

# NONDISCRIMINATION UNDER THE AFFORDABLE CARE ACT

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# Executive Summary

The Affordable Care Act (ACA) has the potential to dramatically improve the availability, affordability, and adequacy of private health insurance. With the law's most significant reforms going into effect on January 1, 2014, many stakeholders—including insurers, state insurance regulators, state exchange officials, and federal officials—have begun the daunting task of designing, reviewing, and approving new health insurance products that make reform a reality. Doing so is no small feat as insurers must meet new standards such as cover a minimum set of essential health benefits, incorporate new limits on cost-sharing, and ensure that plans meet new actuarial value requirements.

In addition to these standards, insurers must comply with the ACA's expansive consumer protections on nondiscrimination. Prior to the ACA, federal and state law included some nondiscrimination protections, but most have had only a limited effect in ensuring that coverage meets the needs of all consumers. Through its broad incorporation of new standards, the ACA is designed to address this gap by prohibiting discrimination based on health status, disability, age, race, gender, and sexual orientation, among other factors. In preventing discrimination against certain groups—and, in particular, the sick—the ACA takes significant steps towards ensuring that private health insurance meets the needs of the most vulnerable.

Yet, there are significant questions about how new nondiscrimination requirements will be implemented in practice. For example, how are insurers incorporating these new standards into their products for 2014? Which areas of plan design—such as coverage exclusions, narrow provider networks, or utilization management—have the most potential for discrimination? And how will the new requirements be enforced at the state and federal level? This report explores how stakeholders are grappling with these questions as insurers design and market new products, regulators review and approve products, and consumers look to obtain coverage that best meets their needs.

Based on interviews with state insurance regulators, insurers, and patient and consumer advocacy organizations, we found that:

- Stakeholders struggled to articulate an ideal standard for identifying discriminatory benefit design and raised concerns about the potential for discrimination in the design of drug formularies and the adoption of narrow provider networks, among other plan features.
- States and insurers have not changed their approach to nondiscrimination but are using new tools, such as attestations, outlier analysis, and internal tracking databases, to monitor for compliance.
- States raised questions about how nondiscrimination requirements relate to the essential health benefits benchmark plan and identified challenges in enforcement because of a lack of clinical expertise and the inability to fully see benefits in the filing process.
- Stakeholders stressed the need for ongoing monitoring of discriminatory benefit design.
- Some stakeholders supported meaningful federal guidance with clear examples of discrimination.

These findings suggest that new nondiscrimination standards have not significantly changed the way that state regulators or insurers approach benefit design and that regulators face practical limitations in trying to implement these requirements. Further, some regulators may not be willing to assume a much broader role in defining discriminatory benefit design without clearer federal standards. In light of such limitations, ensuring that the ACA's nondiscrimination standards are met likely requires ongoing monitoring of consumer complaints, the development of new infrastructure such as tracking systems, robust grievance and appeals processes, and clarification of federal requirements.

To clarify these requirements—and prevent vulnerable consumers from falling through the cracks—the U.S. Department of Health and Human Services (HHS) could:

- Issue guidance with specific examples of benefit design features that would be considered discriminatory under the ACA and define key terms such as “disability” and “medical necessity.” Examples could address all of the types of benefit design with the potential to be discriminatory, including exclusions, cost-sharing, narrow or tiered networks, drug formularies, visit limits, restrictive medical necessity definitions, utilization management, waiting periods, service areas, rating, marketing of products, and benefit substitution.
- Collaborate with state regulators before issuing guidance to leverage state expertise and experience in identifying discriminatory benefit design and better assess and understand emerging compliance issues under the ACA.
- Use feedback from state regulators, exchange officials, agents and brokers, and navigators, as well as analysis of appeals data and information collected under Sections 1311(e) and 2715A of the ACA to monitor implementation of nondiscrimination standards, assess whether further adjustments are necessary, and identify additional examples of discriminatory benefit design.

In addition, our findings suggest that the essential health benefits benchmark plan approach may have perpetuated the inclusion of discriminatory benefit designs in at least some states by requiring the selection of benchmark plans that were not designed to be in compliance with the ACA’s most significant reforms. In reevaluating essential health benefits standards for 2016, HHS should consider whether the benchmark plan approach adequately protects against discrimination. As federal and state regulators review products for discriminatory benefit design, monitor the ways that plans are marketed, and ensure that insurers are good stewards of federal premium tax credits, much may be at stake to ensure that consumers receive the ACA’s protections.

# Background

To understand the significance of the ACA's new nondiscrimination protections, we first discuss existing federal and state nondiscrimination requirements for private health insurance. We then identify the nondiscrimination protections in the ACA, with an emphasis on standards designed to limit discriminatory benefit design such as coverage of essential health benefits.

## **Current Nondiscrimination Standards for Private Health Insurance**

"Discrimination" refers to the ways that insurers differentiate among individuals in designing and implementing private health insurance coverage.<sup>1</sup> Discrimination can occur in many ways, including at the point of enrollment, in the ways that coverage is designed, and the decisions that insurers make when administering benefits and services.<sup>2</sup> While some forms of discrimination (such as the denial of benefits that are clearly covered under a policy) have long been understood as prohibited, others are integral parts of the existing private health insurance system that distinguishes between "actuarial fairness" (based on individual risk) and "solidarity" (based on societal risk pooling).<sup>3</sup> Indeed, actuarial fairness has long been accepted as legitimate market practice to shield insurers from the risk of adverse selection (a disproportionate share of unhealthy individuals).<sup>4</sup>

To limit adverse selection, many insurers use underwriting to evaluate an individual's expected health care costs based on factors such as age, gender, and health status.<sup>5</sup> As a result of underwriting, insurers in most states may decline to cover an applicant, not cover certain costly treatments (such as organ or bone marrow transplants), impose treatment limits (such as caps on visits for physical therapy), or require high cost-sharing on benefits (such as pharmaceutical drugs for chronic conditions).<sup>6</sup> Insurers may also adopt restrictive methods regarding when an insured individual is eligible for covered benefits (through, for example, narrow definitions of "medical necessity" or stringent utilization management) or offer coverage with a network of providers that doesn't include certain specialists.<sup>7</sup> These types of discrimination shift risk from the employer or insurer to the consumer and help explain chronic levels of underinsurance, where even insured consumers face high out-of-pocket medical costs relative to their income.<sup>8</sup>

*Federal standards.* To date, many federal laws focus on limiting discrimination in private health insurance at the point of enrollment, such as requiring insurers to enroll individuals when they leave group coverage.<sup>9</sup> These federal laws include Title VII of the Civil Rights Act of 1964, the Health Insurance Portability and Accessibility Act of 1996 (HIPAA), and the Genetic Information Nondiscrimination Act of 2008, among others (Exhibit 1).<sup>10</sup> HIPAA, for example, requires coverage to be available to any small employer that applies for coverage; prohibits individual employees from being targeted for higher premiums because of health status; and prohibits certain insurers from establishing eligibility rules using factors related to health status, such as disability.<sup>11</sup> Although critical to promoting access to coverage, these laws have been criticized as offering "relatively limited protections."<sup>12</sup>

### **Exhibit 1. Select Federal Laws on Nondiscrimination in Private Health Insurance**

1964 Civil Rights Act	Mental Health Parity Act
Age Discrimination in Employment Act	Mental Health Parity and Addiction Equity Act
Americans with Disabilities Act	Newborns' and Mothers' Health Protection Act
Employee Retirement Income Security Act	Pregnancy Discrimination Act
Genetic Information Nondiscrimination Act	Rehabilitation Act of 1973
Health Insurance Portability and Accountability Act	Women's Health and Cancer Rights Act

Source: Adapted from Sara Rosenbaum, *Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law, and Federal Reform Options* (Washington, D.C.: Georgetown University Law Center O'Neill Institute for National and Global Health Law, 2009).

Other federal laws—such as the Women’s Health and Cancer Rights Act of 1998 (WHCRA), the Newborns’ and Mothers’ Health Protection Act of 2008, and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008—limit discriminatory benefit design by requiring insurers to cover certain benefits (Exhibit 1).<sup>13</sup> For example, WHCRA requires insurers that offer mastectomy coverage to also cover breast reconstructive surgery, prostheses, and treatment of physical complications of the mastectomy.<sup>14</sup> Despite these protections, enforcement has been mixed and many of these laws do not apply uniformly to all types of health insurance.<sup>15</sup> Further, these laws do not actually require insurers to cover specific benefits. Rather, the requirements exist only where insurers already offer certain benefits, such as mastectomy coverage, hospital stays in connection with childbirth, or mental health coverage.<sup>16</sup>

*State standards.* States have historically been the primary regulators of private health insurance and typically enforce requirements that apply to the fully insured market.<sup>17</sup> In addition to enforcement of federal requirements, states prohibit unfair discrimination under their unfair trade practice statutes, and some have other protections, such as human rights law, that prohibit certain types of discrimination in private health insurance.<sup>18</sup> Despite these broad standards, researchers have identified few explicit prohibitions against discrimination based on race, religion, gender, and age.<sup>19</sup> (Even if not explicitly required by law, states may prohibit this type of discrimination in practice by, for example, refusing to approve a policy form that includes language that discriminates based on these factors.) In addition, states often prohibit insurers from discriminating on the basis of domestic abuse, genetic information, sickle cell anemia, and HIV status.<sup>20</sup> States also typically prohibit the use of premiums that are unfairly discriminatory, although only a minority of states require coverage to be available to every applicant or prohibit insurers from varying premiums based on health status.<sup>21</sup>

To ensure that consumers have access to specific benefits, states have also adopted mandates that require insurers to cover certain benefits. These mandates vary significantly between states and range from requiring coverage for basic services—such as childhood immunizations and screening for colorectal cancer—to benefits that are likely to be used by fewer individuals—such as infertility treatment.<sup>22</sup> Mandates, while common, often generate controversy about the appropriate balance between comprehensive coverage and affordability.<sup>23</sup>

Despite existing protections, discrimination in private health insurance persists in the individual and small group markets. Women continue to be charged more for coverage,<sup>24</sup> insurers in most states can deny or limit coverage based on health status,<sup>25</sup> and consumers may face high cost-sharing for chronic diseases.<sup>26</sup> Such practices may persist even when explicitly prohibited. In California and Oregon, for example, legislators prohibited insurers from discriminating based on gender identity in 2005 and 2007, respectively.<sup>27</sup> Yet, some insurers continued to deny or limit coverage on this basis, and regulators in both states only recently issued guidance confirming that insurers cannot do so.<sup>28</sup> In light of ongoing practices such as these, we next identify the nondiscrimination protections in the ACA that were designed to address some of these issues.

## **Nondiscrimination Standards for Private Health Insurance under the ACA**

The ACA introduces expansive new nondiscrimination requirements (Exhibit 2). First, the law includes additional protections to limit discrimination at the point of enrollment. These protections include extending many of HIPAA’s existing protections in the small group market—such as guaranteed issue and eligibility rules based on health status-related factors—to the individual market.<sup>29</sup> Second, the ACA ushers in significant requirements regarding the content of private health insurance, such as prohibiting preexisting condition exclusions and requiring coverage of routine costs for patients participating in clinical trials, among others.<sup>30</sup>

**Exhibit 2. Select ACA Requirements on Nondiscrimination in Private Health Insurance\***

<b>Reform</b>	<b>Nondiscrimination Protection</b>
<b>Civil rights protections</b>	Prohibits individuals from being subject to discrimination, excluded from participation, or denied benefits on the basis of race, color, national origin, sex, age, or disability under certain health programs or activities, programs or activities administered by an executive agency, or entities established under the ACA. <sup>1</sup>
<b>Eligibility for coverage</b>	Prohibits plans from refusing to enroll or charging more for coverage on the basis of health status, medical condition (physical and mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.
<b>Essential health benefits</b>	Requires coverage of specified benefits that include 10 categories of defined benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; chronic disease management; and pediatric services, including oral and vision care. <sup>2,3</sup>
<b>Lifetime and annual dollar limits</b>	Prohibits lifetime limits on the dollar value of essential health benefits; restricts annual limits on the dollar value of essential health benefits, unless waived by HHS. <sup>4</sup>
<b>Preexisting condition exclusions</b>	Prohibits insurers from imposing preexisting condition exclusions with respect to plans or coverage.

\*Unless otherwise noted, each provision becomes effective for plan or policy years beginning on or after January 1, 2014 and applies to 1) new plans in the individual, small group, and large group markets; and 2) grandfathered plans in the small and large group markets.

<sup>1</sup>The civil rights protections in Section 1557 of the ACA became effective on March 23, 2010 and apply to 1) any health program or activity, any part of which receives federal financial assistance (including credits, subsidies, or insurance contracts); 2) any program or activity administered by an executive agency; and 3) any entity established under Title I of the ACA.

<sup>2</sup>This provision does not apply to plans in the large group market. (Employer-sponsored self-insured and insured large group plans are not required to offer every essential health benefits category or conform their plans to an essential health benefits benchmark plan. A proposed rule from the Department of the Treasury and the Internal Revenue Service would clarify that plans wishing to offer “minimum value” must cover at least 60 percent of anticipated covered medical spending for benefits provided under a particular essential health benefits benchmark plan. Plans are allowed to account for benefits that are included in any of the essential health benefits benchmarks.)

<sup>3</sup>This provision does not apply to grandfathered plans. (HIPAA previously required guaranteed issue in the small and large group markets and thus applies to grandfathered plans in these markets.)

<sup>4</sup>The prohibition on lifetime dollar limits became effective for plan years beginning on or after September 23, 2010 and applies to new plans and grandfathered plans in the individual, small group, and large group markets. The prohibition on annual dollar limits became effective for plan years beginning on or after September 23, 2010 unless waived by HHS (in which case it becomes effective on or after January 1, 2014); this provision applies to new plans in the individual, small group, and large group markets and grandfathered plans in the small and large group markets.

Although the ACA includes requirements to improve the availability and affordability of coverage, this analysis focuses on the protections that promote adequate coverage and limit discriminatory benefit design. To date, the ACA’s most explicit protections against discriminatory benefit design are reflected in the regulations implementing essential health benefits requirements and statutory civil rights protections.

*Essential health benefits.* Among the ACA's most significant protections, insurers that offer coverage in the individual and small group markets are required to cover at least 10 categories of essential health benefits and cannot impose lifetime or annual dollar limits on these benefits.<sup>31</sup> In defining essential health benefits, Congress required the Secretary of HHS to ensure that benefits do not discriminate based on age, disability, or expected length of life; account for the health care needs of diverse segments of the population; and are not subject to denials based on age, life expectancy, disability, medical dependence, or quality of life.<sup>32</sup>

In implementing this requirement, HHS asked state officials to select a "benchmark plan" to serve as reference point for coverage of essential health benefits.<sup>33</sup> Federal regulations prohibit insurers from adopting benefit designs—or implementing benefit designs (defined as coverage decisions, reimbursement rates, or incentive programs)—that discriminate based on age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.<sup>34</sup> HHS also prohibited insurers from 1) adopting benefit designs that discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation; or 2) utilizing discriminatory marketing practices or benefit designs that discourage the enrollment of individuals with significant health needs.<sup>35</sup>

*Civil rights protections.* In addition to essential health benefits requirements, Section 1557 of the ACA applies existing federal civil rights protections to private health insurance and prohibits individuals from being subject to discrimination, excluded from participation, or denied the benefits of health programs or activities based on race, color, national origin, sex, age, or disability.<sup>36</sup> These requirements are enforced by the Office of Civil Rights within HHS and apply broadly to include, for example, the exchanges in every state.<sup>37</sup> Although HHS released guidance to clarify that Section 1557 includes discrimination based on gender identity and sex stereotyping,<sup>38</sup> federal regulators have not yet issued implementing regulations. This delay, however, has not prevented challenges to insurer and employer practices under this new protection.<sup>39</sup>

The ACA's requirements represent a substantial change in the federal regulation of private health insurance through new minimum federal standards to protect against discrimination. By prohibiting insurers from offering coverage that discriminates based on race, national origin, sex, age, disability, gender identity, sexual orientation, expected length of life, or significant health needs, the ACA represents a significant shift away from many existing discriminatory practices.

# Methodology

This report focuses on understanding stakeholder approaches to implementing ACA requirements that are designed to limit discriminatory benefit design with an emphasis on the coverage of essential health benefits. Interviews were conducted with state health insurance regulators, insurers, and patient and consumer advocacy organizations. We interviewed insurance regulators in 10 states—Georgia, Maine, Montana, Nevada, New Hampshire, North Carolina, Oregon, Rhode Island, South Carolina, and West Virginia—as well as representatives of national and local insurers, the American Cancer Society Cancer Action Network, the American Heart Association, the National Alliance of State & Territorial AIDS Directors, and the National Women’s Law Center. All interviews were conducted between April and May 2013, and information included in this report was re-verified by interviewees to ensure an accurate reflection of interview discussion.

# Findings

### **No Ideal Standard for Discriminatory Benefit Design**

Regulators noted that the broad nondiscrimination standards included in the ACA and implementing regulations—such as prohibiting discrimination based on “quality of life”—provide little guidance as to how regulators should undertake a systematic review for discriminatory benefit design. This is in part because the application of such broad standards can be highly subjective and requires a holistic analysis of plan features. Despite difficulty in articulating an “ideal” standard, stakeholders had little trouble identifying design features that have the potential to be discriminatory (Exhibit 3). In particular, stakeholders raised concerns about drug formularies, narrow provider networks, exclusions, and benefit substitution (Box 1).

**Exhibit 3. Select Benefit Design Features with the Potential to be Discriminatory**

Cost-sharing	Waiting periods
Medical necessity definitions	Service areas
Exclusions	Rating
Narrow networks	Visit limits
Drug formularies	Marketing of products
Benefit substitution	Utilization management

In part because of the difficulty in developing a comprehensive standard for discriminatory benefit design, none of the study states issued formal guidance regarding nondiscrimination requirements. Instead, many states are allowing insurers to interpret nondiscrimination requirements on their own and then placing the burden on insurers to explain why a feature is *not* discriminatory. As one regulator noted, “issuers could come in totally different, especially if there is nothing out there that says ‘you have to use this language.’”

Insurers and advocates similarly did not identify an “ideal” standard. One insurer noted that part of the difficulty in doing so is because “the whole notion of discrimination implies that there are stable classes of individuals that are observable and definable, but we know that individual preferences and values vary within the same class.” While insurers and some state regulators were confident that discriminatory benefit design would be addressed in response to market demands, other regulators and advocates were more cautious and one advocate noting that existing nondiscrimination standards—such as those in civil rights law—should be applied to the ACA’s requirements.

### **Box 1. Stakeholder Concerns about Benefit Design Features**

*Tiered and narrow networks.* Regulators are already seeing or hearing about the possibility of tiered or narrow provider networks or high cost-sharing associated with out-of-network care. Even in states with network adequacy standards, one regulator noted that plans that meet these standards might not include certain providers or hospitals, which could impact consumers. These concerns were shared by advocates who questioned how federal and state regulators will approach network issues with respect to nondiscrimination when, for example, a child is born with a congenital heart disease but the network does not include a pediatric cardiologist or a consumer has an aggressive form of cancer but cannot afford cost-sharing for the only facility that can treat him immediately. Stakeholders acknowledged that insurers were making such changes to keep premiums down and—instead of discouraging narrow networks—regulators in at least one state will focus on ensuring that consumers receive meaningful disclosures about insurer networks.

*Drug formularies.* Regulators reported difficulty in conducting a meaningful review of the adequacy of drug formularies to ensure that plans do not discriminate based on, for example, expected length of life or disability. Some noted that this type of in-depth review would be an expansion of their traditional regulatory role because it requires an understanding of the latest drug treatments, patient needs, and evidence-based treatments. This type of review is made even more difficult by the fact that insurers change their formularies frequently.

Some regulators believed that consumers will choose the most appropriate formulary for their needs, while others are taking a more proactive approach. Regulators in one state, for example, will review sub-classes of drugs based on past complaints data and emphasized the importance of also analyzing tiering and cost-sharing. Another state will monitor complaints associated with the prescription drug appeals process for drugs included (and not included) on the formulary. A third state has requested complaints data from the benchmark plan insurer regarding its formulary and is exploring whether to partner with the state's pharmacy board to provide the expertise necessary to review formulary adequacy. Advocates emphasized the need for proactive approaches to ensure that drug formularies cover a sufficient number and type of drugs as well as review restrictive utilization management that could result in limited access to more expensive drugs, such as new medications to treat cancer or HIV.

*Exclusions, substitution, and other concerns.* Regulators in at least one state reported that some 2014 filings still include significant exclusion sections and that insurance departments will need to develop expertise over time to analyze exclusions. Benefit substitution was also a concern among some, but not all, states with regulators noting the potential for high cost-sharing that would essentially exclude coverage for a certain benefit. Many states are converting existing dollar limits into visit limits because the ACA prohibits such limits on essential health benefits; however, at least one state will allow insurers to make this conversion for some essential health benefits so long as the conversion is actuarially justified. And, according to one regulator, some insurers hope to use health questionnaires to determine whether prospective enrollees have congenital conditions. States also identified concerns about potential discrimination in geographic rating, the geographic service areas that insurers choose to operate in, and waiting periods that insurers may apply for certain benefits, such as transplants.

### **Same Approach But New Tools to Identify Discrimination**

Most state regulators and insurers reported that the ACA's nondiscrimination protections have not altered their approach to limiting discriminatory benefit design, but that states will use new or adapted tools to monitor for compliance. These tools include form review checklists, insurer attestations, outlier analysis, and internal tracking databases.

*Today's market.* Regulators in every state reported monitoring for discrimination when reviewing insurer policy forms or receiving complaints from consumers or agents and brokers. To identify discriminatory products during the regulatory review process, states often rely on internally developed tools, such as form filing checklists, to ensure that each policy form includes mandated benefits and complies with state law. Past discriminatory practices—identified through the form or rate review process—include instances

of insurers charging younger female spouses (women under the age of 35) more than older female spouses or insurers imposing additional cost-sharing requirements on maternity benefits. These types of practices are consistent with reports from advocates of past exclusions of chemotherapy or eating disorder treatment; limits on the number of visits for therapy; high cost-sharing for specialty drugs; and provider networks that do not include specialists such as radiation oncologists.

Regulators also address discrimination when receiving consumer complaints and typically resolve issues directly with insurers or investigate and initiate market conduct examinations. Regulators did not report receiving a significant number of complaints regarding discriminatory benefit design. (For more on consumer complaints and some of the reasons why regulators might not have received complaints on this topic, see page 12.)

*Under the ACA.* Most regulators reported that their processes have expanded to include additional protected classes but their approach to nondiscrimination is largely unchanged under the ACA. Insurers are also likely to approach benefit design the same way as in the past (Box 2). Although the processes will not change, regulators in some, but not all, states reported that they will monitor benefit design issues more closely than in the past. For example, plan analysts in some states will be asked to look for unusual plan features or more closely review design features that are not always captured in the traditional form review process, such as drug formularies and narrow networks. Others noted that mistakes or oversights are possible and emphasized the importance of being able to revisit an insurer's policy for discriminatory practices, even if already approved by the state.

#### **Box 2. Insurers Reported Few Changes to Their Approach to Benefit Design under the ACA**

Insurers account for a variety of factors when designing plans, with most plan variation as a result of cost-sharing rather than the actual benefits covered. Insurers reported considering factors such as clinical evidence, consumer experience, national coverage standards, technological advances, and long-term goals like reducing inefficiency. In designing products, a national insurer noted that benefits and medical policy are largely standardized, with exclusions based on clinical evidence, the risk of adverse selection, requests from clients such as large employers, and philosophical questions such as whether a benefit is truly medical or not. Another insurer noted that exclusions are often adopted or eliminated based on how frequently a benefit is the subject of appeals and that exclusions may be used to prevent consumers from challenging decisions not to cover a benefit based on medical necessity.

Going forward, insurers reported that they will maintain the same approach to benefit design while being mindful of new requirements. As one insurer noted, the ACA's nondiscrimination requirements "are not the provisions driving major changes in product design decisions." Another echoed this sentiment and noted that their efforts in designing products for 2014 have been focused more on meeting essential health benefits requirements, rather than broad nondiscrimination standards that may result in confusion or inconsistency. For example, one insurer questioned whether the use of age-based clinical criteria (such as preventive services recommended only for children or adults of a certain age) would be considered "reasonable medical management techniques" (which is allowed under federal regulations) or discriminatory based on age (which is prohibited).

Insurers also emphasized that they face significant regulatory oversight by state and federal regulators and that "cherry-picking" of consumers would not be tolerated. In addition, despite some concerns with the methodology, insurers noted that risk adjustment could be a strong incentive to avoid "cherry-picking" and lead to insurers trying to enroll higher-risk populations if they are able to manage care effectively. Insurers were largely not concerned that competitors would use discriminatory benefit design to enroll a healthier segment of the market but did not expect most insurers to provide more benefits than required under federal and state law.

To aid their review, states will use new or adapted tools to require or encourage compliance with nondiscrimination requirements.<sup>40</sup> Many are amending their existing form and rate review checklists to reflect federal requirements while others are requiring insurers to sign an attestation that each policy is in compliance with federal law, including nondiscrimination requirements. A few states will use a tool developed for the federally facilitated exchanges that analyzes cost-sharing levels for the individual benefits of each plan and identifies areas where a plan includes “outliers.”<sup>41</sup> Others, however, cautioned against relying solely on an outlier identification tool; as one regulator put it, “we need to look at actual cost-sharing and utilization management around these benefits ... we’ve got to go a lot more deeply.” And some states will rely on a separate federal tool to determine whether plans include the minimum number of prescription drugs in a given category or class.

One state is building a database to track specific benefits—including exclusionary language and drug formularies—to help ensure that plans do not steer high-risk individuals to other products. Regulators in this state have identified specific benefits with the potential to be discriminatory, with an eye towards balancing the need to allow insurers to effectively manage care while also ensuring that benefit design is not unfairly discriminatory. While decisions to track a specific benefit are made internally, regulators have allowed insurers to offer input if a design feature or benefit is viewed as highly subjective.

### **Challenges in Enforcing Nondiscrimination Requirements**

Although regulators reported few concerns about enforcing the ACA’s nondiscrimination requirements, many noted significant challenges in doing so (Exhibit 4). Some, for example, reported that they expected to face few issues with discriminatory benefit design because new nondiscrimination standards are already consistent with existing unfair trade practices standards: as one put it, the ACA means “there is just more to look for.” Further, some states already require rich benefit packages so there is little room for discrimination. Consistent with reports from insurers who expect to be under significant scrutiny (Box 2), one regulator noted that dual regulation by federal and state regulators in states with federally facilitated exchanges would cause insurers to be cautious about skirting ACA requirements.

Yet, despite this confidence, regulators highlighted significant challenges in enforcing these requirements, including confusion about how nondiscrimination requirements relate to the essential health benefits benchmark plan and a lack of clinical expertise.

#### **Exhibit 4. Select Challenges in Monitoring and Enforcing Discriminatory Benefit Design**

- Broad nondiscrimination standards
- Confusion about discrimination in the benchmark plan
- Insufficient resources for comprehensive reviews
- Limited clinical expertise
- Filing systems that do not enable systematic review

*Benchmark plan confusion.* Regulators in some states and advocates reported concerns that benchmark plans themselves could be discriminatory, and states varied in their willingness to address discriminatory benefit design if the design features were also present in the benchmark plan. This was

particularly true if the discriminatory feature did not explicitly impact the 10 categories of essential health benefits and in states that defaulted to the federally designated benchmark plan (instead of formally selecting a benchmark plan from among the 10 options). As one regulator put it, “we were relying on the federal government to select a nondiscriminatory plan so we didn’t do that kind of analysis.”

Most states did not analyze whether their essential health benefits benchmark plan included discriminatory features.<sup>42</sup> Of those that did, one state did not analyze exclusions and three states identified exclusions that should not have been included in the benchmark plan itself. Based on this review (and consistent with recent determinations in a handful of other states<sup>43</sup>), at least one state is considering whether existing exclusions based on gender identity should be permitted in the future.

Concerns that benchmark plans are discriminatory are exacerbated by the fact that the benchmark selection process was not transparent in many states.<sup>44</sup> According to advocates, only some states publicly released plan materials for analysis by external stakeholders and, even when information was available, materials did not contain a sufficient level of detail—such as contract language—to determine how certain benefits, such as “maternity,” were covered. In addition, insurers indicated that some federal plan analysis was incorrect, and federal regulators did not require reporting of certain design features, such as exclusions, for federal plan summaries.<sup>45</sup>

To address these concerns, regulators in some states are working with insurers to remove problematic exclusions or other design features, even if included in the benchmark plan. As one put it, “if there is something wrong with the benchmark, we wouldn’t allow insurers to do it.” But, regulators in these states reported that insurers were not always pleased to do so; as one noted, “insurers are pushing back to say ‘if the benchmark has them, why can’t we have them?’”

Although some states are addressing these issues, uncertainty remains about how states will approach nondiscrimination as it relates to the benchmark plan. As one regulator put it, “we have tried not to extrapolate from the flaws in the benchmark but there are some gray areas.” While one regulator noted that these issues should be addressed during the federal review of qualified health plans, others had not yet made decisions about reviewing for discrimination in certain plan elements, such as exclusions.

*Lacking expertise.* Regulators did not always feel that they had sufficient clinical expertise to determine whether certain design features might be discriminatory. For example, regulators are ensuring that plans meet federal requirements for prescription drug coverage but felt they did not have the clinical knowledge necessary to undertake a more meaningful review of formulary adequacy as required in ACA regulations.<sup>46</sup> As one regulator put it, “we wouldn’t be able to do it without some other type of resource help [so] we don’t really have a choice except to take [the insurers’] word for it.” One insurer raised similar concerns and questioned whether the requirement that plans cover only a certain number of drugs—described as “a very blunt tool”—would ensure appropriate access to medically necessary drugs. (For more on stakeholder concerns related to drug formularies, see Box 2.) Regulators raised similar concerns in understanding whether certain exclusions have the potential to be discriminatory; as one noted, “we haven’t at this point analyzed the impact of every exclusion and how it affects different people ... it’s a slippery slope.”

*Practical limitations.* Some state filing systems do not allow a simple, streamlined review for discriminatory benefit design. For example, regulators reported difficulty using the templates for 2014 products and making comparisons between policy forms because contract language is presented differently for every insurer. And, in some states, insurers are not required to file full policy forms and, instead, only file changes to an already filed policy. According to regulators, these types of filings require review on a case-by-case basis and have limited their ability to establish a systematic review for discriminatory benefit design.

## **The Need for Ongoing Monitoring**

Given these enforcement challenges, regulators stressed the importance of monitoring consumer complaints. Regulators in one state emphasized that—given all of the options in the market—close monitoring and tracking, while intensive and time-consuming, will be critical to identify areas for potential discrimination. Regulators noted that the need for close monitoring is exacerbated because of the absence of a more specific nondiscrimination standard, with states planning to “listen to the noise” in the market and modify their approach as necessary.

While supportive of ongoing monitoring through the complaints process, advocates stressed the need to address issues before consumers experience difficulty, and some raised concerns that state regulators would not be alerted to all of the issues associated with discriminatory benefit design. For example, advocates noted that consumers—particularly those with chronic conditions—might be unable to go through a burdensome appeals process or file a complaint even if impacted by discrimination. Others noted that not all discriminatory issues may be obvious to regulators; for example, regulators may not learn about discriminatory exclusions because consumers cannot appeal an insurer’s decision not to cover benefits altogether. Further, consumers may be confused about their appeal rights, particularly where multiple regulatory agencies—such as the state insurance department, HHS, the U.S. Department of Labor, or the Office of Personnel Management—could have jurisdiction. As one advocate put it, “I think consumers might just give up.” Another advocate questioned whether these agencies would communicate effectively to identify discriminatory patterns that emerge on a systemic level.

Stakeholders were also cautiously optimistic that the ACA’s risk mitigation programs would limit insurers’ incentives for discriminatory benefit designs. Most cautioned that it will be difficult to assess how well these programs are working in the near term, that no system will be perfect, and that risk adjustment may not be as helpful in states with smaller populations where only a handful of patients with high claims could greatly impact an insurer.

## **Promoting Clarity: Federal Guidance with Clear Examples**

Regulators reported that the nondiscrimination standards included in the ACA and implementing regulations provide little guidance as to how to undertake a systematic review for discriminatory benefit design. Further, some regulators were wary of instructing insurers to make changes and reported that the most discriminatory practices have been ended by state legislatures or in response to market demands. As one put it, “whom to protect and how much is a policy issue that state legislatures, Congress, and HHS have been making and we’re more executing that policy than making it.” Some regulators emphasized that their role is to enforce nondiscrimination requirements, rather than define the content of coverage, and raised concerns that states may not have sufficient resources to devote to a more in-depth review.

*Federal guidance.* Some stakeholders reported that federal guidance could be valuable to address concerns about implementing the ACA’s nondiscrimination standards. Some regulators and insurers were not in favor of a single standard because of the level of state variation in mandated benefits and confidence in state regulators’ ability to identify discriminatory benefit design. One regulator favored only informal guidance, such as an additional tool or advice from other states or experts, while another noted that it would be difficult for federal regulators to provide detailed guidance because they will face the same issues that states have been grappling with in reviewing plans under the ACA. Yet, some states

avored guidance to address confusion about how states should conduct their benchmark analysis and to ensure that insurers comply with these standards. As one regulator put it, “if [federal regulators] want something different, then more guidance would be helpful.”

While insurers were wary of additional guidance and, in particular, formulaic regulatory tools, stakeholders were largely in agreement that any federal guidance should retain flexibility for state regulators while also identifying criteria and specific examples of discriminatory benefit design. This was particularly true given the ACA’s broad standards for discriminatory benefit design. In developing nondiscrimination standards, stakeholders reported the need for more collaboration between federal and state regulators, particularly because of the subjective nature of discriminatory benefit design and the need to understand the issues faced by states in analyzing plans. While most states reported that they would be unable to incorporate new standards for 2014, guidance could be valuable for future plan years so long as it provides clear standards and examples.

## The ACA: A New Era in Nondiscrimination?

By ushering in expansive new protections, the ACA is designed to eliminate discrimination in private health insurance based on race, national origin, sex, age, disability, gender identity, sexual orientation, expected length of life, and significant health needs. Indeed, the ACA represents a fundamental shift away from many long-accepted discriminatory practices while retaining others, such as allowing premium rates to vary by age or tobacco use.

Yet, many questions remain about what these new protections mean and how consumers will benefit from them. Our findings suggest that these new nondiscrimination standards have not significantly changed the way that state regulators or insurers approach benefit design. Regulators raised concerns about tiered and narrow networks, the adequacy of drug formularies, the exclusion of benefits and services, and insurer participation in certain service areas. While most are conducting a closer review of policy forms, regulators largely reported a “business as usual” approach to nondiscrimination. Even in states that would like to assume a more active role in addressing discriminatory benefit design, regulators are limited by a lack of meaningful standards, filing systems that do not easily enable a holistic review, and a lack of clinical expertise. In light of such limitations, ensuring that the ACA’s nondiscrimination standards are met likely requires ongoing monitoring of consumer complaints, the development of new infrastructure such as tracking systems, robust grievance and appeals processes, and clarification of federal requirements.

Amidst the backdrop of these needs, state regulators may be wary of instructing insurers to amend their plans. Mindful of the insurance department’s traditional role of enforcing insurance rules, not all regulators may be willing to assume a broader role in defining discriminatory benefit design without clearer standards. This is particularly true for those that believe that benefit design should be addressed in the market or left to the legislature. Such differences suggest that state approaches to nondiscrimination will continue to vary, notwithstanding the ACA.

Guidance from HHS would provide clearer standards for states in limiting discrimination which, in turn, could prevent vulnerable consumers from falling through the cracks. To clarify these requirements, HHS could:

- Issue guidance with specific examples of benefit design features that would be considered discriminatory under the ACA and define key terms such as “disability” and “medical necessity.” Examples could address all of the types of benefit design with the potential to be discriminatory, including exclusions, cost-sharing, narrow or tiered networks, drug formularies, visit limits, restrictive medical necessity definitions, utilization management, waiting periods, service areas, rating, marketing of products, and benefit substitution.
- Collaborate with state regulators before issuing guidance to leverage state expertise and experience in identifying discriminatory benefit design and better assess and understand emerging compliance issues under the ACA.
- Use feedback from state regulators, exchange officials, agents and brokers, and navigators, as well as analysis of appeals data and information collected under Sections 1311(e) and 2715A of the ACA to monitor implementation of nondiscrimination standards, assess whether further adjustments are necessary, and identify additional examples of discriminatory benefit design.

These findings—including confusion about how nondiscrimination requirements relate to the essential health benefits benchmark plan and varied state approaches to tracking and monitoring—are instructive as HHS reevaluates its essential health benefits standards and the benchmark plan approach for 2016. Although this approach provided states with flexibility, our findings suggest that it may have perpetuated the inclusion of discriminatory benefit designs in at least some states by requiring the selection of benchmark plans that were not designed to be in compliance with the ACA’s most significant reforms. In addition, federal regulators should ensure that future benchmark plan selection processes are transparent, with meaningful stakeholder access to plan materials for a broader understanding of whether benchmark plans include discriminatory benefit designs.

# References

<sup>1</sup> Sara Rosenbaum, *Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law, and Federal Reform Options*, at 6-7 (Washington, D.C.: Georgetown University Law Center O'Neill Institute for National and Global Health Law, 2009).

<sup>2</sup> *Ibid.*

<sup>3</sup> *Ibid.* at 2-8 (describing the concepts and tools used to discriminate on the basis of health status in today's private health insurance market); see generally Deborah A. Stone, "The Struggle for the Soul of Health Insurance," 18 *J. Health Pol. Pol'y & L.* 287 (1993).

<sup>4</sup> See e.g., Jessica L. Roberts, "Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform, 2012 *U. Ill. L. Rev.* 1159, 1163-70 (2012); Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 *U. Kan. L. Rev.* 73, 81-86 (2005).

<sup>5</sup> Gary Claxton, *How Private Insurance Works: A Primer*, at 5 (Washington, D.C.: Kaiser Family Foundation, 2002).

<sup>6</sup> *Ibid.*

<sup>7</sup> Rosenbaum, *supra* note 1, at 6-7.

<sup>8</sup> Sara C. Collins, Ruth Robertson, Tracy Garber & Michelle M. Doty, *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act* (New York City, NY: The Commonwealth Fund, 2013); Crossley, *supra* note 1, at 118-129, 147-48 (describing benefit design features—namely cost-sharing, tiered provider networks, tiered drug formularies, and health savings accounts—that shift costs, and thus risk, from insurers to consumers).

<sup>9</sup> Rosenbaum, *supra* note 1, at 6-14.

<sup>10</sup> Genetic Information Nondiscrimination Act, Pub. L. No. 110-233 (2008); Health Insurance Portability and Accountability Act, Pub. L. No. 104-191 (1996) (codified at 42 U.S.C. §§ 300gg, 1320d et seq., 29 U.S.C. § 1181 et seq.); Title VII of the Civil Rights Act of 1964, Pub. L. No. 88-352 (1964) (codified at 42 U.S.C. § 2000e et seq.).

<sup>11</sup> 42 U.S.C. §§ 300gg-1, 300gg-4 (2012). For additional information on HIPAA's requirements and history of implementation, see Statement of William J. Scanlon, *Health Insurance Standards: Implications of New Federal Law for Consumers, Insurers, Regulators* (Washington, D.C.: U.S. General Accounting Office, 1998).

<sup>12</sup> Rosenbaum, *supra* note 1, at 2. For example, health plans are permitted under federal law to exclude coverage for a disease or limit or exclude benefits for certain treatments so long as the restriction applies uniformly to all "similarly situated" individuals (meaning a restriction cannot be directed at a particular individual based on health status). See, e.g., U.S. Department of Labor, *Frequently Asked Questions: HIPAA Nondiscrimination Requirements*, at Question 4, [http://www.dol.gov/ebsa/faqs/faq\\_hipaa\\_ND.html](http://www.dol.gov/ebsa/faqs/faq_hipaa_ND.html) (last visited June 9, 2013). Thus, a benefit limit that applies to all members of a group is permissible even if it more heavily burdens a certain individual or class of individuals with a particular health need.

<sup>13</sup> Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, Pub. L. 110-343 (2008) (codified at 26 U.S.C. § 9812, 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-26); Women's Health and Cancer Rights Act, Pub. L. No. 105-277 (1998) (codified at 29 U.S.C. § 1185b, 42 U.S.C. §§ 300gg-27, 300gg-52); Newborns' and Mothers' Health Protection Act, Pub. L. No. 104-204 (1996) (codified at 29 U.S.C. § 1185).

<sup>14</sup> 29 U.S.C. § 1185b (2012); 42 U.S.C. § 300gg-27 (2012).

<sup>15</sup> Kathryn G. Allen, *Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve*, Letter to Sen. James M. Jeffords (Washington, D.C.: U.S. General Accounting Office, 2001); see also Ellen Weber, "Equality Standards for Health Insurance Coverage: Will the Mental Health Parity and Addiction Equity Act End the Discrimination?" 43 *Golden Gate U. L. Rev.* 179, 231-35 (2013); Rosenbaum, *supra* note 1, at 8-15.

<sup>16</sup> See, e.g., U.S. Department of Labor, *Women's Health and Cancer Rights Act*, Fact Sheet, <http://www.dol.gov/ebsa/newsroom/fswhcra.html> (last visited June 9, 2013); U.S. Department of Labor, *FAQs About Newborns' and Mothers' Health Protection*, at Question 7, [http://www.dol.gov/ebsa/faqs/faq\\_consumer\\_newborns.html](http://www.dol.gov/ebsa/faqs/faq_consumer_newborns.html) (last visited June 9, 2013); U.S. Department of Labor, *FAQs on Understanding Implementation of the Mental Health Parity and Addiction Equity Act of 2008*, [http://www.dol.gov/ebsa/faqs/faq\\_mhpaeimplementation.html](http://www.dol.gov/ebsa/faqs/faq_mhpaeimplementation.html) (last visited June 9, 2013).

<sup>17</sup> Timothy Stoltzfus Jost, *The Regulation of Private Health Insurance*, at 25 (Washington, D.C.: National Academy of Social Insurance, 2009). Congress reaffirmed this role in 1945, when it passed the McCarran-Ferguson Act, which recognized state authority over private health insurance unless Congress expressed its intent to regulate coverage. See 15 U.S.C. §§ 1011, 1012 (2006).

<sup>18</sup> Crossley, *supra* note 1, at 109-10 (describing state laws that prohibit unfair trade practices with many based on the National Association of Insurance Commissioners' model Unfair Trade Practices Act); *see, e.g.*, Mont. Code § 49-2-309 (prohibiting "discriminat[ion] solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan or coverage ... including discrimination in regard to rates or premiums and payments or benefits").

<sup>19</sup> Ronen Avraham, Kyle D. Logue & Daniel Schwarcz, *Understanding Insurance Anti-Discrimination Laws*, Public Law and Legal Theory Research Paper Series, University of Michigan Law School, No. 289, at 34 (finding that only seven states—California, New Jersey, New Mexico, New York, Texas, Washington, and Wisconsin—explicitly prohibit the use of race, religion, and national origin across all major lines of insurance, including health).

<sup>20</sup> Crossley, *supra* note 1, at 99-105, 110, footnote 54.

<sup>21</sup> Center on Health Insurance Reforms, *Health Insurance Market Reforms: Rate Restrictions*, Fact Sheet, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8328.pdf> (Washington, D.C.: Kaiser Family Foundation, 2012); Center on Health Insurance Reforms, *Health Insurance Market Reforms: Guaranteed Issue*, Fact Sheet, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8327.pdf> (Washington, D.C.: Kaiser Family Foundation, 2012).

<sup>22</sup> *See* Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Cost*, at 71-74 (Washington, D.C.: National Academies Press, 2012) (discussing the variation in existing state mandates and the debate surrounding mandates).

<sup>23</sup> *Ibid.* at 72-73.

<sup>24</sup> National Women's Law Center, *Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act*, at 7 (Washington, D.C.: National Women's Law Center, 2012).

<sup>25</sup> Center on Health Insurance Reforms, *Health Insurance Market Reforms: Guaranteed Issue*, Fact Sheet, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8327.pdf> (Washington, D.C.: Kaiser Family Foundation, 2012).

<sup>26</sup> *See* Dana P. Goldman, Geoffrey F. Joyce, Grant Lawless, William H. Crown & Vincent Willey, "Benefit Design and Specialty Drug Use," 25(5) *Health Affairs* 1319-1331 (noting that, of those included in the study, "[a]ll of these patients are privately insured through large employers, and so one would expect coverage to be generous. Despite this fact, it is clear that patients with these diseases are still at risk for substantial spending"); *see generally* Kate Fitch & Bruce Pyenson, *Benefit Designs for High Cost Medical Conditions* (New York, NY: Milliman Inc., 2011).

<sup>27</sup> In California, legislators prohibited health care service plans and insurers from using gender (defined to include sex, gender identity, and gender expression) to deny or refuse to renew coverage. 2005 Cal. A.B. 1586, Serv. Ch. 421. In Oregon, legislators prohibited discrimination based on sexual orientation, defined as "actual or perceived heterosexuality, homosexuality, bisexuality or gender identity, regardless of whether the individual's gender identity, appearance, expression, or behavior differs from that traditionally associated with the individual's sex at birth." 2007 Or. S.B. 2, Ch. 100.

<sup>28</sup> The California Department of Managed Health Care issued guidance in April 2013, Department of Managed Health Care, "Gender Nondiscrimination Requirements," Letter No. 12-5 (April 9, 2013), *available at* <http://www.dmhc.ca.gov/library/reports/news/dl12k.pdf>, while the California Department of Insurance adopted regulations in 2012, 10 CCR § 2561.2. *See also* Kathy Robertson, "HMO Regulator Clarifies Coverage for Transgender Patients," *Sacramento Business Journal*, April 12, 2013, *available at* <http://www.bizjournals.com/sacramento/news/2013/04/12/hmo-regulator-clarifies-coverage-for.html>. In Oregon, the Department of Consumer & Business Services issued sub-regulatory guidance and a fact sheet clarifying that "medically necessary treatments that are routinely covered for non-transgender people cannot be denied to transgender people." Oregon Department of Consumer & Business Services, *Insurance and Gender Identity Fact Sheet*, (Jan. 2013), *available at* <http://www.cbs.state.or.us/ins/FAQs/genderidentity-factSheet.pdf>; Oregon Insurance Division, *Application of Senate Bill 2 (2007 Legislative Session) to Gender Identity Issues in the Transaction and Regulation of Insurance in Oregon*, Bulletin Ins. 2012-1 (Dec. 2012), *available at* <http://insurance.oregon.gov/bulletins/bulletin2012-01.pdf>.

<sup>29</sup> *See* 42 U.S.C. §§ 300gg-1-300gg-2, 300gg-4 (2012).

<sup>30</sup> *See* 42 U.S.C. §§ 300gg-3, 300gg-8 (2012).

<sup>31</sup> 42 U.S.C. §§ 300gg-11, 18022 (2012).

<sup>32</sup> 42 U.S.C. § 18022(b)(4) (2012).

<sup>33</sup> HHS adopted this approach after reports by the U.S. Department of Labor and the Institute of Medicine. U.S. Department of Labor, *Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services* (2011); Institute of Medicine, *supra* note 20. In states that did not select a benchmark

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plan, HHS defined a “default” benchmark plan as the largest small group plan based on enrollment. 45 C.F.R. § 156.100(c).

<sup>34</sup> 45 C.F.R. § 156.125(a) (stating that an insurer does not provide essential health benefits “if its benefit design, or the implementation of its benefit design, discriminates based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions”).

<sup>35</sup> *Ibid.* at § 156.125(b) (requiring insurers to comply with 45 C.F.R. § 156.200(e), which prohibits insurers that offer qualified health plans through the exchange from discriminating on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation); 45 C.F.R. § 147.104(e) (prohibiting insurers and its officials, employees, agents and representatives from “employ[ing] marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual’s race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions”); 45 C.F.R. § 156.225 (prohibiting insurers that offer qualified health plans through the exchange from “employ[ing] marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs”)

<sup>36</sup> 42 U.S.C. § 18116 (2012).

<sup>37</sup> Office for Civil Rights, *Laws and Regulations Enforced by OCR*, <http://www.hhs.gov/ocr/civilrights/resources/laws/index.html> (last visited June 9, 2013). Section 1557 applies to “any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments).” 42 U.S.C. § 18116 (2012). Exchanges must be administered in a way that ensures compliance “with applicable non-discrimination statutes” and does not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation. 45 C.F.R. § 155.120(c). In a recent notice of proposed rulemaking, HHS proposed extending this requirement to federally facilitated exchanges because “its previous omission ... was inadvertent.” 78 Fed. Reg. 37032, 37045 (June 19, 2013).

<sup>38</sup> Office for Civil Rights, *Questions and Answers on Section 1557 of the Affordable Care Act*, [http://www.hhs.gov/ocr/civilrights/resources/laws/section1557\\_questions\\_answers.html](http://www.hhs.gov/ocr/civilrights/resources/laws/section1557_questions_answers.html) (last visited June 9, 2013).

<sup>39</sup> National Women’s Law Center, *NWLC Section 1557 Complaint: Sex Discrimination Complaints Against Five Institutions*, <http://www.nwlc.org/resource/nwlc-section-1557-complaint-sex-discrimination-complaints-against-five-institutions> (last visited June 9, 2013).

<sup>40</sup> The development of “analytic tools to test for discriminatory plan benefits” was encouraged in final federal rules on essential health benefits. 78 Fed. Reg. 12834, 12846 (Feb. 25, 2013) (stating that “[s]uch analyses could include evaluations to identify significant deviation from typical plan offerings including such as limitations for benefits with specific characteristics”).

<sup>41</sup> See Center for Consumer Information and Insurance Oversight, *Letter to Issuers on Federally-Facilitated and State Partnership Exchanges*, at 14-15 (Washington, D.C.: HHS, 2013) (describing HHS’ approach to identifying outliers with respect to cost-sharing in federally facilitated and partnership exchanges and stating that “[i]dentification as an outlier does not necessarily indicate that a [qualified health plan] benefit design is discriminatory; rather, [federal regulators] will use the outlier identification to target [qualified health plans] for more in-depth reviews”); see also Rebecca Adams, “Officials Outline Details of Reviews of Health Plans,” CQ Healthbeat, Mar. 15, 2013 (discussing comments from a federal regulator on how CCIIO will review plans for discriminatory benefit design “mainly by looking for outliers” in inpatient needs, specialty care, pregnancy care, pharmacy benefits and “perhaps others” and noting that if federal regulators “find that a particular plan has a truly abhorrent benefit plan proposed, we’ll send a deficiency notice” but that “[t]his is an area where we plan on setting the dials pretty low, but we will be looking for obvious points of concern”).

<sup>42</sup> In response to comments that state benchmarks might contain discriminatory benefit designs, federal regulators restated that existing regulations require insurers “to meet the benchmark requirements in a nondiscriminatory manner” even if a benchmark plan includes a discriminatory benefit design. 78 Fed. Reg. at 12846.

<sup>43</sup> Oregon Insurance Division, *supra* note 26; Department of Financial Regulation, *Guidance Regarding Prohibited Discrimination on the Basis of Gender Identity Including Medically Necessary Gender Dysphoria Surgery and Related Health Care*, Bulletin No. 174 (Apr. 2013), available at [http://www.dfr.vermont.gov/sites/default/files/Bulletin\\_174.pdf](http://www.dfr.vermont.gov/sites/default/files/Bulletin_174.pdf); Colorado Division of Insurance, *Insurance Unfair Practices Act Prohibitions on Discrimination Based Upon Sexual Orientation*, Bulletin No. B-4.49 (Mar. 2013), available at <http://cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22B-4.49+Insurance+Unfair+Practices+Act+Prohibitions+on+Discrimination+Based+Upon+Sexual+Orientation.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251852417650&ssbinary=true>; District of Columbia Department of Insurance, Securities and Banking, *Prohibition of Discrimination in Health*

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*Insurance Based on Gender Identity or Expression*, Bulletin 13-IB-01-30/15 (Mar. 2013), available at <http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/Bulletin13-IB-01-30-15.pdf>.

<sup>44</sup> See Sabrina Corlette, Kevin W. Lucia & Max Levin, *Implementing the Affordable Care Act: Choosing an Essential Health Benefits Benchmark Plan*, at 8, 11 (New York City, NY: The Commonwealth Fund, 2013) (suggesting that federal regulators establish minimum standards for the benchmark selection process, such as "requir[ing] states to make all plans publicly available and ensure that decisions are made through a public, transparent process that includes stakeholder engagement").

<sup>45</sup> Federal regulators worked with insurers and states to compile summaries of each state's essential health benefits benchmark plan; however, insurers were not required to submit information regarding all benefit design features and information on minimum stays and exclusions are listed as "optional." See generally Center for Consumer Information and Insurance Oversight, *Additional Information on Proposed State Essential Health Benefits Benchmark Plans*, <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#review> benchmarks (last visited June 9, 2013).

<sup>46</sup> Federal regulations require insurers to cover at least the greater of 1) one drug in every United States Pharmacopeia category and class; or 2) the same number of drugs in each category and class as the essential health benefits benchmark plan. 45 C.F.R. § 156.122. Each health plan must also have procedures in place that allow enrollees to request and gain access to clinically appropriate drugs not covered by the formulary. *Ibid.* In addition, federal regulators note that nondiscrimination requirements apply to all essential health benefits, including prescription drug benefits, and that "states and the [e]xchanges will be responsible for monitoring drug lists for such compliance as part of their enforcement and certification requirements." 78 Fed. Reg. at 12845.