

KEEPING IT SIMPLE: HEALTH PLAN BENEFIT
STANDARDIZATION AND REGULATORY CHOICE UNDER THE
AFFORDABLE CARE ACT†

*Troy J. Oechsner**
*Magda Schaler-Haynes**‡*

I. INTRODUCTION

The recently enacted Patient Protection and Affordable Care Act (“Affordable Care Act” or “ACA”)¹ provides federal and state regulators with an opportunity to address inefficiencies in the health insurance market. Health insurance markets in many areas of the country have a confusing array of benefit choices that make it difficult for consumers to effectively comparison-shop. This lack of transparency contributes to inefficiency in the market.

Rationales exist in support of encouraging a multitude of benefit choices. First, it allows consumers greater choice in finding a health insurance product that fits their needs. Second, it encourages health insurers to innovate new products and benefit designs. Third, the health insurance market, like other markets, works best when it is not overregulated.

† This article is current as of October 2010.

* Troy J. Oechsner, J.D., is an adjunct professor at Albany Law School. He is also the Deputy Superintendent for Health at the New York State Insurance Department. Any views expressed in this article are his and do not necessarily represent the position of the Insurance Department.

** Magda Schaler-Haynes, J.D., M.P.H., is a lecturer of Health Policy and Management at the Mailman School of Public Health at Columbia University. She is also Senior Health Policy Advisor at the New York State Insurance Department. Any views expressed in this article are hers and do not necessarily represent the position of the Insurance Department.

‡ The authors gratefully acknowledge the support and encouragement of New York State Insurance Superintendent James J. Wrynn. The authors also thank Javid Afzali, Albany Law School J.D. candidate 2012, and Domna Antoniadis, Fordham University Law School J.D. candidate 2011, for their invaluable research assistance and analysis.

¹ The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 26, 42 U.S.C.); The Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 42 U.S.C.). The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act are hereinafter collectively referred to as the “Affordable Care Act” or “ACA.”

Conversely, several rationales support standardizing benefit choices. First, as noted above, when consumers are faced with a confusing array of products, they may not be able to comparison-shop. As a result, the market does not efficiently arrive at correct pricing. Second, consumers tend to underestimate their own risk of illness and whether their insurance will cover needed medical services. This can result in tragedy for individual consumers, as well as costs to society, when the uninsured and underinsured cannot pay for medical care they receive. Third, a wide array of confusing benefit choices contributes to inflated administrative costs. For example, consumers, providers, and insurers dispute claims due to confusion over covered services. These inefficiencies in the health insurance market are among the many cost drivers resulting in increasing premiums.

Health insurance premium increases impact many people. For the majority of Americans who have coverage through an employer, high rate increases have resulted in decreased benefits. As employers struggle to pay premium rate increases, many have opted for health plans that provide less actual coverage. Employees see fewer benefits covered, with employers reducing or cutting drug, physical therapy, and other benefits. Employers are also shifting more costs to employees, with higher deductibles, co-payments, and coinsurance. And lower annual and lifetime maximum benefit caps have limited the amount of coverage on the backend. Consumers worry, for good reason, that their coverage will not be sufficient when they need it most. For those without health insurance, premium rate increases have contributed to making many of them uninsured. Rate increases put affordable, quality coverage further out of reach for the uninsured.

The consequences of being uninsured or underinsured are well documented. Those lacking coverage decline or delay care, resulting in worse health outcomes. And medical debt continues to be a leading reason for personal bankruptcy.²

The Affordable Care Act seeks to increase the quality and affordability of health insurance by layering together a number of core components, as described in Section V. Benefit structures are a key to the success of the commercial market reforms in the Affordable Care Act. The benefits in a health insurance contract

² See David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF., W5-70 (Feb. 2, 2005), <http://content.healthaffairs.org/content/early/2005/02/02/hlthaff.w5.63.full.pdf>.

determine which particular medical services will be covered, and to what degree. All states regulate health insurance policies to some extent, most often setting some minimum benefits for certain types of policies sold. However, most states have not standardized benefit choices, and there has been no basic set of national minimum standards. States have weighed competing arguments for benefit flexibility and choice, on one hand, and benefit standardization and uniformity on the other hand. With some notable exceptions, markets in most states reflect compromises that have resulted in a wide variety of benefit choices that are often confusing. These compromises have contributed to market inefficiencies and consumer underinsurance.

The Affordable Care Act reflects a distinct move towards greater standardization. The Act sets out a framework for federal and state regulators to standardize benefits, as well as forms and procedures for administrative functions, such as referrals and explanations of benefits. Within this statutory framework, regulators face a number of options for how to proceed.

This article focuses on some of those options created by the ACA for federal and state regulators, and examines the policy rationales and practical implications of those options. Section II discusses the competing policy rationales underlying the debate between choice and standardization in health plan benefits, and reviews certain elements of basic economic market theory that prompt state and federal efforts at health insurance market reforms. Section III provides an overview of certain provisions of the Affordable Care Act relevant to benefit standardization, and discusses some of the competing arguments regarding options facing federal and state regulators charged with implementing the Affordable Care Act.

II. INFORMATION, RISK PERCEPTION, AND INEFFICIENCY IN THE HEALTH INSURANCE MARKET

A competitive market requires that both buyer and seller have information about the product for sale.³ Information must be truthful and accurate to be useful.⁴ Ideally, each party to a

³ See, e.g., George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q. J. ECON. 488, 492–96 (1970); Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 946 (1963); Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q. J. ECON. 629, 629 (1976); George Stigler, *The Economics of Information*, 69 J. POL. ECON. 224, 224 (1961).

⁴ See Akerlof, *supra* note 3, at 495.

transaction also has complete (as opposed to partial) information. Information is itself a product—sometimes costly to gather, but potentially valuable.⁵

In a competitive market, pricing reflects product quality and value to each party. Information enables buyers and sellers to learn enough about the product that they can arrive at an efficient price.⁶ Consumers expect a correlation between price and quality. Better quality goods should cost more than poorer quality goods. Because consumers rely on information to ascertain product quality, the presence or absence of information directly affects the most fundamental elements of market efficiency.⁷

A. *Asymmetric Information*

Sometimes an informational imbalance exists between buyers and sellers. An informational imbalance or “asymmetry” occurs when one party has more or better information than the other.⁸ When this happens, the party with more information can artificially secure a better price than if the less-informed party was fully informed. A market plagued by informational asymmetry is susceptible to failure because of its persistent inability to arrive at fair and competitive pricing based on full and accurate information.⁹

Asymmetric information pervades the exchange between insurance companies and insurance consumers.¹⁰ One prominent economist initially observed the informational disparity between medical consumers and medical practitioners, but his observations readily apply to the health insurance market.¹¹ The informational asymmetry between consumers and health insurers is due in part to

⁵ See Steigler, *supra* note 3, at 220.

⁶ See Akerlof, *supra* note 3, at 491–92.

⁷ Judith H. Hibbard & Jacquelyn J. Jewett, *Will Quality Report Cards Help Consumers?*, 16 HEALTH AFF. 218, 226 (1997), available at <http://content.healthaffairs.org/content/16/3/218.full.pdf> (With respect to health plan consumers, “a truly informed choice must be based on an understanding of quality differences as well as an understanding of the nature of the choices.”).

⁸ Wendy K. Mariner, *Can Consumer-Choice Plans Satisfy Patients?*, 69 BROOK. L. REV. 485, 493 (2003).

⁹ See William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701, 1727–78 (1999) (pointing out that disclosure requirements intended to boost competition may be a “house of cards” if the assumption that information is asymmetric, but not incomplete, is false).

¹⁰ Karl-Gustaf Lofgren et al., *Markets with Asymmetric Information: The Contributions of George Akerlof, Michael Spence and Joseph Stiglitz*, 104 SCAND. J. ECON. 195, 196 (2002), available at http://emilyskarbek.com/uploads/Asymmetric_Information_-_Contributions_of_Akerlof_Spence_and_Stiglitz.pdf.

¹¹ See Arrow, *supra* note 3, at 941.

the professional and institutional expertise of the insurer.¹² Insurers have detailed knowledge of the value of the benefits they offer, and how those benefits compare to their competitors. Today, much of this information is either not provided or is inaccessible to the average insurance consumer.¹³

In order to be autonomous market actors, consumers require health plan information that is “publicly available, understandable, and relevant to the decision making process.”¹⁴ In many markets other than health insurance, disclosure around quality occurs voluntarily.¹⁵ Fortunately, buyers and sellers in these other markets cooperate with one another for a variety of self-serving or altruistic reasons and, as a result, markets function relatively well.¹⁶ In the health insurance market, however, important information about products is often not fully disclosed, or is confusing. As a result, consumers are unable to effectively compare health insurance products. And consumers may not buy the products they would have purchased if they had access to better information.¹⁷

The inability of consumers to compare plans skews the pricing of health plans: prices therefore do not reflect true consumer preference, demand, or willingness to pay because consumers do not

¹² Derick K. Brinkerhoff, *Accountability and Health Systems: Toward Conceptual Clarity and Policy Relevance*, 19 HEALTH POL'Y AND PLAN. 371, 373 (2004), available at <http://heapol.oxfordjournals.org/content/19/6/371.full.pdf>; Debi P. Mishra et al., *Information Asymmetry and Levels of Agency Relationships*, 35 J. MKTG. RES. 277, 277 (1988), available at <http://www.personal.psu.edu/jxb14/JMR/JMR1998-3-277.pdf> (citing Phillip Nelson, *Information and Consumer Behavior*, 72 J. POL. ECON. 311, 311–25 (1970)).

¹³ Linda J. Blumberg & Karen Pollitz, *Health Insurance Exchanges: Optimizing Health Insurance Marketplaces to Promote Health Reform Goals*, TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY ISSUES (Urban Inst., D.C.), Apr. 2009, at 6, available at http://www.urban.org/UploadedPDF/411875_health_insurance_marketplaces.pdf.

¹⁴ Susan Edgman-Levitan & Paul D. Cleary, *What Information Do Consumers Want and Need?*, 15 HEALTH AFF. 42, 43 (1996), available at <http://content.healthaffairs.org/content/15/4/42.full.pdf>.

¹⁵ Fraud and misrepresentation sometimes occur in the course of disclosure. This is different than non-fraudulent, but insufficient, disclosure and is outside the scope of this article.

¹⁶ eBay is a good example of buyers and sellers voluntarily disclosing quality and defect, with competitive bidding to arrive at a market price. One can imagine a description on eBay including dimensions and photos of a hole, lest the seller receive a bad review which deters future sales. Sometimes, however, the seller is aware of a feature of the product (a hole in a bucket, for example) that affects its performance, but of which the buyer is unaware. Although the unwitting buyer of such a product may have a variety of remedies at law, those remedies are not the subject of this paper.

¹⁷ Hibbard & Jewett, *supra* note 7, at 226 (With respect to health plan consumers, “a truly informed choice must be based on an understanding of quality differences as well as an understanding of the nature of the choices.”).

understand what they are buying.¹⁸ As a result, the current health insurance marketplace does not function as efficiently as it could.

1. Health Plan Information Is Difficult For Consumers To Understand

Consumers¹⁹ often misunderstand health plan information. A recent study used principles of educational psychology to evaluate whether average enrollees can identify and comprehend important health plan details.²⁰ Important plan information contained in Summary Plan Descriptions is often written at a reading level that makes it incomprehensible to the average enrollee.²¹ Specifically, information regarding eligibility, benefits, and participant rights and responsibilities tends to be written at a first year college literacy level which is higher than the recommended reading level required for technical information.²² One study concluded “the primary communication tool used to provide important information to workers who participate in their employer’s health care plan often may be unreadable to them.”²³ For regulators concerned with equal access to health plan information, it is essential to recognize this comprehension disparity and the corresponding need for simplification of plan information.

Accounts of the experience of shopping for health insurance document consumers’ persistent inability to *recognize* much less understand information important to meaningfully evaluate health insurance products.²⁴ For the average consumer, distinguishing among and between health insurance products in the market based on quality or any feature other than price has been nearly

¹⁸ Deborah Haas-Wilson, *Arrow and the Information Market Failure in Health Care: The Changing Content and Sources of Health Care Information*, 26 J. HEALTH, POLS., POL’Y. & LITIG. 1031, 1034 (2001) (“When no information on quality is available prior to purchase, quality deteriorates to the lowest level in the market—a serious market failure since mutually advantageous trades involving higher quality products do not take place.”).

¹⁹ Unless otherwise noted, the term “consumers” refers to the purchasers of health plans and insurance. See Mariner, *supra* note 8, at 491–92, for a discussion of the significance of this terminology.

²⁰ See Colleen E. Medill et al., *How Readable Are Summary Plan Descriptions for Health Care Plans?*, NOTES (EBRI Educ. & Research Fund, D.C.), Oct. 2006, at 2, available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_10-20061.pdf.

²¹ *Id.* at 6.

²² *Id.* at 7.

²³ *Id.* at 8.

²⁴ Mishra, *supra* note 12, at 277 (citing Phillip Nelson, *Information and Consumer Behavior*, 78 J. POLIT. ECON. 311 (1970)).

impossible to this point.²⁵ When making health plan choices, many consumers only have a plan summary available to assist them.²⁶ Consumers are often without information regarding a plan's provider network or coverage of a particular prescription drug before enrolling.²⁷ Consumers typically do not receive a detailed plan description until after enrolled.²⁸

Even in markets where benefits are standardized, purchasing health insurance involves balancing many features, including premiums, cost-sharing, and provider networks. Confusion regarding health plan details frequently continues even after consumers enroll. Health plan enrollees report confusion about how to use their benefits, how to understand coverage determinations, and their rights in the face of adverse coverage determinations.²⁹ The health insurance market lacks a standardized format to convey categories of information about plans both before and after individuals select a policy. The lack of comprehensible health plan information disproportionately disadvantages those with literacy challenges.³⁰ One possible model for standardizing health plan information is a "Coverage Facts" format for health insurance based on the Nutrition Fact label required for packaged food.³¹

²⁵ Blumberg & Pollitz, *supra* note 13.

²⁶ *Id.* at 26.

²⁷ *Id.* at 6. Prior to health reform, some information was available for health consumers to comparison-shop for health plans. For example, the Office of Personnel Management provides considerable information to compare plan options within the Federal Employees Health Benefit Plan. See *Federal Employees Health Benefits Program*, U.S. OFF. PERSONNEL MGMT., <http://www.opm.gov/insure/health> (last visited Jan. 20, 2011). Visitors to the website can compare plans based on a number of quality indicators including "[o]verall [p]lan [s]atisfaction," "[g]etting [n]eeded [c]are," "[g]etting [c]are [q]uickly," "[h]ow [w]ell [d]octors [c]ommunicate," and "[c]laims [p]rocessing." See *FEHB Member Survey Results*, U.S. OFF. PERSONNEL MGMT., <http://www.opm.gov/insure/health/planinfo/quality/satisfaction.asp> (last visited Jan. 20, 2011). The New York State Insurance Department, for example, compiles the New York Consumer Guide to Health Insurance. *New York Consumer Guide to Health Insurance*, N.Y. STATE INS. DEP'T, <http://www.ins.state.ny.us/hgintro.htm> (last visited Jan. 20, 2011). The guide "provides consumers with information about the quality of care their Health Maintenance Organization (HMO), commercial and non-indemnity health insurers are providing so they can make informed decisions about their health care." *Id.* Among other things, the guide includes complaint rankings, grievance and internal appeals statistics, and results from enrollee satisfaction surveys. *Id.* Overall, however, easy-to-understand information about health plans is not readily available.

²⁸ Blumberg & Pollitz, *supra* note 13, at 6.

²⁹ Medill et al., *supra* note 20, at 2–10.

³⁰ *Id.* at 2.

³¹ KAREN POLLITZ ET AL., CTR. FOR AMERICAN PROGRESS, COVERAGE WHEN IT COUNTS: HOW MUCH PROTECTION DOES HEALTH INSURANCE OFFER AND HOW CAN CONSUMERS KNOW? 12 (2009), available at <http://www.americanprogressaction.org/issues/2009/05/pdf/CoverageWhenItCounts.pdf>.

2. Irrational Responses to Complex Information: Consumer Underestimation of Risk

Health insurance is designed to protect the insured from the risk associated with a fortuitous event.³² The decision-making process for health insurance consumers is, therefore, a process of evaluating probabilities rather than certainties.³³ Each health insurance product offers some degree of risk protection. Ideally, a consumer is able to match the health risks they face with the risk protection offered by the insurance product. But in order to match successfully, consumers need to identify the risks they face.³⁴

Consumers who have never been very sick may not appreciate the extent and type of medical care that could be required in the event of a serious illness. Nor would they likely anticipate what such care might cost, in terms of either billed provider charges or insurer allowed charges.³⁵

In the health insurance marketplace, individuals routinely underestimate risk.³⁶ Many people today find themselves unprepared for an adverse health event because their health insurance is not sufficient to cover costs associated with the event.³⁷ Why might a consumer be surprised by the insufficiency of a policy? First, the consumer shopping for a health insurance policy often does not have an accurate impression of the risk that a severe health need may strike or of the extent of his vulnerability if one does.³⁸ Buyers are largely unaware of or unable to understand patterns and causes of chronic illness, accidents rates, or family medical history.³⁹ Second, in the face of uncertainty about the likelihood or cost of an adverse health event, consumers often lean on the side of optimism and buy a health plan insufficient to meet a need that eventually occurs.⁴⁰

Underestimation of risk manifests in the health insurance market

³² Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q.J. ECON. 629 (1976).

³³ Sage, *supra* note 9, at 1729.

³⁴ Rothschild & Stiglitz, *supra* note 32, at 639–40.

³⁵ POLLITZ ET AL., *supra* note 31, at 11.

³⁶ Kostas Koufopoulos, Asymmetric Information, *Heterogeneity in Risk Perceptions and Insurance: An Explanation to a Puzzle* 4 (Nov. 18, 2008) (Working Paper), available at <http://ssrn.com/abstract=1301522>.

³⁷ See Eric J. Johnson et al., *Framing, Probability Distortions, and Insurance Decisions*, 7 J. RISK AND UNCERTAINTY 35 (1993).

³⁸ See Koufopoulos, *supra* note 36, at 4.

³⁹ See Johnson et al., *supra* note 37, at 38.

⁴⁰ Koufopoulos, *supra* note 36, at 4.

in one of two ways. Consumers may purchase health insurance products insufficient to meet their needs in the event of an adverse health event.⁴¹ Those consumers are broadly referred to as “underinsured.” Other consumers do not purchase any health insurance because they do not recognize its value relative to the risk they face.⁴² Sometimes mere disclosure of information is all that is necessary for consumers to arrive at a correct or rational decision regarding health care coverage. But sometimes information is too complex to be useful in choosing among health plans, even by reasonably informed consumers.⁴³

Indeed, many Americans are underinsured.⁴⁴ The mere fact of having insurance is not enough to guard against personal financial loss or to guarantee access to health services. Simply being “insured” does not mean the insured person has either free access to health care or sufficient protection against personal bankruptcy.⁴⁵ Importantly, the *type* of plan a consumer chooses impacts the scope, frequency, and quality of health services the consumer receives.⁴⁶ In other words, consumers are more likely to get care if their insurance policy covers it.

The process of identifying relevant information about health insurance products is different than the process of appreciating that information. Even consumers who are able to *identify* the features of a health plan do not necessarily *appreciate* the chance of actually needing that health plan or of the insufficiency of that health plan

⁴¹ See generally Cathy Schoen et al., *Insured But Not Protected: How Many Are Underinsured?*, HEALTH AFF. (June 14, 2005), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.289>.

⁴² Of course, individuals also may not purchase health insurance because health insurance is unaffordable to them. We recognize that “affordability” is a relative term laden with political, economic and moral assumptions. For purposes of analogy, we recognize the relative value of health insurance products dependent on individual income but presume that *affordable* health insurance options, whether subsidized or unsubsidized, are available to consumers. The many dimensions of “affordable” health insurance options are outside the scope of this article. We instead focus on the choices available in the health insurance market.

⁴³ Sage, *supra* note 9, at 1729 (“Although universal rationality is not necessary for market efficiency, even relatively sophisticated individuals approach health issues with a variety of cognitive biases which may lead them to evaluate health care information inaccurately and reach incorrect decisions.”).

⁴⁴ See Schoen et al., *supra* note 41, at W5-292–93.

⁴⁵ Michelle M. Doty, et al., *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families*, COMMONWEALTH FUND, Aug. 2008, available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2008/Aug/Seeing%20Red%20The%20Growing%20Burden%20of%20Medical%20Bills%20and%20Debt%20Faced%20by%20U%20S%20Families/Doty_seeingred_1164_ib%20pdf.pdf.

⁴⁶ POLLITZ ET AL., *supra* note 31, at 5.

once it is needed.⁴⁷ Given the wide variety of health plans on the market, consumers often do not understand the implications of choosing one health plan over another. The consumer is unable to accurately articulate the ways in which one health plan is better or worse than another health plan in terms of access to health services or financial protection in the event of an unexpected illness.⁴⁸ For the average consumer, maintaining a health insurance policy means that the enrollee will have access to health care and protection from considerable financial risk. What consumers frequently fail to appreciate, however, is that an insufficient health insurance policy may mean that the individual either does not have access to health care or may have to pay considerably more for health care than the individual might have expected or planned to pay.⁴⁹

Although strong disclosure laws improve the amount and quality of information available to health insurance consumers, disclosure laws alone do not address individual underestimation of risk.⁵⁰ This underestimation of risk contributes to consumers being uninsured and underinsured.⁵¹ Universal cognitive biases may prevent consumers from accurately matching their own risk with the benefits offered in a health plan. When faced with complex information, people commonly reduce the information into a very simple form.⁵² This reaction is one of a host of heuristics, described in both psychological research and behavioral economics, that people use to simplify the world in general, and decision-making in particular.⁵³

Purchasing the “right” or “optimal” health insurance package is, therefore, difficult for the average consumer.⁵⁴ In fact, it is

⁴⁷ Ellen Peters et al., *Numeracy Skill and The Communication, Comprehension, and Use of Risk-Benefit Information*, 26 HEALTH AFF. 741, 743 (May/June 2007), available at <http://content.healthaffairs.org/cgi/content/full/26/3/741>.

⁴⁸ See *id.* at 742.

⁴⁹ See Schoen et al., *supra* note 41, at W5-296–99.

⁵⁰ See Sage, *supra* note 9, at 1728–29.

⁵¹ See Koufopoulos, *supra* note 36, at 4–5; Johnson et al., *supra* note 37, at 38; see generally John Cawley & Thomas Philipson, *An Empirical Examination of Information Barriers to Trade in Insurance*, 49 AM. ECON. REV. 827 (1999); Milton Friedman & L. J. Savage, *The Utility Analysis of Choices Involving Risk*, 56 J. POL. ECON. 279 (1948).

⁵² Peters et al., *supra* note 47, at 743 (“We tend to assume that simply providing information will result in a level playing field for all. However, many consumers lack the skills, knowledge, and motivation to access credible sources, process information, and make informed choices. Consequently, they have more health crises and functional declines than those who do have the skills, knowledge, and motivation.”).

⁵³ See generally Amos Tversky & Daniel Kahneman, *The Framing of Decisions and the Psychology of Choice*, 211 SCI. 453, 458 (1981) (concerning “the descriptive question of how decisions are made” and “the normative question of how decisions ought to be made”).

⁵⁴ See Koufopoulos, *supra* note 36, at 14; Johnson et al., *supra* note 37, at 36; Friedman &

exceedingly difficult, if not impossible, to identify an amount of health insurance coverage that is “optimal.”⁵⁵ Many consumers obtain health insurance through their employer, which typically chooses plan options. Thus, the impact of individual predisposition toward poor plan selection is minimized in the employer context.⁵⁶ When left to their own devices, however, consumers tend to select a sub-optimal insurance package.⁵⁷ This sub-optimal selection is, as described above, based on cognitive biases and widespread underestimations of the likelihood of adverse events that health insurance is designed to insure against.⁵⁸

In evaluating a health insurance purchase, consumers will consider their own financial resources, other purchases they want to make, and the likelihood they will need medical services.⁵⁹ Based on those considerations, consumers may either forego a health insurance purchase altogether or be unwilling to pay more for a comprehensive policy. In fact, for the consumer who presumes little to no health risk, spending scarce resources on a high quality health insurance product may be unwise.⁶⁰ Some consumers may consider a lower quality health insurance policy—one with fewer covered services or more limitations—to be good enough, or at least better

Savage, *supra* note 51, at 279; Cawley & Philipson, *supra* note 51, at 827.

⁵⁵ POLLITZ ET AL., *supra* note 31.

⁵⁶ Jeanne M. Lambrew, “Choice” in *Health Care: What Do People Really Want?*, COMMONWEALTH FUND, Sept. 2005, available at http://www.commonwealthfund.org/usr_doc/lambrew_853_choice_ib.pdf.

⁵⁷ See *Addressing Underinsurance in National Health Reform: Hearing Before the S. Comm. On Health, Educ., Labor, and Pensions*, 111th Cong. 10–11 (2009) (written statement of Cathy Schoen, Senior Vice President, Commonwealth Fund) (“Millions more are ‘underinsured’—insured all year yet facing such high cost-sharing relative to income that they lack adequate financial protection when sick or injured. In our recent study of underinsured trends from 2003 to 2007, we defined adults as underinsured if they had insurance all year *and* had out-of-pocket expenses for medical care of 10 percent or more of their annual income or 5 percent if low income (under 200 percent of poverty) or whose deductible alone was 5 percent or more of income. Notably, this definition will miss those with inadequate coverage who were healthy during the year—in other words, the estimate is likely to be conservative. Using this financial definition of the underinsured, as of 2007, 25 million adults ages 19 to 64 were underinsured . . .”) (citations omitted) [hereinafter Schoen Testimony]; see also *Addressing Underinsurance in National Health Reform: Hearing Before the S. Comm. on Health, Educ., Labor, and Pensions*, 111th Cong. 33 (2009) (written statement of Gail Shearer, Director of Health Policy Analysis, Consumers Union) (“Underinsured adults, who have less comprehensive health care coverage, are more likely than the insured to face medical bill and medical debt problems. Some of the key factors were inadequate drug and dental coverage, high premiums as percent of income, out-of-network charges, and benefit gaps.”) (citations omitted).

⁵⁸ Cawley & Philipson, *supra* note 51, at 827.

⁵⁹ Doty, *supra* note 45, at 1.

⁶⁰ See Peters, *supra* note 47, at 741.

than nothing.⁶¹ All too often, however, consumers become ill and only then realize that their policy is not sufficient to cover their medical needs.⁶²

Underestimation of risk has a significant impact on the health insurance market overall.⁶³ Consumers who underestimate the risk or severity of adverse health events, or who overestimate the utility of a policy with fewer benefits, irrationally demand policies with fewer benefits than they need.⁶⁴ This demand can drive the cost for these inadequate policies artificially higher than if consumers understood the risks associated with those products.⁶⁵ Those consumers may also *overvalue* the savings reaped from buying the inadequate policy on the day of purchase relative to the value of having a comprehensive policy on the day of surgery or illness.⁶⁶

3. Intermediaries to Bridge the Gap

Private intermediaries sometimes help individuals make health plan decisions by sorting through daunting information or selecting a few choices for consumers.⁶⁷ Employers and brokers often serve as intermediaries between consumers and insurers when consumers select a product in the health plan market.⁶⁸ In the employment context, the employer selects plan offerings for employees.⁶⁹ In fact, most people are insured through employer plans.⁷⁰ Because employers can serve as a filter for plan offerings, consumers purchasing health plans in the employer setting may be at a relative advantage.⁷¹ Employers and brokers can help reduce

⁶¹ See generally Friedman & Savage, *supra* note 51, at 283–87 (observing and analyzing individuals' behavior when deciding between risk and risk alternatives).

⁶² POLLITZ ET AL., *supra* note 31, at 1.

⁶³ Arrow, *supra* note 3, at 942.

⁶⁴ Schoen Testimony, *supra* note 57, at 14.

⁶⁵ *Id.* at 12–13.

⁶⁶ Amy B. Bernstein & Anne K. Gauthier, *Choices in Health Care: What Are They and What Are They Worth?*, 56 MED. CARE RES. AND REV. 5, 10–11 (1999).

⁶⁷ See *id.* at 14–15.

⁶⁸ *Id.* Other intermediaries, for example customer service representatives from the insurer, may help individuals navigate their health insurance policy once the person is enrolled.

⁶⁹ Lambrew, *supra* note 56, at 3–4. Many times, employees care less about the health plan their employer offers than whether they will be able to access a particular provider. See *id.*

⁷⁰ Danielle Holahan & Peter Newell, *New York State and the Emerging Federal Health Care Reform Blueprint: Taking Stock and Making Plans*, UNITED HOSP. FUND, 3 (July 31, 2009), <http://www.uhfnyc.org/publications/880601>; see Bernstein & Gauthier, *supra* note 66, at 14.

⁷¹ See Bernstein & Gauthier, *supra* note 66, at 11.

confusion, at least compared to those in the individual market.⁷² For others, brokers may serve as intermediaries to navigate plan choices.⁷³

Government actors can also serve as intermediaries. Through regulation or legislation, state or federal governments can structure the interaction between insurers and consumers in at least two ways.⁷⁴ First, disclosure can be required by law.⁷⁵ Regulators can require set specific parameters to govern the format of disclosure, for example to require specific categories and types of information to help consumers understand information most easily.⁷⁶ Second, regulators can standardize products in the market.⁷⁷ For example, health insurance products can be standardized by establishing minimum requirements for a specific market. For health insurance products, standardization could require all health plans to cover preventive health services and to bar annual or lifetime limits, for example. The state, as opposed to the employer or the broker, can limit the products available on the market.

III. RESPONSES TO MARKET INEFFICIENCIES

Strict adherents of free market principles see consumers as able to organize, analyze, and prioritize any amount of information.⁷⁸ They generally support anti-fraud laws but do not trust the government to filter consumer information beyond guaranteeing its accuracy.⁷⁹ According to this view, the more information available to consumers, the better. Free market proponents consider overregulation itself a problem.⁸⁰ Market advocates⁸¹ question whether regulators have the expertise to establish and mandate health insurance products that suit the needs of consumers.⁸²

⁷² *Id.* at 15 (discussing the difficulties consumers face when making health insurance choices).

⁷³ The role of brokers is outside the scope of this article.

⁷⁴ Sage, *supra* note 9, at 1730 (“Effective communication to individuals of complex quality-related information necessitates walking a fine line separating facilitation and manipulation.”).

⁷⁵ See Bernstein & Gauthier, *supra* note 66, at 18–19.

⁷⁶ See *id.* at 19.

⁷⁷ See *id.*

⁷⁸ See *id.*

⁷⁹ See *id.*

⁸⁰ The exception here is that many libertarians support both truth in advertising laws and anti-fraud laws as essential to market functioning.

⁸¹ See e.g., David A. Hyman, *Health Insurance: Market Failure of Government Failure?*, 14 CONN. INS. L. J. 307 (2007–2008).

⁸² *Id.* at 10 (“The basic problem is that health insurance is a bundled product sold into a

Others support vigorous regulation as a cure for insufficient information.⁸³ They suggest government might best serve consumers by eliminating or severely restricting certain products from the market.⁸⁴ Some advocates of a single-payer, government run health plan would eliminate the private health insurance market entirely.⁸⁵ Such an approach could include a single set of benefits for all. Traditional Medicare and, in many states, Medicaid operate in this fashion.

The debate between these two views—unregulated, free choice on the one hand, and regulated, protected choice on the other—raises the question: what exactly is a consumer free to choose? If freedom of choice includes the right to choose suboptimal or inefficient products, legislating away that right reduces freedom. If freedom is defined as freedom *from* the predisposition to choose suboptimal or inefficient products, legislation removing those products from the market increases freedom.

At least two possible middle ground approaches exist amidst the ideological battle over health insurance regulation. First, government can permit a wide variety of benefit choices, but specify the form and content of the information so that consumers better understand their choices.⁸⁶ Second, government can pare down and organize choices, with the goal of consumer-oriented quality control; by standardizing products, the likelihood of picking a bad product is reduced.⁸⁷ This is particularly true if all standardized products

diverse market, to people with varying intensity of preferences for coverage with different cost-quality-access trade-offs. Mandates are based on the assumption that there is one right answer to these trade-offs—but the reality is that all Americans do not want (and some can't afford) coverage which incorporates all the bells and whistles. For many consumers, regulation actually overrides their preferences, instead of protecting them, and does so at their expense.”)

⁸³ See *id.* at 3.

⁸⁴ See *e.g.*, ROBERT CAREY, ROBERT WOOD JOHNSON FOUND., PREPARING FOR HEALTH REFORM: THE ROLE OF THE HEALTH INSURANCE EXCHANGE (2010), available at <http://rwjf.org/files/research/57093.pdf>.

⁸⁵ *Socialist Party on Health Care*, SOCIALIST PARTY USA, <http://socialistparty-usa.org/campaigns/healthcare.html> (last visited Jan. 20, 2011).

⁸⁶ Haas-Wilson, *supra* note 18, at 1036 (“The hope is that more informed health care consumers will be able to select the physicians (or health plans) offering the lowest quality-adjusted prices. In turn, more informed health care consumers may result in physicians (or health plans) decreasing their quality-adjusted prices by decreasing price and/or increasing quality.”). Disclosure, however, should not be mistaken for a panacea. Consumers, even in the best disclosure scenarios today, still report difficulty distinguishing among health plans. See Sage, *supra* note 9, at 1729–33.

⁸⁷ For a discussion of this practice's potential success in other contexts, see George A. Akerlof, *The Market For “Lemons”*: *Quality Uncertainty and the Market Mechanism*, 84 Q. J. ECON. 488, 499–500 (1970).

meet a minimum level of quality. Richard Thaler and Cass Sunstein refer to one sort of regulatory role as “choice architecture.”⁸⁸ Acting as choice architect, the government could assume “responsibility for organizing the context in which people make decisions.”⁸⁹ The health insurance market may be ripe for such organization to the extent that it “give[s] companies a strong incentive to cater to (and profit from) human frailties, rather than to try to eradicate them or minimize their effects.”⁹⁰

A choice architecture approach to health insurance purchasing suggests that autonomous, empowered, and free consumer choice of health plan requires that consumers can (1) understand that choice of health plan impacts the quality of health care they receive; (2) identify the information to look at in order to establish the quality of a health plan; (3) comprehend the information after identifying it; and (4) compare several health plans on the same variables in order to (5) arrive at a decision that reflects ones’ foreseeable and unforeseeable health needs.⁹¹

Regulators can overcome the individual inability to accurately assess risk by requiring individuals to: (1) purchase health insurance and (2) purchase a policy that includes a minimum amount of benefits. Benefit standardization laws can be designed to guarantee that the products available in the health insurance market place are generally “good” products regardless of consumer ability to recognize health plan quality. To the extent standardized benefits still offer consumers a range of choices, all of which meet minimum levels of coverage, consumers can be protected from unwittingly underestimating their risk and purchasing a “lemon” health plan.⁹² Standardizing health benefit options is a regulatory mechanism intended to increase the likelihood that consumers

⁸⁸ CASS R. SUNSTEIN & RICHARD H. THALER, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH AND HAPPINESS* 3 (Penguin Books 2009) (“A choice architect has the responsibility for organizing the context in which people make decisions.”).

⁸⁹ *Id.*

⁹⁰ *Id.* at 74.

⁹¹ Hibbard & Jewett, *supra* note 7, at 218.

⁹² See generally Akerlof, *supra* note 87. Consumers of health insurance, like consumers of cars or other products, are dissatisfied when they purchase a product believed to be of high quality that turns out to be a “lemon.” In such situations consumers are either (1) unaware that the product is a lemon because the price was sufficiently high to signal good quality to the consumer, or (2) tipped off by price or other means of disclosure that the product is discounted because of its quality. In the first case, lemon laws protect consumers by requiring car dealers to either fully disclose the quality of the car or to allow the consumer to return the car upon discovering its poor quality after purchase. In the second case, the consumer is free to affirmatively choose a product knowing the price is reduced because the quality is reduced.

select health insurance products to best suit their needs.

IV. STATE REGULATION OF HEALTH INSURANCE BENEFITS BEFORE THE ACA

Under the authority granted by the McCarran-Ferguson Act, states play a lead role in the regulation of health insurance.⁹³ States have, in varying degrees, attempted to improve the functioning of their health insurance markets.⁹⁴ The American federal system allows for, if not encourages, variation among the states. In the commercial health insurance markets, states have recognized market inefficiencies which skew the quality and pricing of health insurance products.⁹⁵ As noted above, whether states can or should, among other efforts, regulate information disclosure in order to optimize consumer purchases is a subject of debate.⁹⁶ This ideological debate over the proper role of government in the health insurance market is reflected in the manner in which states have (or have not) regulated health insurance to this point.⁹⁷

Prior to federal health reform, several states standardized benefits and benefit information in their own health insurance markets and even enacted sweeping efforts at landmark health reform.⁹⁸ A number of states have pursued benefit standardization pursuant to larger health reform efforts while others have pushed standardization efforts as stand alone improvements.⁹⁹ When contemplating benefit design, policymakers consider and balance a number of priorities and as a result state efforts include a number of divergent approaches.¹⁰⁰ States have thus far largely failed to

⁹³ Hyman, *supra* note 81, at 310.

⁹⁴ Jonathan Gruber, *Incremental Universalism for the United States: The States Move First?*, 22 J. ECON. PERSPECTIVES 51, 53 (2008), available at <http://pubs.aeaweb.org/doi/pdfplus/10.1257/jep.22.4.51>.

⁹⁵ For an overview of recent state-based health reform efforts, see SHELLY TEN NAPEL ET AL., ROBERT WOOD JOHNSON FOUND., STATE OF THE STATES: THE STATE WE'RE IN (2010), available at <http://www.rwjf.org/files/research/55308.pdf>.

⁹⁶ See Hyman, *supra* note 81.

⁹⁷ See *id.* at 310–11.

⁹⁸ TEN NAPEL ET AL., *supra* note 95, at 29 (Prior to federal health reform, Maine, Oklahoma, Oregon, Rhode Island, Utah, Washington, and West Virginia were either considering, planning, or implementing their own insurance exchanges.).

⁹⁹ *Id.* at 29–33.

¹⁰⁰ BARBARA YONDORF, COLORADO HEALTH FOUND., HEALTH INSURANCE BENEFIT ADEQUACY 6–7 (2009), available at www.ColoradoHealth.org/studies.aspx (For example, a report by the Colorado Health Foundation suggested that policymakers seeking to set benefit packages can: (1) “Prioritize benefits based on effectiveness of medical treatments”; (2) “Follow the private insurance market”; (3) “Use a benchmark plan as a guide”; (4) “Focus on catastrophic (back-end) coverage”; (5) “Focus on coverage for prevention and early

achieve informational equilibrium between consumer and health insurer.

States, more than the federal government,¹⁰¹ have required specific benefits be covered by health insurers offering products in their markets.¹⁰² For states, benefit mandates tend to be piecemeal legislative efforts that occur in circumstances different from comprehensive benefit standardization efforts.¹⁰³ Although there are over 1800 benefit mandates in the United States,¹⁰⁴ benefit mandates remain a topic of considerable debate.¹⁰⁵ Benefit mandates range from requiring coverage for hearing aids, maternity/length of hospital stay post delivery, chiropractic care, mammography screening and breast reconstruction, or specific prescription drugs.¹⁰⁶ In addition, although “[m]andates may address market failures that lead to the under-provision of certain benefits . . . the additional cost associated with those benefits may reduce consumer or employer/employee willingness to have coverage at all.”¹⁰⁷ Benefit mandates are incremental and seemingly random efforts to expand coverage that ultimately do not provide standardized comprehensive health insurance products.¹⁰⁸

intervention (front-end coverage”); (6) “Provide more coverage for some based on need”; (7) “Cover all medically necessary care.”).

¹⁰¹ POLLITZ ET AL., *supra* note 31, at 6 (“Federal law generally does not address the content of health insurance coverage, with a few exceptions, such as the recently enacted mental health parity requirements.”).

¹⁰² Miriam J. Laugeson et al, *A Comparative Analysis of Mandated Benefit Laws, 1949–2002*, 41 HEALTH SERVS. RES. 1081, 1085 (2006), available at http://chbrp.org/documents/man_benefit_laws_hsr062006.pdf (defining benefit mandates as “requirements that health insurers and health plans offer or provide coverage for treatment by a particular type of health care provider, treatment or service, including for a specific disease or condition”).

¹⁰³ *Id.* at 1086.

¹⁰⁴ *CAHI Issues: State Mandates*, COUNCIL FOR AFFORDABLE HEALTH INS., http://www.cahi.org/cahi_contents/issues/article.asp?id=491 (last visited Jan. 20, 2011).

¹⁰⁵ See *Mandated Health Insurance Benefits and State Laws*, NCSL (Jan. 2010), <http://www.ncsl.org/default.aspx?tabid=14463>; see also Richard Cauchi et al., *Health Insurance Coverage Mandates: Are They Too Costly?*, NCSL (May 28, 2009), <http://www.ncsl.org/portals/1/documents/health/mandatesCauchi09.pdf>; Carrie Gavora, *How Health Insurance Mandates Misdiagnose the Disease*, HERITAGE FOUND. (Apr. 10, 1997), <http://www.heritage.org/Research/Reports/1997/04/BG1108nbsp-How-Health-Insurance-Mandates>.

¹⁰⁶ Laugeson, *supra* note 102, at 1092.

¹⁰⁷ *Id.* at 1083–84.

¹⁰⁸ *Id.* at 1095 (“In some cases, mandated benefit laws may be viewed as ‘political theater’ that allows legislators to be on the right side of an issue, rather than passing more fundamental legislation to address a problem.”); see Hyman, *supra* note 81 (“In-depth examination of individual mandates reveals an important commonality: provider lobbying figures in most of them—often aided by a small group of affected patients and/or relatives of patients.”).

To standardize health insurance policies, states define a specific set of benefits and cost-sharing requirements.¹⁰⁹ In doing so, states seek to improve consumers' ability to comparison-shop across plans.¹¹⁰ States also seek to prevent insurers from designing benefit packages that will disproportionately attract healthy individuals as a means of cherry-picking good risk.¹¹¹ In the small group market, twenty-four states require insurers to offer standardized policies.¹¹² Maryland and New Jersey prohibit insurers in the small group market from offering plans other than standardized policies.¹¹³ In the individual market, twelve states require insurers to offer individual standardized policies.¹¹⁴ However, only New Jersey prohibits the marketing of non-standardized plans in the individual market.¹¹⁵ In the states where standardized plans are not exclusively offered, insurers can sell non-standard policies and often heavily market other plans.¹¹⁶

In the course of its comprehensive health reform, Massachusetts standardized benefit packages and plan information more than any other state to date.¹¹⁷ Massachusetts residents are required to maintain health coverage that meets minimum benefit criteria.¹¹⁸ The Massachusetts Connector is the state entity through which standardized, subsidized insurance is sold.¹¹⁹ The Connector is much like the Exchange, discussed below, under the ACA. The Connector's website provides consumer information intended to facilitate easy comparison between plans that satisfy the individual

¹⁰⁹ *Standardized Plans in the Small Group Market, as of January 2009*, KAISER FAMILY FOUND., <http://www.statehealthfacts.org/comparereport.jsp?rep=7&cat=7> (last visited Jan. 20, 2011) [hereinafter KFF Report].

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.* The states that require insurers to offer standardized small group policies are: Alaska, Colorado, Connecticut, Delaware, Florida, Idaho, Maryland, Massachusetts, Mississippi, Montana, Nebraska, Nevada, New Jersey, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, and Wyoming. *See id.*

¹¹³ *Id.*

¹¹⁴ *Id.* The states that require insurers to offer standardized individual policies are Idaho, Maine, Massachusetts, Montana, Nevada, New Jersey, New York, North Dakota, Ohio, Oregon, Utah, and Vermont. *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ See Edmund F. Haislmaier & Nina Owcharenko, *The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs*, 25 HEALTH AFF. 1580 (2006), available at <http://content.healthaffairs.org/cgi/content/full/25/6/1580>.

¹¹⁸ KFF Report, *supra* note 109, at n.2.

¹¹⁹ Jon Kingsdale, *Health Insurance Exchange—Key Link in a Better Value Chain*, 362 New Eng. J. Med. 2147, 2147–48 (2010).

mandate.¹²⁰ The Connector offers health plans grouped into the “precious metal” coverage tiers of gold, silver, and bronze with plan options within each tier.¹²¹ Most policies provide the same set of comprehensive benefits.¹²² Even though benefits in Massachusetts are now highly standardized, cost-sharing differences among plans are significant enough that enrollees are still financially exposed at divergent levels depending on the plan they select.¹²³

Massachusetts conducted focus groups on plan and product design options for the Connector.¹²⁴ Respondents indicated disapproval of severely limited plan options (only one plan design option and one carrier option within each coverage tier).¹²⁵ Respondents indicated a preference for a “lot of choice” but “many felt that too much choice could be confusing as well—strong sentiment to keep things simple.”¹²⁶ Consumers spend an average of thirty minutes shopping for health insurance on the Massachusetts Connector website.¹²⁷

New York has its own experience with health insurance benefit standardization.¹²⁸ For example, New York’s individual market has standardized coverage for two HMO products.¹²⁹ The Healthy NY program is subsidized through a state reinsurance mechanism and offers coverage to eligible small businesses, sole proprietors and individuals.¹³⁰ Healthy NY offers two standardized benefit packages; each package covers essential health needs including inpatient and outpatient hospital services, physician services,

¹²⁰ *Id.* at 2148–49.

¹²¹ PAUL PRECHT, CONSUMERS UNION, REPORT SYNOPSIS: THREE HEALTH INSURANCE PROGRAMS DEMONSTRATE HOW STANDARDIZED HEALTH BENEFITS PROTECT CONSUMERS 4 (2009), available at <http://consumersunion.org/pdf/Role-Modes-Report.pdf>.

¹²² *Id.* at 4 (“[T]he standardized benefits, and in particular the comprehensive out-of-pocket caps in all plans reduce the risk of a bad choice, counselors said. Fully standardized benefits simplify health plan selection, enabling consumers to focus on premium costs and whether the plan allows access to preferred health care providers.”). One exception to the standardized benefits is the young adult policy which provides limited benefits. POLLITZ ET AL., *supra* note 31, at 5.

¹²³ POLLITZ ET AL., *supra* note 31, at 6 (Analyzing coverage disparities for, among other things, breast cancer or diabetes between plans offered in the Connector: “Among the 10 Massachusetts policies studied—referred to as plans A–J—the breast cancer patient would incur very different cost-sharing expenses under two seemingly similar bronze policies.”).

¹²⁴ Commonwealth Health Insurance Connector Authority, Commonwealth Choice Plan and Product Design Options (Apr. 2009) (PowerPoint presentation) (on file with authors).

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ See generally Holahan & Newell, *supra* note 70, at 114.

¹²⁹ *Id.* at 115.

¹³⁰ *Id.* at 134.

maternity care, preventive health services, diagnostic and x-ray services, and emergency services.¹³¹ The two benefit packages vary depending on whether enrollees choose a benefit package with or without a limited prescription benefit.¹³² The website describing Healthy NY coverage includes both a “Keep in Mind”¹³³ section and a “Services Not Covered by Healthy NY”¹³⁴ to alert potential enrollees of the limitations of the streamlined benefit offerings.

In 2009, Oregon passed landmark health reform legislation to, among other things, begin establishing a health insurance exchange.¹³⁵ Pursuant to that legislative effort, Oregon’s Health Policy Board was charged with establishing baseline health benefits to be offered by every product sold within the exchange.¹³⁶ Building off of New York’s Healthy NY program, Texas recently created the Healthy Texas program which offers a standardized benefit package with several customization options to eligible employers.¹³⁷ The future of state efforts to both standardize benefit packages and formulate uniform plan descriptions will undoubtedly be shaped by their implementation of the ACA.

Many more states have engaged in benefit restructuring efforts to this point. Regardless of past efforts, all states are currently analyzing the preemptive effect of the ACA on their regulatory structure. The section below identifies key areas of opportunity for states to go beyond the new federal floor, and relates those opportunities to several specific examples.

¹³¹ *Keep in Mind...*, N.Y. STATE INS. DEPT., <http://www.ins.state.ny.us/website2/hny/english/hnybp.htm> (last visited Jan. 20, 2011); see generally *Annual Reports on the Healthy NY Program*, N.Y. STATE INS. DEPT., <http://www.ins.state.ny.us/website2/hny/english/hnyrep.htm> (last visited Jan. 20, 2011).

¹³² See *Keep in Mind*, *supra* note 131.

¹³³ *Id.* (“Keep in Mind . . . Even though Healthy NY benefit packages are the same, the health plans may charge different premium rates. Once you have chosen which type of benefit package you want—with or without the prescription drug benefit—you will not be able to change your choice of benefit package until your annual recertification or if your premium rate changes. Covered services are subject to a copayment. All benefits are provided ‘in-network’ only, except for emergency services or where care is not available through a health care plan’s providers. Otherwise, you must use a health care plan’s network of providers.”).

¹³⁴ *Services Not Covered by Healthy NY*, N.Y. STATE INS. DEPT., <http://www.ins.state.ny.us/website2/hny/english/hnybp.htm> (last visited Jan. 20, 2011).

¹³⁵ TEN NEPAL ET AL., *supra* note 95, at 29–30.

¹³⁶ *Id.* at 30 (“This benefit package will be based on the OHP Prioritized List and will promote a patient-centered, primary care home model; require little or no cost sharing for evidence-based preventive care services; require greater cost sharing for elective services; and, create incentives for individuals to improve their health status.”).

¹³⁷ *Id.* at 27.

V. THE AFFORDABLE CARE ACT: NEW OPPORTUNITIES TO ADDRESS MARKET FAILURES

The ACA is perhaps the most significant step to date towards greater health benefit standardization. In the debate between unregulated choice, on one hand, and strict uniformity, on the other, the ACA occupies a middle ground of “structured choice.” The Act establishes a framework for federal and state regulators to standardize benefits,¹³⁸ as well as forms and procedures for administrative functions such as referrals and explanations of benefits.¹³⁹

The health benefit standardization provisions in the ACA provide a solid basis to address the information gap between consumers and insurers that, as discussed above, contributes to market failure in health insurance.¹⁴⁰ The ACA confronts the problem of asymmetric information through (1) disclosure requirements that make it easier to get specific information about health insurance products on the market, and (2) standardized formatting requirements that make it easier to compare health insurance products.¹⁴¹ Thus, consumers will be able to more effectively comparison-shop. Likewise, insurers will compete to a greater degree on price and quality, rather than on risk selection.¹⁴² Standardization of benefits promises to substantially improve the asymmetry of information in the current health insurance market.¹⁴³

In addition, the ACA’s standardization addresses the problem of

¹³⁸ See *e.g.*, Affordable Care Act §§ 1301–1302, 42 U.S.C. §§ 18021–18022 (2010) (highlighting the minimum requirements for consideration as a Qualified Health Plan as well as what is considered Essential Benefits); *id.* § 1252, 42 U.S.C. § 18012 (2010) (requiring that all rating reforms apply uniformly to all health insurance issuers and group health plans).

¹³⁹ *Id.* § 2715, 42 U.S.C. § 300gg-15 (2010) (Secretary of HHS, in consultation with the NAIC and a working group of consumer advocacy organizations, insurers, health care professionals, patient advocates, and other qualified individuals must develop standards for a summary of benefits and coverage explanation to be provided to all potential policyholders and enrollees. The summary must contain: uniform definitions of insurance and medical terms; a description of coverage and cost-sharing for each category of essential benefits and other benefits; exceptions, reductions and limitations in coverage; renewability and continuation of coverage provisions; a “coverage facts label” that illustrates coverage under common benefits scenarios; a statement of whether it provides minimum essential coverage with an actuarial value of at least sixty percent that meets the requirements of the individual mandate; a statement that the outline is a summary and that the actual policy language should be consulted; a contact number for the consumer to call with additional questions and the web address of where the actual policy language can be found.).

¹⁴⁰ See *supra* Part IV; see also Rothschild & Stiglitz, *supra* note 32.

¹⁴¹ See Affordable Care Act § 1103(b), 42 U.S.C. § 18003(b) (2010).

¹⁴² See *id.* § 1311(c)(1)(A), 42 U.S.C. § 18031(c)(1)(A) (2010).

¹⁴³ See *id.* § 2715, 42 U.S.C. § 300gg-15 (describing the information disclosure requirements).

risk underestimation discussed above.¹⁴⁴ Reforms to the commercial insurance market restrict some of the more problematic benefit limitations allowed by states.¹⁴⁵ And new health insurance plans will be required to meet minimum benefit requirements.¹⁴⁶ Furthermore, the ACA establishes an individual mandate, requiring most Americans to have a minimum level of health insurance coverage beginning in 2014.¹⁴⁷

Within the ACA framework, federal and state regulators have options to implement standardization. The ACA gives HHS opportunities to maximize or minimize uniformity in benefit structure and administration.¹⁴⁸ Similarly, state insurance regulators have a number of possible approaches to increase uniformity beyond the new federal regulatory floor established by the ACA.¹⁴⁹

This section discusses some of the transparency and standardization provisions in the ACA. In addition, this section reviews some of the choices available both to federal regulators when setting minimum rules for benefits, and to state regulators when establishing rules that create uniformity beyond the new federal minimums.

A. ACA Overview

1. Broad Objectives of the ACA

Health insurance coverage is consistently a top concern of Americans.¹⁵⁰ Most Americans receive health insurance coverage through an employer.¹⁵¹ However, high premium rate increases have resulted in decreased benefits, as employers shift costs to

¹⁴⁴ See *id.* §§ 1341–1343, 42 U.S.C. §18061–18063 (2010) (requiring payments to insurers of high-risk individuals and describing risk adjustment methods).

¹⁴⁵ See *id.* § 1302, 42 U.S.C. § 18022 (2010) (listing the requirements of essential health benefits).

¹⁴⁶ See *id.* § 2713 (codified in scattered sections of 42 U.S.C. § 300gg) (requiring minimum coverage of preventive health services).

¹⁴⁷ *Id.* § 1501, 26 U.S.C. § 5000A (2010).

¹⁴⁸ See *id.* § 1001 (codified as amended at scattered sections of 42 U.S.C. § 300gg); *id.* § 2715, 42 U.S.C. § 300gg-15; *id.* § 10101, 42 U.S.C. § 300gg-11; *id.* § 2718, 42 U.S.C. §300gg-18.

¹⁴⁹ See *id.* § 1321(b), 42 U.S.C. § 18041(b).

¹⁵⁰ See *Health Care Top Domestic Concern: Poll*, REUTERS (Mar. 2, 2007), <http://www.reuters.com/article/idUSN0121448720070302>.

¹⁵¹ See MARK W. STANTON, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, EMPLOYER-SPONSORED HEALTH INSURANCE: TRENDS IN COSTS AND ACCESS 2 (2004), *available at* <http://www.ahrq.gov/research/emspria/emspria.pdf>.

employees.¹⁵²

The uninsured and underinsured face serious risks to health and finances. Those without coverage, or with inferior coverage, have worse health outcomes because they decline or delay care.¹⁵³ In addition, the uninsured and underinsured face financial difficulties. Health care costs are the leading cause of personal bankruptcy in the United States.¹⁵⁴ In 2009, over 50 million were without health insurance in the United States, up from approximately 46 million uninsured in 2008.¹⁵⁵ In 2009, the number of Americans with health insurance *decreased* for the first time since 1987.¹⁵⁶ Those without health insurance suffer worse health outcomes, worse financial outcomes, or both.

The ACA seeks to increase the quality and affordability of health insurance. The ACA layers several key strategies to improve the quality of health insurance coverage and reduce the number of uninsured. First, the ACA expands public programs, covering more of the poorest under Medicaid.¹⁵⁷ Second, the ACA reforms commercial health insurance market.¹⁵⁸ Reforms include limiting problematic insurance practices such as pre-existing condition exclusions.¹⁵⁹ Reforms also include ensuring a basic set of benefits for any new health insurance products.¹⁶⁰ Existing products will be

¹⁵² David S. Hilzenrath, *Employers Plan to Shift More Health-care Costs to Workers, Survey Reports*, WASH. POST, Mar. 12, 2010, at A4, available at <http://www.washingtonpost.com/wp-dyn/content/article/2010/03/11/AR2010031100740.html>.

¹⁵³ Dianne Miller Wolman & Wilhelmine Miller, *The Consequences of Uninsurance for Individuals, Families, Communities, and the Nation*, 32 J. L., MED. & ETHICS 397, 400 (2004).

¹⁵⁴ Affordable Care Act § 1501(a)(2)(G), 42 U.S.C. § 18091(a)(2)(G) (“62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.”); see Himmelstein et al., *supra* note 2, at W5-70.

¹⁵⁵ CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE IN THE UNITED STATES: 2009 71 (2010), available at <http://www.census.gov/prod/2010pubs/p60-238.pdf>.

¹⁵⁶ *Id.* at 22.

¹⁵⁷ JOCELYN GUYER & JULIA PARADISE, KAISER FAMILY FOUND., EXPLAINING HEALTH REFORM: BENEFITS AND COST-SHARING FOR ADULT MEDICAID BENEFICIARIES 1 (2010), available at www.kff.org/healthreform/upload/8092.pdf (“On January 1, 2014, the program [Medicaid] will be expanded to provide eligibility to nearly all people under age 65 with income below 133 percent of the federal poverty level [FPL]. As a result, millions of low-income adults without children who currently cannot qualify for coverage . . . will become eligible for Medicaid.”) (footnote omitted).

¹⁵⁸ Most of the private health insurance provisions amend Title XXVII of the Public Health Service Act. See Affordable Care Act § 1001 (amending 42 U.S.C. § 300gg). Title XXVII includes requirements on health insurance coverage for both group and nongroup markets, enforcement applicable to such requirements, relevant definitions, and other provisions. 42 U.S.C. § 300gg (as amended by Affordable Care Act § 1001).

¹⁵⁹ See Affordable Care Act § 1201, 42 U.S.C. § 300gg-1 (amending 42 U.S.C. § 300gg).

¹⁶⁰ See *id.* § 1302(b), 42 U.S.C. § 18022(b).

exempt from new minimum benefit requirements.¹⁶¹ Third, the ACA creates a new health insurance exchange in each state.¹⁶² The exchanges are intended to make commercial coverage more affordable by providing a sliding scale of federal subsidies based on need,¹⁶³ leveraging the purchasing power of individuals and small businesses to obtain better rates,¹⁶⁴ and forcing insurers to compete on price and quality rather than risk selection.¹⁶⁵ Fourth, the ACA establishes an individual mandate which requires,¹⁶⁶ with certain exceptions, that everyone maintain a minimum level of health insurance or face a penalty.¹⁶⁷

Ultimately, the Affordable Care Act features at least two normative judgments. First, individuals *should* have health insurance. As discussed below, the ACA requires individuals to purchase health insurance, with limited exceptions. Second, individuals *should* maintain a prescribed minimum level of health insurance. The ACA provides a framework for HHS to set a minimum level of standardized benefits for new health plans, also discussed below.¹⁶⁸ Thus, the ACA seeks to mitigate the impact of risk underestimation by: (1) standardizing benefit packages to meet the minimum needs of the average consumer¹⁶⁹ and (2) mandating that individuals purchase a benefit package that meets these minimum average requirements.¹⁷⁰

¹⁶¹ See BERNADETTE FERNANDEZ, CONG. RES. SERV., P.L. 111-148, GRANDFATHERED HEALTH PLANS UNDER PPACA (2010).

¹⁶² Affordable Care Act § 1311, 42 U.S.C. § 18031.

¹⁶³ See *id.* § 1401, 26 U.S.C. § 36B.

¹⁶⁴ See *id.* § 1312(c), 42 U.S.C. § 18032(c).

¹⁶⁵ DAVID BALTO, CTR. FOR AMERICAN PROGRESS, *MAKING HEALTH CARE COMPETITION WORK: HOW TO ENSURE HEALTH INSURANCE REFORM IS TRANSPARENT AND EFFECTIVE 2* (2010), available at http://www.americanprogress.org/issues/2010/06/pdf/balto_memo.pdf (“Consumers simply cannot make an informed buying decision without transparency and adequate information about a plan’s coverage, terms, and conditions. Insurers are meanwhile protected by complexity and opaque arrangements, and can avoid real competition in price, quality, and service.”).

¹⁶⁶ See Affordable Care Act § 1501, 42 U.S.C. § 18091.

¹⁶⁷ See *id.* § 1501(b), 26 U.S.C. § 5000A(b). This section also includes congressional findings that address the constitutionality of an individual mandate to obtain health insurance. See *id.* § 1501(a), 42 U.S.C. § 18091(a). For more information on this issue, see JENNIFER STAMAN & CYNTHIA BROUGH, CONG. RES. SERV., *REQUIRING INDIVIDUALS TO OBTAIN HEALTH INSURANCE: A CONSTITUTIONAL ANALYSIS* (2009).

¹⁶⁸ See Affordable Care Act § 1311, 42 U.S.C. § 18031.

¹⁶⁹ See *id.* § 1302(b), 42 U.S.C. § 18022(b).

¹⁷⁰ See *id.* § 1501(b), 26 U.S.C. § 5000A(b).

2. Federal Floor, Not State Ceiling

The Affordable Care Act creates new federal standards in numerous areas of the health insurance market. Drafters of the legislation stated that the reforms would establish a federal floor, but not a state ceiling, thereby allowing states the flexibility to exceed new federal minimums.¹⁷¹ In many instances the statute does just that. In certain other areas, however, the ACA is both a federal floor and a federal ceiling, thereby limiting state flexibility.¹⁷²

Title I of the ACA contains many of the new federal standards relating to health insurance coverage. Regarding preemption of state laws, the statute provides: “[n]othing in this title shall be construed to preempt any state law that does not prevent the application of the provisions of this title.”¹⁷³

The text of this subsection is similar to provisions in the Health Insurance Portability and Accountability Act (“HIPAA”)¹⁷⁴ and the Employee Retirement and Income Security Act (“ERISA”).¹⁷⁵ Both HIPAA and ERISA ensure a basic set of minimum national standards regarding areas they govern, but allow states to make and enforce laws that provide greater consumer protections.¹⁷⁶ The scope and application of the preemption provisions of both laws—particularly ERISA—have been the subject of much dispute and litigation.¹⁷⁷

In some areas, the ability of states to regulate beyond the federal minimum standards is reasonably apparent. For example, the ACA

¹⁷¹ *See id.* § 1331(a), 42 U.S.C. § 18051(a).

¹⁷² Although the ACA allows a State to require additional benefits to be considered a Qualified Health Plan, the State must pay for the additional cost of the mandated benefits. *See id.* § 1311(d)(3)(B), 42 U.S.C. § 18031(d)(3)(B). This may actually reduce coverage in some states.

¹⁷³ *Id.* § 1321(d), 42 U.S.C. § 18041(d).

¹⁷⁴ *See* 42 U.S.C. § 300gg-23(a)(1) (2010).

¹⁷⁵ 29 U.S.C. § 1911(a)(1) (2010).

¹⁷⁶ *See* 42 U.S.C. § 300gg-23(a)(1); 29 U.S.C. § 1911(a)(1).

¹⁷⁷ *See generally* WILLIAM PIERRON & PAUL FRONSTIN, EMP. BENEFIT RES. INST, ERISA PRE-EMPTION: IMPLICATIONS FOR HEALTH REFORM AND COVERAGE (2008), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf (discussing key issues of ERISA pre-emption and State reforms). Over the years, the Supreme Court has examined the scope of ERISA’s pre-emption in several cases. *See e.g.*, Kentucky Ass’n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003); Boggs v. Boggs 520 U.S. 833 (1997); DeBuono v. NYSA-ILA Med. & Clincial Servs. Fund, 520 U.S. 806 (1997); N.Y. State Conf. of Blue Cross & Blue Shield v. Travelers Ins. Co., 514 U.S. 645 (1995); District of Columbia v. Wash. Bd. of Trade, 506 U.S. 125 (1992); FMC Corp. v. Holliday, 498 U.S. 52 (1990); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987); Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985); Shaw v. Delta Air Lines, 463 U.S. 85 (1983).

sets a federal standard for how insurers calculate premium rates with respect to the experience (or level of sickness) of the group or individual.¹⁷⁸ Specifically, the statute requires all insurers to comply with an adjusted community rating standard with a maximum variation for age of 3:1.¹⁷⁹

Presumably, state laws could require less variation in rating by age, but not more. Thus, New York State's pure community rating standards, which prohibit any age variation in rating, would not be preempted. The New York standard affords consumers greater rating protection than under the federal minimum standard.

The general rule of "federal floor, not state ceiling" may be tested in the area of health benefits. The ACA contains certain specific provisions that will impact whether, and in which circumstances, states can regulate benefits to provide greater protections for consumers than federal minimum standards. As discussed below, HHS has options under the ACA to set federal minimum benefit standards both for commercial insurance offered within new health insurance exchanges, as well as in the commercial market outside the exchanges.¹⁸⁰ The degree of flexibility states retain to exceed those federal minimum standards appears clear in some instances, but may be limited in other instances.

B. Initial Transparency Improvements in Health Insurance Benefits under the ACA

The ACA addresses benefit standardization in two fundamental ways. First, the statute requires improved transparency and disclosure.¹⁸¹ Federal and state regulators have choices within the ACA structure to maximize or minimize the uniformity and accessibility of benefit information, and these choices will impact the degree to which the ACA reduces the health insurance market failure resulting from asymmetric information. Second, the ACA standardizes new health plan benefits, providing a more structured

¹⁷⁸ Affordable Care Act § 1201 (codified in scattered sections of 28 U.S.C.); *id.* § 1201, 42 U.S.C. §300gg(a).

¹⁷⁹ *Id.* Adjusted, or modified, community rating prohibits issuers from pricing health insurance policies based on health factors, but allows it for other key characteristics such as age or gender. Under the law, premiums will vary based only on the following risk factors: self-only or family enrollment; rating area, forty as specified by the state; age (by no more than a 3:1 ratio across age rating bands established by the Secretary, in consultation with the National Association of Insurance Commissioners ("NAIC"), and tobacco use (by no more than 1.5:1 ratio). *See id.* § 1201(a)(1)(A)(i)-(iv).

¹⁸⁰ *Id.* § 1001(5), 42 U.S.C. § 300gg-13.

¹⁸¹ *Id.* § 2709, 42 U.S.C. § 300gg-9.

set of options for consumers.¹⁸² Again, however, federal and state regulators have choices about how uniform the benefit packages will be. These choices will impact the degree to which the ACA successfully addresses information gaps and underestimations of risk.

The first set of reforms to take effect requires insurers to provide a greater degree of transparency for consumers about health benefits. As discussed above, an information imbalance exists between insurers and consumers regarding health plan benefits. The ACA addresses this problem in part by requiring insurers to disclose additional or better quality information.¹⁸³ The ACA standardizes the format of disclosure to increase consumer ability to understand benefit choices.¹⁸⁴ Uniform benefit information promises to be a significant step toward allowing consumers comparative information that may at least partially address the persistent information asymmetry plaguing health plan consumers.¹⁸⁵

1. Web Portal

One of the first of many “Immediate Actions to Preserve and Expand Coverage” in the ACA requires HHS, in consultation with the States, to establish an internet portal.¹⁸⁶ The internet portal is intended to help individuals and small businesses identify affordable health insurance options.¹⁸⁷ Pursuant to the ACA’s tight timeframe, HHS created the web portal by the July 1, 2010 deadline.¹⁸⁸

The ACA’s web portal provision is a prompt, initial response to the difficulty consumers experience in finding health insurance options in their state. The legislation specifies that the website

¹⁸² *Id.* § 10101(b), 42 U.S.C. § 300gg-15.

¹⁸³ *Id.* § 2709, 42 U.S.C. § 300gg-9.

¹⁸⁴ *Id.* § 1103, 42 U.S.C. § 18003.

¹⁸⁵ Balto, *supra* note 165, at 1. (“The transparency necessary for a well functioning market is also lacking. Insurance policies are inordinately complex and not standardized. Consumers simply do not have access to the information they need to make well-informed decisions, giving insurers the ability to mislead or deceive them. Consumers who testified before Congress detailed egregious, misleading, and deceptive conduct by health insurers. Health insurers would search for loopholes and novel policy interpretations to deny coverage for medically necessary treatments.”).

¹⁸⁶ Affordable Care Act § 1103(a), 42 U.S.C. § 18003(a).

¹⁸⁷ *Id.*

¹⁸⁸ See *Affordable Care Act: Web Portal, Pre-Existing Condition Insurance Plan & Health Insurance Exchanges*, NACO (2010), 1, http://www.naco.org/programs/csd/Documents/Health%20Reform%20Implementation/Portal_PCIP_Exchanges.pdf.

must include information on commercial coverage (other than single disease, single condition coverage and “unreasonably” limited coverage), Medicaid, SCHIP, state high risk pools (if the state has one), the newly created federal pre-existing condition insurance plan, and small group coverage, including the early retiree reinsurance program and other tax credits.¹⁸⁹ This list is a minimum requirement. States may identify other coverage options.¹⁹⁰

The web portal provision also requires HHS to create a standardized format to present the information about each of the coverage options described above.¹⁹¹ HHS issued an Interim Final Rule and began a comment period on May 10, 2010.¹⁹² The web portal is intended to both increase consumer awareness of available health insurance plans and also to provide a way for consumers to compare health insurance options.¹⁹³ Five pieces of information are required to be presented to enhance comparisons across options: the percentage of total premium revenue expended on nonclinical costs; eligibility details; availability; premium rates; and cost-sharing information.¹⁹⁴ Notably, HHS may carry out the duties described in this section by contracting with qualified entities.¹⁹⁵ Because of the quick timeline for the web portal, and for much of health reform implementation, HHS anticipated a phased rollout with basic information available in July 2010, and more detailed pricing information available in October 2010.¹⁹⁶

Although the web portal provides important information on health insurance options to consumers, its impact is limited. The web portal will work together with other key pieces of the ACA to

¹⁸⁹ Affordable Care Act § 1103(a)(2), 42 U.S.C. § 18003(a)(2).

¹⁹⁰ *Id.*

¹⁹¹ *Id.* § 1103(b)(1), 42 U.S.C. § 18003(b)(1).

¹⁹² 45 C.F.R. 159.100 (2010).

¹⁹³ In the Interim Final Rule, HHS states, “[i]n implementing these requirements, we seek to develop a website (hereinafter called the web portal) that would empower consumers by increasing informed choice and promoting market competition. To achieve these ends, we intend to provide a web portal that provides information to consumers in a clear, salient, and easily navigated manner. We plan to minimize the use of technical language, jargon, or excessive complexity in order to promote the ability of consumers to understand the information and act in accordance with what they have learned. We will engage in careful consumer testing to identify the best methods to achieve these goals.” 75 Fed. Reg. 24,470, 24,471 (May 5, 2010).

¹⁹⁴ Affordable Care Act § 1103(b), 42 U.S.C. § 18003(b).

¹⁹⁵ *Id.* § 1103(c), 42 U.S.C. § 18003(c).

¹⁹⁶ *Fact Sheet on Establishing the Web Portal Called For in the Affordable Care Act*, U.S. DEP’T HEALTH & HUMAN SERVS., <http://www.hhs.gov/ociio/gatheringinfo/factsheet.html> (last visited Jan. 20, 2011).

respond comprehensively to the information void faced by consumers. As discussed in more detail below, the Exchanges will likely conduct many of the web portal functions. The Exchanges should provide considerably more assistance to consumers than the portal alone. Nevertheless, the web portal is an initial, interim step that will provide more understandable information to consumers about health benefits.

2. Uniform Explanation of Coverage Documents

The first provision to take effect regarding standardization of benefit information in the ACA directs HHS to develop and use uniform explanation of coverage documents with standard definitions of important terms.¹⁹⁷ This provision of the ACA holds significant promise for the development of standardized information that will improve the ability of consumers to comparison-shop.¹⁹⁸

Specifically, within one year of enactment, HHS must develop standard benefit summaries for insurers offering products in the individual and group markets.¹⁹⁹ In developing these standards, HHS is directed to “consult with” the National Association of Insurance Commissioners (“NAIC”), as well as a working group that includes representatives from a broad range of stakeholders.²⁰⁰

The statute sets some particular parameters for HHS to develop standard benefit information. Specifically, the Act includes requirements regarding the appearance,²⁰¹ language,²⁰² and content²⁰³ of the benefit summary. The benefit summary provisions

¹⁹⁷ Affordable Care Act § 2715(a)(3)(A), 42 U.S.C. § 300gg-15(a)(3)(A).

¹⁹⁸ See SURVEY OF PEOPLE WHO PURCHASE THEIR OWN INSURANCE, KAISER FAMILY FOUND. 12 (2010), available at <http://www.kff.org/kaiserpolls/upload/8077-R.pdf>.

¹⁹⁹ Affordable Care Act § 2715(a), 42 U.S.C. § 300gg-15(a).

²⁰⁰ See *id.* Specifically, the statute directs the HHS Secretary to “consult with the [NAIC], a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.” *Id.*

²⁰¹ See *id.* § 2715(b)(1), 42 U.S.C. § 300gg-15(b)(1) (HHS regulation “shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.”).

²⁰² See *id.* § 2715(b)(2), 42 U.S.C. § 300gg-15(b)(2) (HHS regulation “shall ensure that the summary is presented in a linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.”).

²⁰³ See *id.* § 2715(b)(3), 42 U.S.C. § 300gg-15(b)(3) (HHS regulation “shall ensure that the summary of benefits and coverage includes: (A) uniform definitions of standard insurance terms and medical terms . . . so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage); (B) a description of the coverage, including cost sharing for (i) each of the categories of the essential health benefits

apply to both fully insured and self-insured health plans.²⁰⁴ Health plans will be required to provide the benefits summary either before enrollment or reenrollment, or at the time the policy is issued.²⁰⁵ And there is a penalty for health plans that fail to provide the required summary.²⁰⁶

Perhaps most significant to the standard benefits summary is the requirement that directs HHS to develop standards for the definitions of terms used in health insurance coverage.²⁰⁷ The ACA directs HHS to develop standard definitions for both “insurance-

described in [ACA § 1302(b)(1)(A)–(J)]; and (ii) other benefits, as identified by the Secretary; (C) the exceptions, reductions, and limitations on coverage; (D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations; (E) the renewability and continuation of coverage provisions; (F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines; (G) a statement of whether the plan or coverage (i) provides minimum essential coverage (as defined under [the Internal Revenue Code § 5000A(f)]; and (ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs; (H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and (I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.”).

²⁰⁴ See *id.* § 2715(d)(3), 42 U.S.C. § 300gg-15(d)(3) (stating that the requirements of the provision apply to: “(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or (B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement and Income Security Act of 1974).” *Id.* Whether a health plan is insured or self-insured depends on who assumes risk. In a fully insured plan, the insurance company assumes the risk that claims from policyholders who use covered medical services will not exceed premiums. In a self-insured plan, the employer assumes that same risk. For a more detailed discussion on the difference between fully insured and self-insured health plans, see *Health Plan Differences: Fully-Insured vs. Self-Insured*, FAST FACTS (Emp. Benefit Research Inst., D.C.), Feb. 11, 2009, available at <http://www.ebri.org/pdf/FFE114.11Feb09.Final.pdf>.

²⁰⁵ Affordable Care Act § 2715(d), 42 U.S.C. § 300gg-15(d) (requiring the health plan to: “provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standers developed by [HHS] under subsection (a) to (a) and application at the time of application; (B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and (C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate”).

²⁰⁶ See *id.* § 2715(f), 42 U.S.C. § 300gg-15(f) (stating that a health plan that “willfully fails to provide the information required under this section shall be subject to a fine of not more than \$1,000 for each such failure”). The requirement that the health plan “willfully” failed to provide the summary makes enforcement more difficult, as intent is typically more difficult to prove. However, the fact that the \$1,000 maximum fine applies to “each enrollee” as a “separate offense” means that, if regulators can demonstrate requisite intent, the penalty may be significant.

²⁰⁷ See *id.* § 2715(g)(1), 42 U.S.C. § 300gg-15(g)(1) (HHS “shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).”).

related terms”²⁰⁸ and “medical terms.”²⁰⁹ This directive provides HHS with an extraordinary opportunity to improve transparency²¹⁰ and begin to increase the availability of reliable, standardized consumer information.

The ACA further requires disclosure of crucial additional information that will assist consumers in benefit selection. Specifically, the ACA requires health plans to submit to both HHS and state insurance regulators the following information, in plain language. First, health plans are required to submit information on “cost-sharing and payments with respect to any out-of-network coverage.”²¹¹ Second, periodic financial information must be disclosed.²¹² Third, health plans are required to provide data related to enrollment and disenrollment.²¹³ Fourth, the number of claims the health plan denies must be disclosed.²¹⁴ Fifth, health plans must provide information on how premium rates are set.²¹⁵ Sixth, information on consumer rights under the ACA must be provided.²¹⁶ Seventh, health plans must submit claims payment policies and practices.²¹⁷ Lastly, the ACA gives HHS broad discretion to require health plans to submit any other information that HHS determines is appropriate.²¹⁸

Each of these disclosure requirements gives HHS an opportunity to provide more uniform information to consumers. Depending on

²⁰⁸ *See id.* § 2715(g)(2), 42 U.S.C. § 300gg-15(g)(2) (“The insurance-related terms described in this paragraph are premium, deductible, con-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as [HHS] determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.”).

²⁰⁹ *See id.* § 2715(g)(3), 42 U.S.C. § 300gg-15(g)(3) (“The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipments, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).”).

²¹⁰ BALTO, *supra* note 165, at 1.

²¹¹ Affordable Care Act § 10104(f)(3)(A)(vii), 42 U.S.C. § 18031(f)(3)(A)(vii).

²¹² *See id.* § 10104(f)(3)(A)(ii), 42 U.S.C. § 18031(f)(3)(A)(ii).

²¹³ *See id.* § 10104(f)(3)(A)(iii)–(iv), 42 U.S.C. § 18031(f)(3)(A)(iii)–(iv).

²¹⁴ *See id.* § 10104(f)(3)(A)(v), 42 U.S.C. § 18031(f)(3)(A)(v).

²¹⁵ *See id.* § 10104(f)(3)(A)(vi), 42 U.S.C. § 18031(f)(3)(A)(vi).

²¹⁶ *See id.* § 10104(f)(3)(A)(viii), 42 U.S.C. § 18031(f)(3)(A)(viii).

²¹⁷ *See id.* § 10104(f)(3)(A)(i), 42 U.S.C. § 18031(f)(3)(A)(i).

²¹⁸ *See id.* § 10104(f)(3)(A)(ix), 42 U.S.C. § 18031(f)(3)(A)(ix); *see also* CURTIS W. COPELAND, CONG. RESEARCH SERV., P.L. 111-148, REGULATIONS PURSUANT TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010), *available at* <http://www.nga.org/Files/pdf/1004CRSPACA.pdf> (outlining specific provisions that give the Secretary authority to promulgate new criterion).

how HHS chooses to draft regulations with respect to these disclosure requirements, states may have opportunities to require uniformity—in the state, at least—that exceeds the federal minimum standards. The next section discusses the first disclosure requirement above—information on “cost-sharing and payments with respect to any out-of-network coverage” and how federal and state regulators might approach standardization and uniformity.

3. Out-of-Network Benefits: An Example of Informational Asymmetry, Market Failure, and Government Response

The lack of transparency for out-of-network benefits illustrates the adverse impact of asymmetric information on consumers and the health insurance market.²¹⁹ To date, neither the market nor regulators provide an effective method for consumers to determine the level of coverage provided for out-of-network benefits.²²⁰ Subscriber contract language describing these benefits is typically vague and often misleading.²²¹ As a result, consumers typically do not fully understand what they are buying and cannot effectively comparison-shop for an out-of-network benefit among health plans.²²²

In the decades following World War II, most health insurance products were based on indemnification.²²³ Under indemnity products, health plans reimbursed consumers for all or some of the costs of covered medical services.²²⁴ The health plan did not have a contract with the doctor, hospital or other provider.²²⁵ Rather, the consumer had a direct contractual relationship with the provider, and the consumer retained responsibility to pay the provider.²²⁶ After receiving the bill from the provider, the consumer would

²¹⁹ JOHN R. THOMAS, MEDSYNERGIES, INSURANCE BENEFITS: MANAGING AN OUT-OF-NETWORK EXPERIENCE 1–2 (2007), available at http://www.medsynergies.com/downloads/whitepapers/wp_OutofNetwork_0307.pdf.

²²⁰ *Id.*

²²¹ See Russell Korobkin, *The Efficiency of Managed Care “Patient Protection” Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 76 (1999).

²²² See, e.g., Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 494–95 (June, 1997) (providing a discussion on the effects of asymmetrical information between buyers and sellers of healthcare).

²²³ PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 327 (Basic Books 1982); see also Melissa Thomasson, *Health Insurance in the United States*, ECON. HISTORY SERVICES (Feb. 1, 2010), <http://eh.net/encyclopedia/article/thomasson.insurance.health.us>.

²²⁴ STARR, *supra* note 223, at 291.

²²⁵ *See id.*

²²⁶ *See id.*

submit a claim to the health plan, which would then pay (or indemnify) the consumer for all or some of the claim amount.²²⁷

In the last several decades, the health insurance market has shifted away from indemnity to managed care as the predominant model.²²⁸ Under managed care, health insurers seek to contain costs, in part, by entering into contracts with providers.²²⁹ One primary cost containment feature of provider contracts is reduced fee schedules for medical services.²³⁰ By paying the provider less, the managed care plan lowers its costs.²³¹

Some managed care plans, like a traditional health maintenance organization (“HMO”) or an exclusive provider organization (“EPO”), have a closed network of providers.²³² Under these closed networks, consumers typically have a modest copayment, or set fee, for services received from a network provider.²³³ Under most circumstances, consumers in these closed network model managed care plans have no coverage for services received from an out-of-network provider.²³⁴

However, many consumers are in health plans that allow them to go out-of-network without obtaining approval from the plan gatekeeper.²³⁵ Such plans include preferred provider organization (“PPO”) plans, which often use gatekeepers, lower in-network out-of-pocket expenses and other design features to encourage consumers to use a provider in contract with the plan, or an “in-network” provider.²³⁶ When consumers use these in-network providers, they typically pay a set copayment, similar to an HMO or EPO.²³⁷ The difference is that consumers in PPO plans receive some reimbursement, typically on an indemnity basis, if they obtain care from an out-of-network provider.²³⁸

²²⁷ See *id.*

²²⁸ *Managed Care and the States*, NCSL (Dec. 2009), <http://www.ncsl.org/Default.aspx?TabId=14470>.

²²⁹ See Stephen Blakely, *The Backlash Against Managed Care*, NATION’S BUS. (U.S. Chamber of Commerce, D.C.), July 1998, available at http://findarticles.com/p/articles/mi_m1154/is_n7_v86/ai_20797610/?tag=content;coll.

²³⁰ *Id.*

²³¹ *Id.*; see also KAISER FAMILY FOUND., HOW PRIVATE HEALTH COVERAGE WORKS: A PRIMER 2008 UPDATE 4 (Apr. 2008), <http://www.kff.org/insurance/upload/7766.pdf>.

²³² Blakely, *supra* note 229.

²³³ *Id.*

²³⁴ *Id.*

²³⁵ *Id.*

²³⁶ *Id.*

²³⁷ *Id.*

²³⁸ See *High Deductible Health Plans*, PERFECT HEALTH, <http://www.perfecthealthsavings.com/deductible.htm> (last visited Jan. 20, 2011).

The amount of reimbursement a consumer receives for care from an out-of-network provider has two basic forms. First, the subscriber contract may define out-of-network reimbursement according to a set fee schedule.²³⁹ For example, the subscriber contract states that it will pay (or indemnify) the consumer according to the Medicare rate (fee schedule) or one of the health plan's in-network provider rate schedules. If the provider's fees exceed the amount paid by the health plan according to the set fee schedule, the consumer is liable for the difference.

Second, and more frequently, the subscriber contract often describes the out-of-network payment as some percentage of the "usual and customary rate" ("UCR") for the service at issue.²⁴⁰ The UCR is typically either not defined, or only vaguely defined. Consumers have very little ability to discern the scope of this benefit.²⁴¹ It is this second method of defining an out-of-network benefit, reimbursement at a percentage of the UCR, that has generated the greatest controversy.

Health plan use of UCR as a basis for out-of-network benefits has been the focus of numerous lawsuits and investigations. In March 2000, a class action lawsuit was filed against United HealthCare ("United") in New York by the American Medical Association and the Medical Society of the State of New York, among others.²⁴² The suit alleged that the method by which United determined UCR improperly reduced reimbursements to consumers and, by extension, providers.²⁴³ Several other class action lawsuits were filed against health plans making similar allegations regarding the inadequacy of UCR reimbursement for out-of-network care.²⁴⁴

The core allegation in these lawsuits is that the data used to calculate UCR is flawed.²⁴⁵ That data was generated by Ingenix, Inc., a company owned by United.²⁴⁶ Most health insurers, not just

²³⁹ *Id.*

²⁴⁰ *Usual, Customary, and Reasonable: Benefit Fact Sheet*, ARLENGROUP (2008), http://www.arlengroup.com/facts/fact_ucr.pdf.

²⁴¹ *Id.*

²⁴² *Am. Med. Ass'n v. United Healthcare Corp.*, Nos. 00 Civ. 2800(LMM), 00 Civ. 7246(LMM), 2001 WL 863561 (S.D.N.Y. July 31, 2001).

²⁴³ *Id.* at *2.

²⁴⁴ *See, e.g.*, *Am. Med. Ass'n v. United Healthcare Corp.*, No. 00 Civ. 2800(LMM)(GWG), 2002 WL 31413668, at *1 (S.D.N.Y. Oct. 23, 2002), *aff'd* 2003 WL 348963 (S.D.N.Y. Feb. 7, 2003); *Michael Davekos, P.C. v. Liberty Mut. Ins. Co.*, No. 10002, 2008 WL 241613, at *1 (Mass. App. Div. Jan. 24, 2008).

²⁴⁵ *Am. Med. Ass'n*, 2001 WL 863561, at *9.

²⁴⁶ Press Release, Office of the Attorney Gen., State of N.Y., Attorney General Cuomo Announces Historic Nationwide Health Insurance Reform; Ends Practice of Manipulating Rates to Overcharge Patients by Hundreds of Millions of Dollars (Jan. 13, 2009), *available at*

United, used Ingenix data, as it was the primary source of data purporting to reflect provider rates based on claims submitted to insurers.²⁴⁷

After years of pretrial maneuvers and discovery, the conflict over UCR came to a head. In January 2008, the court in one of the class action cases, *Michael Davekos, P.C. v. Liberty Mutual Insurance Co.*, found that Ingenix data did not have sufficient indicia of reliability to be admissible evidence, in part because Ingenix did not verify the accuracy or completeness of the underlying claims information used in its data.²⁴⁸

In August 2008, the court in another class action identified specific errors in the Ingenix database. In *McCoy v. Health Net, Inc.*, the court upheld a proposed settlement in which Health Net agreed to pay \$215 million to consumers who had been underpaid due to failings in the Ingenix data used to calculate UCR.²⁴⁹ Health Net also agreed to increase future reimbursements by 14.5% due to the shortfalls of the data.²⁵⁰ The *McCoy* court found that flaws in the Ingenix database fell into three areas.²⁵¹ First, Ingenix data collection is problematic because the claims—which are voluntarily submitted by insurers—are not tested to see if they are an accurate representative sample for a particular procedure in a particular geographic area.²⁵² Ingenix data collection is also problematic because the data fails to account for the skill level of the provider, mixing specialists with nurses.²⁵³ Second, the creation of the database is defective because it excludes certain outlier values (high claims) without determining whether the values are accurate.²⁵⁴

http://www.ag.ny.gov/bureaus/health_care/HIT2/pdfs/FINALHITIngenixReportJan.13,%202009.pdf [hereinafter Health Insurance Reform].

²⁴⁷ Prior to Ingenix, similar data was produced by the Health Insurance Association of America (“HIAA”), the primary trade group for the health insurance industry. Specifically, HIAA produced the Prevailing Healthcare Charge System (“PHCS”), which professed to provide claim submissions to insurers. COMM. ON COMMERCE, SCI, AND TRANSP., U.S. SENATE, STAFF REPORT FOR CHAIRMAN ROCKEFELLER 3 (2009). Ingenix purchased the PHCS database from HIAA in 1998. *Id.* Ingenix already owned the other primary data source for provider claim information, Medical Data Resource. *Id.* In 2001, Ingenix merged the two databases. *Id.* at 3–4; see also Barbara G. Quackenbos & Linda V. Tiano, *The Evolution of Coverage and Payment for the Services of Out-of-Network (ONET) Providers in Managed Care Plans*, in *Payors, PLANS AND MANAGED CARE LAW INSTITUTE* (Am. Health Lawyers Ass’n ed., 2009).

²⁴⁸ *Michael Davekos, P.C.*, 2008 WL 241613, at *1.

²⁴⁹ *McCoy v Health Net, Inc.*, 569 F. Supp. 2d 448, 452 (D. N.J. 2008).

²⁵⁰ *Id.* at 453.

²⁵¹ *Id.* at 464.

²⁵² *Id.* at 465.

²⁵³ *Id.* at 466.

²⁵⁴ *Id.* at 467.

Third, in the majority of its reported rates, an insufficient number of claims existed.²⁵⁵ The insufficient number of claims “skewed” the end result of the method by which Ingenix estimated rates.²⁵⁶

In January 2009, the AMA announced a proposed settlement with United, in which United agreed to pay \$350 million for patients and providers who had been reimbursed less than they should have due to flaws in the Ingenix data.²⁵⁷ The court subsequently raised concerns about the sufficiency of settlement amount, as well as the quality of information that United provided to the plaintiffs during negotiations.²⁵⁸ The settlement has gone forward, however.²⁵⁹

Significantly, even before the *McCoy* decision and settlement of the AMA lawsuit, the UCR issue gained national attention when then New York State Attorney General, Andrew Cuomo, announced an investigation in February 2008.²⁶⁰ Less than one year later, in January 2009, the Attorney General issued a report on the investigation, concluding that a conflict of interest existed because United, one of the nation’s largest health insurers, owned Ingenix.²⁶¹ The Attorney General found that the Ingenix database resulted in under-reimbursement to consumers in New York by up to twenty-eight percent.²⁶²

The New York Attorney General’s investigation focused on deceptive business practices.²⁶³ Health insurers had represented that out-of-network services would be covered at the “usual and customary rates.”²⁶⁴ However, defects in the Ingenix data lowered the calculations, making the rate neither “usual” nor “customary.”²⁶⁵

However, in addition to being deceptive, the lack of accurate

²⁵⁵ *See id.* at 467–68.

²⁵⁶ *Id.* According to the court, the end result was skewed on the third area because Ingenix failed to take into account both the mean value and the standard deviation when standardizing values with groups of codes. *Id.* at 468 n.12.

²⁵⁷ *Am. Med. Ass’n v. United Healthcare Corp.*, No. 00 Civ. 2800(LMM), 2009 WL 1437819, at *2) (S.D.N.Y. May 19, 2009).

²⁵⁸ *Id.* at *6.

²⁵⁹ *Id.* at *2.

²⁶⁰ Press Release, Office of the Attorney Gen., State of N.Y., Cuomo Announces Industry-Wide Investigation into Health Insurers’ Fraudulent Reimbursement Scheme (Feb. 13, 2008), http://www.ag.ny.gov/media_center/2008/feb/feb13a_08.html.

²⁶¹ Press Release, Office of the Attorney Gen., State of N.Y., Attorney General Cuomo Announces Historic Nationwide Health Insurance Reform; Ends Practice of Manipulating Rates to Overcharge Patients by Hundreds of Millions of Dollars (Jan. 13, 2009), *available at* http://www.ag.ny.gov/media_center/2009/jan/jan13a_09.html [hereinafter Press Release, Historic Nationwide Health Insurance Reform].

²⁶² Health Insurance Reform, *supra* note 246.

²⁶³ *Id.*

²⁶⁴ *Id.*

²⁶⁵ *Id.*

information about the level of out-of-network benefits in subscriber contracts has been one of many factors contributing to inaccurate pricing and an inefficient market.²⁶⁶ Consumers (whether individuals or businesses who are purchasing insurance) did not have accurate information about the true level of benefits in the subscriber contracts.²⁶⁷ They did not know that “usual and customary rates” were calculated by a company owned by an insurer that used flawed data.²⁶⁸ And consumers did not know that this flawed data led to rates lower than the rate that was usual and customary for real out-of-network providers to actually charge.²⁶⁹ Without this knowledge, consumers presumably believed they were getting a better benefit than they actually were. In short, consumers paid too much.

The Attorney General settled the matter with the health insurers.²⁷⁰ The groundbreaking settlement agreement contained certain transparency requirements and prohibited future use of flawed data in calculating the “usual and customary rates.”²⁷¹ Significantly, the settlements required insurers to help fund and then use a new data service for calculating such rates.²⁷² The new data service will be a non-profit without the conflicts of interest that plagued Ingenix.²⁷³ However, the settlements did not ban the insurers from using Ingenix while the new data service was being established.²⁷⁴ A new not-for-profit company, called FAIR Health, aims to have the new data service up and running in 2011.²⁷⁵

The New York State Insurance Department made public draft regulations consistent with Attorney General Cuomo’s

²⁶⁶ OFFICE OF THE ATTORNEY GEN., STATE OF N.Y., HEALTH CARE REPORT: THE CONSUMER REIMBURSEMENT SYSTEM IS CODE BLUE 17 (2009), available at http://www.ag.ny.gov/bureaus/health_care/HIT2/pdfs/FINALHITIngenixReportJan.13,%202009.pdf.

²⁶⁷ *Id.* at 18.

²⁶⁸ *Id.*

²⁶⁹ *Id.* at 2–3.

²⁷⁰ Press Release, Historic Nationwide Health Insurance Reform, *supra* note 261.

²⁷¹ See Reed Abelson, *New Database to Help Set Payouts by Health Insurers*, N.Y. TIMES, Oct. 27, 2009, <http://www.nytimes.com/2009/10/28/business/28insure.html>. Here, the costs are referred to as “reasonable and customary” while traditionally called “usual and customary.” *Id.*

²⁷² Press Release, Historic Nationwide Health Insurance Reform, *supra* note 261.

²⁷³ *Id.*

²⁷⁴ Danny Hakim & Reed Abelson, *Big Health Insurer Agrees to Update Its Fee Data*, N.Y. TIMES, Jan. 13, 2009, http://www.nytimes.com/2009/01/13/health/policy/13care.html?_r=1&scp=30&sq=ingenix&st=cse.

²⁷⁵ See PRODUCT DESCRIPTIONS, FAIR HEALTH INC., <http://www.fairhealthus.org/data-products/product-descriptions> (last visited Jan. 20, 2011).

settlements.²⁷⁶ The regulations proposed to make permanent key elements of those settlements.²⁷⁷ The draft regulations require insurers to ensure that any “usual and customary rates” are free from the defects in the Ingenix data calculations. In short, insurers must pay what they promise.²⁷⁸

In addition, the draft regulation proposes to require disclosure of set rates for out-of-network benefits.²⁷⁹ Insurers must specifically announce the set rate being used, whether the Medicare fee schedule, the insurer’s in-network fee schedule, or some other set rate.²⁸⁰

The New York Insurance Department’s draft regulation further proposes to require health plans to disclose the methodology for calculating the rate.²⁸¹ And it will mandate that plans disclose the specific amount that the insurer will reimburse.²⁸² Taken together, the reforms included in this proposed regulation will greatly improve disclosure regarding out-of-network benefits.

The New York Insurance Department’s draft regulation is one approach available to federal or state regulators implementing the ACA. In particular, the regulation may be instructive for implementing the ACA’s benefit disclosure requirements with

²⁷⁶ Minimum Standards for the Form, Content, and Sale of Health Insurance, Including Standards for Full and Fair Disclosure, 43rd Amendment to Regulation No. 62 (proposed June 2009) (to be codified at 11 N.Y. COMP. R. & REGS. tit. 11, § 52.67), http://www.ins.state.ny.us/r_misc/draft_reg_ucr_062009.pdf [hereinafter Minimum Standards].

²⁷⁷ *Compare* Press Release, Historic Nationwide Health Insurance Reform, *supra* note 261 (explaining Attorney General Cuomo’s settlement agreement), *and* Hakim & Abelson, *supra* note 274 (explaining the transparency requirements), *with* Minimum Standards, *supra* note 276.

²⁷⁸ *See* Minimum Standards, *supra* note 276; *see also* Press Release, Office of the Attorney Gen., State of N.Y., Attorney General Cuomo Announces Final Agreement in Historic Reform on Health Insurance Industry—Every Insured New Yorker Now Protected From Corrupt Reimbursement System (June 18, 2009), http://www.ag.ny.gov/media_center/2009/june/june18a_09.html.

²⁷⁹ Minimum Standards, *supra* note 276. Subscriber contracts typically describe out-of-network benefits one of two ways. First, as discussed above, the health plan promises to pay some percentage of the “usual and customary rate.” Second, the health plan promises to pay according to a set rate. For example, the health plan may pay the Medicare rate (the federally-established rate of payment for medical services provided to Medicare beneficiaries). Or the health plan may pay some other rate based on the health plan’s in-network payments to contracted providers or some other rate. The set rate is typically lower than what most out-of-network providers actually charge. If the set rate is not lower, the percentage of the rate covered is typically lower than what most out-of-network providers actually charge (e.g., the health plan pays eighty percent of the set rate). Otherwise, health plans would provide little incentive for consumers to stay in-network.

²⁸⁰ *Id.*

²⁸¹ *Id.*

²⁸² *Id.*

respect to “cost-sharing and payments with respect to any out-of-network coverage.”²⁸³ HHS could require health plans to provide disclosure for UCR or set fee rates, similar to the New York Insurance Department regulation. Should HHS decline to fully adopt this approach, state regulators should be able to adopt all or parts of this approach, to the extent the state rules exceed any federal minimums.

To the extent health plans continue to use UCR as a basis for out-of-network benefits, this approach would ensure that UCR payments are not subject to the data defects and conflicts of interest identified in the legal actions against Ingenix by the New York Attorney General and others discussed above. If the FAIR Health data system provides more accurate UCR data, consumers will have better ability to understand their true coverage for out-of-network benefits.²⁸⁴ And disclosure to consumers will be enhanced by a requirement that the health plan provide a calculator for consumers to determine the amount their health plan will pay for particular procedures.²⁸⁵

The degree to which this approach improves transparency is limited. In the wake of the reforms resulting from the New York Attorney General’s settlements and the New York Insurance Department draft regulation that followed, health plans in New York have increasingly moved to set fee rates with lower amounts. Improved transparency in New York can allow consumers to understand their out-of-network benefits. However, the New York approach does not limit the ability of health plans to offer, and for employers to purchase, benefits with lower rates. Often these lower rates are not evident to consumers. For example, a health plan that switches from paying eighty percent of UCR to paying one hundred percent of a set fee rate may appear to the consumer to have increased its benefit (from eighty percent to one hundred percent). But if the set fee rate is half that of the UCR under the improved FAIR standard, consumers actually receive less benefits. Because these lower rates are not apparent to consumers, New York’s approach may not fully address the problem of asymmetric information.

To address this concern, federal and state regulators may wish to consider going beyond New York’s approach. For consumers to be

²⁸³ Affordable Care Act § 1303, 42 U.S.C. § 18031 (2010).

²⁸⁴ See *McCoy v. Health Net, Inc.*, 569 F. Supp. 2d 448, 451 (D. N.J. 2008).

²⁸⁵ See *id.*

able to shop effectively among competing health plans with respect to out-of-network benefits, they must be able to compare “apples to apples.” Thus, regulators could set a standard value for out-of-network benefits by which all such benefits can be measured. For example, regulators could require health plans to express the value of their out-of-network benefits as measured against total actuarial value, or the FAIR standard for UCR, or some other standard. By doing so, regulators might better help consumers compare the actual overall value of out-of-network benefits in each plan according to a uniform standard. This may be a creative solution to information imbalance regarding out-of-network benefits in the health insurance market.

C. *Benefit Minimums and Uniformity*

As discussed above, the ACA provisions for standardized disclosure will significantly improve the quality and accessibility of consumer health plan information. The minimum benefit requirements under the ACA, however, provide an even more viable opportunity for federal and state regulators to optimize consumer choices. The individual mandate requires individuals to maintain minimum essential coverage.²⁸⁶ The ACA grants HHS authority to set the standard for minimum essential coverage.²⁸⁷ HHS will, by regulation, establish the essential minimum benefits package.²⁸⁸

The new minimum benefits requirements can provide consumers with the enhanced ability to compare competing health plan benefits because all new health plans will begin with the same basic template.²⁸⁹ Moreover, the ACA’s benefit minimums address the

²⁸⁶ Affordable Care Act § 1303, 42 U.S.C. § 1501.

²⁸⁷ *Id.* § 248, 26 U.S.C. § 5000A(F)(1)(e).

²⁸⁸ *Id.* § 248, 26 U.S.C. § 5000A.

²⁸⁹ See generally Judith H. Hibbard & Ellen Peters, *Supporting Informed Consumer Health Care Decisions: Data Presentation Approaches that Facilitate the Use of Information in Choice*, 24 ANN. REV. PUB. HEALTH 413 (2003); *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways & Means*, 111th Cong. 23 (2009) (statement of William Vaughan, Senior Policy Analyst, Consumers Union). William Vaughan goes on to say:

Require standardization of insurance definitions and forms so consumers can easily compare policies on an ‘apples-to-apples’ basis. This is key. Hospitalization should mean hospitalization. Drug coverage should mean drug coverage, etc. In our May magazine article, we describe a policy in which the fine-print excluded the first day of hospitalization—usually or often the most expensive day when lab and surgical suite costs are incurred. NAIC could be charged with developing these definitions, backed up by the Secretary if they fail to act. Require insurers to clearly state (in standardized formats) what’s covered and what’s not in every policy offering, and to estimate out-of-pocket costs under a set of typical treatment scenarios.”

problem of risk underestimation because they establish a floor below which no benefit package may exist.²⁹⁰ The minimum benefit package may become the default health plan for those seeking the lowest cost way to satisfy the individual mandate. Some of the important options for such structured choice, and the factors that federal and state regulators may want to consider in selecting among the options, are discussed below.

1. The Individual Mandate

The ACA includes an “individual responsibility requirement” to maintain minimum health insurance coverage.²⁹¹ Beginning in January 2014, all applicable individuals are required to maintain, on behalf of themselves and their dependents, a health insurance benefit package that meets the minimum essential coverage criteria.²⁹² Failure to maintain such coverage will result in a penalty, called the “shared responsibility payment.”²⁹³

The individual mandate is, at least in part, also a response to underestimation of risk. The mandate to purchase theoretically removes the decision whether to purchase health insurance.²⁹⁴ By requiring individuals to have health insurance, the ACA targets individuals who, without a mandate prompting them to do so, would not buy health insurance at all. Another of the many purposes of the mandate is to bring healthy, young individuals into the larger market.²⁹⁵ Although Americans have consistently resisted a social insurance model for health care, the temptation to bring young healthy individuals into the risk pool stems from a desire to cross-subsidize health costs.²⁹⁶ These “young invincibles” decline health

²⁹⁰ See generally Koufopoulos, *supra* note 36, at 5 (May 2008), http://www.soc.uoc.gr/asset/accepted_papers/paper322.pdf; Eric J. Johnson et al, *Framing, Probability Distortions, and Insurance Decisions*, 7 J. RISK UNCERTAINTY 35, 36 (1993), available at <http://www.springerlink.com/content/x535827t2m525776/fulltext.pdf>; Milton Friedman & L. J. Savage, *The Utility Analysis of Choices Involving Risk*, 58 J. POL. ECON. 279, 279–80 (1948).

²⁹¹ 26 U.S.C. § 5000A(a).

²⁹² *Id.*

²⁹³ *Id.* § 5000A(b).

²⁹⁴ Of course one could opt to pay the shared responsibility penalty rather than maintain health coverage.

²⁹⁵ See 42 U.S.C. § 18091(a)(2)(C)–(F) (2010).

²⁹⁶ Tom Baker & Peter Siegelman, *Tontines for the Invincibles: Enticing Low Risks into the Health Insurance Pool with an Idea from Insurance History and Behavioral Economics*, 2010 WIS. L. REV. 79, 81 (2010). To the extent young invincibles choose to purchase “young invincible” products instead of other major medical health insurance, the impact of their participation in the health insurance market may be limited.

insurance in part because it is expensive and in part because they are healthy and do not see a significant immediate likelihood they will need medical services.²⁹⁷ In short, these young adults underestimate their risk of needing health insurance. The individual mandate mitigates the individual and communal impacts of that underestimation.

Congress primarily justified the individual mandate based on the broad economic impact of uninsurance and underinsurance. In the legislation itself, Congress noted that the costs to society of uninsurance are not borne by the uninsured individual alone.²⁹⁸ The costs of uninsurance are spread across large populations.²⁹⁹ Costs associated with uninsurance include uncompensated medical care (actual health care costs), increased health insurance premiums and lost economic productivity due to avoidable illness.³⁰⁰ Congress found that the economy loses large sums each year “because of the poorer health and shorter lifespan of the uninsured.”³⁰¹ To the extent that individuals are uninsured or underinsured because they underestimate risk, their costs are a burden on the majority of Americans who maintain coverage, and the economy in general.

Congress also noted that “many individuals would wait to purchase health insurance until they needed care.”³⁰² Congress did have the choice to enact fewer insurance market reforms. But many of the reforms are interdependent, and enacting some but not others might have unintended consequences. For example, Congress could have enacted guaranteed issue and open enrollment laws without

²⁹⁷ *Id.*

²⁹⁸ Affordable Care Act, 42 U.S.C. § 18091 (2010).

²⁹⁹ Baker & Siegelman, *supra* note 296, at 81.

³⁰⁰ Affordable Care Act, 42 U.S.C. § 18091 (2010). The ACA goes on to state:

The cost of providing uncompensated care to the uninsured was \$43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over \$1,000 a year. By significantly reducing the number of the uninsured, the requirement [that individuals maintain health insurance], together with other provisions of this Act, will lower health insurance premiums.

³⁰¹ *Id.* § 1501(a)(2)(F), 42 U.S.C. § 18091 (“By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.”).

³⁰² *Id.* § 1501(a)(2)(I), 42 U.S.C. § 18091. A portion of § 1501(a)(2)(I) is reprinted here:

By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

the mandate. But allowing individuals to purchase health insurance at any time without restriction basically grants the option to “wait to buy fire insurance until after their house burned down.”³⁰³ This creates a “death spiral” in which healthy people have no reason to buy insurance until they are sick.³⁰⁴ As a result, only the sickest buy insurance and premiums are exorbitantly high. By requiring everyone to buy insurance, individuals cannot wait until they are sick to obtain coverage.³⁰⁵ And insurers have a larger pool, including healthier individuals, upon which to set rates.³⁰⁶ By requiring healthy lives to enter the insurance pool, costs will be reduced.³⁰⁷

Other policy rationales exist for the individual mandate. For example, the individual mandate permits the abolishment of pre-existing condition exclusions.³⁰⁸ Preexisting condition exclusions have long been a barrier to coverage for consumers.³⁰⁹ However, insurers need preexisting conditions exclusions to prevent consumers from waiting to purchase insurance until they are sick.³¹⁰ If the insured risk pool consists of disproportionately sick individuals, costs for coverage will be higher.³¹¹ The individual mandate facilitates eliminating preexisting condition exclusions because, as discussed above, healthy lives will be in the insurance pool.

Whether these grounds justify a government mandate to purchase health insurance coverage was and still is debated. The ideological battle over the proper role of government in the market figured prominently throughout the federal health reform debate and focused in large part on the individual mandate.³¹² That debate

³⁰³ Alan Katz, *Obama's Health Care Reform Plan Out of Balance*, ALAN KATZ HEALTH CARE REFORM BLOG (Feb. 10, 2008), <http://alankatz.wordpress.com/2008/02/10/obamas-health-care-reform-plan-out-of-balance/>.

³⁰⁴ Paul Krugman, *One Health Care Reform, Indivisible*, CONSCIENCE OF A LIBERAL BLOG (Jan. 8, 2010), <http://krugman.blogs.nytimes.com/2010/01/08/one-health-care-reform-indivisible/>.

³⁰⁵ See Jonathan Gruber, *Incremental Universalism for the United States: The States Move First?*, 22 J. ECON. 51, 53 (2008).

³⁰⁶ See *Id.*

³⁰⁷ See *id.*

³⁰⁸ Affordable Care Act § 1501(a)(2)(F), 42 U.S.C. § 18091 (2010).

³⁰⁹ Eleanor Pearlman, *The Impact of Preexisting Conditions on the Individual and the Community*, LEAGUE OF WOMEN VOTERS (2009), <http://www.lwv.org/AM/Template.cfm?Section=Home&CONTENTID=13879&TEMPLATE=/CM/ContentDisplay.cfm>.

³¹⁰ See *id.*

³¹¹ See *id.*

³¹² See generally *The Constitutionality of National Health Reform Law*, COLUM. L. SCH., http://www.law.columbia.edu/center_program/ag/policy/health/resources/reformarticles (last visited Nov. 8, 2010).

continues even now as Attorneys General pursue constitutional challenges to the ACA.³¹³ The penalty for failing to have health insurance will motivate at least some of the uninsured to purchase coverage. Of course, the individual mandate is aided by premium subsidies and other reforms to make coverage more affordable.³¹⁴ Whether significant portions of the uninsured—in particular the young invincibles—choose to pay the penalty, rather than obtain health insurance, remains to be seen.³¹⁵ The first penalty, to be administered beginning in 2014, has been criticized as too low to effectively prompt all applicable individuals to purchase health insurance coverage.³¹⁶ This means that a significant number of people may prefer to pay the penalty than buy health insurance.

However, requiring individuals to obtain health insurance is only one piece of how the ACA addresses underestimation of risk. Equally important is the quality of the health insurance individuals will be required to purchase. As discussed below, the ACA addresses the issue of quality, “optimal” health insurance by establishing the minimum benefits package. The individual mandate requires individuals to maintain minimum essential coverage.³¹⁷

2. Benefits in the New Health Insurance Exchanges

a. What is a Health Insurance Exchange?

Among the most crucial of its many reforms, the ACA creates new “Health Benefits Exchanges.”³¹⁸ Each new Exchange will be a market within a market. That is, the Health Benefit Exchanges

³¹³ Mark Hall, *Are the Attorneys General's Constitutional Claims Bogus?*, HEALTH CARE BLOG (Mar. 30, 2010), http://www.thehealthcareblog.com/the_health_care_blog/2010/03/are-the-attorneys-generals-constitutional-claims-bogus.html.

³¹⁴ Affordable Care Act § 1413, 42 U.S.C. § 18083 (2010).

³¹⁵ Young adults potentially have other coverage options.

³¹⁶ See Editorial, *Curing a Sick System*, L.A. TIMES (Oct. 24, 2010), <http://articles.latimes.com/2010/oct/24/opinion/la-ed-health-20101024> (discussing the penalty for healthy people who chose to go without coverage); see also Ezra Klein, *How Does the Individual Mandate Work?*, WASH. POST (Mar. 25, 2010), http://voices.washingtonpost.com/ezra-klein/2010/03/how_does_the_individual_mandat.html (discussing lack of criminal sanctions against those who do not comply with the individual mandate).

³¹⁷ Affordable Care Act § 1501(b), 42 U.S.C. § 5000A (2010) (“An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.”).

³¹⁸ Affordable Care Act § 1301, 42 U.S.C. § 18021 (2010).

will exist, at least initially, alongside the existing commercial health insurance market.³¹⁹ The Exchanges use several methods to increase affordability of health insurance.³²⁰

First, the Exchange is the platform through which premium subsidies will be administered.³²¹ As discussed, the individual mandate requires the purchase of essential coverage, but does not specify where coverage is purchased.³²² Consumers will have a choice whether to buy coverage inside or outside the Exchange.³²³ The Exchange is, however, the only place where subsidies can be accessed for those who are subsidy eligible.³²⁴

Second, the Exchange offers the possibility for individuals and small groups to leverage purchasing power by pooling together to spread risk and negotiate better premium rates.³²⁵ To the extent that exchanges have been attempted previously, they have largely failed.³²⁶ Until now, exchanges have not had much success attracting good risks and insurers who have had the option to avoid the exchange and participate exclusively in the market outside the exchange have chosen to do so.³²⁷ The Exchanges created under the ACA are poised to do better. The newly created Exchanges may have larger risk pools resulting from the individual mandate, subsidies to attract consumers, and lower administrative costs achieved by economies of scale.³²⁸

Third, the Exchange seeks to make coverage more affordable by forcing health plans to compete based on price and quality, not risk selection.³²⁹ Standardization in benefit design and administration

³¹⁹ *Id.* § 1304, 42 U.S.C. § 18024 (discussing and defining the creation of the Exchange alongside the market).

³²⁰ *Id.* § 1311, 42 U.S.C. § 18031 (explaining affordable choices, expenditures, and limits under the Health Benefit Exchanges).

³²¹ *See id.*

³²² *See id.* § 18091, 42 U.S.C. § 18091.

³²³ Timothy S. Jost, *Health Insurance Exchanges in Health Care Reform Legal and Policy Issues* 4 (Wash. & Lee Legal Studies Research Paper Series, Working Paper No. 2009-11, 2009), available at <http://law.wlu.edu/deptimages/Faculty/jost.exchange%20georgetown%20final.uploadcopy.pdf>.

³²⁴ Affordable Care Act §§ 1401–1415, 10105, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, §§ 1001, 1004, 124 Stat. 1029, 1032, 1034 (2010) (codified as amended in scattered sections of 26, 42 U.S.C.) (stating that cost-sharing subsidies will only be available for silver plans sold through an exchange, including private plans).

³²⁵ *See Jost, supra* note 323, at 3.

³²⁶ *Id.* at 4.

³²⁷ *Id.* at 5.

³²⁸ *Id.*

³²⁹ *See* CHRIS L. PETERSON, CONG. RESEARCH SERV., R 40491, SETTING AND VALUING HEALTH INSURANCE BENEFITS 3 (2009), available at <http://www.policyarchive.org/handle/>

is integral to achieving this goal.

Insurers make a profit when they take in more money in premiums than they pay out in claims and administrative expenses.³³⁰ Claims include all bills for covered medical services, such as doctor visits, hospital stays, and prescription drugs.³³¹ Administrative expenses include all other costs, such as claims processing, salaries, office expenses, and taxes.³³² In nearly all health plans, medical claims are the largest share of premiums.³³³ Medical claims for the sickest members disproportionately drive up premiums.³³⁴ By one estimate, the sickest five percent of the population drives approximately fifty percent of medical claims.³³⁵ As a result, the existing commercial market includes a strong incentive for insurers to avoid these sickest of the sick consumers. One of the primary methods that health plans employ to deter sick consumers is benefit design.³³⁶ Simply put, sicker consumers are often drawn to richer benefit packages. Thus, uniformity in benefit design is a key to ensuring that health plans compete on the basis of price and quality, as opposed to avoiding the sickest consumers.

Exchanges are well positioned to provide consumers with uniform, comprehensive data regarding available health insurance options. As discussed above, the web portal and uniform benefit documents begin to provide consumers with this important information. But the Exchange has the opportunity to better fulfill that mission through standardized benefits, as discussed below.

10207/bitstreams/19244.pdf.

³³⁰ See D. ANDREW AUSTIN & THOMAS L. HUNGERFORD, CONG. RESEARCH SERV., R 40834, THE MARKET STRUCTURE OF THE HEALTH INSURANCE INDUSTRY 11, 15, 22 (2009), available at <http://www.fas.org/sgp/crs/misc/R40834.pdf>.

³³¹ *Id.* at 14.

³³² *Id.* at 22.

³³³ Mark W. Stanton, *The High Concentration of U.S. Health Care Expenditures*, RES. IN ACTION, June 2006, at 7, available at <http://www.ahrq.gov/research/ria19/expendria.pdf>.

³³⁴ AUSTIN & HUNGERFORD, *supra* note 330, at 17.

³³⁵ Stanton, *supra* note 333, at 5. An analysis of a 2002 Medical Expenditure Panel Survey data found that “[h]alf of the population spends little or nothing on health care, while [five] percent of the population spends almost half of the total amount.”

³³⁶ Another primary method that health plans select risk is by pricing. Sicker consumers are often willing to pay more than healthier consumers. The ACA addresses health plan selection through premium price in part by reforms to rating rules and increased regulatory oversight. Affordable Care Act § 1341, 42 U.S.C. § 18061 (2010). In addition, health plans select risk by marketing and broker incentives. *Id.* § 1343, 124 Stat. at 212. The ACA provides federal and state regulators with opportunities to create rules to minimize adverse selection through these and other methods. *Id.* § 1341, 124 Stat. at 208–10.

*b. The Essential Benefits in the Exchange*³³⁷

Few provisions in the ACA are likely to have a greater impact on consumers than the requirement that health plans in the Exchange offer an “Essential Health Benefits Package” beginning in 2014.³³⁸ The new standards for the Essential Health Benefits Package do more to increase uniformity than perhaps any single law to date. The ACA provides a set of directives regarding the form and content of new minimum standards for health insurance benefits.³³⁹ However, the ACA also creates a range of choices for federal and state regulators that can affect the uniformity, transparency and ease of benefit selection for consumers.

i. The Statutory Parameters

The ACA directs HHS to define the Essential Health Benefits Package, within broad parameters.³⁴⁰ Those parameters include general categories of services that must be part of the Essential Health Benefits Package: (1) doctor visits and other “[a]mbulatory patient services,” (2) “emergency services,” (3) “[h]ospitalization,” (4) “[m]aternity and newborn care,” (5) “[m]ental health and substance” abuse services, (6) “[p]rescription drugs,” (7) “[r]ehabilitative and habilitative [care] and devices,” (8) “[l]aboratory services,” (9) “[p]reventative and wellness services and chronic disease management,” and (10) “[p]ediatric services, including oral and vision care.”³⁴¹

In developing regulations around these ten benefit areas, HHS must ensure that the scope of Essential Health Benefits is equal to the scope of benefits provided “under a typical employer plan.”³⁴²

³³⁷ *Id.* § 1302, 124 Stat. at 163–68, 42 U.S.C. § 18022 (2010) (establishing the Essential Health Benefits requirements).

³³⁸ *Id.*

³³⁹ *Id.*

³⁴⁰ *See id.* The ACA specifies that government sponsored programs such as Medicare, Medicaid, CHIP, military health plans, employer sponsored plans, grandfathered plans, plans in the individual market and certain other select plans all meet the minimum essential coverage criteria.

³⁴¹ *Id.* § 1302(b)(1)(A)–(J), 42 U.S.C. § 18022 (2010).

³⁴² *Id.* § 1302(b)(2)(A), 42 U.S.C. § 18022 (2010). The section goes on to state that: [HHS] shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by [HHS]. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to [HHS].
Id.

Further, the ACA directs HHS to consider numerous factors.³⁴³ First, the benefits must balance the categories of services, “so that benefits are not unduly weighted toward any category.”³⁴⁴ Second, HHS is directed not to “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.”³⁴⁵ Third, HHS must consider “the health care needs of diverse segments of the population.”³⁴⁶

In addition, emergency services covered as Essential Health Benefits must meet certain minimum requirements.³⁴⁷ Such benefits may not require pre-authorization of emergency services.³⁴⁸ In addition, coverage may not be more limited for emergency services by an out-of-network provider than emergency services from an in-network provider.³⁴⁹ Indeed, consumer cost-sharing (such as copayments or coinsurance) for emergency services—as distinct from the benefits covered—must be the same whether the provider is in-network or out-of-network.³⁵⁰

HHS is required to make periodic reports that review successes, problems and suggested improvements in the Essential Health Benefits Package.³⁵¹ Moreover, the ACA also directs HHS to

³⁴³ *Id.* § 1302(b)(4), 42 U.S.C. § 18022 (2010).

³⁴⁴ *Id.* § 1302(b)(4)(A), 42 U.S.C. § 18022 (2010).

³⁴⁵ *Id.* § 1302(b)(4)(B), 42 U.S.C. § 18022 (2010).

³⁴⁶ *Id.* § 1302(b)(4)(C), 42 U.S.C. § 18022 (2010).

³⁴⁷ *Id.* § 10101(h), 42 U.S.C. § 300gg-19(a) (2010). If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a participating provider. Services provided by nonparticipating providers must be provided with cost-sharing that is no greater than that which would apply for a participating provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing. *Id.*

³⁴⁸ *Id.*

³⁴⁹ *Id.* § 1302(b)(E), 42 U.S.C. § 18022 (2010). This section requires HHS regulations to: provide [coverage] that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that (i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan.

³⁵⁰ *Id.* § 1302(b)(4)(E)(ii), 42 U.S.C. § 18022 (2010), which provides that “if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network.”

³⁵¹ *Id.* § 1302(b)(4)(G), 42 U.S.C. § 18022 (2010). This section provides that HHS shall: periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains[:] (i) an assessment of whether enrollees

periodically update the essential health benefits to address problems or reflect new medical or other information.³⁵²

The ACA provides four basic levels of coverage in the Essential Health Benefits Packages. The four packages are named for precious metals: platinum, gold, silver, and bronze. The packages are differentiated according to their relative actuarial value.³⁵³ Actuarial value is a measure that indicates the percent of health related costs that a particular plan might pay generally based on the cost-sharing provisions of the plan.³⁵⁴ A plan's actuarial value does not necessarily indicate how much a consumer will pay for a given plan.³⁵⁵ Rather, the actuarial value provides the consumer with a reference point to compare plans.³⁵⁶ A correlation should exist between the premium rate for a particular plan and the overall actuarial value of that plan. Generally speaking, the platinum plan, with a higher premium, will cover more.³⁵⁷ A bronze plan, with a lower premium, will cover less, requiring greater out-of-pocket expenses at the time of service.³⁵⁸ In addition to the precious metal levels of services, the ACA includes a "catastrophic plan" with fewer benefits, but it is only available to those under thirty years old, and to those who are exempt from the individual mandate because they do not have an affordable health insurance

are facing any difficulty accessing needed services for reasons of coverage or cost; (ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement; (iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base; (iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2).

³⁵² *Id.* § 1302(b)(4)(H), 42 U.S.C. § 18022 (2010) (which requires HHS to "periodically update the essential health benefits under paragraph (1) to address and gaps in access to coverage or changes in the evidence base [that HHS] identifies in the review conducted under subparagraph (G)").

³⁵³ *Id.* § 1302(d), 42 U.S.C. § 18022 (2010). The bronze, silver, gold, and platinum levels provide coverage actuarially equivalent to sixty percent, seventy percent, eighty percent, and ninety percent respectively, of the full actuarial value of the benefits provided under the plan.

³⁵⁴ *See generally*, HOLLY KWIATKOWSKI, AMERICAN ACAD. OF ACTUARIES, ACTUARIAL EQUIVALENCE OF MEDICARE PRESCRIPTION DRUG PLANS 4-5 (2003), http://www.actuary.org/pdf/medicare/briefing_072103.pdf. For example, a health plan with an actuarial value of eighty percent would, on average, pay eighty percent of the medical expenditures of a given population.

³⁵⁵ *Id.* at 6.

³⁵⁶ *See id.* at 20; ROLAND MCDEVITT, CALIFORNIA HEALTHCARE FOUND, ACTUARIAL VALUE: A METHOD FOR COMPARING HEALTH BENEFITS 5 (2008), <http://www.chcf.org/~media/Files/PDF/H/PDF%20HealthPlanActuarialValue.pdf>.

³⁵⁷ Affordable Care Act § 1302(d)(1), 42 U.S.C. § 18022 (2010).

³⁵⁸ *See id.*

option.³⁵⁹

The Essential Health Benefit requirements of the ACA, therefore, provide a set of federal basic minimum standards. The ACA establishes minimum rules for the services to be covered, cost-sharing, and standardized levels of coverage. These provisions enable consumers to compare health plans more easily by providing more accessible information to consumers. In addition, by setting minimum benefit levels the provisions increase the likelihood that individuals select health plans sufficient to match their risk of an adverse health event.

ii. Options for Regulators for Essential Health Benefits in the Exchanges

The ACA presents federal and state regulators with choices. These choices will impact the degree to which benefits within the Exchanges are standardized. As noted above, the ACA directs HHS to establish regulations providing details for the operation of Essential Health Benefits Packages within the structure of the statute. The statute, however, does not specify the degree to which benefits must be uniform between the basic levels of coverage, or even within a basic level of coverage.

Minimum Exchange Plan Uniformity in the Exchange. HHS has the option to minimize the degree to which health plans inside the Exchange offer uniform coverage.³⁶⁰ For example, HHS could permit each health plan offering a silver package to meet the coverage requirements by offering a divergent mix of varying covered services.³⁶¹ Thus, each of the silver plans could look different from each other. HHS could broadly require that health plans adhere to other statutory requirements, such as the prescription that the Essential Health Benefits “reflect an appropriate balance among the [ten general] categories” of services required to be included.³⁶² However, the final federal regulation could permit a qualified health plan to meet the level of coverage requirements by providing differing covered services that, in the aggregate, provide the appropriate overall actuarial value.³⁶³ In

³⁵⁹ *Id.* § 1302(e)(1)–(2), 42 U.S.C. § 18022 (2010).

³⁶⁰ *Id.* § 1302(a)(1), 42 U.S.C. § 18022 (2010).

³⁶¹ *Id.* § 1302(b)(4)(A)–(H), 42 U.S.C. § 18022 (2010).

³⁶² *Id.* § 1302(b)(4)(A), 42 U.S.C. § 18022 .

³⁶³ *Id.* § 1302(d)(2), 42 U.S.C. § 18022 (2010). The Act leaves the degree of uniformity in the Essential Health Benefits to the Secretary’s discretion. *Id.* § 1302(d)(3), 42 U.S.C. § 18022 (2010).

this scenario, a qualified health plan could cover services in a platinum level plan that are not covered—in whole or in part—in a lower level plan. Thus, for example, a platinum level plan could conceivably cover speech therapy services that the bronze level plan covered at fewer hours of service, or not at all. For consumers, that means that not only are bronze and gold packages permitted to offer different benefits, but that a silver plan offered by one insurer need not necessarily match the benefits as a silver plan offered by another insurer.³⁶⁴

Maximum Exchange Plan Uniformity in the Exchange. On the other hand, HHS could issue regulations that maximize the uniformity in the Essential Health Benefits package. For example, HHS could require that all Essential Benefits offer the exact same set of covered services without variation.³⁶⁵ Under this approach, the level of coverage would only differ based on cost-sharing. Thus, HHS regulations would require that every Essential Health Benefits Package include precisely the same service coverage in each of the ten enumerated categories. The only aspect of the benefits that would distinguish the levels of coverage would be the amount of cost-sharing, whether the plan has a higher (or lower) copayment, coinsurance, or deductible. A bronze level health plan would require more out-of-pocket expenses than a silver level plan, but they would both cover the same exact benefits. The silver level plan would require more cost-sharing than the gold level plan, which would in turn require more cost-sharing than the platinum level plan. Other than the cost-sharing for the consumer, each level of Essential Health Benefits would look exactly the same.

Comparing the Two Options. Maximizing uniformity in the Exchange—by standardizing packages so that covered services are exactly the same across all levels of coverage, varying only by cost-sharing—is a dramatic departure from the current health insurance market landscape.

On one hand, Exchange offerings that differ only by cost-sharing would provide consumers with a simple set of choices. Such “choice architecture” would substantially address the health insurance market’s failure to enable informed benefit comparisons by consumers. Likewise, this maximum uniformity approach would provide a minimum set of covered benefits, minimizing the likelihood that consumers seriously underestimate their risk of

³⁶⁴ *See id.*

³⁶⁵ *See id.*

insufficient coverage.

On the other hand, if HHS requires maximum uniformity, consumers would necessarily forego the opportunity to select a baseline benefit package on their own. The ACA appears to permit states to allow consumers to purchase supplemental coverage to increase benefits.³⁶⁶ Such supplemental insurance could be purchased through a rider or other supplemental product. However, the baseline comprehensive package would be decided by HHS, not market demand. Strict free market adherents would argue that maximum uniformity limits consumer choice and stifles innovation in product design.

Moreover, consumers may not fully understand the varying cost-sharing amounts between levels of coverage (e.g., gold versus silver levels). To be fully informed, consumers should comprehend the basic amounts of cost-sharing required, such as copayments, coinsurance, and deductibles. However, consumers may not fully understand the overall actuarial value for each level of coverage and how it relates to their real risk. Thus, consumers may not fully realize, and may underestimate, the implications of cost-sharing differences among the levels of coverage. Whether maximum uniformity will provide meaningful structured choice remains to be seen.³⁶⁷

HHS may want to evaluate the impact on the commercial market outside the Exchange before opting for maximum uniformity. The success of the Exchange rests in part on its offerings relative to those outside the Exchange, as discussed below.

States' ability to require plans in the Exchange to provide coverage beyond Essential Health Benefits. To the extent that HHS opts for an Essential Health Benefits regulation that does not provide for maximum uniformity, states may be able require greater uniformity inside the Exchange. As noted above, the ACA preempts state laws that "prevent the application" of the ACA. State laws that provide more uniform benefits than federal minimums inside the Exchange do not appear to violate this principle.

As discussed above, HHS may choose to provide only general guidance on which services in each of the ten required coverage

³⁶⁶ *Id.* § 1302(b)(5), 42 U.S.C. § 18022 (2010).

³⁶⁷ See POLLITZ ET AL., *supra* note 31, at 7 (describing the utility of cost-sharing differences for consumers to compare plans in the standardized Connector market in Massachusetts). "How these differences combine to affect how much a patient ultimately pays depends on the type of care a patient needs. The interactions can be complex and, for healthy consumers who don't know what future care needs might be, difficult to anticipate." *Id.*

areas need to be included in each level of coverage. Under this scenario, states could theoretically require greater uniformity without preventing application of the ACA. Thus, a state could require that every Essential Health Benefits Package sold in that state's Exchange must include precisely the same service coverage in each of the ten enumerated categories. The only aspect of the benefits that would distinguish the levels of coverage would be the amount of cost-sharing. In short, if HHS decides not to require maximum uniformity inside the Exchange, a state may be able to do so.

While states may require *greater uniformity* inside the Exchange, they have limited ability to require *additional covered services*—i.e., state-mandated benefits that exceed the minimum Federal Essential Health Benefits. The ACA expressly permits, but in practice limits, the ability of states to require benefits to be sold in the Exchange that exceed federal minimums with respect to Essential Health Benefits.³⁶⁸ States are specifically authorized under the statute to require a qualified health plan to offer benefits in addition to Essential Health Benefits.³⁶⁹ However, the state must assume the full cost of the additional benefit.³⁷⁰ Given the current difficult fiscal situation facing many state governments, the requirement that the state pay for any additional benefits is likely, at a minimum, to engender strenuous discussion over which, if any, additional state-mandated benefits to keep.

2. Benefits in the Commercial Market Outside the Exchange

The ACA requires that, with the exception of health plans in existence when the statute passed in March 2010 (“Grandfathered Plans”), any new health plan must meet the Essential Health Benefits rules.³⁷¹ As with health plans sold inside the Exchange, this requirement is a distinct move in the direction of providing uniformity in health plan benefits. However, federal and state regulators are faced with numerous options that can promote or reduce uniformity.

³⁶⁸ Affordable Care Act, § 1311(d)(3)(B)(i), 42 U.S.C. § 18022 (2010) (which provides that a “State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b)”).

³⁶⁹ *See id.*

³⁷⁰ *Id.* § 1311(d)(3)(B)(ii), 42 U.S.C. § 18031 (2010).

³⁷¹ *Id.* §§ 1201(4), 42 U.S.C. § 300gg-6 (2010); 1251(a)(1), 42 U.S.C. § 18011 (2010).

a. Grandfathered Plans

In the debate on federal health reform, President Obama pledged to Americans that “if you like your health plan, you can keep it.”³⁷² Accordingly, the ACA includes a broad provision that allows individuals and businesses to keep the plan they had when the Act was passed.³⁷³ The ACA balances this goal of preserving the ability to maintain existing coverage with the objective of expanding access to, and improving the quality of, health coverage. The Act therefore exempts health insurance plans in existence at the time the bill was passed from many of the new insurance market reforms.³⁷⁴

Certain insurance market reforms apply to all health plans, even grandfathered plans. A number of these reforms impact benefits covered, including limits on excessive waiting periods,³⁷⁵ prohibiting lifetime limits³⁷⁶ and rescissions,³⁷⁷ and extending dependent coverage to age twenty-six.³⁷⁸ Further reforms apply to grandfathered group health plans, including the ban on pre-existing condition exclusions (for children in 2010 and for adults in 2014),³⁷⁹ and restrictions on annual limits.³⁸⁰

However, many other insurance market reforms apply only to new plans that have not been grandfathered. Those reforms include: a prohibition on cost-sharing for certain preventive care³⁸¹ and certain patient protections such as guaranteed access to emergency, pediatric, and obstetrical and gynecological care.³⁸²

The ACA does not, however, address which specific changes a health insurance plan can make and still be considered “the health plan you [had]” when the bill passed in March 2010. Federal regulators provided guidance which purports to “ease the transition of the healthcare industry into the reforms established by the

³⁷² *Fact Sheet: Keeping the Health Plan You Have: The Affordable Care Act and “Grandfathered” Health Plans*, HEALTHREFORM.GOV, http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html.

³⁷³ Affordable Care Act, § 1251, 42 U.S.C. § 18011 (2010).

³⁷⁴ *Id.* § 1251(a)(1), 42 U.S.C. § 18011 (2010). This provision states that “[n]othing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.”

³⁷⁵ *Id.* § 1201(4), 42 U.S.C. § 300gg-7 (2010).

³⁷⁶ *Id.* § 1001(5), 42 U.S.C. § 300gg-11 (2010).

³⁷⁷ *Id.* § 1001(5), 42 U.S.C. § 300gg-12 (2010).

³⁷⁸ *Id.* § 1001(5), 42 U.S.C. § 300gg-4 (2010).

³⁷⁹ *Id.* § 1331(c)(2)(B), 42 U.S.C. § 18051 (2010).

³⁸⁰ *Id.* § 1001(5), 42 U.S.C. § 300gg-11 (2010).

³⁸¹ *Id.* § 1001(5), 42 U.S.C. § 300gg-13 (2010).

³⁸² *Id.* § 10101(h), 42 U.S.C. § 300gg-19(a) (2010).

Affordable Care Act by allowing for gradual implementation of reforms through a reasonable grandfathering rule.”³⁸³

The grandfather rules allow some change to health plans without loss of grandfather status, but only within certain specified parameters. To maintain grandfathered status, a health plan may not significantly cut or reduce benefits to diagnose or treat a specific condition.³⁸⁴ In addition, a health plan may not increase a coinsurance percentage.³⁸⁵ An increase in a deductible by more than a percentage equal to medical inflation plus fifteen percent will cause a health plan to lose grandfather status.³⁸⁶ Similarly, health plans cannot raise a copayment by more than the greater of five dollars (adjusted annually for medical inflation) or a percentage equal to medical inflation plus fifteen percent.³⁸⁷ Doing either of those things will cause a health plan to lose grandfather status.³⁸⁸

³⁸³ 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. 34,538, 34,541 (June 17, 2010) (to be codified at 26 C.F.R. pts. 54, 602, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147) [hereinafter Interim Final Rules].

³⁸⁴ *Id.* at 34,560 (describing the “elimination of benefits”). Section (g)(i) is reprinted here in its entirety:

The elimination of all or substantially all benefits to diagnose or treat a particular condition causes a group health plan or health insurance coverage to cease to be a grandfathered health plan. For this purpose, the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition.

³⁸⁵ *Id.* (discussing “increase in percentage cost-sharing requirement”). Section (g)(1)(ii) provides that “[a]ny increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as an individual’s coinsurance requirement) causes a group health plan or health insurance coverage to cease to be a grandfathered health plan.” Co-insurance usually pays consumers for some percentage of a charge or rate (e.g., twenty percent of the “usual customary rate” for a doctor’s bill).

³⁸⁶ *Id.* Section (g)(1)(iii), discussing increases in a fixed-amount cost-sharing requirement other than a copayment, is reprinted here in its entirety:

Any increase in a fixed-amount cost-sharing requirement other than a copayment (for example, deductible or out-of-pocket limit), determined as of the effective date of the increase, causes a group health plan or health insurance coverage to cease to be a grandfathered health plan, if the total percentage increase in the cost-sharing requirement measured from March 23, 2010 exceeds the maximum percentage increase (as defined in paragraph (g)(3)(ii) of this section).

Section (g)(3)(ii) provides that “[f]or purposes of this paragraph (g), the term maximum percentage increase means medical inflation (as defined in paragraph (g)(3)(i) of this section), expressed as a percentage, plus 15 percentage points.” *Id.* at 34,561.

³⁸⁷ *Id.* at 34,560, 34,569.

³⁸⁸ *Id.* at 34,568–69 (discussing increases in fixed-amount copayment). Section (g)(1)(iv) is reprinted here in its entirety:

Any increase in a fixed-amount copayment, determined as of the effective date of the increase, causes a group health plan or health insurance covered to cease to be a grandfathered health plan, if the total increase in the copayment measured from March 23, 2010 exceeds the greater of: (A) An amount equal to \$5 increased by medical inflation, as defined in paragraph (g)(3)(i) of this section (that is, \$5 times medical

A decrease in employer contribution level by more than five percent is not permitted for grandfathered plans.³⁸⁹ Also, a health plan is not allowed to add or reduce annual caps on the dollar amount paid for all benefits.³⁹⁰ Furthermore, if an employer changes insurance companies, the new insurer will not be considered a grandfathered plan.³⁹¹ However, this rule does not apply to collective bargaining agreements or to self-insured health plans that switch administrators.³⁹²

Several rules exist to prevent health plans from using the grandfather rule to evade compliance with other insurance reforms and consumer protections in the Act. For example, when health plans distribute materials to consumers, a plan must disclose that it believes it is a grandfathered plan, not subject to some protections under the ACA.³⁹³ In addition, health plans may not switch consumers to a different grandfathered plan that, compared to the

inflation, plus \$5), or (B) The maximum percentage increase (as defined in paragraph (g)(3)(ii) of this section), determined by expressing the total increase in the copayment as a percentage.

³⁸⁹ *Id.* at 34,569 (discussing decreases in contribution rates by employers). Section (g)(1)(v) is reprinted below:

A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on cost of coverage (as defined in paragraph (g)(3)(iii)(A) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in section 146.121(d) of this subchapter) by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010. . . . A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on a formula (as defined in paragraph (g)(3)(iii)(B) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in section 146.121(d) of this subchapter) by more than 5 percent below the contribution rate for the coverage period that includes March 23, 2010.

³⁹⁰ *Id.* (discussing changes in annual limits). Section (g)(3)(vi) is reprinted below:

A group health plan, or group health insurance coverage, that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage imposes an overall annual limit on the dollar value of benefits. . . . A group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010. . . . A group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all benefits).

³⁹¹ *Id.* at 34,558.

³⁹² *Id.* at 34,542.

³⁹³ *Id.* at 34,554.

existing plan, has fewer benefits or greater cost-sharing.³⁹⁴ Lastly, a health plan cannot be purchased by, or merge with, another plan and continue to avoid or limit compliance with the ACA.³⁹⁵

The projected impact of the grandfather provisions on both consumers and plans is significant at first, but lessens over time.³⁹⁶ Federal regulators estimate that thirty-one percent of small employers and eighteen percent of large employers would make changes that would require them to relinquish grandfather status in 2011.³⁹⁷ By 2013 more large and small employers will have changed their health plans and thereby will no longer qualify for the grandfathered status. Approximately sixty-six percent of small employer plans and forty-five percent of large employer plans are expected to relinquish their grandfather status by the end of 2013.³⁹⁸

The market for health insurance purchased by individuals is more volatile when compared to the employer based plans. Individual plans are often transitional, and are used to bridge the gap from one group health plan to another when employees change jobs, and are therefore in effect for shorter periods of time.³⁹⁹ Because individuals make changes to their plans more frequently, and assuming the replacement plans are not themselves grandfather plans, federal regulators estimate that between forty and sixty-seven percent of individual plans will lose their grandfathered

³⁹⁴ See *id.* at 34,558.

³⁹⁵ See *id.*

³⁹⁶ The Departments of Labor, Treasury, and Health and Human Services, estimate that in 2009 there were 72,000 ERISA-covered health plans covering employers with more than one hundred employees ("large employers") with an estimated ninety-seven million participants and beneficiaries in these large group plans. The Departments also estimate that for employers with less than one hundred employees ("small employers"), there are 2.8 million group health plans with 40.9 million participants and beneficiaries. Additionally, there are 126,000 governmental plans with 38.4 million participants and 16.7 million individually purchased policies. *Id.* at 34,550.

³⁹⁷ *Id.* at 34,552. There are several assumptions made in determining this estimate, therefore these numbers represent a mid-range scenario. As a low-range, the Departments estimate that approximately twenty-one percent of small employers and thirteen percent of large employers would make changes that would require them to relinquish grandfather status in 2011. As a high range, the Departments estimate forty-two percent of small employers and twenty-nine percent of large employers will relinquish their grandfathered statuses; for computational methodologies and assumptions. *Id.*

³⁹⁸ *Id.* 2013 projections for low-range estimates are forty-nine percent and thirty-four percent of small and large employer plans, respectively, while the high-range estimates are eighty percent and sixty-four percent, respectively.

³⁹⁹ ADELE M. KIRK, ACAD. HEALTH, THE INDIVIDUAL INSURANCE MARKET: A BUILDING BLOCK FOR HEALTH CARE REFORM? INSIGHTS FROM HCFO RESEARCH RESULTS 1-3 (2008) (finding that almost half of all individual plans were in effect for six months or shorter, and up to two-thirds of plans were shorter than one year).

status.⁴⁰⁰

State regulators may need to closely watch grandfathered plans to ensure they are not offloading unhealthy plan members to the Exchange. Grandfathered plans could “cherry pick” good risk a variety of ways, including marketing and outright disenrollment. However, to the extent a grandfathered plan offers fewer benefits to a sick enrollee who determines the Exchange offers a better product, there may be little regulators can do.

b. Essential Benefits Outside the Exchange

i. Federal Minimum Requirements

The ACA requires that all non-grandfathered plans outside the Exchange provide the Essential Health Benefits Package.⁴⁰¹ This requirement will promote uniformity in health plan benefits. Regulators are again faced with options that can maximize or minimize the standardization of benefits.

The choices that HHS has with respect to defining Essential Health Benefits outside the Exchange are the same as those inside the Exchange. The ACA contemplates only one set of Essential Health Benefits, whether they are sold inside or outside the Exchange.⁴⁰² Thus, as discussed in more detail above, HHS could provide only general guidance, allowing varying services to be covered at varying amounts. Alternatively, HHS could require a high degree of uniformity, requiring that all levels of coverage include exactly the same covered services in each of the ten required categories, varying in level of coverage only by the amount of cost-sharing.⁴⁰³

The ACA provides one significant difference between benefits offered inside the Exchange compared to benefits allowed to be offered outside the Exchange. As noted, all non-grandfathered health insurers in the commercial market outside the Exchange will only be permitted to sell Essential Health Benefits.⁴⁰⁴ However, an insurer that sells products outside the Exchange need not provide all levels of coverage in the Essential Health Benefits package, as

⁴⁰⁰ Interim Final Rules, *supra* note 383, 75 Fed. Reg. 34,538, 34,553.

⁴⁰¹ Affordable Care Act, § 1302(a), 42 U.S.C. § 18022 (2010).

⁴⁰² *Id.* § 1302(b)(1), 42 U.S.C. § 18022 (2010).

⁴⁰³ *Id.* § 1302(b)(2), 42 U.S.C. § 18022 (2010).

⁴⁰⁴ *See id.* §§ 1302(b)(4)(E)(i)–(ii), 42 U.S.C. § 18022 (2010).

long as the insurer does not participate in the Exchange. For example, an insurer exclusively operating outside the Exchange can choose to offer only bronze level plans, or catastrophic plans to those under thirty years old.⁴⁰⁵

At least two concerns arise from the ability of non-Exchange insurers to offer lower levels of coverage without also offering more comprehensive coverage. These concerns flow from the fact that consumers retain the choice to seek coverage inside or outside the Exchange under the ACA.⁴⁰⁶ First, by offering only lower levels of coverage (presumably at lower prices than more comprehensive coverage), health plans can cherry pick good risk and keep it outside of the Exchange. This is because, as described above, lower levels of coverage are inherently more appealing to those who use less health care services (i.e., healthier consumers).⁴⁰⁷ To the extent health plans inside the Exchange offer more comprehensive coverage than plans outside the Exchange, the Exchange may attract a sicker pool of consumers.⁴⁰⁸

Accordingly, regulators must guard against unhealthy consumers migrating toward—or away from—the Exchange. This migration of risk, or “adverse selection,” is of significant concern to the viability of the Exchange.⁴⁰⁹ The limited experience available on exchanges prior to the ACA suggests that exchange participation rates tend to be low, particularly in the beginning. And exchanges “have become the victims of risk selection. Insurers that have the option of selling outside of the exchange have found exchanges unattractive because exchanges tend to include higher risk individuals and groups and because insurers prefer to control their own relationships with employers.”⁴¹⁰ As discussed below, requiring insurers to offer uniform benefits inside and outside the Exchange could be a powerful tool for regulators to minimize such adverse selection.⁴¹¹

Second, if outside-Exchange insurers only offer lower levels of coverage, consumers outside the Exchange may be left with sub-

⁴⁰⁵ *Id.* §§ 1302(e)(1)–(2), 42 U.S.C. § 18022 (2010)..

⁴⁰⁶ *Id.* §§ 1312(d)(3)(A)–(B), 124 Stat. at 182–83.

⁴⁰⁷ From a risk pooling perspective, the viability of the Exchange rests on the participation of healthy individuals (low health care users). Blumberg & Pollitz, *supra* note 13, at 2.

⁴⁰⁸ If only high health care users seek coverage through the Exchange, the Exchange will find itself in a death spiral—a fate suffered by other exchanges to this point. *See id.*

⁴⁰⁹ *See id.* at 3.

⁴¹⁰ Jost, *supra* note 323, at 5.

⁴¹¹ SARAH LUECK, CTR. ON BUDGET AND POLICY PRIORITIES, STATES SHOULD STRUCTURE INSURANCE EXCHANGES TO MINIMIZE ADVERSE SELECTION 7 (2010), <http://www.cbpp.org/files/8-17-10health.pdf>.

optimal coverage choices. Individuals buying coverage outside the Exchange may not have a full range of benefit choices. Lower levels of coverage, combined with the individual predisposition to underestimate risk, could lead to problems of underinsurance for those outside the Exchange. As discussed below, standardization inside and outside the Exchange may help ensure consumers are protected from becoming underinsured.⁴¹²

ii. State Options Beyond the Federal Minimums

States appear to have a number of options to exceed federal minimums regarding uniformity in benefit choices outside the Exchange. To the extent HHS promulgates Essential Health Benefits regulations that do not establish maximum uniformity, states may be able to exceed the federal minimums.⁴¹³ As noted above, the ACA preempts state laws that “prevent the application” of the ACA.⁴¹⁴ State laws limiting, or strictly regulating, benefit plans offered outside the Exchange do not appear to violate this principle. One notable exception to this view of states’ authority to regulate beyond federal minimums is the Employee Retirement and Income Security Act (ERISA), which preempts states from any regulation of self-insured plans.⁴¹⁵ Notwithstanding ERISA, states appear able to maintain considerable flexibility with respect to benefit regulation under the ACA.

(1) Maximum Uniformity of Essential Benefits Outside the Exchange. First, if HHS opts not to do so, states could require a maximum degree of uniformity in the content of Essential Benefits sold outside the Exchange. Under this approach, states could require that all services covered be exactly the same in Essential Health Benefits plans. The levels of coverage in each plan would differ only by cost-sharing. Thus, by operation of state rules, there would only be one set of covered services that insurers would be able to sell outside the Exchange, with levels of coverage differing only by the amount that consumers pay out-of-pocket.⁴¹⁶

⁴¹² See POLLITZ ET AL., *supra* note 31, at 11.

⁴¹³ Affordable Care Act, § 1001(5), 42 U.S.C. § 300gg-15 (2010).

⁴¹⁴ *Id.* § 1321(d), 42 U.S.C. § 18041 (2010).

⁴¹⁵ Employee Retirement Income Security Act, Pub. L. No. 93-406, § 514, 88 Stat. 829, 897 (1974).

⁴¹⁶ Put another way, states can require maximum uniformity even if HHS does not. As noted above, the ACA limits the ability of states to include state-mandated benefits in the Essential Health Benefits package offered through an Exchange; states must pay the full cost of such additional mandated benefits. Affordable Care Act, § 1311(d)(3)(b)(ii), 124 Stat. at 176. This limitation on requiring additional benefits does not apply outside the Exchange.

This first approach appears to have the same advantages for states as those discussed above for federal regulators. Specifically, maximum uniformity in this scenario could address both asymmetric information and underestimation of risk. Such uniformity would make comparison-shopping quite easy for consumers, whether individuals or small businesses, and maximum uniformity would ensure a basic minimum set of benefits.⁴¹⁷

On the other hand, this first approach could be viewed as unduly restrictive of consumer choice. Distinguishing health plans based solely on cost-sharing, rather than on benefits covered, does not permit consumers to select more (or less) covered services, which they may want. Moreover, such a rigid approach to benefit design could stifle innovation. For example, insurers have experimented in recent years with new benefits that encourage consumers to join a gym or go to a smoking cessation class.⁴¹⁸ Health insurers seek to promote consumer health, and reduce medical expenses, through such innovative benefit designs. The Essential Health Benefits packages might be flexible enough to incorporate new ideas. Of course, the ACA requires HHS to periodically review and update the covered services requirements.⁴¹⁹ Fiscal considerations notwithstanding, there is no reason states could not do the same, so long as the states' uniformity requirements do not prevent application of federal minimum rules. It remains to be seen whether this approach will be sufficient to address the concerns of those opposed to maximum uniformity.

Another concern with this first approach is that it may not fully address inefficient decisions due to consumer underestimation of

Moreover, states may be able to require greater uniformity in the form and content of Essential Health Benefit Packages sold inside the Exchange. As discussed above, HHS may provide only general guidance regarding which of the services in each of the ten required coverage areas need to be included in each level of coverage. Under this scenario, states could theoretically require greater uniformity without preventing application of the ACA. Thus, a state could require that every Essential Health Benefits Package sold in that state's Exchange must include precisely the same service coverage in each of the ten enumerated categories. The only aspect of the benefits that would distinguish the levels of coverage would be the amount of cost-sharing.

⁴¹⁷ Because, under this scheme, the list of covered services in a platinum plan would be exactly the same as in a gold, silver, or bronze plan, consumers could simply compare the cost-sharing differences among plans. Similarly, because each level of coverage—platinum through bronze—would have the exact same covered services, the likelihood that consumers would seriously underestimate their risk would be limited to the out-of-pocket cost-sharing in the plan.

⁴¹⁸ See, e.g., *Take Charge! Health Promotions Programs from SCHA*, SOUTH COUNTRY HEALTH ALLIANCE, http://www.mnscha.org/members_healthpromo.htm (last visited Jan. 20, 2011).

⁴¹⁹ Affordable Care Act § 1001(5), 42 U.S.C. § 300gg(15) (2010).

risk.⁴²⁰ Maximum uniformity of covered services only allows consumers to distinguish benefits on the basis of cost-sharing. Of course, if there is only one set of covered services, consumers cannot select a suboptimal benefit package. Still, consumers may not fully understand, and may underestimate, the implications of cost-sharing differences among the levels of coverage.⁴²¹

State policymakers will have to balance these competing concerns of uniformity and choice. However, there is at least one additional approach that could bridge the gap between these concerns. If a state decides to require maximum uniformity, it could permit choice to consumers in the form of supplemental insurance. As discussed below, states need to carefully examine supplemental insurance, if permitted, under federal rules.

(2) Same Choices Inside and Outside the Exchange. Second, states could require that all insurers offering coverage outside the Exchange offer the exact same choices inside the Exchange. A state could enact such a requirement by statute or regulation, as a condition for licensure, as part of product approval, or as part of a marketing directive. The state law would simply direct that any insurer selling a product to the commercial market outside the Exchange must sell the same exact product inside the Exchange.

One advantage of this second approach is that it maximizes uniformity across all lines of commercial insurance. Consumers would be able to compare insurance policies on features other than benefits. This ability to make apples-to-apples comparisons would traverse inside and outside the Exchange.

Another related advantage of unifying inside—and outside—Exchange benefits is to minimize adverse selection. As noted above, one of the primary methods that health plans use to avoid the bad risk of unhealthy consumers is to offer less generous coverage.⁴²² By standardizing coverage options both inside and outside the Exchange, state regulators could limit the impact of adverse selection on both the Exchange and the commercial market outside the Exchange. Once again, standardizing benefits outside the Exchange could encourage commercial market insurers to compete to a greater degree on price and quality rather than risk selection.

⁴²⁰ POLLITZ ET AL., *supra* note 31, at 11.

⁴²¹ *See id.* at 7.

⁴²² As health policy experts acknowledge: “Comparable benefit packages must also be offered inside and outside the exchange; otherwise, sicker patients will gravitate toward the market where more comprehensive coverage is sold.” Blumberg & Pollitz, *supra* note 13, at 3.

However, standardizing coverage options inside and outside of the Exchange could be viewed as limiting both consumer choice and insurer innovation. States, like HHS, could regularly review and modify benefit offerings. State regulators may not be able to act as responsively as the market, thereby delaying or discouraging development of new health insurance products. In addition, the ability of the states to add benefits beyond the federal minimum standards is limited by the ACA requirement that states pay for additional benefit costs. As noted above, state fiscal difficulties seriously undermine the viability of this option for states.

As a slightly less restrictive alternative to requiring all insurers to offer the exact same benefit choices both inside and outside the Exchange, states could ban insurers from offering only bronze or catastrophic levels of coverage outside the Exchange. This would require insurers in the market outside the exchange to offer a level of coverage beyond the bare minimum. Though less effective at fully deterring adverse risk selection by health plans, this alternative could still improve choice and limit risk selection by insurers.

(3) Compliance with All Requirements Inside and Outside the Exchange. Third, states could require that insurers outside the Exchange comply with all requirements applicable to plans sold inside the Exchange. Under this approach, states would require all insurers, whether selling inside or outside the Exchange, to meet the standards for qualified health plans sold through the Exchange. All insurers would have to comply with identical certification, quality measurement, reporting, marketing, enrollment and disenrollment, transparency and other requirements. Among these identical requirements are those related to benefits, including that a health plan must offer at least a gold and silver level of coverage.⁴²³

There are several advantages to this approach. As with the first and second approaches discussed above, this third approach would promote uniformity in benefits inside and outside the Exchange. It would have the additional advantage of minimizing the cost advantages that insurers outside the Exchange would otherwise possess. Such cost advantages include the reduced administrative burden of complying with the certification, quality measurement,

⁴²³ Although the federally defined minimum benefits package explicitly does not preempt state authority to set benefits beyond the federal floor, the practicality and fiscal viability of such an effort remains unclear at this point.

and other requirements. However, compliance with these requirements would likely help provide consumers with better, more standardized, and more complete information about the quality of their health plan.

(4) All Coverage Exclusively Purchased Inside the Exchange. Fourth, states could require that all health insurance be purchased inside the Exchange. Under this option, states would essentially eliminate the market outside the Exchange. The ACA does not allow HHS to eliminate the market outside the Exchange. However, nothing in the ACA explicitly prohibits a state from doing so.

There are several advantages to the fourth approach. By eliminating the commercial insurance market outside the Exchange, a state could achieve maximum uniformity. Health plans would have to offer at least a gold and silver level of coverage, ensuring all consumers have options to purchase a level of Essential Health Benefits coverage less likely to constitute an underestimation of risk. And a state could go one step further, requiring all health plans to offer all levels of coverage. More importantly, this fourth approach would take advantage of the Exchange infrastructure. Thus, all consumers—individuals and groups—would benefit from the certification, rating, reporting, and other requirements of the Exchange. And, by having all of the market under one roof, government regulation could achieve an economy of scale.

In addition, this approach could more fully realize a goal of the Exchange—to establish a place for “one-stop shopping” for health coverage. The ACA already requires every Exchange to create a central portal for consumers to access all coverage, whether purely public (e.g., Medicaid, Family Health Plus or Child Health Plus), purely private (e.g., the commercial market outside the Exchange), or a hybrid of private plans with subsidies to those eligible (i.e., qualified health plans sold through the Exchange).⁴²⁴ However, by essentially eliminating the non-Exchange commercial market, states could arguably improve the ability of consumers to increase the simplicity and uniformity of their choices. Instead of merely being linked to a commercial health plan operating outside the Exchange (perhaps under different rules regarding benefit offerings), consumers could have qualified health plans offered directly in the Exchange. This approach could offer a maximum

⁴²⁴ Affordable Care Act § 1103(a), 42 U.S.C. § 18003 (2010).

degree of standardization and simplicity, and provide consumers with the ability to easily comparison-shop.

A further advantage to this fourth approach is the impact on risk selection. As discussed above, one concern facing every Exchange is the ability of health plans operating outside the Exchange to “cherry pick” healthy consumers and dump sick consumers inside the Exchange. By eliminating the commercial market outside the Exchange, states could likewise eliminate the ability of health plans outside the Exchange to adversely select against the Exchange.

On the other hand, eliminating the commercial market outside the Exchange has several distinct disadvantages. One disadvantage is that this approach could undermine the ability of states to serve as active purchasers. As noted above, one way the Exchange may be able to reduce costs for individuals and small groups is to pool their numbers and negotiate large group discounts from insurers. While the ACA does not specifically authorize this “active purchaser” approach, it is not prohibited. Thus, to the extent this active purchaser approach does not prevent enactment of the ACA, a state could award Exchange coverage to one or a few of the health plans that negotiate or bid with the best rate. However, this would effectively eliminate competitors, since other insurers would not be able to continue in the commercial market outside the Exchange. With the competition eliminated, and only one or a few insurers left in the state, the ability of the Exchange to negotiate and drive future discounts could be undermined.

Another disadvantage of eliminating the commercial market outside the Exchange is the impact on immigrant access to coverage. The ACA expressly limits participation in the Exchange to United States citizens or those “lawfully present” in the United States.⁴²⁵ The commercial market outside the Exchange may be the sole potential source of coverage for at least some of those who are excluded from the Exchange because they cannot satisfactorily demonstrate that they are “lawfully present.” Thus, a state rule that effectively eliminates the commercial market outside the Exchange would deprive some immigrants of a potential source of

⁴²⁵ *Id.* § 1312(f)(3), 42 U.S.C. § 18032 (2010). Section § 1312(f)(3) is reprinted here in its entirety:

If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

coverage that would be unavailable to them inside the Exchange.

Without question, eliminating the non-Exchange market would be a drastic reengineering of the health insurance marketplace.

3. Limited Medical Benefit Plans: One Product's Uncertain Future

“Limited medical benefit plans” or “mini-med Plans” are broad terms that refer to a range of insurance products that fall outside major medical coverage. Limited benefit plans provide a variety of restricted hospital and or medical benefits. These plans typically have strict coverage limits and are not comprehensive health insurance policies.⁴²⁶

The fate of limited benefit plans post-federal health reform is unclear. First, in the transition period from present time until the ACA's minimum benefit requirements are effective, states may seek greater regulation of limited benefit products to address consumer confusion and misleading marketing practices, as well as the inadequate level of benefits. Second, in the long run, these plans do not appear to include sufficient coverage to satisfy the ACA's minimum benefit standards.⁴²⁷ As such, limited benefit plans represent a challenge for state regulators concerned with information asymmetry and risk underestimation.

a. Failure to Disclose Leads to Consumer Confusion

Because limited medical plans reduce coverage relative to comprehensive health insurance products, premiums are reduced as well. Reduced premiums make the policies attractive to lower income individuals. Certain employers offer the limited benefit policies to workers especially in industries with large numbers of part time or seasonal workers. Other limited medical benefit plans are offered in an “association” context.⁴²⁸

⁴²⁶ Isabel Friedenzohn, *Issue Brief: Limited-Benefit Policies: Public and Private-Sector Experiences*, ST. COVERAGE INITIATIVES, July 2004, at 1, <http://www.statecoverage.org/files/Limited-Benefit%20Policies%20-%20Public%20and%20Private-Sector%20Experiences.pdf>.

⁴²⁷ See Reed Abelson, *U.S. Turns to Waivers to Address Talk of Dropping Health Coverage*, N.Y. TIMES, Oct. 7, 2010, at B1.

⁴²⁸ See *Limited Benefit Plans, High Deductible Plans and Health Savings Plans: Contemplating Options When Comprehensive Health Insurance Isn't Available to You*, NAT'L ASS'N OF INS. COMMISSIONERS, http://www.naic.org/documents/consumer_alert_high_deductible_plans.htm (last visited Jan. 20, 2011). The Consumer Alert provides the following guidance to consumers regarding Limited Benefit Health Insurance Plans:

Limited benefit health insurance plans are not replacements for comprehensive health insurance coverage. If you lost coverage under a comprehensive plan and are considering a limited benefit plan, there are several things you should have in mind

Limited medical benefit plans often present a significant information disclosure problem for consumers. Consumers of limited medical benefit plans tend not to understand the limits of their coverage. Consumers often believe that the limited medical plan offers comprehensive health insurance coverage. These bare-bones policies do make insurance—even just a little bit of insurance—more affordable to low-income consumers. However, the limits on coverage pose enormous financial risks relative to comprehensive health insurance policies. Out-of-pocket costs could easily exceed ten percent of income for low-wage consumers enrolled in a limited medical benefit plan. This can leave consumers facing catastrophic costs well in excess of their annual income.⁴²⁹ On the other hand, if a consumer must choose between a limited benefit plan and no plan at all, regulators should carefully consider whether these products may provide some value. Actuarial analysis of limited medical benefit plans could help regulators ascertain that value.

States maintain divergent views of limited medical benefit plans and alternately encourage or restrict their presence in state markets.⁴³⁰ Consumer groups warn against purchasing limited benefit plans.⁴³¹ Consumers generally appear, however, to not be aware of the limited nature of these products. Regardless of the future of these products, consumers must be made aware of their potential limitations to avoid confusing them with major medical

when reviewing the coverage offered by a plan:

Consider the current or future medical needs you or your family may have.

Decide which medical expenses you may need covered by a limited benefit policy and which you can pay for out-of-pocket.

If you are considering a limited benefit health plan instead of continuing existing benefits under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or purchasing an individual policy, figure out if the premium savings will offset the high out-of-pocket expense for medical services not covered by the limited benefit plan.

Before deciding if a limited benefit health insurance plan is right for you, carefully consider if the plan meets your current and future needs. Know the limitations of the coverage and understand the expenses that will and will not be covered under the policy.

Also, ask your agent if there are any exclusions or limitations specifically spelled out in the policy, so expenses that fall within the coverage gaps do not surprise you.

⁴²⁹ Sherry Glied et al., *Bare-Bones Health Plans: Are They Worth the Money?*, COMMONWEALTH FUND, May 2002, at 2, available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2002/May/Bare%20Bones%20Health%20Plans%20%20Are%20They%20Worth%20the%20Money/glied_barebones_518%20pdf.pdf.

⁴³⁰ See Friedenzohn, *supra* note 426, at 2.

⁴³¹ *7 Signs a Health Plan Might Be Junk*, CONSUMERREPORTS.ORG (May 2009), <http://www.consumerreports.org/health/insurance/health-insurance/7-signs-that-the-plan-is-junk/health-insurance-7-signs-the-plan-is-junk.htm> (consumers are warned to “[n]ever buy a product that is labeled “limited benefit” or “not major medical” insurance. In most states those phrases might be your only clue to an inadequate policy”).

products.

In some cases, consumers have been affirmatively led to believe that the limited medical benefit plans are comprehensive health coverage by the carriers themselves.⁴³² For example, in the recent enforcement action by the New York State Insurance Department, a number of consumer complaints about American Medical and Life Insurance Company (“AMLI”) and Cinergy Health, an affiliated entity, documented discrepancies between the coverage consumers were led to believe they purchased and the claims that were paid by AMLI on their behalf.⁴³³ A nationwide television commercial suggested consumers could purchase “real health insurance” for \$5 per day (individual) or \$10 per day (family) coverage.⁴³⁴ The Insurance Department conducted an investigation into AMLI’s practices and ultimately fined the company and prohibited AMLI from selling its limited benefit products in New York.⁴³⁵ The New York State Insurance Department also fined Cinergy Health \$500,000 for “violations including misleading consumers into believing they were buying comprehensive health insurance.”⁴³⁶

b. Limited Medical Benefit Plans and the ACA

The ACA’s minimum benefit requirements make the future uncertain for limited medical benefit plans.

In September 2010, numerous insurance market reforms under the ACA became effective. Among the most relevant to limited medical benefit plans are the restrictions on lifetime and annual benefit caps. These benefit caps are common in limited medical benefit plans. However, in the interim period leading up to 2014, HHS has the option to waive the ACA’s benefit caps. This could allow certain limited medical benefit plans to continue operating until 2014.⁴³⁷ Other limited benefit plans may not even need a

⁴³² Press Release, N.Y. State Ins. Dep’t, Governor Patterson Takes Action Against Misleading Sales of Limited Benefit Health Insurance Plans (Aug. 13, 2009), http://www.ins.state.ny.us/press/2009/P0908131_aml.htm.

⁴³³ *Id.*

⁴³⁴ *5 a Day*, CINERGY HEALTH, http://www.ins.state.ny.us/video/cinergy_health.htm (last visited Jan. 20, 2011).

⁴³⁵ See Press Release, N.Y. State Ins. Dep’t, *supra* note 432.

⁴³⁶ Press Release, N.Y. State Ins. Dep’t, TV, Internet Health Plan Sales Agent Fined \$500,000 (Oct. 6, 2010), <http://www.ins.state.ny.us/press/2010/p1010061.htm>.

⁴³⁷ Affordable Care Act, 75 Fed. Reg. 37,188, 37,207 (to be codified at 46 C.F.R. pts. 54, 602, 29 C.F.R. pt. 2590, 45 C.F.R. pts. 144, 146–147). The Departments’ rationale for the waiver was as follows:

The Departments provided for this waiver in order to prevent the loss of coverage for enrollees in low-benefit plans (for example, “mini-med” plans) that have low annual

waiver. To the extent such plans do not include annual or lifetime benefit caps, the ACA restrictions will not apply. This could be true for a specific disease policy, for example.

Thus, in the interim period before the ACA minimum benefit requirements fully take hold in 2014, state regulators have several options to address the problem of limited benefit plans. First, states can increase enforcement efforts. State insurance departments and attorneys general can commence actions against limited benefit plans (or any plans) that misrepresent or mislead. Second, states can seek to increase regulation. Increasing medical loss ratios (the percent of premium dollar spent on claims for medical services) can ensure better value. Standardizing the limited benefits can ensure better disclosure, and improve the ability of consumers to comparison-shop. Limiting fees charged by associations that sell limited benefit plans could also help protect consumers. Requiring that such plans be sold as supplemental to major medical in some, or all, instances could ensure minimum coverage. Third, states can ban some, or all, limited benefit plans.

Few would argue with the first approach. Protecting consumers from misleading sales practices is rarely controversial. States should carefully weigh concerns raised by seeking to increase regulation to ban some, or all, limited benefit plans under the second and third approaches. Perhaps the greatest concern is that insurers may stop offering some, or all, types of limited coverage. These plans are inexpensive in part because they are so limited. But for some, these plans may be the only affordable product on the market, at least until the Exchanges are up and running in 2014. During this interim period, certain states may decide that some coverage is better than none at all.

Beginning in 2014, limited medical benefit plans sold outside the Exchange will likely not satisfy the minimum essential coverage criteria as defined by HHS.⁴³⁸ Limited medical benefit plans sold inside the Exchange are even more unlikely to satisfy the minimum requirements. In addition, limited medical benefit plans sold inside the Exchange must meet all the requirements under the ACA to be qualified health benefit plans.⁴³⁹ Regardless, some consumers may want to buy limited medical benefit plans, either now or in 2014.

limits. While the impact of this policy is not quantified, it, too, is intended to mitigate any unintended consequences given the paucity of data on the incidence and prevalence of annual limits in the markets today.

⁴³⁸ See generally Affordable Care Act § 1502(b), 26 U.S.C. § 5000A (2010).

⁴³⁹ See *id.* § 1311(c), 42 U.S.C. § 18031 (2010).

Regulators have at least three options to improve the post-2014 limited medical benefit plan market. Many options are similar to the options available during the transition period before 2014. First, regulators could ban limited benefit plans altogether. Banning these plans leaves no room for consumers to be misled by the minimal level of coverage.⁴⁴⁰ Second, regulators could improve the quality of limited medical benefit plans by increasing the medical loss ratio (“MLR”). This will require insurers to spend a greater percentage of premium revenue on medical care, rather than administrative costs or profit.⁴⁴¹ Third, states might restrict the sale of limited benefit plans to coverage that supplements minimum essential benefit packages, similar to Medicare supplement policies.⁴⁴² HHS will issue guidance on these and related issues in the coming months.⁴⁴³ In the event that limited medical benefit plans exist in the post-2014 market as supplemental products, regulators might seek to standardize their benefit packages to ensure quality and transparency. Fourth, at a minimum, regulators can establish robust disclosure requirements for all limited medical benefit plans to help consumers better understand these products. Finally, states can enforce any misleading or deceptive marketing practices by insurers.

As with the interim period before 2014, state regulators will have to determine the value that the limited medical benefits provide. Regulation of limited benefit plans should balance the need to ensure a minimum level of benefits, on the one hand, with cost, on the other hand. Certain consumers will not qualify for public

⁴⁴⁰ David A. Hyman, *Health Insurance: Market Failure or Government Failure?* 10 (U. Ill. Law & Econ. Research Paper Series, Research Paper No. LE08-003, 2008), available at <http://ssrn.com/abstract=1087830> (“It is clear that the cost of health insurance is a major factor in why so many people are uninsured. Given that reality, it is far from clear why we should accept a regulatory framework that offers people the choice between ‘nothing but the best and nothing.’”) (citations omitted).

⁴⁴¹ Some companies appear to have concern that, because of the high administrative costs associated with frequent enrollment and disenrollment from these products, the MLR requirements established by the ACA are incompatible with the products altogether. See Janet Adamy, *McDonald’s May Drop Health Care*, WALL ST. J., Sept. 30, 2010, at A1.

⁴⁴² Medicare supplemental policies, or “Medigap” policies, offer one standardized set of basic benefits in Medigap plans A–G, and different sets of basic benefits in Medigap plans K–N. See *What Are Medigap Basic Benefits*, MEDICARE.GOV, <http://www.medicare.gov/find-a-plan/staticpages/learn/more-about-medigap-basic-benefits.aspx> (last visited Jan. 20, 2011). The medicare.gov website offers standardized, simplified descriptions of each benefit plan option and includes categorical descriptions to explain the supplement as follows: “What Medicare Pays,” “What Medigap Pays,” and “What You Pay (for covered services).” *Id.*

⁴⁴³ Press Release, U.S. Dep’t of Health & Human Servs., Statement on the Application of Medical Loss Ratio Standards to Certain Health Plans Under the Affordable Care Act (Sept. 30, 2010), <http://www.hhs.gov/news/press/2010pres/09/20100930c.html>.

programs or ACA subsidies to purchase private health insurance through the Exchange. And, notwithstanding the individual mandate, some portion of these consumers is likely to remain uninsured even after 2014. These individuals deserve special attention, particularly in high cost, high premium states like New York. State regulators should carefully balance the need to establish minimum levels of coverage with affordability. In short, is some coverage better than none?

Whether limited medical benefit products exist outside the Exchanges depends on the quality of the products created by carriers for that market. Insurance regulators will look carefully at coverage, cost, and disclosure features of limited medical plans when evaluating their value. In any event, regulators should establish clear consumer-oriented ground rules for any limited benefit plans permitted in the commercial market outside the Exchange.

VI. CONCLUSION

The ACA provides a framework for standardizing health benefits. The ACA uses a “structured choice” approach, which strikes a balance between unregulated choice and strict uniformity. Within the ACA’s structured choice framework, federal and state regulators have options which can increase or decrease the uniformity of benefit choices.

In evaluating options under the ACA, regulators should consider the problems of asymmetric information and underestimation of risk. The ACA offers regulators options to increase useful disclosure of benefit information. These options can maximize the ability of consumers to effectively comparison-shop. Markets, including the health insurance market, typically work better when consumers can effectively comparison-shop. The ACA also gives regulators a framework to protect consumers from choosing less coverage than they actually need. The individual mandate and minimum benefit standards will help ensure consumers do not seriously underestimate their risk. States have options to maximize uniformity beyond federal minimums, both inside and outside the new Exchanges. Each of these options has advantages and disadvantages. Regulators should keep consumer choice and health insurance market viability at the forefront of health reform decision making.