a treatment or service. While prospective and concurrent review are more desirable than the traditional approach of retrospective review, in which review of the appropriateness of the procedure at issue occurs only after the service has been delivered, prospective and concurrent review may result in the advance rejection or termination of coverage and thus the loss of access to healthcare.⁵⁶

Care Coordination and Case Management. An insurer or health plan may also either offer or require case management for patients with particular conditions. In extreme cases, a care coordination or management program operates more like an embedded treatment guideline by restricting coverage to predetermined services, regardless of a patient's unique needs. When designed in this fashion, "coordination" or "management" of care is more like a coverage exclusion for a particular treatment or condition and less like a process for tailoring covered benefits to individual illness.⁵⁷

C. Pre-Affordable Care Act Law and the Content of Health Insurance

It is fair to say that pre-PPACA, neither state insurance laws, nor employee benefit law, nor civil rights laws reached practices

56. ROSENBLATT ET AL., *supra* note 37, at 214–15; *see also* Bedrick v. Travelers Ins. Co., 93 F.3d 149, 154 (4th Cir. 1996); Wickline v. State, 239 Cal. Rptr. 810, 820 (Cal. Ct. App. 1987).

57. *See* Glenn Mays et al., *Convergence and Dissonance: Evolution in Private-Sector Approaches to Disease Management and Care Coordination*, 26 HEALTH AFF. 1683, 1683–84 (2007).

aimed at discriminating against certain conditions. As noted, state benefit mandates addressed particular treatments, like a law mandating coverage of reconstructive surgery following a mastectomy, but mandates related to isolated treatments do not make for a broad prohibition against discrimination. Federal laws regulating employee health benefit plans similarly took an isolated, condition-specific approach to the problem of coverage discrimination, like required minimum hospital stays for new mothers, or mandated minimum mental illness coverage. The absence of a broad framework for averting coverage discrimination was a presence in coverage law despite the existence of federal civil rights laws specifically aimed at protecting persons with disabilities; most importantly is the Americans with Disabilities Act (ADA),⁵⁸ whose protections have been limited to protecting against discrimination in access to care itself or access to places in which insurance is sold.⁵⁹ The law's permissive approach to the regulation of insurance design and risk avoidance stems from the fundamentally voluntary nature of health insurance and the concomitant willingness of society to tolerate the types of risk shielding devices, noted above, by insurers faced with a market fraught with the potential for adverse selection and moral hazard.

1. Insurance Law and Employee Benefit Law

Because health insurance has not been a requirement, insurers have not been required to sell it. Furthermore, because the concept of affordability has not been a basic aspect of health care, insurers have been free to introduce coverage limits that greatly reduce the value of their products in the case of individuals with high health needs. Thus, when insurers or employers do elect to offer insurance products to individuals, groups, or

58. 42 U.S.C. §§ 12101–213 (2006).

59. *See, e.g.,* *Bragdon v. Abbott*, 524 U.S. 624, 654 (1998) (prohibiting a dentist from refusing to treat a qualified individual with a disability); *Doe v. Mut. of Omaha Ins. Co.*, 179 F.3d 557, 564 (7th Cir. 1999) (prohibiting insurers from refusing to sell policies to persons with HIV who are qualified persons with disabilities but not prohibiting an AIDS exclusion in the policy). In the case of race and sex, civil rights law produces a different outcome where discrimination in insurance design is concerned. Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e-2 (2006), prohibits intentional and unintentional disproportionate impact discrimination on the basis of race, sex, or national origin in employment and the conditions of employment (including fringe benefits, such as health insurance). Title VII has been interpreted as prohibiting the provision of lesser benefits based on race, greater financial charges based on sex for similar benefits, and lesser-value benefits based on sex. *See* Crossley, *supra* note 27.

employees, they are free to decide whether to offer a product and, if so, what its terms of design and administration will be.⁶⁰ State governments, which traditionally have regulated both insurance and insurance markets, tend to do little to decisively shape either one, out of concern that too much regulation will scare off new insurance carriers and/or drive away existing ones.⁶¹

This is not to say that states do not regulate health insurers. Since the earliest days of insurance, states have sought to protect insurance holders from plan insolvency and fraudulent behavior. Thus, for example, states impose licensure requirements, capitalization requirements, and requirements related to medical underwriting practices on insurers to protect plan solvency and ensure corporate financial stability.⁶² States also go to some lengths to regulate insurer conduct in relation to policyholders, prohibiting fraudulent and deceptive behaviors by registering and licensing insurance agents, outlawing unfair sales tactics, and requiring fairness in claims processing and review.

Furthermore, states do in fact regulate the content of insurance coverage, albeit in relatively narrow ways. Over the years states have mandated the inclusion of coverage for numerous distinct treatments and services, singling out specific conditions or services for required coverage. Typical examples include coverage of certain mental health treatments, prohibitions against same-day discharges of mothers and newborns, coverage of certain reproductive health items and services, and other treatments that either suffer from acute market failure or that wider society accepts as redeeming. However, for the most part, state law leaves enormous discretion to the insurance industry, including the discretion over plan design.

Federal laws, including both the Public Health Service Act⁶³ and the Employee Retirement Income Security Act (ERISA),⁶⁴ have been similarly circumspect when it comes to intervening in plan design. While ERISA establishes disclosure, information, and fiduciary obligations with respect to plan administration, its provisions related to the content of coverage are few. Congress has amended ERISA over time to address discrimination against certain types of patients and conditions, such as reconstructive

60. See *McGann v. H & H Music Co.*, 946 F.2d 401, 408 (5th Cir. 1991).

61. For a lengthy discussion of the rise and evolution of health insurance and its regulation, see ROSENBLATT ET AL., *supra* note 37, at 139–71.

62. *Id.* at 142–44.

63. Pub. L. No. 78-410, 58 Stat. 682 (codified as amended at 42 U.S.C. §§ 201–300jj).

64. Pub. L. No. 93-406, 88 Stat. 951 (codified as amended at 29 U.S.C. §§ 1001–1461).

treatment following breast cancer and disparities in the treatment of persons with mental illness and addiction disorders.⁶⁵ In the end, however, ERISA generally accords employers broad discretion in health benefit plan design.⁶⁶

2. Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1974 ("Section 504")⁶⁷ prohibits discrimination against "qualified handicapped persons"⁶⁸ on the basis of an individual's disability in any program or activity that receives federal financial assistance. Under Title VI of the 1964 Civil Rights Act,⁶⁹ which prohibits discrimination on the basis of race, color, or national origin by any entity receiving federal financial assistance, "contract[s] of insurance" have been exempt from the reach of the term "Federal financial assistance."⁷⁰ This means that in the absence of other laws extending the term to reach insurance and tax subsidies to support insurance, the provisions of Section 504 would not extend to the private market. However, cases involving the application of Section 504 to public health insurance underscore the limited reach of disability law to protect qualified persons with handicaps, at least where the content and administration of health insurance are concerned.

*Alexander v. Choate*⁷¹ involved a lawsuit by a class of Medicaid recipients with disabilities who challenged Tennessee's decision to reduce Medicaid-coverage for inpatient hospital care from twenty to fourteen days. Among other claims, beneficiaries alleged that the reduction violated Section 504 because its effect was to discriminate on the basis of disability, given the compara-

65. See Women's Health and Cancer Rights Act of 1998, Pub. L. 105-277, § 902(a), 112 Stat. 2681-436 (current version at 29 U.S.C. § 1185b (2006)); Mental Health Parity Act of 1996, Pub. L. 104-204, § 702(a), 110 Stat. 2944 (current version at 29 U.S.C. § 1185a (2006)).

66. See, e.g., *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983) ("ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits."); *McGann v. H & H Music Co.*, 946 F.2d 401, 408 (5th Cir. 1991) ("ERISA does not broadly prevent an employer from 'discriminating' in the creation, alteration or termination of employee benefits plans . . .").

67. 29 U.S.C. § 794 (2006).

68. *Id.* § 794(a). A qualified handicapped individual is defined as any individual who has "a physical or mental impairment that substantially limits one or more major life activities of such individual." 29 U.S.C. § 705(20)(B); 42 U.S.C. § 12102(2)(A).

69. Title VI of the Civil Rights Act of 1964, Pub. L. 88-352, § 601, 78 Stat. 252 (current version at 42 U.S.C. § 2000d (2006)).

70. 42 U.S.C. § 2000d-1.

71. 469 U.S. 287 (1985).

tively higher need for health care among the population.⁷² Ruling against the plaintiffs unanimously,⁷³ the Supreme Court determined that the Tennessee plan treated all populations equally and where the content of health insurance coverage is concerned, nothing in the Rehabilitation Act required that public programs modify their terms to expressly take into account the greater needs occasioned by disability.⁷⁴ The Court concluded that Section 504 requires equality of opportunity, but not fundamental alteration of benefits and services.⁷⁵

3. The Americans With Disabilities Act

Congress passed the ADA with the intention of providing a “clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.”⁷⁶ While Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability only in the case of federally assisted programs, the ADA extends the duty not to discriminate to all publicly funded programs,⁷⁷ public and private places of employment, and public accommodations, including health care.⁷⁸ Employee health benefits are considered an aspect of employment, and thus a court would consider discrimination on the basis of disability in the provision of health benefits equivalent to discrimination on the basis of employment. Similarly, the sale of health insurance is a private act that under the terms of the ADA conceivably operates as a public accommodation, thereby raising the potential for the ADA to reach private health insurance.

In addition to its general provisions, the ADA contains an insurance “safe harbor” that provides that the law:

72. *Id.* at 290.

73. *See id.* at 303–06.

74. *Compare id.*, with *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999) (issue was not the discriminatory effect of an across the board limit, but the state’s failure to extend benefits covered under the state plan—home and community based service slots approved by the federal government—to individuals with mental illness). In *Choate*, the issue was the non-discriminatory application of a benefit design to persons with disabilities; in *Olmstead*, the issue was discriminatory administration of the approved plan itself.

75. *See Choate*, 469 U.S. at 308.

76. 42 U.S.C. § 12101(b)(1) (2006).

77. *See id.* § 12132.

78. Unlike other civil rights statutes, the ADA classifies health care as a public accommodation. *See* Joel Teitelbaum & Sara Rosenbaum, *Medical Care as a Public Accommodation: Moving the Discussion to Race*, 29 AM. J.L. & MED. 381, 381–82 (2003).

shall not be construed to prohibit or restrict . . . an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law[,]”⁷⁹

provided that insurer actions are not intended as “a subterfuge to evade the purposes”⁸⁰ of the ADA. According to an interpretation of these provisions by the U.S. Equal Employment Opportunity Commission (EEOC), disability-based distinctions in coverage that result in unequal benefits violate the ADA, *unless* employers can prove that the coverage at issue is not meant as a subterfuge.⁸¹ Effectively, the EEOC interprets the safe harbor and subterfuge provisions as creating a safe harbor for insurance discrimination based on disability, as long as actuarial data supports the differential classifications.⁸²

Early case law interpreting the ADA’s public accommodations provision questioned whether the law reached the content of insurance and thus provided new protections for individuals with disabilities who routinely faced discrimination in a coverage context. In *Carparts Distribution Center, Inc. v. Automobile Wholesaler’s Association of New England, Inc.*,⁸³ an employee with an AIDS-related illness received notice from his employer that going forward, benefits for AIDS-related illnesses could not exceed \$25,000. The employee and his employer, Carparts Distribution Center, Inc., sued the insurer, claiming that the AIDS-related benefit cap was both a violation of the ADA’s Title I prohibition against discrimination on the basis of disability in employment, as well as unlawful discrimination by a public accommodation.

Reversing and remanding the case following a decision for the insurer, the First Circuit Court of Appeals rejected the notion that the term “public accommodation” requires a physical structure. The court then discussed the meaning of a public accommodation in an insurance context at some length:

As a matter of bare language, one could spend some time arguing about whether [Title III of the ADA, concerning public accommodations] . . . is intended merely to provide access to whatever product or service the subject entity may

79. 42 U.S.C. § 12201(c) (2006).

80. *Id.*

81. U.S. EQUAL EMPLOYMENT OPPORTUNITY COMM’N, EEOC COMPLIANCE MANUAL, CHAPTER 3: EMPLOYEE BENEFITS (2000), *available at* <http://www.eeoc.gov/policy/docs/benefits.html>.

82. *See* Crossley, *supra* note 27, at 93.

83. 37 F.3d 12 (1st Cir. 1994).

offer, or is intended in addition to shape and control which products and services may be offered [T]here is nothing in that history that explicitly precludes an extension of the statute to the substance of what is being offered The statute's treatment of insurance is a good example of these ambiguities. On the one hand, the ADA carves out a safe harbor of sorts for anyone who is "an insurer, hospital, or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations" One might initially suppose that this is because Title III would otherwise cover the substance of the insurance plans. However, there is some indication in the legislative history that the industry received this exemption not because its policies would otherwise be substantively regulated under Title III, but because "there is some uncertainty over the possible interpretations of the language contained in titles I, II and III as it applies to insurance" We think that at this stage it is unwise to go beyond the *possibility* that the plaintiff may be able to develop some kind of claim under Title III even though this may be a less promising vehicle in the present case than Title I [plaintiff's employment claim].⁸⁴

Other courts considering the question rejected the First Circuit notion regarding the potential reach of the ADA and ruled that the public accommodations provision does not reach the design of insurance products.⁸⁵ The leading case in this string of rejections to *Carparts* is *Doe v. Mutual of Omaha Insurance Com-*

84. *Id.* at 19–20 (emphasis in original); *see also* Henderson v. Bodine Aluminum, Inc., 70 F.3d 958, 960 (8th Cir. 1995) (insurer's denial of coverage for a particular treatment in the context of breast cancer, but not other types of cancer, would "arguably" violate the ADA's public accommodations provision).

85. *See* Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104, 1113 n.48 (9th Cir. 2000); McNeil v. Time Ins. Co., 205 F.3d 179, 186 (5th Cir. 2000); Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 559 (7th Cir. 1999); Rogers v. Dep't of Health & Envtl. Control, 174 F.3d 431, 433 (4th Cir. 1999); Lenox v. Healthwise of Ky., Ltd., 149 F.3d 453, 456 (6th Cir. 1998); Ford v. Schering-Plough Corp., 145 F.3d 601, 614 (3d Cir. 1998); Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1013 (6th Cir. 1997) (en banc); Vaughn v. Sullivan, 83 F.3d 907, 912 (7th Cir. 1996). At the same time, courts agree that the ADA's public accommodations statute prohibits disability discrimination in the context of gaining physical access to health care services. *See* Bragdon v. Abbott, 524 U.S. 624, 646 (1998); Abernathy v. Valley Med. Ctr., No. C06-001 MJP, 2006 WL 1515600 (W.D. Wash. May 25, 2006); Majocho v. Turner, 166 F. Supp. 2d 316, 325 (W.D. Pa. 2001); Woolfolk v. Duncan, 872 F. Supp. 1381, 1390 (E.D. Pa. 1995).

pany,⁸⁶ in which the plaintiffs, individuals with AIDS, had purchased health insurance from the defendant. Each of the health plans purchased by the plaintiffs contained an AIDS and AIDS-related condition lifetime cap ranging from \$25,000 to \$100,000, compared to the standard lifetime cap of \$1 million. The insurance company explicitly stipulated as part of the record that it had absolutely no actuarial basis for the cap.⁸⁷

In their suit, plaintiffs claimed that the ADA's public accommodations provision reached not just their right to buy an insurance policy, but also the content of the insurance itself. Plaintiffs premised their argument on the insurance "safe harbor" under the EEOC's interpretation, arguing that the safe harbor was evidence of clear intent on the part of Congress to reach the content of insurance in cases in which state or federal law precluded a justifiable benefit limit and existed merely as a subterfuge to evade ADA requirements.⁸⁸ Because the safe harbor effectively establishes a narrow exception for health insurance products that are based in principles of actuarial soundness, plaintiffs argued that the public accommodations statute could only be interpreted as reaching discriminatory content and design; otherwise the safe harbor exception would have no legal or practical function.

The Seventh Circuit Court of Appeals did not agree with the plaintiffs' arguments, viewing plaintiffs' claims as essentially a demand for the customization of a product to meet the particularized needs of persons with disabilities. According to the court, the ADA does not require this type of realignment of the design and structure of goods and services and "does not require a seller to alter his product in order to make it equally valuable to the disabled and to the nondisabled, even if the product is insurance."⁸⁹ As a result, coverage limits embedded in plan design and applicable to all purchasers would not violate the ADA's public accommodations statute.

The court further asserted that it could not read the insurance safe harbor provision as the plaintiffs proposed, citing the obscurity of the provision and the standard that such a reading would impose on courts, which would have to scrutinize virtually every coverage limitation permitted under law either for its actuarial soundness or its potential to operate as a subterfuge. The fact that Mutual of Omaha readily admitted that it had no basis

86. 179 F.3d at 557.

87. *Id.* at 558.

88. *Id.* at 562.

89. *Id.* at 563.

(other than, by implication at least, outright prejudice against persons with HIV/AIDS) for its coverage limitations made no difference. Nor did it matter to the court that the very purpose of the ADA was to assure that covered entities would make reasonable accommodations in the case of qualified persons with disabilities and that by its very admission, the insurer had made none.

In sum, Section 504 and the ADA prohibit insurers from refusing to sell products to, or barring enrollment of, individuals with disabilities. However, neither law prohibits insurance content design that unfairly discriminates⁹⁰ against persons with disabilities by unreasonably limiting the value of coverage in relation to health care needs.⁹¹ Coverage limitations (or exclusions) applied uniformly to all participants in the insurance product are acceptable under Section 504 and the ADA, regardless of whether those limitations arbitrarily single out individuals and conditions for differential treatment.

4. Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA)⁹² represented an important step by federal lawmakers to address the problem of insurer discrimination against persons with disabilities. Indeed, HIPAA protections apply to “[h]ealth status,”⁹³ rather than “disabilities,” meaning the law’s reach is potentially broader than that found in the ADA, the protections

90. Health insurance has long recognized the concept of fair discrimination, that is, the adjustment of price in relation to health need. This concept might justify higher premiums; it does not justify coverage limits that unreasonably constrain the level of benefits that are available in the face of need. *See* RAND E. ROSENBLATT, SYLVIA A. LAW & SARA ROSENBAUM, LAW AND THE AMERICAN HEALTH CARE SYSTEM 169 (Supp. 2001).

91. The court might have concluded that the ADA prohibited unreasonable limits but not adjustments in pricing (*i.e.*, a higher premium rate) to accommodate higher health risk policyholders in the individual market. The Health Insurance Portability and Accountability Act did not address rating in the individual or group markets. The PPACA prohibits both annual and lifetime caps on covered benefits, *see* PPACA, Pub. L. No. 111-148, § 1001, 124 Stat. 119, 130–38 (2010) (amending the Public Health Service Act), and requires the use of modified community rating for health insurance products sold in both the individual and group markets, permitting variations based only on age, family status, and use of tobacco. *See id.* § 1201, 124 Stat. at 154–61 (same). This fact would seem to underscore the fundamental purpose of health insurance, namely, to protect against health risks among the covered population without the use of unreasonable limitations designed to reduce the value of coverage in ways that unfairly and unreasonably discriminate against the sick.

92. Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in various sections of 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

93. 29 U.S.C. § 1182(a)(1)(A) (2006); 42 U.S.C. § 300gg-1(a)(1)(A) (2006).

of which are contingent on being a qualified individual with a disability.⁹⁴ However, as with both Section 504 and the ADA, HIPAA's application extends only to the threshold question of eligibility for coverage, not to the post-eligibility questions of coverage content or plan administration.

The central aim of HIPAA was to eliminate considerations of individual health status from decisions concerning the eligibility and group-specific coverage costs in the group health insurance market.⁹⁵ The law made virtually no changes in the inherently discriminatory nature of individual coverage products, where medical underwriting has been the historic norm in determining both eligibility and coverage rates charged to specific policyholders.⁹⁶ HIPAA specifically prohibited insurers and employer-sponsored group health plans from considering health status, mental or physical health conditions, claims experience, the prior receipt of care, medical history, genetic information, evidence of insurability, and disability in making eligibility and premium decisions in the group market.⁹⁷ Furthermore, its prohibitions attached to the initial and renewal enrollment periods, waiting periods, late and special enrollment rules, eligibility for benefit packages, benefits (both cost sharing and benefit restrictions), continued eligibility, and coverage termination.⁹⁸ Despite the reforms HIPAA brought about, the law generally still did not reach insurance coverage design or plan administration techniques that reduced the value of coverage for certain individuals. Indeed, the reforms in eligibility and pricing embodied in HIPAA conceivably may have contributed to tighter coverage limits; in a voluntary market, as eligibility and pricing barriers are scaled back, a natural retaliatory strategy would be to lessen the value of the product, either for the group as a whole or for selected members and conditions within the group.

94. We note, however, that HIPAA protections only apply to individuals with prior insurance coverage, so individuals without coverage (or with a lapse of coverage of more than six months) can still be denied access to the insurance in the first instance.

95. Greta E. Cowart, *HIPAA Nondiscrimination and Portability Update*, in 33RD ANNUAL ALL-ABA ADVANCED COURSE REPRESENTING THE PROFESSIONAL AND CLOSELY HELD BUSINESS 1, 15–16 (2004).

96. KAREN POLLITZ, RICHARD SORIAN & KATHY THOMAS, THE HENRY J. KAISER FAMILY FOUND., *HOW ACCESSIBLE IS INDIVIDUAL HEALTH INSURANCE FOR CONSUMERS IN LESS-THAN-PERFECT HEALTH?* 20–26 (2001), <http://www.kff.org/insurance/upload/How-Accessible-is-Individual-Health-Insurance-for-Consumer-in-Less-Than-Perfect-Health-Report.pdf>.

97. See 29 U.S.C. § 1182(a) (2006); 42 U.S.C. § 300gg-1(a) (2006).

98. 29 C.F.R. § 2590.702(b)(1)(ii) (2004); 45 C.F.R. § 146.121(b)(1)(ii) (2010).

5. Mental Health Parity Laws

The Mental Health Parity Act of 1996,⁹⁹ revised and expanded by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008,¹⁰⁰ represents the most significant law enacted prior to the PPACA that directly addresses discrimination in the content and administration of state-regulated health insurance and employer-sponsored health benefit plans. While the law is important for this reason, it reaches only mental illness and addiction disorder conditions to the extent that a plan in fact covers them.

The original 1996 law addressed parity only as the concept related to both annual and lifetime financial limits on coverage, prohibiting such limits in the context of mental illness if not applied to other illnesses and conditions. The 2008 amendments significantly extended the concept of parity to reach beyond the tip of the iceberg and delve down into the types of limitations, exclusions, and plan administration techniques that can diminish the value and scope of coverage for particular conditions. Interim final regulations implementing parity, promulgated in 2009,¹⁰¹ adopted an aggressive interpretation of the amendments, barring the use of both “qualitative” and “quantitative” limitations on coverage, including both differentials in the amount of coverage as well as differential approaches to considering the medical necessity of coverage. For example, the regulations clarified that the amendments barred the use of fixed clinical treatment guidelines that limit coverage for mental illnesses and addiction disorders to certain covered treatments irrespective of medical evidence, unless a similar approach was taken to the treatment of physical conditions.¹⁰² The interim final rule also barred the use of medical necessity terms and definitions that were more restrictive in the case of mental illness and addiction disorders.¹⁰³

A breakthrough in federal regulation of health plan content, and applicable to both the fully insured and self-insured group markets, the 2008 parity amendments nonetheless con-

99. Pub. L. No. 104-204, § 701–03, 110 Stat. 2944, 2944–50 (codified as amended at various sections of 29 U.S.C. and 42 U.S.C.).

100. Pub. L. 110-343, §§ 511–12, 122 Stat. 3765, 3881–93 (2008) (codified as amended at 26 U.S.C. § 9812, 29 U.S.C. § 1185a, and 42 U.S.C. § 300gg-5).

101. Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410 (Feb. 2, 2010) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pt. 146).

102. 29 C.F.R. § 2590.712(b)(4) (2010).

103. 45 C.F.R. § 146.136(b)(4) (2010).

strain themselves to mental illness and addiction disorders and then, of course, only if a plan covers the conditions at all. Nothing in the parity statute compelled such coverage; furthermore, the parity amendments did not affect the individual insurance market.

III. THE PPACA'S ESSENTIAL BENEFITS STATUTE

A. *Overview of the Affordable Care Act*

To understand the provisions of the essential benefits statute, it is helpful to review the broad outlines of the PPACA, as they relate to coverage and the content of coverage. Drawing on a range of ideas, including Republican proposals to create a subsidized competitive health insurance market, the PPACA at its core is a series of reforms aimed at shoring up the multi-payer approach to coverage in the U.S. while making coverage available and affordable to most Americans. The *quid pro quo* for this effort to restructure health insurance to make it accessible and more comprehensive is what is commonly referred to as the PPACA's "insurance mandate," which in reality is the imposition of a tax penalty on individuals who are considered to have access to affordable coverage as defined under the Act¹⁰⁴ but who do not obtain it.¹⁰⁵

The PPACA utilizes an expanded Medicaid program to cover the poorest Americans.¹⁰⁶ Citizens and persons legally present in the U.S.¹⁰⁷ and considered to be without access to afford-

104. PPACA, Pub. L. No. 111-148 § 1501, 124 Stat. 119, 242-52 (2010).

105. See *Thomas More Law Center v. Obama*, 720 F. Supp. 2d 882 (E.D. Mich. 2010), for defendants' response to plaintiffs' motion for preliminary injunction and brief in support.

106. See *When 133 Equals 138: FPL Calculations in the Affordable Care Act*, STATE HEALTH ACCESS DATA ASSISTANCE CTR. (Jan. 13, 2011), <http://www.shadac.org/blog/when-133-equals-138-fpl-calculations-in-affordable-care-act>. PPACA § 2001 requires states to cover individuals not otherwise eligible for Medicaid with incomes up to 133% of the Federal Poverty Level. *Id.* However, under § 2002(I), beginning January 1, 2014, states will be required to use a new method for determining income eligibility. The new method, termed "modified adjusted gross income," is determined by calculating the "dollar equivalent of the difference between the upper income limit on eligibility for such an individual (expressed as a percentage of the poverty line) and such upper income limit increased by five percentage points; and . . . utilize as the applicable income of such individual in determining income eligibility . . ." PPACA § 2002(a)(14)(I)(i), 124 Stat. at 279-82. According to the State Health Access Data Assistance Center, the language will result in an "income disregard," resulting in states being required to cover individuals with incomes up to 138% of FPL. *When 133 Equals 138*, *supra* note 106.

107. See PPACA § 1312(f)(3), 124 Stat. at 184.

able employer-sponsored coverage¹⁰⁸ would have access to an organized individual insurance market through state entities known as health insurance exchanges.¹⁰⁹ Individuals deemed qualified to purchase coverage through exchanges would, depending on family income, be entitled to advance premium tax credits whose purpose is to bring the cost of coverage within the range considered affordable under the Act.¹¹⁰ Small employers¹¹¹ would also be able to purchase coverage through state exchanges and be entitled to tax subsidies. Large employers¹¹² offering no coverage, or unaffordable coverage, would pay a fee toward the exchange subsidy system.¹¹³ Although Congress and the Obama Administration envision that all states will operate health insurance exchanges,¹¹⁴ the PPACA also empowers the Secretary of the U.S. Department of Health and Human Services (HHS) to establish and operate an exchange in states that elect not to operate their own exchanges.¹¹⁵

Beyond the threshold restructuring of the insurance market to make it accessible, the PPACA also reaches into the content and fairness of health insurance coverage and employee health benefits in a number of respects. With certain limited exceptions, the reforms will take effect in January 2014 when the obligation to purchase affordable coverage commences.¹¹⁶

108. *Id.* § 1401(a), 124 Stat. at 213–19.

109. *Id.* § 1311(b), 124 Stat. at 173–74.

110. *Id.* § 1312(f)(2)(B), 124 Stat. at 184. Individuals not eligible for Medicaid and those without affordable employer-sponsored coverage are eligible for income-related premium subsidies. The subsidies are fully phased-out for individuals with incomes above 400% of the federal poverty level. *Id.* § 1401(a), 124 Stat. at 213–19.

111. Small employers eligible to purchase the exchange are defined as those with 100 or fewer employees. Beginning January 1, 2016, states have the option of lowering the threshold for employers that may purchase through an exchange from those with fifty or fewer employees. *Id.* § 1304(b)(3), 124 Stat. at 172. In addition, beginning in 2017, states may permit large employers to purchase coverage through an exchange. *Id.* § 1312(f)(2)(B)(i), 124 Stat. at 184.

112. *Id.* § 1301(b)(1), 124 Stat. at 163.

113. *Id.* § 1513, 124 Stat. at 253–56.

114. *See* Press Release, U.S. Dep't of Health & Human Servs., HHS Announces New Resources to Help States Implement Affordable Care Act (Jan. 20, 2011), available at <http://www.hhs.gov/news/press/2011pres/01/20110120b.html>. On January 20, 2011, Secretary Sebelius announced a second round of planning grants made available to states to assist in the establishment of state-level exchanges. According to the Secretary, "States are moving forward, implementing the Affordable Care Act and making reform a reality." *Id.*

115. PPACA § 1321(c), 124 Stat. at 186–87.

116. *Id.* § 1253, 124 Stat. at 162. To achieve that balance in insurance market reforms, the PPACA seeks to minimize disruption in existing insurance

The insurance reform provisions of the PPACA build on HIPAA, extending its reach and applying the reforms to the individual market. The law bars all insurers and group health plans from denying coverage to all individuals based on health status, thereby extending the reach of HIPAA's non-discrimination provisions, which previously had applied only to those with prior group coverage.¹¹⁷ The PPACA bars rescissions (post-enrollment insurance cancellations) in the absence of evidence of fraud or misrepresentation on the part of the insured,¹¹⁸ while guaranteeing both issuance of policies and their renewal.¹¹⁹ The PPACA also requires coverage of certain preventive services without cost-sharing¹²⁰ and bars annual and lifetime limits.¹²¹ In the case of insurance products, it requires the use of modified community rating, with rating differentials limited to age, family status, and tobacco use. The PPACA dictates that medical loss ratios, or the proportion of premium dollars that an insurer spends on health care services and certain recognized plan administration costs relative to health insurance premiums paid by subscribers, be established in order to assure minimum standards for medical expenditures in both the individual and group insurance markets.¹²²

All of these changes go to the issue of *access* to insurance for persons with health conditions that previously would have been barred coverage entirely or would have obtained coverage only at an unaffordable cost. The reforms are possible because of the

markets by incorporating a transition period and by providing "grandfather" status for plans in existence prior to the March 23, 2010, date of enactment. While some insurance market reforms became effective in plan years beginning after October 1, 2010, it is not until plan years beginning on or after January 1, 2014, that plans will be required to comply with the most sweeping federal minimum insurance market standards. "Grandfathered" plans are not required to meet many of the new standards unless the plan changes significantly, triggering a loss of grandfather status. Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,598 (June 17, 2010). *See also* Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 70,114 (Nov. 17, 2010).

117. PPACA §§ 1201–1304. 124 Stat. at 154–72.

118. *Id.* § 1001, 124 Stat. at 130–38 (amending Public Health Service Act, 42 U.S.C. § 2712 (2006)).

119. *Id.* § 2703, 124 Stat. at 319–23.

120. *Id.* § 1001, 124 Stat. at 131–32.

121. *Id.*, 124 Stat. at 131.

122. *Id.*, 124 Stat. at 136–37. Medical loss ratio requirements do not apply to self-funded plans regulated under ERISA.

assumption that the tax penalty applicable to individuals who do not buy affordable coverage will create the type of health insurance risk pool essential to curbing discrimination against the sick.

The PPACA also deals directly with the question of the scope and depth of coverage by setting federal standards for all products sold in the individual and small group markets, whether as qualified health plans certified to be sold in health insurance exchanges, and thus eligible to receive advance premium tax credits, or in states' remaining non-exchange individual and group health markets. Put another way, the PPACA permits states to continue operating non-exchange individual and group health insurance markets. At the same time, the law sets minimum content standards for products sold to individuals and small groups, defined for purposes of the content standard as 100 full-time employees or fewer,¹²³ regardless of whether the point of sale is an exchange or a state's remaining non-exchange market. These minimum content requirements are set forth under the law's "essential health benefits" statute.¹²⁴

The history of enactment of the PPACA is the stuff of legend. A measure rammed through by a determined majority over the aggressive objections of a minority,¹²⁵ the PPACA that became law is, word for word, the measure passed in the Senate on December 24, 2009,¹²⁶ with the exception of a handful of amendments that followed initial passage.¹²⁷ In March 2010, to

123. *Id.* § 1304, 124 Stat. at 171–72.

124. *Id.* § 1302, 124 Stat. at 163–68.

125. This was not the first time such a thing happened, of course; one need look no further than the Medicare Prescription Drug Improvement and Modernization Act of 2003 to find a similar story. See Sara Rosenbaum, *Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System*, 7 SUFFOLK J. HEALTH & BIOMEDICAL L. (forthcoming Winter 2011).

126. H.R. 3590, 111th Cong. (2009).

127. See, e.g., Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). This Act changed the structure of the premium and cost-sharing subsidies to make them more generous for the lowest-income individuals; decreased the penalty for failure to purchase health insurance coverage; decreased the employer penalty for failing to provide health insurance coverage; lowered and delayed implementation of a tax on "high-cost" insurance plans; increased federal payments to states under Medicaid to help offset the cost of expansions; accelerated the rate at which the Medicare Part D "donut hole" is closed in order to lower seniors' out-of-pocket expenses for prescription drugs; extended certain insurance market reforms including prohibitions on rescissions and lifetime caps on coverage to all insurance plans, including grandfathered plans; and increased the general excise tax on health insurance plans to offset the costs of changes. Finally, the law eliminated certain special provisions that benefited Nebraska and other states.

stave off defeat of passage, the House of Representatives accepted the Senate bill in its entirety.¹²⁸ Doing so avoided having to complete what had by then become a futile conference agreement with the Senate, whose composition by January 2010 had fallen below filibuster-proof levels with the election of Republican Senator Scott Brown of Massachusetts.

For a law whose provisions are highly complex and whose enactment was undoubtedly one of the hardest fought in U.S. history, the PPACA is remarkably short on legislative history. The essential benefits statute originated in a measure reported by the Senate Health, Education, Labor, & Pensions (HELP) Committee; The Senate Majority Leader subsequently joined the measure¹²⁹ with a separate measure from the Senate Finance Committee, the second of the two principal Senate health policymaking committees.¹³⁰ As passed on the Senate floor (with no floor discussion of the provision) and as finally enacted into law, the essential benefits statute retains a good portion of the committee provisions that preceded it while nonetheless modifying those provisions in key ways.

In defining “essential health benefits,” the statute sets forth a series of broad benefit classes¹³¹ that the Secretary of HHS must include in the definition. The Secretary can define the scope of essential health benefits more broadly but must include “at least” the following groups of benefits as well as the “items and services”¹³² falling within these benefit classes: “ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.”¹³³ The statute leaves the terms undefined and gives the Secretary discretion to define them. At least one prominent health insurance industry expert has noted that the list includes at least one benefit class not found in the large group market, which tends to provide benefits that are more generous than those found in the individual and small group markets.¹³⁴

128. S. 1796, 111th Cong. (2009).

129. H.R. 3590, 111th Cong. (2009).

130. America’s Healthy Future Act of 2009, S. REP. NO. 111-89 (2009).

131. PPACA, Pub. L. No. 111-148, § 1302, 124 Stat. 119, 163–68 (2010).

132. *Id.*

133. *Id.* § 1302(b)(1), 124 Stat. at 163–64.

134. Jeffrey Kang, Chief Med. Officer, CIGNA Corp., Statement to the Committee on Determination of Essential Health Benefits at the Institute of

Although the HHS Secretary thus has broad discretion to define the scope of essential benefits, the PPACA places important limits on the Secretary's authority. The first is an admonition tying the scope of coverage to that found in "typical" employer-sponsored plans¹³⁵ although, as noted, industry experts report that in scope the essential health benefit classes reach beyond typical plans. In achieving this result, the Secretary must consult with the Secretary of the U.S. Department of Labor (DOL), who will conduct a congressionally mandated survey of employer plans designed to inform that decision.¹³⁶

Most importantly for purposes of this Article, the PPACA places further limits on her discretion by specifying a series of "elements for consideration" that the Secretary must address in defining essential benefits.¹³⁷ First, the Secretary must ensure that the benefits "reflect an appropriate balance," among the essential health benefit classes.¹³⁸ Second, the Secretary may not "*make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability or expected length of life.*"¹³⁹ Third, the Secretary must "take into account the health care needs of diverse segments of the population including women, children, persons with disabilities, and other groups."¹⁴⁰ Fourth, the Secretary must ensure that health benefits are not subject to denial on the basis of individuals' "age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life."¹⁴¹

Finally, the PPACA includes language limiting the Secretary's discretion with respect to utilization management, which the statute does not define. Specifically, the law states that

[n]otwithstanding any other provision of [this] . . . Act, nothing in such Act . . . shall be construed to prohibit (or authorize the Secretary of Health and Human Services to promulgate regulations that prohibit) a group health plan or health insurance issuer from carrying out utilization

Medicine (Jan. 13, 2011), available at <http://www.iom.edu/~media/Files/Activity%20Files/HealthServices/EssentialHealthBenefits/2011-JAN-12/Kang-Statement.pdf>. Dr. Kang noted in his testimony that habilitation services are rarely covered as a benefit in the group market.

135. PPACA § 1302(b)(2)(A), 124 Stat. at 164.

136. *Id.*

137. *Id.* § 1302(b)(4), 124 Stat. at 164–65.

138. *Id.* § 1302(b)(4)(A), 124 Stat. at 164.

139. *Id.* § 1302(b)(4)(B), 124 Stat. at 164 (emphasis added).

140. *Id.* § 1302(b)(4)(C), 124 Stat. at 164.

141. *Id.* § 1302(b)(4)(D), 124 Stat. at 164.

management techniques that are commonly used as of the date of enactment of this Act.¹⁴²

B. *Application of the Essential Benefits Statute to Persons with Disabilities*

It is important to note that under the terms of the essential health benefits statute, the actual extent of coverage will vary depending on the level of premium paid (the statute envisions four levels of premium/cost sharing combinations).¹⁴³ Furthermore, the statute permits exceptions to essential benefit requirements in the case of products sold to very young adults.¹⁴⁴ At the same time, the essential benefit statute applies to all products and all coverage levels in the affected markets, regardless of whether the products are available through state exchanges.

As noted, the essential benefit statute offers little in the way of legislative history. During testimony in January 2011 before the Institute of Medicine (IOM), which HHS charged with assisting in defining the term “essential health benefits,”¹⁴⁵ Senate committee staff noted that legislative history was lacking but were able to provide some insight into congressional intent underlying the statute.¹⁴⁶ Staff offered differing views of the breadth of coverage the provision intended and the extent to which the Secretary should delegate decisions to health insurance plans, as opposed to including them in regulation or other agency guidance.¹⁴⁷ One area of agreement among the witnesses, however, was that Congress intentionally drafted the law broadly in order to vest the Secretary with considerable discretion in order to avoid the political controversy associated with clearly defining benefits in the statute.¹⁴⁸

142. *Id.* § 1562(d)(1), 124 Stat. at 269.

143. *Id.* §§ 1302(a)(3), 1563, 124 Stat. at 163, 270–71.

144. *Id.* § 1302(e), 124 Stat. at 168. Congress included a lower-cost insurance policy that covers essential benefits that would be made available to individuals under the age of thirty and those that are certified as exempt from the individual requirement because coverage is unaffordable. *See* America's Healthy Future Act of 2009, S. REP. NO. 111-89, at 33 (2009).

145. For information about the joint HHS-IOM effort, see *Project: Defining and Revising an Essential Health Benefits Package for Qualified Health Plans*, THE NAT'L ACADS., <http://www8.nationalacademies.org/cp/projectview.aspx?key=49299> (last visited June 13, 2011).

146. *See* Audio tape: Essential Health Benefits Workshop, held by the Institute of Medicine (Jan. 13, 2011), available at http://www.nap.edu/webcast/webcast_detail.php?webcast_id=430.

147. *Id.*

148. *Id.*

At the same time, the statute offers the Secretary virtually no guidance on how to “take into consideration” matters such as plan design, coverage limits, and plan administration matters in determining the permissible level of discretion on the part of insurers whose products are subject to the statute. The statute does not define terms such as “discriminate” and “disability.”¹⁴⁹ Nor does the law define the concept of a “utilization management” technique, “typical” employee coverage, “on the basis of,” or other key terms that appear in the statute and that the Secretary must consider when setting the parameters of the essential health benefit package.

Given the scope of the statute in the context of disability discrimination, existing health insurance practices, and the overall structure and design of the PPACA, the question becomes how might the Secretary approach the “considerations” that she must weigh in promulgating standards. Perhaps the starting point is the paradoxical statutory juxtaposition of the concept of a “typical” employer plan and the considerations the statute requires the Secretary to take into account in defining essential health benefits. On the one hand, “typical”¹⁵⁰ plans are the legal opening salvo. But the Secretary should weigh the results of the DOL survey against the requirement that she “not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their . . . disability”¹⁵¹ By its terms, therefore, the law appears to envision that the Secretary will begin with a typical plan—typical in the entire employer market? the small group market?—and will then adjust coverage terms in a manner that reflects the command of the statute.

The second question relates to the meaning of terms. Will the Secretary adopt the ADA definition of “disability”?¹⁵² Moreover, will the prohibition against discrimination apply to all per-

149. According to former Senate Finance Committee staff, the language was included in the Senate version of the PPACA during the merger of provisions from the Senate Finance and Health, Education, Labor & Pensions Committees. This language was offered as amendment number 285 in the Senate HELP Committee markup by Senator Mike Enzi (R-Wyo.) and was accepted by the majority with no debate. The amendment was praised as an anti-rationing amendment in a press release issued by the National Right to Life Committee. See *The HELP Bill*, NAT’L RIGHT TO LIFE COMM., <http://www.nrlc.org/Health-CareRationing/HELPbill.html> (last visited June 13, 2011).

150. PPACA, Pub. L. No. 111-148, § 1302(b)(2)(A), 124 Stat. 119, 164 (2010).

151. *Id.* § 1302(b)(4)(B), 124 Stat. at 164.

152. 42 U.S.C. § 12102(1) (2006). The ADA defines the term “disability” as “a physical or mental impairment that substantially limits one or more major

sons with disabilities or only those who are considered “qualified persons” with disabilities, which in the context of the ADA presumably could encompass qualified persons protected under Titles I (employer coverage), II (public programs),¹⁵³ and III.¹⁵⁴ The PPACA’s civil rights statute is oddly silent on the applicability of the ADA, even as it mentions Section 504. Nothing in the PPACA suggests that the law is exempt from previous rulings regarding the reach of the ADA into employee health benefits and insurance as a form of public accommodation.¹⁵⁵

The key question focuses on the meaning of “discriminate.” As noted, the “typical” employer product discriminates against persons with disabilities in the sense that products typically use benefit design, payment, and plan administration techniques that reduce the value of the product for specific conditions or populations. For example, as noted, insurers may cap coverage for HIV/AIDS. Insurers may also define specific service classes to exclude their reach in the case of children with developmental disabilities (for whom covered medical benefits are developmental rather than restorative), and adults with conditions such as multiple sclerosis or other disabling conditions from which they will never recover. Medical necessity definitions may hinge on a finding of restoration or improvement. Embedded treatment guidelines may be appropriate for individuals with no underlying disability while unfairly restrictive in cases in which a condition is

life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.” *Id.*

153. PPACA § 1311, 124 Stat. at 173–81. A related question is whether coverage purchased through an exchange is considered a public program. One could argue that it is, since exchanges operate under the authority of public law, even though their products are private health insurance products. In this regard, the civil rights provision of the Act appears to classify tax subsidies as federal financial assistance for purposes of applying Section 504 of the Rehabilitation Act. *See id.* § 1557, 124 Stat. at 260. The statute is inconclusive as to whether exchanges themselves are considered a public program for purposes of the ADA, although in their establishment, exchanges receive federal grants and are operated as programs with public accountability under state and federal law.

154. As noted above, the insurance cases under the ADA classify insurance as a public accommodation, at least insofar as the sale of insurance products is concerned.

155. In cases in which two federal statutes are silent as to their relationship, a court must read them with an eye toward preserving each. Only if statutes are irreconcilably conflicting, or if the later law covers the whole subject of the first and is clearly intended to be a substitute, will courts apply the rule that the later of the two prevails. *See* YULE KIM, CONG. RESEARCH SERV., STATUTORY INTERPRETATION: GENERAL PRINCIPLES AND RECENT TRENDS 26–27 (2008) <http://www.fas.org/sgp/crs/misc/97-589.pdf> (citing *Watt v. Alaska*, 451 U.S. 439, 453 (1981); *Posadas v. Nat’l City Bank*, 296 U.S. 497, 503 (1936)).

compounded by a disability that necessitates more intensive or additional treatment to make an intervention effective. For example, a woman with breast cancer who also has an underlying heart condition may require greater or different treatments from the types of cancer treatments that otherwise applicable practice guidelines would normally cover.

Given other provisions of the PPACA, such as the elimination of annual and lifetime caps, the prohibition against discrimination based on condition or health status, and the use of modified community rating, it is arguable that the prohibition against discrimination based on disability would require insurers to employ only “soft” coverage limits that permit adjustments based on the presence of a disability. That is, the statutory consideration that the Secretary must give to disability discrimination arguably might bar the use of hard stops on covered treatments that by their very nature are arbitrary and unrelated to the presence of a disability. Such hard stops might find expression in fixed coverage limits, the use of fixed treatment guidelines, or the use of benefit and coverage definitions that exclude based on the presence of a disability that will endure even if a treatment may avert further decline, improve function, or enable an individual to participate in activities of daily living. This is not to say that insurers would have to cover benefit classes not encompassed in the definition of an essential health benefit. For example, the definition does not cover personal care services, a major service for persons with disabilities (although, conceivably, personal care might be classified as a form of habilitation or a rehabilitation treatment). In effect, in order to avert discrimination on the basis of disability, the regulations arguably would require insurers to provide an exceptions process under which an individual with a disability could demonstrate the need for a disability-based adjustment to a normative treatment limit in order to avert discrimination. Such a process presumably would be fact-based and subject to the appeals protections available to all claims involving all covered persons under the PPACA.¹⁵⁶

Furthermore, the requirement that the “typical” plan be adjusted to bar discrimination would seem to prohibit the use of coverage limits tied to “restoration” or “recovery.” That is to say that the essential benefits statute, by its very terms, precludes insurers’ use of limiting terms that exclude persons with disabilities from coverage by effectively requiring that an individual

156. PPACA § 1001, 124 Stat. at 130–38 (amending Public Health Service Act, 42 U.S.C. § 2719 (2006)).

somehow has been “normal” to begin with, so that treatments are in effect a restoration of “normalcy.” Speech therapy or surgery on a cleft palate for a child whose disability precludes speech is not restorative; it is instead a medical intervention that enables speech initially. Similarly, the purpose of physical therapy for an adult with multiple sclerosis is not to restore normal functioning or to enable recovery; its purpose instead is to avert further decline and maintain functioning. Nothing about these purposes makes the intervention any less medical; the nature of the intervention turns on the individual furnishing the service, such as a licensed or certified health professional, and whether health professionals classify the treatment as medical when such a professional performs it.

Beyond benefit design, the statute requires that the Secretary consider the discriminatory potential of coverage determinations. Two types of coverage determinations (the term is not defined) are potentially on the table: whether a particular treatment or procedure will merit coverage for any plan member (*e.g.*, whether to place a particular treatment within the scope of coverage); and whether an individual receives coverage for a particular service based on the facts of a case. Nothing in the law suggests that Congress intended to exclude either type of coverage determination. Regarding the first type of determinations, or “macro” decisions, the determination would appear to require that disability specifically considered. For example, cosmetic services or educational services would presumably be excluded for all persons. But what is cosmetic for an individual without a disability (*i.e.*, someone who wants a prettier nose), might not be cosmetic in the case of an individual whose dento-facial deformity amounts to a disability. As with benefit design limits that attempt to utilize hard stops, the same might be said about macro exclusions; that is, an exclusion would be permissible unless an exception were necessary to adjust the coverage determination to account for the presence of a disability. Similarly, an educational exclusion could assure that insurance does not treat the educational services of licensed teachers as medical care. But where the intervention is cognitive development furnished by a therapist as a habilitation service to a child with a disability and pursuant to an individualized education plan under the Individuals with Disabilities Education Act (IDEA),¹⁵⁷ the service arguably would cease to be educational, since it is a covered benefit furnished by a licensed health professional, although potentially in an educational setting (*i.e.*, in an elementary school during

157. 20 U.S.C. § 1414(d) (2006).

school hours). Indeed, to allow an educational setting to trump habilitation coverage runs the risk of excluding many of the most important types of health care interventions furnished to children with physical and mental disabilities resulting in developmental delays, the effects of which health interventions can ameliorate. To be sure, insurers would retain the ability to place training, network membership, and other reasonable limitations on who may provide the service; but a total exclusion of a service simply through the use of an “education” label would appear to be precisely the type of exclusion that historically has reduced the value of coverage for persons with disabilities in an arbitrary fashion.

Similarly, the Secretary would need to consider incentive plans. A possible approach would be to bar the use of plans that incentivize only the reduction of resource use and that fail to adjust for the underlying health status of a provider’s patients. Thus, network exclusion or penalties (in the form of not being classified as a “preferred” provider with lower cost-sharing) that do not adjust for the presence of disability among a provider’s population arguably would constitute discrimination against persons with disabilities, because the presence of patients with disabilities simply is not taken into account when designing provider compensation arrangements.

IV. CONCLUSION

In light of what preceded it, the essential health benefits statute represents a leap into the content of health insurance that, in its own way, is nearly as breathtaking as the PPACA’s leap into insurance accessibility itself. Given the fundamental purpose of the PPACA—to halt discrimination by health insurers against the sick while creating access for most Americans—it makes sense to read the essential benefits statute broadly. The considerations required of the Secretary could not be clearer: even if employer benefit plans today typically discriminate against the sick, this type of discrimination should cease given the risk-spreading design of the statute and its purpose of assuring reasonable coverage for covered persons. Insurance is not simply about having something that the market calls coverage, no matter how inadequate. Insurance is about having reasonable financial protection against the cost of necessary health care. For persons with disabilities, the cost of necessary health care frequently will be higher as a result of the disability. The essential benefits provisions of the PPACA, which reach the very content of coverage, represent a breakthrough in the concept of what it

means to be insured that extend beyond the limits of prior laws, including civil rights laws specifically intended to protect persons with disabilities.

The policy leap embodied in the PPACA makes sense on two grounds. First, why would Congress take the enormous step of assuring risk pooling and fair treatment of all eligible persons while continuing to sanction a level of health benefits that unfairly discriminates against persons with disabilities, by failing to level the playing field on what it means to have coverage? As the dissent noted in *Doe v. Mutual of Omaha*,¹⁵⁸ understanding a bar on discrimination as an effort to customize insurance products misses the point: the issue is not creating an unfair disadvantage for persons with disabilities by reducing the value of their coverage below reasonable levels.

Second, it makes sense to understand health insurance reform as advancing several social purposes. Certainly reform advances the goal of assuring a reasonable level of health care financing for nearly all Americans. But American society has other great aims, one of which, embodied in the Americans With Disabilities Act, is the fullest reasonable community integration of persons with disabilities. Fortunately, American society is far beyond the time when only people without disabilities had jobs, married, raised families and children, and actively participated in society. It makes eminent sense that if the nation went through the gut-wrenching experience of a great leap forward in national health reform, policymakers also should use the opportunity to assure that to the greatest degree reasonably possible, persons with disabilities enjoy the full benefit of reform.

One of the great unknowns is how the essential benefits statute will affect the large group markets that are exempt from its reach. Nothing in the statute requires larger employer group plans, whether fully insured or self-insured, to stop discriminating in insurance content against the sick. But with full and robust implementation of the essential benefits statute, one can at least hope that the nation will come to understand the enormous value of an approach to coverage that moves away from penalizing persons with disabilities, that learns to adjust in ways that level the playing field, and that recognizes the importance of reasonable investments in all people. Perhaps in time, as the risk pool grows and stabilizes, non-discriminatory conduct will become the new normal for the insurance industry as a whole.

158. *Doe v. Mut. of Omaha Ins. Co.*, 179 F.3d 557, 565 (7th Cir. 1999) (Evans, J., dissenting).