Administrative Law Protections in Coverage Expansions for Consumers under Health Reform

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I. Introduction

The Patient Protection and Affordable Care Act of 2010 ("PPACA"), as amended by the Health Care and Education Reconciliation Act of 2010, initiated comprehensive reform of the health care sector in the United States.1 In addition to increasing access to health care coverage through the expansion of public programs and the reform of the private health insurance market, PPACA has several initiatives that improve and control the quality and cost of health care services.2

The new law has four major goals: (1) increase health care coverage through insurance market reforms and public program expansions; (2) enhance the health care workforce; (3) control health care costs; and (4) improve the health care delivery system. Each of these goals represents a monumental undertaking given that the health care

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2 See, e.g., Patient Protection and Affordable Care Act of 2010 tit. IV, V, VI, VII, IX, X (reforming health care delivery, quality, and financing). The Patient Protection and Affordable Care Act’s ("PPACA") initiatives include: workforce enhancement, cost control in existing public programs, and reorganizing the delivery of health care generally to control costs and improve efficiency. Id. tit. V, VI, X, §§ 5301-5315, 6401-6508, 10101-10909, respectively. PPACA also includes measures to prevent chronic disease and improve public health. Id. at tit. IV, §§ 4001-4402. Further, PPACA encourages the purchase of long-term care insurance. Id. at tit. VIII, §§7001-7103. There are also revenue provisions contained in the reform, the purpose of which is to provide funding for the reform. See id. at tit. IX, §§ 9001-9017.
sector comprises 17.6 percent of the total United States economy.\textsuperscript{3} The number of individuals who are either underinsured or uninsured in the U.S. justifies the magnitude of these anticipated changes.\textsuperscript{4} Indeed, prior to PPACA’s enactment, the percent of the U.S. population without health insurance was 16.7 percent, a rate that reflected a significant increase as compared to 2008.\textsuperscript{5}

PPACA also implements a number of provisions that raise important administrative law issues, including a provision that implements new administrative policy processes and appeal procedures. These administrative law issues, among others, will be identified and discussed in detail below. PPACA also requires a tremendous amount of traditional notice and comment rulemaking, as well as other policy-making initiatives to fully implement its goals. Given the import of these administrative provisions to PPACA’s successful implementation, there is much at stake for consumers in the deliberations that are currently underway regarding how to effectuate reform.

To that end, this article reviews the administrative law issues associated with the first goal of health reform—to increase health care coverage through insurance market reforms and public program expansions. Section II of this article describes the U.S. health sector prior to PPACA and the major PPACA titles establishing coverage protections and improvements. More specifically, the first two titles of PPACA contain the major reforms that will immediately affect consumers by improving and expanding coverage for uninsured. Further, Section III will focus on three administrative law issues that arise from the major insurance market reforms. The first issue is the establishment of new public agencies, their institutional structures, and their governance arrangements. The second issue addresses the special appeal procedures and other governance arrangements. Lastly, the third issue centers on major policy making initiatives that will be needed to implement the health care reform.


\textsuperscript{4} See infra Section II A. 3 (discussing health insurance coverage and current uninsured rates).

II. The U.S. Health Care Sector and PPACA Coverage Expansions and Protections

Health insurance coverage is the most important means for assuring that individuals have access to expensive health care services. In the U.S., health coverage is a mix of private and public programs. Accordingly, the reform law regulates the private health insurance market to expand and protect coverage for consumers, and it builds upon existing public programs to increase health insurance coverage.

A. Organization of the U.S. Health Care Sector

As stated, the U.S. health care sector provides coverage through a mix of private and public health insurance. Prior to reform, this patchwork system provided little to no coverage for individuals who were not offered health insurance by their employer, could not afford to purchase coverage privately in the individual and small group markets, and failed to qualify for Federal and State subsidized insurance programs.6

1. Private Health Insurance Coverage

Most people in the U.S. have private health insurance—either through an employer or through an individually-purchased plan.7 Employers include primarily private corporations with employee benefit plans regulated under the Employee Retirement Income Security Act (“ERISA”), as well as government agencies and offices that offer private health plans to public employees.8 Prior to PPACA’s enactment, no federal or state law required employers to provide health coverage to employees.9 Employers were nevertheless motivated to do so because employee health insurance is a deductible business expense under the federal tax code.10

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7 See U.S. CENSUS BUREAU, supra note 5, at 25.
9 See infra note 50, (discussing employers’ shared responsibilities under PPACA and the penalties the reform imposes on employers for failure to offer adequate coverage).
10 26 U.S.C. § 162(a) (2006). This section amends the I.R.C and makes the provision of health insurance deductible to employers: “There shall be allowed as a deduction all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business,
Both the federal government and the states regulate private health insurance in the U.S. ERISA regulates employer-sponsored health insurance plans. Congress has enacted a number of health insurance reforms over the years with amendments to ERISA and the federal tax laws, as well as through mandates for states. As a general matter, however, states regulate private health insurance that is not offered through employment and risk bearing plans employers purchase for their employees.

According to the U.S. Census, about 70 percent of the U.S. population had private health insurance coverage in 2009. The great majority, 55.8 percent, obtained coverage through their employer. About eight percent purchased private health coverage through the private market.

including—(1) a reasonable allowance for salaries or other compensation for personal services actually rendered . . . " Id.; see also 26 U.S.C. § 106 (employer contributions to ERISA employee health plans). “Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.” 26 U.S.C. § 106(a).


13 See Kathleeen Heald Ettinger ET AL., STATE INSURANCE REGULATION 129-63 (1st ed. 1995). In addition to solvency and market conduct with respect to consumers, state health insurance regulation has focused on improving benefit packages of health insurance plans by mandating specific benefits for the plans. See generally NAT'L ASS'N INS. COMM'RS, COMPENDIUM OF STATE LAWS ON INSURANCE TOPICS: MANDATED BENEFITS (2011), available at http://www.naic.org/documents/store_CSI_TOC.pdf. The piece surveys the laws and regulations on mandated benefits throughout the United States, specifically the regulating, underwriting, and pricing practices that discriminate against seriously ill people in individual and small-group health plans. Id.

14 U.S. CENSUS BUREAU, supra note 5, at 25 fig. 8.

15 U.S. CENSUS BUREAU, supra note 5, at 25 fig. 8.

16 U.S. CENSUS BUREAU, supra note 5, at 25 fig. 8.
2. Public Health Insurance Programs

Although the majority of Americans obtain health insurance through their employer, public health insurance programs have a significant role in the U.S. health care system. Specifically, approximately twenty-three percent of the federal budget was dedicated to Medicare and Medicaid alone in 2011.\(^{17}\) The primary public health insurance programs in the U.S. are Medicare, Medicaid, and the State Children’s Health Insurance Program ("SCHIP"). The Medicare program is a social insurance program that provides basic coverage to the aged, severely disabled, and people with end stage renal disease.\(^{18}\) Medicaid, which the federal government and the states jointly finance and administer, provides health insurance for some disabled and aged poor, as well as poor mothers, infants, and children.\(^{19}\) However, Medicaid does not cover all poor.\(^{20}\) SCHIP provides supplemental financial assistance to states, through a federally-funded block grant, that covers poor children who are ineligible for benefits under a state’s Medicaid program.\(^{21}\)


\(^{18}\) See generally Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 291 (codified as amended at 42 U.S.C. § 1395). In 1965, Congress enacted the Medicare and Medicaid programs to provide health insurance coverage for the elderly and some poor. See id. Basic Medicare benefits include hospital and extended-care services, as well as physician and other outpatient services on a fee-for-service basis or as part of a prepaid health plan. See id. §§ 1395c-1395w-4; id. § 1395w-21. As of 2003, the Medicare program includes an optional, outpatient prescription drug benefit. Id. § 1395w-101.

\(^{19}\) Id. § 1396-1. The federal Medicaid statute sets forth requirements for eligibility and benefits that states must adopt. 42 U.S.C. § 1396a (2006). It also allows states to cover families who have higher incomes but still meet the characteristics of categorically eligible Medicaid recipients, e.g., pregnant moms, children, the aged and disabled, and the statutes enables states to provide other benefits at the state’s option. Id. The Medicaid program provides basic hospital, physician, and long-term care services to eligible individuals. Id.

\(^{20}\) To qualify for Medicaid, individuals have to meet both categorical and income eligibility requirements set by the federal government and the states. See Evelyn Baumrucker et al., Cong. Research Serv., 7-5700, Medicaid and CHIP: Changes Made by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152) to the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148) 3 (2010). Prior to PPACA, non-disabled, childless adults were categorically exempt from Medicaid. See id. at 2-3. In order to be deemed eligible for Medicaid, categorically eligible individuals also had to prove that their incomes were below a state set threshold. See id. at 3. Although thresholds varied by state, to receive federal matching aid, states could not have thresholds that were below one-hundred percent of the FPL. See id.

The federal government also sponsors health care systems for the military and veterans. Additionally, the federal government funds direct health care services through various block grants to complement the public health services that states provide. Another crucial federal program provides direct services to the poor through community health centers around the country in rural and medically underserved areas. But, despite the breadth of federal involvement in the provision and funding of health care services in the U.S., only about thirty percent of the population or less in 2008 and 2009 had health insurance through the government.

3. The Uninsured

Congress passed PPACA in 2010 to close the gaps in health insurance coverage left by existing public programs and the private market. The most recent U.S. Census data indicates that as of 2009, 50.7 million individuals were without health insurance coverage of any kind. Moreover, between 2008 and 2009, the number of persons covered by private health insurance decreased, while the number covered by government health insurance climbed from 87.4 million to 93.2 million, a pattern that is in line with changes in coverage over time. This shift in the insurance landscape is perhaps best explained by the fact that employer-sponsored health care is decreasingly available because employers are dropping coverage due to rising costs. Insurers or the state Medicare programs. Id.; see also Children’s Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, 123 Stat. 8 (codified as amended in scattered sections of 42 U.S.C.) (financing CHIP through 2013).

23 42 U.S.C. §§ 300w-300y-11 (2006). These provisions of the Public Health Service Act provide block grants for preventive health and health services, community mental health services, prevention and treatment of substance abuse, and interim maintenance treatment of narcotics dependence. Id. at §§ 300x-300x-9, 300y-11.
24 42 U.S.C. §§ 254b-254c-1 (2006). One of these provisions deals specifically with community health centers and the National Health Service Corps Fund. Id. at § 254b-2. Another deals with rural health care services outreach, rural health network development, and small health care provider quality improvement grant programs. Id. at § 254c.
25 See U.S. CENSUS BUREAU, supra note 5, at 25 fig. 8.
27 Id.
29 See id. at 16 (noting the link between rising un-insurance rates and the recent decline in
economic downturn explains these trends in part, the data indicates that government action to improve health coverage was needed and indeed, appropriate.

B. PPACA Coverage Expansions and Protections

This section reviews the two titles of PPACA that expand coverage for the uninsured, and it identifies the major administrative law issues in each title. PPACA builds on the existing design and structure of the U.S. health care system. It reforms private insurance that is employer-sponsored or individually purchased and expands the eligibility requirements for Medicaid, thus providing additional coverage to low income persons.

1. Title I—Quality, Affordable Health Care For All Americans

Title I addresses the reform of the private health insurance market, which expands access to health insurance coverage for the uninsured. Subtitles A and B pertain to immediate improvements to the private health insurance market to expand access to the uninsured. These provisions include individual and group market reform. More specifically, PPACA amends ERISA and the Internal Revenue Code (“IRC”) by incorporating Part A’s provisions of Title XXVII of the Public Health Service Act.


32 Id. § 1562(e) (to be codified as amended at 29 U.S.C. § 1185(d)).

33 Id. § 1562(f) (to be codified as amended at 29 U.S.C. § 9815(a)(1)).

34 See id. §§ 1001, 1201, 10501 (to be codified as amended at 42 U.S.C. §§ 300gg et seq., 42 U.S.C. 294q) (amending the Public Health Service Act “PHSA”). Of note, the term “group health plan” includes both insured and self-insured group health plans. See Patient Protection and Affordable Care Act of 2010 § 1001 (to be codified as amended at 42 U.S.C. §§ 300gg et seq.) (applying many rules to “A group health plan and a health insurance issuer offering group or individual health insurance coverage”). The term “group health plan” is used in title XXVII of the PHSA, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term “health plan,” as
Table 1 displays the table of contents for Title I, indicating the major reforms to the private insurance market. These reforms are to take effect both immediately, as well as over the next three years.

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a. State Health Insurance Market Reform

Subtitle A of Title I contains provisions for the immediate reform of state insurance markets, such as ending health insurance companies’ practice of rescission and extending coverage of parents to their dependent young adult children until the age of twenty-six.\(^{35}\) One of the most important provisions under Subtitle A is the creation of a temporary high risk insurance pool that allows for immediate access to insurance for individuals who were previously denied coverage because of preexisting conditions.\(^{36}\) As an oversight, Subtitle B requires the Secretary to establish an appeals process enabling individuals to appeal an adverse determination by or on behalf of these high-risk pools.\(^{37}\)


\(^{37}\) Patient Protection and Affordable Care Act of 2010 § 1101(6)(1) (to be codified as amended at 42 U.S.C. § 18001(6)). This provision will apply to both determinations regarding benefit coverage and individual’s eligibility according to interpretation by DHHS. Interim Final Rule and Pre-existing Condition Insurance Plan Program, 75 Fed. Reg. 146, 45013 (July 30, 2010). An appeal reviewed by either an existing mechanism already established under State law; an
Subtitle C contains further measures to ensure quality health coverage for all Americans over the long term. The main provisions in Subtitle C are insurance market reforms to be implemented before 2014. These reforms are listed in Table 2. Under PPACA’s revised appeals procedures, which apply to state regulated insurers, as well as ERISA regulated plans, aggrieved consumers will be able to appeal an adverse determination on the basis of these new provisions if the denial of coverage is the result of a PPACA Title I violation.

Subtitle D contains the provisions for expanding adequate health coverage for the uninsured. This subtitle contains the major reform of the entire health reform statute—to create state health insurance exchanges that make available to the consumers and employers affordable health insurance that meets federal standards.

| Table 2 |
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| **State Health Insurance Market Reforms in Subtitle C** |
| Sec. 2704. | Prohibition of preexisting condition exclusions or other discrimination based on health status. |
| Sec. 2701. | Fair health insurance premiums. |
| Sec. 2702. | Guaranteed availability of coverage. |
| Sec. 2703. | Guaranteed renewability of coverage. |
| Sec. 2705. | Prohibiting discrimination against individual participants and beneficiaries based on health status. |
| Sec. 2706. | Non-discrimination in health care. |
| Sec. 2707. | Comprehensive health insurance coverage. |
| Sec. 2708. | Prohibition on excessive waiting periods. |

Part I of Subtitle D establishes requirements for health plans that will be available through the exchanges. Of note, exceptions to these requirements exist for employer self-insured plans regulated under section 514 of ERISA. To assure availability of adequate and affordable health

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38 Patient Protection and Affordable Care Act of 2010 § 1201 (to be codified as amended at 42 U.S.C. §§ 300gg et. seq.) (amending Public Health Service Act); see infra Section III.B.

39 See infra Section III.C (detailing the appeals process for consumers under PPACA).

40 See Patient Protection and Affordable Care Act of 2010 §§ 1301-1415 (to be codified as amended in scattered sections of 42 U.S.C.); see also infra Section III A.

41 Patient Protection and Affordable Care Act of 2010 § 1301 (to be codified as amended at 42 U.S.C. § 18021). A qualified health plan has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 1311(c) issued or recognized by each exchange through which such plan is offered, provides the essential health benefits package described in section 1302(a), and meets other statutory criteria.

insurance, Part II of Subtitle D calls on states, with federal financial assistance until January 2015,\textsuperscript{43} to develop health insurance exchanges.\textsuperscript{44} No later than January 1, 2014, each state must institute an “American Health Benefit Exchange” that “facilitates the purchase of qualified health plans” and “provides for the establishment of a Small Business Health Options Program [a “SHOP Exchange”] that is designed to assist qualified employers . . . [with] the enrollment of their employees in qualified health plans.”\textsuperscript{45} Subtitle D closes with procedures for states to follow if they want to develop alternative programs, instead of the program contained in Subtitle C,\textsuperscript{46} and provisions regarding reinsurance and risk adjustment.\textsuperscript{47}

Subtitle E contains the measures providing for subsidies and tax expenditure credits for making health insurance affordable to consumers and employers.\textsuperscript{48} Low income individuals are entitled to premium tax credits and cost-sharing reductions.\textsuperscript{49}

\textsuperscript{43}Id. § 1311(a)(4)(B) (to be codified as amended at 42 U.S.C. § 18031). Each fiscal year, the Secretary of the Department of Health and Human Services (“HHS”) will determine the total amount of assistance available for each state. \textit{Id.} § 1311(a)(2) (to be codified as amended at 42 U.S.C. § 18031). The Secretary will only renew a grant of financial assistance each year if the state is making progress towards establishing an exchange, is implementing the reforms described in subsections A and C, and is meeting other requirements the Secretary sets. \textit{Id.} § 1311(a)(4)(A) (to be codified as amended at 42 U.S.C. § 18031).

\textsuperscript{44}Id. § 1311 (to be codified as amended at 42 U.S.C. § 18031) (describing procedure for creation and implementation of state-based “exchanges”).

\textsuperscript{45}Id. § 1311(b)(1) (to be codified as amended at 42 U.S.C. § 18031).

\textsuperscript{46}Id. §§ 1331-1333 (to be codified as amended at 42 U.S.C. §§ 18051, 18052, 18053) (providing various procedures by which states may establish alternative programs). Alternative programs must be approved by the Secretary and must meet certain minimum requirements. See \textit{id.; see, e.g., NAT’L CONFERENCE OF STATE LEGISLATURES, STATE ACTIONS TO IMPLEMENT THE AMERICAN HEALTH BENEFIT EXCHANGE, http://www.ncsl.org/?tabid=21388 (last visited Apr. 23, 2011) (describing varying actions taken by states in response to PPACA regulation and mandate).}

\textsuperscript{47}Patient Protection and Affordable Care Act of 2010 §§ 1341-1343 (to be codified as amended at 42 U.S.C. §§ 18061, 18062, 18063) (providing reinsurance and risk adjustment provisions of Act).


\textsuperscript{49}Id. §§ 1401-1402 (to be codified as amended at 26 U.S.C § 36, 42 U.S.C § 18071) (containing the premium tax credit and cost-sharing reduction provisions for low income individuals).
There is also a tax credit for the employee health insurance expenses of small businesses.\textsuperscript{50} From the perspective of consumers, the most important provisions of Subtitle E are those regarding eligibility determinations for the tax credit, reduced cost-sharing, and individual responsibility exemptions.\textsuperscript{51} In addition to detailed requirements for determining eligibility, PPACA contains a provision for consumers to appeal adverse eligibility determinations and to obtain redeterminations.\textsuperscript{52} PPACA does not specify the appeals process in great detail except to say that the, “Secretary [of Health and Human Services (“HHS”)], in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security,” must establish procedures in which the Secretary or other federal officers “hears and makes decisions with respect to appeals of any determinations” and “redetermines eligibility on a taxpayer whose income is between 100\% and 400\% of the poverty line is eligible for a refundable tax credit for insurance coverage purchased through a health care exchange. See Michael B. Synder, Assistance for Low-Income Individuals – Premium Tax Credits, BENEFITS GUIDE § 3:219 (2011) (citing Patient Protection and Affordable Care of 2010 section 1401(a)). Issuers covering those qualified individuals are also required “to reduce the out-of-pocket limit for an individual who enrolls in a qualified health plan through a health care exchange.” See Michael Synder, Cost-Sharing Reductions, 4 HR SERIES: COMPENSATION & BENEFITS § 58:31 (2011) (citing Patient Protection and Affordable Care of 2010 section 1402).

\textsuperscript{50} Patient Protection and Affordable Care of 2010 § 1421 (to be codified as amended at 26 U.S.C. § 45R) (providing for tax credit for employee health insurance expenses for small businesses). The eligible small employer health insurance will receive a credit equal to fifty percent of the lesser of either: the aggregate amount of non-elective contributions the business owner made for the employee during the taxable year for premiums qualified health plans offered by the business to its employees; or the aggregate amount of non-elective contributions which the employer would have given during the year under the health care arrangement if each employee had enrolled in the qualified health plan that had a “Premium equal to the average Premium for the small group market in the rating area in which the employee enrolls.” \textit{Id.} at § 1421(a) (to be codified as amended at 26 U.S.C. § 45R).

\textsuperscript{51} \textit{Id.} §§ 1412-1414 (to be codified as amended at 26 U.S.C. §§ 45R). Section 1412 in part provides that the Secretary can make advance payments of the credit or reduction to issuers of the qualified health plans for the purpose of reducing the amount eligible individuals pay for premiums. \textit{Id.} at § 1412(a) (to be codified as amended at 26 U.S.C. § 45R). Section 1413 provides how the Secretary will establish a system allowing individuals in each state to apply for enrollment and participation in the applicable state’s health subsidy program. \textit{Id.} at § 1413 (to be codified as amended at 26 U.S.C. § 18083). Section 1414 provides for limited disclose to certain personnel the return information of a taxpayer whose income is relevant for determining the eligibility of any Premium tax credit, cost-sharing reduction, a state’s health subsidy programs or a basic health program. \textit{Id.} at § 1414 (to be codified as amended at 26 U.S.C § 6103).

\textsuperscript{52} Patient Protection and Affordable Care Act of 2010 § 1411(f) (to be codified as amended at 26 U.S.C. § 18081).
periodic basis in appropriate circumstances.” PPACA thus provides consumers with a right to a hearing—however informal—with respect to the federal support individuals can claim in purchasing insurance through the exchanges.

Subtitle F, entitled “Shared Responsibility for Health Care,” has become one of the most controversial provisions of the health reform law. Part I of Subtitle F requires individuals to maintain “minimum essential coverage” and report their compliance with this section to the Internal Revenue Services (“IRS”). To justify Congress’ authority to mandate the individual purchase of insurance, section 1501 opens with a list of findings regarding the relevance of health insurance in the national economy and links this purchase to interstate commerce. The constitutionality of the mandate on individuals to purchase health insurance, however, is currently being challenged in several lawsuits around the country. Section 1501 goes on to also amend the Internal Revenue Code to establish reporting requirements under which consumers must indicate their compliance with the health insurance mandate. Enforcement of the mandate is left to the IRS and its current enforcement apparatus for enforcing the

53 Id. § 1411(f)(1) (to be codified as amended at 42 U.S.C. § 18081). PPACA establishes a separate set of appeals procedures for employers who are notified that they may be liable for the tax imposed section 1489H of the Internal Revenue Code of 1986 for failure to provide minimum essential coverage as defined by the act. Id. § 1411(f)(2) (to be codified as amended at 42 U.S.C. § 18081).


55 Id. §§ 1501-1502 (to be codified as amended at 42 U.S.C. § 18091, 26 U.S.C. § 6055) (providing for tax credit for employee health insurance expenses for small businesses); see U.S. CONST. art. I, § 8, cl. 3.

56 See U.S. CONST. art. I, § 8, cl. 3.


58 See Patient Protection and Affordable Care Act of 2010 § 1501(b) (to be codified as amended at 42 U.S.C. § 18091). Further, section 1501 carves out a series of exceptions, for those who are not considered “applicable” to the mandate or penalty. Id. The exempt classes include certain religious groups, illegal aliens, foreign nationals, and incarcerated prisoners. Id. While the indigent and members of Indian tribes are not exempt from the mandate, they are not subject to the penalty for failure to conform. Id.
federal tax laws. Part II of this Subtitle imposes responsibilities on employers.

Finally, Subtitle G closes with a variety of miscellaneous provisions, most of which do not raise important administrative law issues. An important provision for consumers, however, is section 1554, which prohibits the Secretary of HHS from promulgating regulations that adversely affect access to specified therapies. Section 1557 is also significant because it reaffirms the protection various nondiscrimination laws afford to individuals.

2. **Title II—The Role of Public Programs**

Title II of PPACA contains provisions to cover lower income uninsured people through the Medicaid program. Under the new law, beginning in 2014, Medicaid will cover non-elderly individuals with incomes up to 133 percent of the federal poverty line—about $29,000 for a family of four. The Congressional Budget Office (“CBO”) estimates that by 2019, 16 million more adults and children will enroll in Medicaid and

\[\text{References}\]

59. See Internal Revenue Code (“I.R.C”), 26 U.S.C.A. § 5000A (1986). The individual mandate will become effective in 2014, with penalty for noncompliance being the greater of $95 per individual or 1% of household income over the filing threshold (phasing up to $695 or 2.5% in 2016). William F. Sweetnam, Jr., *Pension, Profit-Sharing, Welfare & Other Compensation Plans: Groom Law Group Memos and Federal Register Excerpts on Various Health Care Reform Issues*, SS011 A.L.I.-A.B.A. 703 (Oct. 2010) (citing Patient Protection and Affordable Care Act of 2010 section 1501(b); I.R.C. sections 5000A(c) and10106(b); Health Care and Education Reconciliation Act of 2010 section 1002).


61. Id. §§ 1551-1563 (to be codified in scattered statutes of 26 and 42 U.S.C.).

62. Id. § 1554 (to be codified as amended at 42 U.S.C. § 18114).

63. Id. § 1557 (to be codified as amended at 42 U.S.C. § 18116). PPACA sanctions all health programs receiving federal money from discriminating on grounds prohibited by title VI of the Civil Rights Act, title IX of the Education Amendments, the Age Discrimination Act, or section 504 of the Rehabilitation Act of 1973. *Id.* The sanctions imposed for violation of section 1557 are the same as those for violations of the relevant underlying act. *Id.* PPACA also gives the Secretary the power to promulgate regulations to implement the anti-discrimination provisions. Patient Protection and Affordable Care Act of 2010 § 1557 (to be codified at 42 U.S.C. § 18116).

64. See id. §§ 2001-2006 (amending the Social Security Act); see also Matt Broaddus & January Angeles, *Medicaid Expansion in Health Reform Not Likely to “Crowd Out” Private Insurance*, *CTR. ON BUDGET & POLICY PRIORITIES*, (Jun. 22, 2010), http://www.cbpp.org/files/6-22-10health.pdf (listing applicable income amount and noting that states are instructed to disregard five percent of the individual or family applicant’s income in determining eligibility for Medicaid).
gain access to affordable coverage as a result. As such, the Medicaid program expansion may well provide greater access to health insurance than the reforms under Title I.

Other than the provisions expanding Medicaid to low income people, Title II contains multiple provisions improving and modifying the Medicaid and SCHIP programs in many respects. However, these changes do not raise important administrative law issues for consumers, so they are not addressed in this article. Clearly, Title II contemplates that the newly eligible individuals will fit into existing state programs. The existing appeals processes for the Medicaid and SCHIP programs are in place to handle the complaints about eligibility, coverage, and other concerns facing consumers.

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65 See Broaddus & Angeles, *supra* note 64, at 1; see also Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Speaker Nancy Pelosi, Speaker House of Representatives (March 20, 2010), at Table 4, available at http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

III. Administrative Law Issues for Consumers: Coverage Expansions

PPACA establishes a major regulatory program for private insurance carriers and also creates significant expansions in existing public benefit programs. It is thus not surprising that important administrative law issues are implicated in this legislation. As indicated above, there are three categories of administrative law issues posed in Titles I and II of PPACA. The first is the formation of new governmental agencies to manage the benefits and guarantees PPACA creates. The second issue entails the critical policy-making initiatives of interest to consumers. The third consists of the important appeal procedures that are established under these titles to protect the rights of consumers to their health care benefits under the Act.

A. New Governmental Agencies

There are two major administrative structures for states to establish—the state health insurance exchanges and a consumer protection agency. Also, within the Centers Medicare and Medicaid Services (“CMS”), the Secretary of HHS has created a new center to oversee the health reform effort at the state and federal level. These new agencies are described below.

1. State Agencies

a. Establishment of State Health Benefit Exchanges

The establishment of health benefit exchanges is one of the most ambitious efforts under PPACA. Accordingly, the exchanges are subject to a host of requirements specified in the statute.

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i. Requirements for State Health Benefits Exchanges

First, an exchange can only be a state agency or a not-for-profit corporation.69 States have some flexibility regarding exchanges. They can consolidate their exchanges with exchanges in other states and also contract out functions of the exchange itself to other entities.70 With some limitations, an exchange can only offer qualified health plans to qualified individuals and qualified employers.71 Moreover, in carrying out their functions, exchanges are required to consult with stakeholders, including health care consumers who are enrollees in qualified health plans, individuals and entities with experience in facilitating enrollment in qualified health plans, representatives of small businesses and self-employed individuals, state Medicaid offices, and advocates for enrolling hard to reach populations.72 The statute specifies a list of functions the exchanges must fulfill, which are presented at Table 4, below.73

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71 Id. § 1311(d)(2)-(3) (to be codified as amended at 42 U.S.C. § 18031) (describing offering of coverage and rules related to additional required benefits).

72 Id. § 1311(d)(6) (to be codified as amended at 42 U.S.C. § 18031) (listing what programs an exchange must consult with in carrying out activities).

73 Id. § 1311(d)(4) (to be codified as amended at 42 U.S.C. § 18031) (listing mandatory minimum functions of an exchange).
There are several additional important provisions regarding the health benefits exchange program. Specifically, consumers are guaranteed a freedom of choice of any plan on the exchange if purchasing insurance independently, or if employed, individuals can select a plan that has the same level of coverage their employer selected. This

freedom of choice is an important benefit as it may offer access to different providers that are attractive to consumers.

In 2010, the National Association of Insurance Commissioners (“NAIC”) published the American Health Benefit Exchange Model Act (“Model Act”). The NAIC’s Model Act is a very useful statutory template for states to use in crafting their own legislation. Like other NAIC model legislation, it represents a consensus among state insurance commissioners, developed in an established and respected process as to appropriate statutory language that can be used to address the details and complexity accompanying the regulation of insurance. As such, the Model Act may well provide states with a useful tool to establish the health benefit exchanges and mitigate some of the political pressure that is likely to accompany their implementation.

ii. The Controversy over State Health Benefits Exchanges

Not surprisingly, the establishment of State Health Benefits Exchanges is a formidable challenge and has proven controversial. States have much to do in establishing exchanges and much of their work is pursuant to federal direction. The Secretary of HHS has an important responsibility in setting policy and technical assistance to guide the work of the exchanges. Specifically, the Secretary must promulgate regulations on criteria for the certification of qualified health plans. The Secretary must develop a rating system that will be used to rate qualified health plans offered through an exchange on the basis of the relative quality and price. Most importantly, the Secretary must develop an enrollee satisfaction survey system to evaluate and publish the level of enrollee satisfaction with larger qualified health plans offered through an exchange. From a consumer’s perspective, these are among the

provisions).


76 Patient Protection and Affordable Care Act of 2010 § 1311(c) (to be codified as amended at 42 U.S.C. § 18031).

77 Id. § 1311(c)(2) (to be codified as amended at 42 U.S.C. § 18031). At a minimum, a certified health plan must, (1) meet marketing requirements, (2) ensure a sufficient choice of suppliers, be accredited with certain local performance requirements and others. Id.


79 See id. § 1311(c)(4) (to be codified as amended at 42 U.S.C. § 18031) (providing that the Secretary shall develop an enrollee satisfaction survey system for the purpose of evaluating qualified health plans that had greater than 500 enrollees in the previous year). The act also provides that the results of this survey shall be made available on the internet. Id.
most important of the reforms because they give consumers the requisite information they need to choose among plans. It is expected that the resulting competition among plans will motivate insurers to provide or pay for higher quality care at a lower price.

The Secretary has considerable discretion in developing the standards for qualified health plans. In a report for the Commonwealth Fund, law professor Timothy S. Jost identified eight challenges that the state health benefit exchanges nonetheless must address. Six of the eight concerns have to do with the successful operation of the exchanges. These challenges include: (1) how exchanges avoid the problem of adverse selection of participants; (2) how to make the exchanges attractive to small employers; (3) how to integrate large employers with formerly self-insured plans; (4) how to prepare the required consumer information on insurance plans and materials; (5) how to make eligibility determinations for premium tax credits, cost-sharing reduction payments, and public programs; and (6) how to keep down administrative costs. Many have shared these same concerns about the actual success of exchanges, especially with respect to employer-sponsored health coverage.

Professor Jost also recognized two issues that are particularly important from an administrative law perspective. The first is the governance of the exchanges. They can be run by either an independent state agency or nonprofit body, and states will have to determine which organizational form is most appropriate for the state. Also, the NAIC American Health Benefit Exchange Model Act addresses the problems attending both forms of governance:

Some possible advantages to having the exchange within a State agency include having a direct link to the State administration and a more direct ability to coordinate with other key State agencies, such as the

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80 See Jost, supra note 67, at 6-8.
81 See Jost, supra note 67, at 6-8.
84 See Jost, supra note 67, at 2-6. However, as Professor Jost notes, although the exchanges must coordinate closely with state insurance departments or Commissioners, the exchanges should be separate from state insurance departments, as the purpose of the exchanges are to market insurance programs. Id.
State Medicaid agency and the State insurance department. Some possible disadvantages include the risk of the exchange’s decision-making and operations being politicized and the possible difficulty for the exchange to be nimble in hiring and contracting practices, given most States’ personnel and procurement rules. The exchange could also be established as an independent public agency, or a quasigovernmental agency, with an appointed board or commission responsible for decision-making and day-to-day operations. Some possible advantages to establishing the exchange as an independent public agency, or a quasi-governmental agency, include possible exemption from State personnel and procurement laws and more independence from existing State agencies, which could result in less of a possibility of the exchange being politicized.85

Regardless of these concerns, the exchange must have a governing board representative of various interests to ensure that there is less of a chance of the exchanges’ decisions being politicized, to enhance accountability, and not thwart the exchanges’ likelihood of success.86 Furthermore, it will be crucial for states to select a knowledgeable board that can shepherd the work of the exchange in its early years.

The second administrative law issue of import regarding the exchanges is the conferred responsibility to certify health plans that meet certain requirements for participation in the exchange. Professor Jost emphasizes the importance of carefully delineating the criteria that exchanges would apply in certifying plans.87 If the Secretary

86 See Jost, supra note 67, at 7-8. Jost writes,

In each state, the exchange should be placed in an independent agency, which should be explicitly exempted, as necessary, from the requirements of specific state administrative law or government operations requirements. The governing board of the exchange could represent interested parties, state agencies with which the exchanges must work, and persons with relevant expertise. Management, on the other hand, should be apolitical and professional.

Id.
87 See Jost, supra note 67, at 27-32 (explaining the rules for certification and how the exchanges would then set their criteria in order to comply with these provisions).
does not get it right with respect to criteria, state exchanges could certify plans that do not function as intended and jeopardize the operation of the health reform. Clearly, the authority to regulate the specific exchange participation requirements, and the rules promulgated there under, will play a critical role in whether the exchanges will be able to create the kind of competitive market in health insurance that will allow consumers affordable, high quality health insurance. More specifically, certification standards will clearly affect the price of health coverage, the value of health coverage, and the competitiveness of the health insurance market. Insurers will want their products to be available on exchanges. Therefore, they will put political pressure on the exchanges to have more flexible certification requirements. Exchanges will have to resist the political pressure and marshal the expertise to certify plans in ways that achieve the goals of a competitive market in affordable, high quality health insurance.

In sum, the state health benefit exchanges are among the most controversial aspects of health reform and have critical implementation challenges waiting. However, there have been some successes with health exchanges in state initiated health reform. The obvious example is Massachusetts, which has already established an exchange, the Connector, and has successfully expanded affordable coverage in that state. Utah and California have established health benefit exchanges as well. The ultimate success of this health reform strategy will depend on the political will and skill of state governments as well as the soundness of the governing policies from HHS.

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88 See Jost, supra note 67, at 27-31 (describing the interplay between the standards set by the exchanges for a plan to be certified and the type of competitive market for health insurance that evolves).
89 See Jost, supra note 67, at 27-31.
90 See Jost, supra note 67, at 28. Under a more exclusive exchange model, health insurers who do not meet the certification standards are essentially excluded from the entire market; therefore, this setup will almost inevitably lead to insurers imposing pressure on exchanges in desperate attempts have their plans certified. Id. Since most insurance markets in the U.S. are highly concentrated, exchanges are likely to face consistent pressure from insurers who are trying to get into the crowded market. See Jost, supra note 67, at 29.
91 See generally Jost, supra note 67.
92 See 2006 Mass. Act ch. 58, § 13(b), § 101 (2), An Act Providing Access to Affordable, Quality, Accountable Health Care (providing for individual mandate and establishing the Commonwealth Connector, respectively).
b. Establishment of Consumer Protection Offices

Subtitle A of Title I also provides grants to states to establish or support “offices of health insurance consumer assistance” or “health insurance ombudsman programs.” To be eligible for grant funding, states must designate an independent office as either the office of health insurance consumer assistance or the health insurance ombudsman. The new office must also coordinate with state health insurance regulators and consumer assistance organizations, as well as receive and respond to inquiries and complaints about health insurance coverage in conformity with state and federal law. All newly federally funded entities must comply with criteria the Secretary of HHS establishes and comply with specific duties. These duties include: (1) assisting consumers with filing of complaints and appeals; (2) collecting, tracking, and quantifying problems and inquiries consumers encounter; (3) educating consumers on their rights and responsibilities under health reform; (4) assisting consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and (5) resolving problems with obtaining premium tax credits.

PPACA appears to give states great latitude in designing this office and its authorities. For example, states will have to determine the structure and governance of the office, as well as its size. Also the states will have to decide if these offices are to have rulemaking authority. At best, these offices could play a very important role in assisting consumers to navigate the exchanges and the other requirements of PPACA. But, for the promise of this reform to be fully realized, it will be critical for these offices to be accorded the appropriate design, authority, and resources to serve consumers effectively coordinate among new and existing state and federal programs.

2. A New Federal Oversight Agency

Initially, the Office of Consumer Information and Insurance Oversight (“OCIIO”), within the Office of the Secretary of HHS, had the lead in the

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95 Id. (codified as amended at 42 U.S.C § 300gg-93(b)(1)).
96 Id. (codified as amended at 42 U.S.C § 300gg-93(b)(1)).
97 Id. (codified as amended at 42 U.S.C § 300gg-93(b)-(c)).
98 Id. (codified as amended at 42 U.S.C § 300gg-93(c)(1)-(5)).
implementation of reforms under Title I. But, in February 2011, the OCIIO became the Center for Consumer Information and Insurance Oversight ("CCIIO") within the CMS, and significantly, the CCIIO's purpose is to assist in further implementing PPACA's provisions that relate only to private health insurance, rather than all insurance reforms under Title I. This new center, according to its website, has several functions. Perhaps the most important of these, in terms of ensuring the quality of insurance, include monitoring health care insurance reforms and providing consumers with comprehensive information on insurance coverage options established under PPACA. Moreover, the CCIIO is responsible for ensuring compliance with the new insurance reforms, such as the Patient's Bill of Rights, which are a set of interim regulations that seek to help children with preexisting conditions, and eventually all Americans, obtain health insurance coverage. In addition, the new agency is charged with overseeing and conducting the external appeals process, which patients can use to appeal adverse insurance decisions, in states that do not establish such authority under state law. This is an important function because under the interim regulations and


101 See id. The CCIIO is currently focusing on:

- ensuring compliance with new insurance market rules, such as the Patient’s Bill of Rights, helping states review unreasonable rate increases and overseeing new Medical Loss Ratio rules, providing oversight for the State-Based Health Insurance Exchanges and compiling data for www.HealthCare.gov, and
- administering the Consumer Assistance Program, Pre-Existing Condition Insurance Plan, and Early Retiree Reinsurance Program.

Id.

102 See U.S. DEP’T OF HEALTH & HUMAN SERVS., THE OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, ENSURING THE AFFORDABLE CARE ACT SERVES THE AMERICAN PEOPLE, supra note 100. The CCIIO is primarily “charged with helping implement many provisions of the Affordable Care Act.” Id.


PPACA, insurers have a choice to either comply with the state’s external review process or the federal external review process.105 The agency will also enforce the new rules regarding the business of insurance at the state level.106 Finally, the agency will administer and oversee programs, such as the Pre-Existing Condition Insurance Plan, which is designed to make health insurance available to persons with preexisting conditions who did not have access to affordable options in the private market prior to 2010, under Subtitle A of Title I.107 These offices could well be instrumental in achieving an effective state exchange and helping consumers obtain the benefits of health reform.

B. Rule and Policy Making

An important matter for consumers is the delineation of the essential health benefits that must be offered in each plan. In defining the essential health benefits and in revising the benefits, the Secretary must provide notice and an opportunity for public comment in accordance with the Administrative Procedure Act (“APA”) section 553.108 The term “essential health benefits package” means, with respect to any health plan, coverage that limits cost-sharing for such coverage in accordance with statutory standards.109 Within Table 5 are the basic categories of services that the Secretary must include in the essential health benefits package.110 The concept of a standard essential health benefits package is an enormous step in making insurance sufficient to cover needs of all insured individuals, including the disabled.111

105 See U.S. DEPT OF HEALTH & HUMAN SERVS., CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, EXTERNAL APPEALS, supra note 104.
110 Id. § 1302(b)(1) (to be codified as amended at 42 U.S.C. § 18022).
However, PPACA imposes limits on the Secretary in executing the process of defining essential health benefits. First, the Secretary must ensure that the scope of the essential health benefits is equal to the scope of benefits provided under a typical employer plan, as the Secretary determines. This determination is based on a survey of employer-sponsored coverage that the Secretary of Labor conducts. The Secretary of HHS must submit a report to the appropriate Congressional committees containing a certification from the Chief Actuary of CMS that such essential health benefits meet the statutory requirements. Further, the secretary must develop a policy on cost-sharing and levels of coverage for qualified health plans.

Currently, a committee of the Institute of Medicine (‘‘IOM’’) is examining the essential health benefits issues at the behest of the Secretary of HHS. The IOM will

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<th>Table 5</th>
<th>Categories of Services to be Included in Essential Health Benefits</th>
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<td>(A)</td>
<td>Ambulatory patient services;</td>
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<td>(B)</td>
<td>Emergency services;</td>
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<td>(C)</td>
<td>Hospitalization;</td>
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<td>(D)</td>
<td>Maternity and newborn care;</td>
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<td>(E)</td>
<td>Mental health and substance use disorder services, including behavioral health treatment;</td>
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<td>(F)</td>
<td>Prescription drugs;</td>
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<td>(G)</td>
<td>Rehabilitative and habilitative services and devices;</td>
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<td>(H)</td>
<td>Laboratory services;</td>
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<td>(I)</td>
<td>Preventive and wellness services and chronic disease management, and</td>
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<tr>
<td>(J)</td>
<td>Pediatric services, including oral and vision care.</td>
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113 Id. § 1302(b)(2)(A) (to be codified as amended at 42 U.S.C. § 18022).


115 Id. § 1302(b)(2)(B) (to be codified as amended at 42 U.S.C. § 18022). The Secretary must consider such things as the health care needs of diverse segments of the population and whether benefits are unduly weighted toward any one category. Id. § 1302(b)(4) (to be codified as amended at 42 U.S.C. § 18022).

116 Id. § 1311(c)-(d) (to be codified as amended at 42 U.S.C. § 18031) (explaining the requirements relating to cost-sharing and the levels of coverage).

117 INST. OF MED., ACTIVITY: DETERMINATION OF ESSENTIAL HEALTH BENEFITS (Jan. 19,
not define specific service elements of the benefit package. Rather, according to the IOM:

[T]he IOM will review how insurers determine covered benefits and medical necessity and will provide guidance on the policy principles and criteria for the Secretary to take into account when examining QHPs [qualified health plans] for appropriate balance among categories of care; the health care needs of diverse segments of the population; and nondiscrimination based on age, disability, or expected length of life.

The delineation of essential health benefits is one of the most important aspects in the entire health reform legislation for consumers. This is so because the process will define the content of medical care for most health plans that will be available to consumers and employers through the exchanges. Thus, the challenge the Secretary faces is of crafting a benefit package that is generous enough to meet most of the health care needs of the population but not so generous that providers are encouraged to order excessive and unnecessary care. The benefit package must also be structured so that insurers can make a profit from the business of health insurance—otherwise they will not participate in the health benefit exchanges. Given the importance of this aspect of PPACA’s implementation, it is essential for consumer groups, voluntary health organizations, and professional societies to become involved in the notice and comment process and other deliberations. It is critical that that the Secretary gets it right with respect to the essential health benefits package.

2011, http://www.iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx (last visited Apr. 23, 2011). Currently, PPACA stipulates that the following general categories are covered under qualified health plans: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services; prescriptions drugs; rehabilitative services; laboratory services; preventive and wellness services; chronic disease management; and pediatric services which include oral and vision care. Id. The Institute of Medicine (“IOM”) will make recommendations on the criteria and methods for determining other categories that should be included within the essential health benefits package. Id.

Id. The IOM will also provide advice regarding the criteria and process for occasionally reviewing the benefits package. Id.

C. Federal Standards for Health Plan Appeal Processes

Subtitle A of Title I also reforms the appeals processes for coverage and claim disputes for health plans.121 All health plans must have an internal claims appeal process.122 Accordingly, to assist enrollees, the review process must provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, as well as provide notice about the availability of any applicable office of health insurance consumer assistance or ombudsman, established under PPACA.123 This process must further allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.124 Finally, the appeals process must, at a minimum, also provide an external appeals process that includes the consumer protections in the Uniform External Review Model Act,125 of the National Association of Insurance Commissioners.126 The appeal provisions in PPACA apply to both state-regulated and ERISA-regulated plans and thus will end the piecemeal protections that apply only in some states to some plans, and it will also facilitate consumers in navigating the complex system.127

In July 2010, HHS, the U.S. Department of Labor ("DOL"), and the IRS promulgated regulations implementing these appeal provisions for state-regulated plans and ERISA-regulated plans.128 The rules followed a March 2010 report of the U.S.

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124 Id. § 1001(5) (to be codified as amended at 42 U.S.C. § 300gg-19(a)(1)(C)).
125 NAT'L ASS'N OF INS. COMM'RS, UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT (Apr. 2010), http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf [hereinafter "Model Act of 2010"]. The purpose of the Model Act is to “provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination” as defined by NAIC. MODEL ACT OF 2010 § 2.
128 Internal Revenue Service, Department of the Treasury; Employee Benefits Security
General Accountability Office (“GAO”) that the appeal reversal rates for private health insurers was quite varied and quite high. Specifically, the GAO reported that thirty-nine percent to fifty-nine percent of appeals were successfully reversed. These figures are troublesome as they indicate that insurers are often not making medically appropriate calls on coverage decisions in the first instance.

These interim final regulations set forth six new requirements for internal claims and appeal procedures. First, the regulations clarify and broaden the definition of adverse benefit determination to include rescission of coverage, as well as “a denial, reduction, or termination of . . . a benefit” in whole or in part. Second, the regulations establish deadlines for notification of benefit determination of twenty-four hours.

Administration, Department of Labor; Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 43,332. The interim rules establish that, “An adverse benefit determination is defined by incorporating the definition under the Department of Labor’s regulations governing claims at 29 C.F.R. § 2560.503-1 . . . and also includes a rescission of coverage.” Id. 29 C.F.R. § 2560.503-1 states:

The term “adverse benefit determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.


130 Id.

131 Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 43,332. The interim rules establish that, “An adverse benefit determination is defined by incorporating the definition under the Department of Labor’s regulations governing claims at 29 C.F.R. 2560.503-1 . . . and also includes a rescission of coverage.” Id. 29 C.F.R. § 2560.503-1 states:
Third, the regulations create additional criteria to ensure that a claimant receives a full and fair review. For example, the plan must provide the claimant, free of charge, with any new or additional evidence. Fourth, the regulations establish conflict of interest rules for adjudicators, so as to ensure decision-makers are impartial and independent.

[A] plan or issuer must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care . . . as soon as possible . . . but not later than 24 hours after the receipt of the claim by the plan or health insurance coverage, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance coverage.

These conflict of interest rules establish:

The plan or issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. For example, a plan or issuer cannot provide bonuses based on the number of denials made by a claims adjudicator. Similarly, a plan or issuer cannot contract with a medical expert based on the expert's reputation for outcomes in contested cases, rather than based on the expert's professional qualifications.
Fifth, new standards are set regarding notice to enrollees; these standards detail the information that must be included in the notice, such as that necessary to identify the claim, reasons for the denial, and a description of available appeals processes.\textsuperscript{135}

The sixth change provides that, in the case of a plan or issuer that fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a claim, the claimant is “deemed to have exhausted the internal claims and appeals process, regardless of whether the plan or issuer asserts that it complied with these requirements or that any error it committed was de minimis.”\textsuperscript{136} At that point, the rule explains, “the claimant may initiate an external review and pursue any available remedies under applicable law, such as judicial review.”\textsuperscript{137} This sixth provision offers a potentially very effective enforcement mechanism on group health plans and insurance issuers to provide appropriate internal claims and appeals procedures because if insurers do not strictly comply with all of the requirements, they may face judicial penalties and sanctions.

In March 2011, the DOL announced an additional delay in the enforcement of these regulations. In Technical Release 2011-01, the DOL’s Employee Benefits Security Administration explained that a six-month extension of the enforcement grace period was necessary to accommodate comments received on the interim final rule in

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\textsuperscript{135} Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 43,333.

\textsuperscript{136} Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 43,333. Notice requirements to new enrollees include that a plan or issuer must “ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved,” including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the meanings of codes. \textit{Id.} The plan or issuers must also include in the notice “the reason or reasons for the adverse benefit determination or final adverse benefit determination includes the denial code . . . and its corresponding meaning.” \textit{Id.} The standard in denying the claim must be included, as well as a discussion of the decision. \textit{Id.} Additionally, the notice must provide description of available internal appeals and external review processes, and the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act. \textit{Id.}

\textsuperscript{137} \textit{Id.}
accordance with APA section 553. This new Technical Release follows an earlier Technical Release delaying the original implementation to July 1, 2011. The sticking points insurers raised are that the deadlines for urgent review of claims are unrealistic, especially the requirement to add diagnostic codes to the appeals and the burdensome language requirements for consumer information. Consumer groups, on the other hand, are concerned that delays may signal an evisceration of the consumer friendly claims appeal procedures.

These appeal procedures reflect many of the best practices for appeal procedures of benefits programs that have evolved in recent years. They include external review procedures, effective expedited review cases in emergency cases, and real measures to empower beneficiaries in the appeal process. Yet, these are the same sticking points on which insurers are now pushing back. Obviously, all regulations need tinkering to reflect comments and comport with the realities on the ground. Nevertheless, genuine consumer protections should not be mitigated to accommodate insurers' requests. The appeals process is critical to ensure that consumers are able maintain essential health benefits and fulfill PPACA's overarching goal in expanding health insurance access.

138 U.S. DEPT OF LABOR, EMP. BENEFITS SEC. ADMIN., TECHNICAL RELEASE NO. 2011-01: EXTENSION OF NON-ENFORCEMENT PERIOD RELATING TO CERTAIN INTERIM PROCEDURES FOR INTERNAL CLAIMS AND APPEALS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (Mar. 18, 2011), available at http://www.dol.gov/ebsa/pdf/tr11-01.pdf. The Release explained that during the grace period the Department of Labor will not take any enforcement action against a group health plan, and the Department of Health and Human Services would not take action against a self-funded nonfederal governmental health plan, so long as it is working in good faith to implement the appropriate standards. Id.


140 Susan Jaffe, Administration Delaying Some Rules For Appealing Health Insurance Denials, KAISER HEALTH NEWS, (Mar. 25, 2011), http://www.kaiserhealthnews.org/Stories/2011/March/25/appeals-delay.aspx (last visited Apr. 23, 2011). Among the delayed rules includes the reduction in time that an insurance company is allowed to review a denial of coverage in urgent cases, and the requirement that insurers provide information about the denial process and the appeal process in languages for non-English speaking plan holders. Id.

141 Jaffe, supra note 140. The consumer groups are concerned that the delays mean that the improvements will not happen. Id.

IV. Conclusion

The importance of administrative law in health reform cannot be overstated. A statute can convey with words a host of benefits and promises. But without administrative procedures open to consumers to affect policy making and to raise and adjudicate appeals, these benefits and promises may not be realized. The structure and powers of agencies with new responsibilities for implementation is critical for effective implementation, especially in an environment in which there is not universal or substantial consensus over whether to establish these agencies in the first place. Rulemaking procedures—particularly on such important issues as the essential health benefits package—must effectively garner the best input from affected parties. Finally, appeal procedures are essential to identify implementation problems and achieve justice for individual consumers and patients.