NAIC/CONSUMER LIAISON COMMITTEE
Sunday, March 29, 2015
1:30 – 3:00 p.m.
Phoenix Convention Center North—Room 132—Street Level

ROLL CALL

Marguerite Salazar, Chair  Colorado  Mike Rothman  Minnesota
Ken Selzer, Vice Chair  Kansas  Mike Chaney  Mississippi
Jim L. Ridling  Alabama  Scott J. Kipper  Nevada
Lori K. Wing-Heier  Alaska  John G. Franchini  New Mexico
Dave Jones  California  Wayne Goodwin  North Carolina
Anne Melissa Dowling  Connecticut  Mary Taylor  Ohio
Karen Weldin Stewart  Delaware  John D. Doak  Oklahoma
Chester A. McPherson  District of Columbia  Laura N. Cali  Oregon
Gordon I. Ito  Hawaii  Raymond G. Farmer  South Carolina
TBD  Illinois  David Mattax  Texas
Stephen W. Robertson  Indiana  Todd E. Kiser  Utah
Sharon P. Clark  Kentucky  Jacqueline K. Cunningham  Virginia
Al Redmer Jr.  Maryland  Mike Kreidler  Washington
Annette E. Flood  Michigan  Michael D. Riley  West Virginia
Ted Nickel  TBD  TBD  TBD

2015 NAIC Consumer Liaison Representatives

Elizabeth Abbott  State of California, Office of the Patient Advocate  Peter Kochenburger  University of Connecticut School of Law
Amy Bach  United Policyholders  Sonja L. Larkin-Thorne  Consumer Advocate
Birny Birnbaum  Center for Economic Justice (CEJ)  Angela Lello  Autism Speaks
Brendan M. Bridgeland  Center for Insurance Research  Adam Linker  North Carolina Justice Center
Bonnie Burns  California Health Advocates  Sarah Lueck  Center on Budget and Policy Priorities
Brenda J. Cude  University of Georgia  Annalise Mannix  Fair Insurance Rates in Monroe
Howard Goldblatt  Coalition Against Insurance Fraud  Claire McAndrew  Families USA
Kathleen Gmeiner  Universal Health Care Action Network (UHCAN) of Ohio  Stephanie Mohl  American Heart Association
Marguerite Herman  Consumer Advocates: Project Healthcare  Lincoln Nehring  Voices for Utah Children
Anna Howard  American Cancer Society  Jesse O’Brien  Oregon State Public Interest Research Group (OSPIRG)
Timothy Stoltzfus  Cancer Action Network  Christina Postolowski  Young Invincibles
Jost  Virginia Organizing  Andrew Routh  Consumers Union
Debra Judy  Colorado Consumer Health Initiative  Alyssa Vangeli  Missouri Health Advocacy Alliance
Karrol Kitt  The University of Texas at Austin  JoAnn Volk  Health Care For All
   
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AGENDA

1. Introduce 2015 NAIC Consumer Representatives—Commissioner Marguerite Salazar (CO)

2. Consider Adoption of Nov. 17 Minutes—Commissioner Marguerite Salazar (CO) (see NAIC Proceedings – Fall 2014, NAIC/Consumer Liaison Committee Nov. 17, 2014, minutes)

3. Hear a Presentation on a New Risk Classification Providing an Example of Unfair Discrimination in Current Rate Filings—Birny Birnbaum (CEJ) Attachment One

4. Hear a Presentation on the Potential Consequences of King v. Burwell for State Insurance Regulation—Timothy Stoltzfus Jost (Virginia Organizing), Kathleen Gmeiner (UHCAN) and Adam Linker (North Carolina Justice Center)

5. Hear a Presentation on Consumer Perspectives on Recent NAIC Market Analysis and Market Conduct Initiatives as They Affect Health Insurance—Andrea Routh (Missouri Health Advocacy Alliance)

6. Hear a Presentation on Out-of-Network Bills, Legislative and Regulatory Remedies Being Considered by the States and Network Adequacy—Lynn Quincy (Consumers Union), Anna Howard (American Cancer Society Cancer Action Network) and Claire McAndrew (Families USA) Attachment Two

7. Hear a Presentation on Incentivizing Mitigation: Premium Discounts and Support for Consumers to Make Risk Reduction Improvements to Structures—Amy Bach (United Policyholders) and Annalise Mannix (Fair Insurance Rates in Monroe) Attachment Three-a and Three-b

8. Hear a Presentation on Non-Discrimination in Health Plan Benefit Design—Stephanie Mohl (American Heart Association)

9. Discuss Any Other Matters Brought Before the Committee—Commissioner Marguerite Salazar (CO)

10. Adjournment
Regulatory Oversight of Insurers' Use of Big Data

Birny Birnbaum
Center for Economic Justice

NAIC Consumer Liaison Committee
March 2015

The Center for Economic Justice

CEJ is a non-profit consumer advocacy organization dedicated to representing the interests of low-income and minority consumers as a class on economic justice issues. Most of our work is before administrative agencies on insurance, financial services and utility issues.

On the Web: www.cej-online.org

Why CEJ Works on Insurance Issues

**Essential Financial Security Tool for Individual and Community Economic Development:** CEJ Works to Ensure Access and Fair Prices for These Essential Products and Services, particularly for Low- and Moderate-Income Consumers.

**Primary Institution to Promote Loss Prevention and Mitigation:** CEJ Works to Ensure Insurance Institutions Maximize Their Role in Efforts to Reduce Loss of Life and Property from Catastrophic Events.

Outline of Presentation

1. Big Data Defined
2. Insurer Big Data Application: Lexis Nexis Claims Tools
3. Public Policy and Insurer Goals of Risk Classification
4. Regulatory Framework For Risk Classification
5. History of Insurer Use of Big Data for Risk Classification
6. Insurer Big Data Application: Price Optimization
7. Insurer Rationale for PO: “Not Risk Classification, But Management Judgment”
8. PO and “Demand Models” Are Prohibited Risk Classes
9. Existing Risk Class Regulatory Framework Out of Date
10. Regulatory Big Data to Monitor Market Outcomes
Big Data Defined

• Massive databases of information about (millions) of individual consumers

• Associated data mining and predictive analytics applied to those data

• Scoring models produced from these analytics.

Insurance Big Data Example: LexisNexis Claims Tools


For third-party bodily injury settlements, the study found that more data earlier resulted in:
• 15–25 percent lower severity payments*
• 25–49 percent lower attorney involvement
• 5–15 percent shorter cycle times

Similar results were obtained for third-party property damage claims:
• 10–15 percent lower severity payments
• 8–15 percent shorter cycle times

LexisNexis Claims Tools

LexisNexis (LN) seeks to provide a Single Point of Entry for delivering all of information directly back into a carrier’s system whether from a marketing standpoint, underwriting process or especially the claims part.

LN has over 10,000 data sources that feed into its infrastructure each month and has contributed information from the industry.

“Claims Data Fill” – deliver data and analytics directly into claims system in the claims process regarding parties, vehicles and carrier information. Used to verify information provided to insurers and provide indicators beyond the data to identify whether a social security number is an indicator of fraud or whether an address provided is a good address.

LexisNexis Claims Tools

Has an analytic component at first notice of loss and throughout the claim, constantly monitoring the claim looking for fraudulent activities. Real time data verification and enhancement with fraud scoring and attributes

Example, insured was rear-ended, all I got was license plate:

Claims Data Fill takes that license plate, reach out to DMV to get vehicle registration to get VIN number, we have policy database and get the carrier and policy information, take the registered owner, go out to public records, pull back their address, date of birth, telephone number, social security, wrap that into a package and put it back into our system, 88% of the time done in less than 5 seconds.
LexisNexis Claims Tools

Take minimum information provided at first notice of loss, provide a fraud score at the initial notice of loss. Daily monitoring of claim every time new information comes in, able to run various scores: fraud scores, severity score

New contributory claims database, much deeper than prior claims databases – this is claims file submitted as new information added – allows us to track vehicles across carriers, medical providers across carriers – sharing of information much deeper than has been done before. Text mining, watch list mixed with LexisNexis data.

**Take-Away:** Many databases and scoring models with little or no transparency to consumers and regulators and outside the scope of consumer protection laws like the FCRA.

Public Policy Goals of Risk Classification

1. Protect Insurer Financial Condition by Minimizing Adverse Selection
2. Promote Loss Mitigation by Providing Incentives for Less Risky Behavior and Disincentives for More Risky Behavior

**Foundation of Risk Classification is Cost-Based Pricing**

**Foundation of Statutory Standards for Rates – “Not Unfairly Discriminatory” – is Cost-Based Pricing**

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**History of Insurer Big Data Use for Risk Classification**

**Old Old School Big Data:** Advisory Organization Loss Costs. Oversight of Data, Advisory Organization, Analytic Techniques, Filings, Complete Transparency

**Old School Big Data:** Credit-Based Insurance Scores. Limited Consumer Protections for Completeness and Accuracy of Data via the FCRA, Limited Oversight of Modelers and Models, Limited Transparency

**New School Big Data:** Predictive Modeling of Any Database of Personal Consumer Information. No Consumer Protections for Completeness and Accuracy of Data, No Oversight of Modelers and Models, No Transparency to Consumers

**Insurer Big Data Application: Price Optimization**

Adjusting cost-based rate indications based on “demand models.” Demand models are models of consumer price elasticity of demand and competitive alternatives. Price elasticity of demand is consumer willingness to pay in face of price change – how likely a consumer is to shop for new insurance in face of, say, 7% rate increase.
Insurer Justification for Price Optimization

1. Insurers have always deviated from indicated rates for a variety of competitive and business reasons, relying on management judgment for such deviations. PO is simply a more scientific, data-driven approach to employing such management judgment.

2. Rating factors are factors related to costs of transfer of risk – loss costs or expenses. Since PO is not related costs of transfer of risk, it is not a rating factor and, consequently, not subject to regulatory oversight.

3. There is a statistical confidence interval around the indicated rate and any selection based on management judgment within that confidence interval is actuarially sound.

Insurers' Historical Deviation from Indicated Rates

- Historical deviation from rates has typically been an insurer selecting a lower rate than the indicated rate.
- Regulators have not routinely approved insurer requests for, say, a 20% rate increase when the insurer's indication is for a 5% rate increase.
- Historical deviation from indicated rates has almost always been a lower selected than indicated rate and the lower selection has been across broad risk groups.

Price Optimization is Risk Classification

**Definition:** A risk classification/rating factor is any characteristic of the consumer, vehicle or property utilized by the insurer to determine the premium charge.

Rating factors are risk classifications and, by statute, must be related to expected costs of the transfer of risk – expected losses or expenses to issue and administer the policy.

- PO is clearly a rating factor as it is based on individual consumer characteristics and is applied to individual consumers to determine the premium charge for that consumer. At once, it is now obvious that **PO is an impermissible rating factor because it is not related to the cost of transfer of risk.**

“PO Not Applied to Individual Consumers, But to Risk Classes”

- Modeling of Rates and Ultra-Refined Risk Classification Has Created Tens of Millions of Rating Cells Within A State – Far More Rating Cells Than Policyholders
- Allstate Complementary Rating Group (CRG) includes factors based on birthdates – two consumers otherwise identical but born a day apart are treated differently. CRG factor based on rating territory, gender, years with prior carrier and birthdate.
Drivers with same gender, rating territory and years with prior carrier:

<table>
<thead>
<tr>
<th>Birthdate</th>
<th>Rate Relativity</th>
<th>Rate Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/16/1943</td>
<td>0.9803</td>
<td>+7.2%</td>
</tr>
<tr>
<td>4/16/1943</td>
<td>1.0510</td>
<td></td>
</tr>
<tr>
<td>12/7/1980</td>
<td>0.9374</td>
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</tr>
<tr>
<td>12/8/1980</td>
<td>1.0252</td>
<td></td>
</tr>
<tr>
<td>7/4/1983</td>
<td>1.1784</td>
<td>+13.2%</td>
</tr>
<tr>
<td>7/7/1983</td>
<td>1.0406</td>
<td></td>
</tr>
</tbody>
</table>

"Adjustments Are Within the Confidence Interval"

- A confidence interval is created around the output of a statistic or statistical model. The size and nature of the confidence interval is determined by inputs chosen by the modeler, including the type of probability distribution used and the size of the data set used (e.g., number of observations), among many other factors.

- Ratemaking has been transformed from actuarial analysis of historical experience into a modeling exercise. Modeling is highly subjective and the results of the underlying ratemaking model can be manipulated.

Ohio DOI Bulletin on Price Optimization

Price optimization, however, involves gathering and analyzing data related to numerous characteristics specific to a particular policyholder that are unrelated to risk of loss or expense. Though not an exhaustive list, the Department has been presented with factors such as: whether the policyholder has complained about his or her policy, the amount or percentage change of the policyholder’s auto premium at renewal in prior years, and the amount or percentage change of the policyholder’s homeowners premium at renewal in prior years. From this and similar data, insurers are able to determine the "price elasticity of demand," or how much of a premium increase a particular policyholder will tolerate before switching insurance carriers.
Ohio DOI Bulletin cont’d: Thus, price optimization techniques allow insurers to set premiums based on an analysis of individual policyholder behavior reflecting a willingness to pay higher premiums than others - a factor completely unrelated to risk of loss or expense.

The use of price optimization represents a departure from traditional cost-based rating and can result in two insureds with similar risk profiles being charged different premiums. Therefore, by its nature, price optimization involves "discriminat[ing] between individuals of the same class and of essentially the same hazard" based on factors which do not have a demonstrable "probable effect upon losses or expenses."

Consequently, the use of price optimization results in rates that are unfairly discriminatory . . . .

PO Undermines Public Policy Goals of Risk Classification

- Undermines Risk Classification as Tool to Assure Financial Condition of Insurer – Replaces traditional and proven actuarial analysis for rates with modeling of prices. Introduces modeling risk to financial condition of insurers.
- For example of modeling risk, AIG Financial Services risk modeling indicated a 98.15% probability that AIG would not lose money on credit default swaps.
- Undermines Loss Mitigation Role of Insurance by Making Pricing More Opaque to Consumers and Less Related to Activities a Consumer Can Take or Avoid to Impact Pricing.

PO, Other Insurer Big Data Models Lack Key Consumer Protections

- Accuracy and Completeness of Data
- Regulatory Oversight of Data Bases
- Disclosures to Consumer: Data Used and How Used
- Consumer Ability to Challenge False Information
- Discrimination Against Low-Income and Minority Consumers
- Exacerbate Availability and Affordability Issues
- Undermine Insurance Pricing Role in Loss Mitigation

Regulatory Oversight of Insurers’ Use of Big Data: Existing Risk Class Regulation Doesn’t Work

Existing risk class regulation based on old old school big data, where regulators have oversight of all factors going into pricing and the data underlying the risk class analysis of rating factors and relativities.

Today, regulators simply do not have the resources to monitor all the databases and scoring models used by insurers nor access to the data underlying these new models.

If it is unrealistic to expect regulators to provide the type of historical review of advisory loss costs to new pricing tools, what is the way forward?
Regulatory Oversight of Insurers’ Use of Big Data:

The current approach of allowing insurers to use any factor they want unless specifically prohibited does not fit with current data availability and technology. Regulators and legislators need to consider an approach of pro-actively identifying permissible risk classifications based not only on actuarial considerations, but also public policy goals of loss mitigation and availability.

Regulatory Big Data for Monitoring Market Outcomes

If regulators’ ability to monitor what goes into marketing, sales, pricing and claims practices is realistically limited, then monitoring market outcomes is essential:

- Who is offered what insurance products at what prices in what locations?
- How are different groups of consumers treated in claims settlement?

Regulatory Big Data as a tool and strategy to improve effectiveness, efficiency and uniformity of state-based insurance market regulation.

Regulatory Big Data Already Used/Planned By State Insurance and Other Financial Regulators:

- Home Mortgage Disclosure Act data on individual mortgage applications by state and federal banking regulators
- Statutory Annual Statement data on individual bonds and investments by insurance prudential regulators
- PBR Transaction data on life insurance, disability insurance, long-term care insurance and annuities by insurance regulators as part of principles-based reserving.
- FINRA Comprehensive Automated Risk Data System (CARDS) – data relating to securities and account transactions, holdings, account profile information (excluding personally-identifiable information and securities reference data.)
Center for Economic Justice Comments

To NAIC Auto Study Group on

Price Optimization

August 16, 2014

The Auto Study Group has received lengthy presentations by Earnix and Towers Watson describing price optimization and explaining, in their view, why price optimization is not a rating factor and, consequently, not subject to regulatory oversight. The purveyors of price optimization services for insurers make the following points:

1. Insurers have always deviated from indicated rates for a variety of competitive and business reasons, relying on management judgment for such deviations. PO is simply a more scientific, data-driven approach to employing such management judgment.

2. Rating factors are factors related to costs of transfer of risk – loss costs or expenses. Since PO is not related costs of transfer of risk, it is not a rating factor and, consequently, not subject to regulatory oversight.

3. There is a statistical confidence interval around the indicated rate and any selection based on management judgment within that confidence interval is actuarially sound.

Each of these contentions is clearly erroneous. Demonstrating the falsehood of any one of these assertions renders PO illegal and unfair under current statutory rate standards. Clearly, demonstrating the falsehood of all three should make clear that regulators should take immediate action to stop PO under existing regulatory authority.

Insurers have historically and routinely deviated from indicated rates and PO is simply an extension of this historical practice.

It is correct that insurers have deviated from indicated rates in the past, but that deviation has not been anything like PO. Historical deviation from rates has typically been an insurer selecting a lower rate than the indicated rate. Regulators have not routinely approved insurer requests for, say, a 20% rate increase when the insurer’s indication is for a 5% rate increase. Historical deviation from indicated rates has almost always been a lower selected than indicated rate and the lower selection has been across broad risk groups. For example, the indicated rate change is +20%, but the insurer selects a base rate increase of 5%.
PO is new on both quantitative and qualitative bases. It employs consumer-specific information to deviate from indicated rates not by broad risk groups but by individual consumer and those deviations are as likely or more likely to be higher than indicated rates than lower than indicated rates.

The engine of PO is price elasticity of demand – meaning the rate charged is dependent on the consumer’s likely response to a higher rate. PO means that an insurer will charge a higher rate to a consumer for whom the PO scoring model indicates the higher rate will not prompt the consumer to shop for insurance from other providers. This is not a symmetrical exercise in which some consumers will see lower rates while other will see higher rates. PO is optimization of price to maximize profit so higher prices will be assessed on these consumers the insurer believes will accept prices greater than the expected and indicated cost of the transfer of risk.

Insurers’ definition of a rating factor has historically been fungible to justify shielding their practices from regulatory oversight.

Historically, there was a clear demarcation between underwriting and rating factors. Underwriting utilized very few and simple criteria to determine if an insurer would offer coverage and, if so, in which company – during a period in which insurers might have one company (and one set of rates per company) for preferred, standard and non-standard underwriting evaluations. Rating factors were any characteristic of the consumer, vehicle or property used to determine the premium charged for an individual policyholder. Historically, underwriting was left to insurer and not subject to routine regulatory oversight, while regulators did require the filing of rating manuals and reviewed those rating manuals for compliance with the statutory requirement that rates not be unfairly discriminatory.

Around the time of introduction to credit scoring, some insurers figured out that if they took a rating factor and use that rating factor to create different base rates, then they could call the rating factor a tier placement factor, declare it as part of underwriting and not tell regulators about. So instead of using credit score as a rating factor with, say, relativities of .75, 1.0 and 1.25 (reflecting a discount of 25%, base rate and a surcharge of 25%) the insurer could call credit score a tier placement factor and have three sets of base rates: 25% below the average, the average and 25% above the average.

Clearly, this approach was an effort to avoid regulatory scrutiny. For many years, there have been sessions at the Casualty Actuarial Society’s Annual Ratemaking Seminar instructing company actuaries how to utilize “tier placement” to avoid regulatory scrutiny.

Given this history, is it reasonable to ask if PO is another effort by insurers to avoid regulatory scrutiny by simply calling a rating factor something else? And the answer is yes.
At this point, it is necessary to have a definition of rating factor. A rating factor is any characteristic of the consumer, vehicle or property utilized by the insurer to determine the premium charge. Rating factors must be risk classifications to comply with statutory rate standards; that is, a rating factor must related to expected costs of the transfer of risk – expected losses or expenses to issue and administer the policy.

By this definition of rating factor, PO is clearly a rating factor as it is based on individual consumer characteristics and is applied to individual consumers to determine the premium charge for that consumer. At once, it is now obvious that PO is an impermissible rating factor because it is not related to the cost of transfer of risk, as admitted by both Earnix and Towers Watson.

Simply stated, the definition of a rating factor must be a constant and not subject to re-definition any time insurers want to introduce new pricing methods without regulatory oversight.

The concept of a confidence interval around indicated rates misapplies a statistical concept to insurance ratemaking and regulation. The confidence interval is a function of choices made by the insurer in specifying the rate development model and, consequently, is subject to manipulation. It is incorrect that any rate within the confidence interval is as reasonable an estimate of the expect cost of risk transfer as the indicated rate.

A confidence interval is created around the output of a statistic or statistical model. The size and nature of the confidence interval is determined by inputs chosen by the modeler, including the type of probability distribution used and the size of the data set used (e.g., number of observations), among many other factors. Consequently, the size and nature of a confidence interval – like the results of the underlying ratemaking model – can be manipulated by the insurer.

In the Towers Watson presentation, an example was given showing an indicated rate of $500 and a confidence interval of $400 to $600. It is incorrect that a rate of $599 is as good an estimate of the expect cost of transfer of risk as $500.

Given that the size and nature of confidence intervals (as well as the results of the underlying ratemaking model) are subject to manipulation based on selected inputs and data and given that it is incorrect that any rate within an alleged confidence interval is as reasonable an estimate of the rate as the indicated rate, this third pillar of the PO justification crumbles.
While there are many issues within the world of insurance regulation that reasonable people can disagree upon, surely PO is not one of them. PO is clearly related to lessened auto insurance affordability for low- and moderate-income consumers.

As I wrap up, I ask regulators, do you accept all three pillars of insurer justification for PO?

If no, why haven’t you taken action?

If yes, how do you respond to the points raised by CEJ, CFA and others? I hope you will take the time during this meeting to explain why you accept the industry arguments.

The final thought I will leave you with is that PO means higher prices predominantly for those low- and moderate-income consumers least able to afford auto insurance because these are consumers living in communities with the least competition among auto insurer for business. PO means taking advantage of those with the fewest alternatives. Addressing PO is not only an issue of enforcing existing statutory standards regarding unfair discrimination, but also an issue essential to promoting greater affordability of insurance among those consumers for whom the cost of auto insurance is the greatest burden.
CEJ Recommendations for
A State-Based Insurance Market Regulation Accreditation Program
March 9, 2015

The current discussion about Market Regulation Accreditation reflects the long-standing tension between state insurance regulators on the one hand and industry and state legislators on the other hand. Industry and state legislators seek more detailed guidelines as requirements for market regulation actions generally and more guidelines and hurdles for market conduct examinations, specifically. Industry argues that market regulation is inefficient and costly for them, but their proposals all involve more procedures layered onto the current market conduct exam-focused infrastructure. The inevitable result will be either less effective market regulation because of additional hurdles that regulators need to leap to protect consumers or greater cost to regulated entities or both.

Market regulators recognize that industry proposals will have the effect of limiting state flexibility and capability to identify and address market problems. That is why states rightfully reject “domestic deference” for market regulation. And why states seek a voluntary – and not prescriptive – market regulation accreditation program.

The tension between regulators and industry on market regulation stems from a system centered on market conduct examinations increasingly carried out by contract examiners because of limited state resources for market regulation.

If we define success of state-based insurance market regulation as

- improved state capabilities for market analysis and enforcement
- improved effectiveness at pro-actively stopping market problems
- improved efficiency through enhanced market analysis and targeted use of continuum tools, and
- improved collaboration and consistency among states, then

CEJ suggests that for a market regulation accreditation program to be successful, it must be a set of resources that appeal to states and, consequently, that states want to participate in because the resources improve their abilities and efficiencies without limiting their ability to protect consumers.
CEJ suggests that an accreditation program that attracts states to participate in has the following foundation:

1. **Enhanced collection of market outcome data.** This means collection of granular, transaction level data from insurers about sales and claims – Regulatory Big Data. By collection of such data through a centralized source – such as the NAIC (in the same manner that the NAIC collects financial data for the states) – states will have access to the timely and relevant data necessary for establishing market analysis as the foundation of insurance market regulation.

2. **Enhanced market analysis capabilities.** With the collection of Regulatory Big Data comes the requirement for state regulators to possess the skills to utilize the detailed data. These skills include data mining, predictive analytics and modeling. Just as the NAIC employs a staff of skilled financial analysts to provide baseline and sophisticated analyses of financial data, so can the NAIC develop the staff capabilities to provide baseline and sophisticated analysis of granular market regulation data to assist the states.

By establishing a centralized data collection program for granular market regulation data with analytic skills to assist the states in utilizing the data, the states and the NAIC create a resource that will lead to greater effectiveness and efficiencies of market regulation and a path towards greater uniformity through voluntary state participation.

Greater efficiency and effectiveness results from more sophisticated and detailed market analysis, allowing states to better focus on problem markets and problem regulated entities, devoting fewer resources to unnecessary regulatory inquiries into those regulated entities playing by the rules and achieving solid market outcomes.

Greater uniformity results from more consistent and more sophisticated market analysis across the states. While states should always maintain the ability to address problems specific to their jurisdictions, enhanced and centralized market analysis will lead to more consistent market analysis across states and more consistent identification of problems or lack of problems. It is critical to stress that enhanced and centralized market analysis does not preclude state-specific market analysis or state-specific employment of continuum tools. Rather, enhanced and centralized market data collection with enhanced and centralized market analysis is a resource for states to utilize. It will be such a powerful and attractive resource that states will seek to participate in such a program – a program of the states housed at the NAIC. This is the path to accreditation – create a powerful and essential resource for the states that leads to greater effectiveness, efficiency and uniformity by states simply making use of the resource.
Regulatory Big Data collection is practical, feasible and reasonable. State regulators, often through the NAIC as well as individually, already collect transaction-level data from insurers and insurers report additional transaction level to advisory organizations.

Examples abound. The NAIC is embarking on transaction-level data collection for life insurance, annuities, disability insurance and long-term care insurance as part of the principles-based reserving initiative. Some of this builds on the current transaction-level reporting by insurers to the Medical Information Bureau.

Many states collect transaction-level directly or indirectly. Texas collects transaction data from all homeowners insurers and from the largest auto insurers comprising over 80% of the market. Most states have promulgated (or adopted) statistical plans for transaction detail reporting of workers compensation experience as well as personal and commercial lines experience for insurers reporting to the Insurance Services Office.

Regulatory Big Data collection is reasonable and necessary for regulators to monitor market outcomes in an era of insurer use of Big Data. The current data collection and rate regulation framework among the states was established during a period when regulators had extensive oversight of what went into insurer pricing – data collection by advisory organizations licensed and supervised by regulators with filing and review of rating manuals and risk classifications tied to the data collection of insurer experience. With such a regulatory regime, regulators could reasonably believe that effective oversight of what went into rates and underwriting could assure fair outcomes for consumers. But the world has changed and regulators no longer have the ability to meaningfully identify – let alone review – what goes into insurer marketing, pricing, claims and other activities. This is because of insurer use of Big Data – tapping into all manner of non-insurance databases of personal consumer information for data mining, predictive analytics and modeling. Again, example abound, from price optimization-based pricing based on consumer willingness to pay to other black-box scoring models used for marketing, identifying fraudulent claims, pricing and claims settlement. In an era when regulators do not have the resources to monitor insurer use of Big Data, it is imperative for regulators to monitor the market outcomes of insurer practices and such monitoring requires regulatory Big Data.

Regulatory Big Data collection and analysis creates regulatory opportunities which do not exist today. These opportunities include better and more sophisticated identification of market problems which will allow more refined and sophisticated regulatory intervention. Regulatory Big Data collection will allow states to develop exponentially-improved information for consumers to enhance consumer market power in an era when insurers’ market power has increased because of asymmetric information and knowledge. Today, insurers can instantly obtain detailed personal information about any applicant or policyholder, yet consumers have no greater knowledge of insurer market performance or practices today than 20 years ago.
Regulatory Big Data collection will drive efficiencies and uniformity in market conduct examinations. First, Regulatory Big Data will allow and compel states to focus on problem entities, reducing the regulatory burden on entities with good market outcomes for consumers. Second, Regulatory Big Data will expedite market conduct examination because regulators will already have the vast majority of data needed for sampling policies and claims. Stated differently, regulators will be able to do more exam preparation before initiating an exam and will be able to reduce the initial exam data request. Third, Regulatory Big Data will dramatically reduce the number (and cost on insurers) of ad hoc data calls. Fourth, Regulatory Big Data will dramatically improve the quality of data collected because it will be collected routinely. Routine data collection produces far more accurate and complete data than ad hoc requests both because insurers can fix problems over time and because the regulatory data collector has greater ability to check data for reasonableness and accuracy. Fifth, more consistent market analysis of a regulated entity’s across states will lead to more consistent conclusions about market performance and, consequently, more uniformity in regulatory response. Sixth, Regulatory Big Data will enhance and facilitate multi-state cooperation because of states’ use of common resources. The critical takeaway from this discussion is that the efficiencies and greater uniformity will occur by states wishing to participate in centralized Regulatory Big Data collection and analysis and not from prescriptive requirements on states.

Regulatory Big Data works hand-in-hand with the development and implementation by states of Core Competencies. One of the core competencies, however, must be improved capability for data collection (which might be satisfied with centralized data collection) and improved analytic skills. Just as insurers have turned to statisticians, economists and physicists to implement their Big Data initiatives, so must regulatory core competencies include sophisticated data analytics capabilities to make full use of Big Data Collection?

Regulatory Big Data also with process improvements for market conduct examinations and other continuum activities. But, making Regulatory Big Data collection and analysis the focus of a market regulation accreditation program places those process improvements in the proper context – refinement of ongoing procedures as opposed to establishing regulatory hurdles which do not improve the efficiency or effectiveness of market regulation.
In conclusion, a market regulation accreditation program based on a Regulatory Big Data initiative will take time – a five-year time horizon is reasonable – but will actually lead to greater effectiveness, efficiency and uniformity of insurance market regulation not because of unachievable prescriptions for the states but because of a path to essential resources that states will embrace. There is no quick fix to the problems facing insurance market regulation today, but Regulatory Big Data is a strategy to move market regulation towards the goals that all stakeholders seek. The problems facing insurance market regulation today are significant and won’t be solved by tinkering around the edges. Regulatory Big Data represents an initiative significant enough to address the big problems of insurance market regulation and secure the future of state-based insurance regulation.
Surprise Out-of-Network Medical Bills

Resources for Advocates & Regulators – download from: ConsumersUnion.org/Surprise-Medical-Bills

Case Study

A recent legislative victory in New York provides consumers with the strongest protections in the nation against surprise, out-of-network medical bills, including a mandatory arbitration provision for health plan-provider disputes.

This advocacy case study summarizes the consumer protections passed in New York, and describes the advocacy strategy that lead to the legislation.

State Report

New York’s insurance regulator reports that surprise out-of-network bills are the state’s leading consumer complaint about insurance issues, and analyzes the many different reasons consumers receive these bills.

The report proposed new consumer protections that later formed the core of the New York law enacted in March 2014.

Consumer Stories

Consumers Union collected over 80 stories from New York patients who received surprise medical bills for emergency and non-emergency care.

Patients express frustration about the high cost of care, and problems obtaining care from in-network providers, despite their best efforts.
Have You Experienced Medical Bill Shock? Around the U.S., consumers sometimes receive “surprise medical bills” they didn’t expect to receive, usually for care involving “out-of-network” services. Surprise out-of-network bills may range from small amounts to huge bills of $100,000 or more.

The surprise bills occur for a variety of reasons:
- Inadequate or outdated provider directories
- Difficulty comparing and understanding out-of-network coverage
- Difficulty identifying all the providers involved with an episode of care, in order to ensure they are in-network.
- High charges for emergency care, where in-network providers may be routinely not available
- “Drive-by-doctoring,” where consumers are not informed that out-of-network providers will be involved in their care; lack of appropriate consumer disclosures

These bills can be very large, due to:
- Low reimbursement levels for out-of-network care, and unexpected changes in health plan reimbursement practices
- Excessive charges by specialists and other providers that provide care outside of insurance networks.

State policymakers are beginning to consider new consumer protections to help patients avoid surprise bills. In March 2014, New York State passed a law (Chapter 60 of the Laws of 2014) to prevent surprise medical bills. Among other things, the law creates the following new protections:

1. Consumers are held harmless from out-of-network emergency bills and non-emergency claims, where an in-network provider was unavailable or disclosure of services provided by an out-of-network provider was not made. In these situations, consumers will be responsible only for their usual in-network cost-sharing, with no balance bill.

2. An independent arbitration process between providers and insurers will resolve disputes more quickly, and eliminate the need for patients to be involved in payment negotiations.

3. Plans offering out-of-network coverage are required to provide a minimum level of coverage for out-of-network services.

4. Plans must provide improved disclosure so consumers can understand reimbursement levels and have an idea of the amount their plan will cover for out-of-network services.

5. Plans must meet minimum network adequacy requirements.

6. Consumer external appeal rights were extended to include out-of-network referrals.

7. Plans will make it easier for consumers to submit out-of-network claims online and out-of-network doctors will have to include an insurance claim form with their bills.

Advocates in New York hope these protections can serve as a model for other states. The provisions directly address the problems that consumers face and represent a balanced compromise between the competing concerns of health providers and insurers. Our web site features the reports shown on the other side of this page, plus the full text of the bill, a bill summary and an archived webinar explaining the new consumer protections.

For more information, visit: ConsumersUnion.org/Surprise-Medical-Bills

Contact: Chuck Bell, Programs Director (914) 378-2507
         Lynn Quincy, Associate Director, Health Care Policy (202) 462-6262
HHS Proposed Policy On Non-Discrimination: Does It Adequately Protect Children?

On November 26, 2014, the United States Department of Health and Human Services (HHS) published a proposed 2016 Notice of Benefits and Payment Parameters, an omnibus regulation published annually that sets “rules of the road” for the administration of federally regulated insurance plans. Among other matters, this year’s Notice contained a discussion of non-discrimination in coverage.

The concept of non-discrimination in coverage is a basic tenet health plans subject to the Affordable Care Act (ACA)’s “essential health benefit” requirements applicable to non-grandfathered health plans sold in the individual and small group markets (42 U.S.C. §18022, added by PPACA §1302). The non-discrimination standard is a watershed in U.S. law that extends the reach of prior federal civil rights laws and regulates the design, content, and administration of health insurance including Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, Title VI and VII of the Civil Rights Act of 1964, and the Age Discrimination Act of 1975.

In accordance with its provisions, the HHS Secretary is barred from “mak[ing] coverage decisions, determin[ing] reimbursement rates, establish[ing] incentive programs, or design [ing] benefits that discriminate against individuals because of their age, disability, or expected length of life,” (42 U.S.C. §18022(b)(4)(B)). The provision further requires the Secretary to “take into account” the health needs of “diverse segments of the population including women, children, persons with disabilities, and other groups,” (42 U.S.C. §18022(b)(4)(C)).

As the nation continues to evolve toward a national health policy in which near-universal health insurance coverage is the norm, addressing insurance practices that limit the effectiveness of coverage based on age, disability, or other factors unrelated to the need for health care is an equally important aspect of this policy evolution. No population, least of all children, should experience coverage denials based on factors other than the appropriateness of care.

Insurance Coverage Benchmarks

The general approach taken by HHS to implementing the essential health benefit statute has been to devolve the Secretary’s powers and duties to interpret and apply the provisions of the law to states and insurers. Rather than articulating a broad national coverage standard, the essential health benefit regulations build on insurance coverage “benchmarks” specific to each state and drawn from that state’s private insurance market.

These benchmarks are in turn adjusted to reflect certain broad federal regulatory parameters that are designed to fill in and modify as needed certain key elements of the state’s benchmark (45 C.F.R. §156.110). For example, where a state benchmark fails to cover habilitation services (a required essential health benefit that improves or maintains skills needed for daily living), the regulations provide an adjustment in order to ensure that the state benchmark plan, once adjusted, reflects habilitation coverage.

The original essential health benefit regulations gave states and insurers considerable discretion to determine the precise parameters of essential health benefits. The 2014 Notice proposes to narrow this flexibility in order to correct what the Administration (correctly in our view) perceives as inadequacies of initial state and insurer approaches (79 Fed. Reg. 70717-70718).
The proposed rule similarly would narrow state and plan discretion over the design and administration of certain benefits, including habilitation services and prescription drug formularies (79 Fed. Reg. 70718-70721 [5]). The proposed changes, grounded in the ACA’s ban on discrimination based on factors unrelated to the need for health care, are indeed welcome.

**Non-Discrimination Standard**

Beyond addressing these specific issues of coverage, the proposed rule’s Preamble discusses the importance of this non-discrimination standard (79 Fed. Reg. 70722 [6]). The Department’s original implementing rule, 45 C.F.R. §156.125 [7], did little more than parrot the language of the statute [8]. Although the Department did not propose to alter the regulation itself, the Preamble described at some length the types of practices that would be considered to constitute discrimination (79 Fed. Reg. 70722-70723):

>[We] have become aware of benefit designs that we believe would discourage enrollment by individuals based on age or based on health conditions, in effect making those plan designs discriminatory . . . Some issuers have maintained limits and exclusions that were contained in the State EHB benchmark plan. . . . We caution both issuers and the States that age limits are discriminatory when applied to services that have been clinically effective at all ages. For example, it would be arbitrary to limit a hearing aid to enrollees who are 6 years of age or younger, since there may be some older enrollees for whom a hearing aid is medically necessary. Although we do not enumerate which benefits fall into each statutory EHB category, issuers should not attempt to circumvent coverage of medically necessary benefits by labeling the benefit as a “pediatric service”, thereby excluding adults.

Withholding clinically effective care from adults (or even older children and adolescents) on the basis of an inappropriate age cutoff is precisely the type of discriminatory activity that might have been lawful under prior law but that is nonetheless preempted under the essential health benefit statute.

Unfortunately however, as we reported in our recent Health Affairs [9] article, the Preamble overlooks the many instances in which children—in particular, children with mental disabilities—are the focus of unlawful limits and exclusions. In this regard, the Preamble furthermore misses an opportunity to clarify those situations in which age is, in fact, an important clinical factor in identifying what constitutes an appropriate level of pediatric coverage.

**A Patchwork Pediatric Coverage Standard**

In our article, we noted that the ACA gives the HHS Secretary the power to define a pediatric benefit standard at the national level. Our research into the benchmark plans for all 50 states and the District of Columbia found that no state benchmark contained a definition of pediatric services.

In fact, to the contrary, our review of the plans revealed wide variation in coverage for children and adolescents’ special health care needs. For example, we found variation by states regarding covered benefits affecting children with autism who need Applied Behavior Analysis therapy (ABA); hearing-impaired children who need hearing aids; and those who have a speech problem tied to developmental delays or stuttering, as well as coverage gaps because treatment allegedly would be available in school and therefore would be excluded as “educationally” related or tied to a child’s “behavior.”

Limits such as these have no place in health plans governed by the essential health benefits standard, which prohibits health plans from withholding clinically appropriate care based on age factors. Especially serious is the fact that federal laws governing the education of children with disabilities make no provision for payment of medical care covered by health insurance plans.

Despite the fact that the need for treatment for children with disabilities does not stop at state borders, the regulations, by their silence, countenance such variation. Furthermore, by
singling out coverage limits that favor children and not those that disadvantage them, the Preamble, through its silence, seems to countenance the exclusionary treatment of children. For this reason, we urged the Administration to articulate a minimum national pediatric coverage standard.

It goes without saying that states and insurers should not use children as a pretext to withhold appropriate covered services from adults. But the converse also is true; children should not be deprived of treatment simply because they also happen to go to school; indeed, allowing insurers to withhold covered services on this basis triggers severe and long-lasting damage, diminishing life prospects as well as health.

A further problem with the Preamble’s non-discrimination statement is its incompleteness. Not only does the Preamble limit its examples solely to those that disfavor adults, but it fails to explain the circumstances under which age limits would be appropriate. For example, how would states treat behavioral health therapies like Parent Children Interaction Therapy or Focused-Family Therapy which are uniquely pediatric in nature (albeit with a dual generation approach)?

Ultimately what is needed is a population-wide health insurance standard for children that aims for care of the highest quality. At a minimum, however, a clear articulation of non-discrimination in the context of pediatric coverage is of enormous and immediate importance.
NONDISCRIMINATION UNDER THE AFFORDABLE CARE ACT

Katie Keith, Kevin Lucia, and Christine Monahan

July 2013
The Health Policy Institute at Georgetown University is a multidisciplinary group of faculty and staff dedicated to conducting research on key issues in health policy and health services. In addition to this core research mission, the Institute also acts as a focal point for policy and health services research in the University and has provided support for the development of new, interdisciplinary health services research initiatives.

The Center on Health Insurance Reforms (CHIR), based at Georgetown University’s Health Policy Institute, is composed of a team of nationally recognized experts on private health insurance and health reform. CHIR faculty and staff study health insurance underwriting, marketing and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. CHIR provides policy expertise and technical assistance to federal and state policymakers, regulators, and stakeholders seeking a reformed and sustainable insurance marketplace in which all consumers have access to affordable and adequate coverage.

Acknowledgments

The authors thank the state insurance regulators who participated in this study for sharing their insights, reviewing our findings, and contributing thoughtful comments. We are also grateful to the insurance industry representatives and consumer and patient advocacy organizations who agreed to be interviewed and made invaluable contributions that informed our findings and analysis. We also thank Tim Jost, Sara Rosenbaum, and Karen Pollitz for their thorough review and incisive feedback on this report.
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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.
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. 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. 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). 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).

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. 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). 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. 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.

**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. 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). 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. Although critical to promoting access to coverage, these laws have been criticized as offering “relatively limited protections.”

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

<table>
<thead>
<tr>
<th>1964 Civil Rights Act</th>
<th>Mental Health Parity Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Discrimination in Employment Act</td>
<td>Mental Health Parity and Addiction Equity Act</td>
</tr>
<tr>
<td>Americans with Disabilities Act</td>
<td>Newborns’ and Mothers’ Health Protection Act</td>
</tr>
<tr>
<td>Employee Retirement Income Security Act</td>
<td>Pregnancy Discrimination Act</td>
</tr>
<tr>
<td>Genetic Information Nondiscrimination Act</td>
<td>Rehabilitation Act of 1973</td>
</tr>
<tr>
<td>Health Insurance Portability and Accountability Act</td>
<td>Women’s Health and Cancer Rights Act</td>
</tr>
</tbody>
</table>

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). For example, WHCRA requires insurers that offer mastectomy coverage to also cover breast reconstructive surgery, prostheses, and treatment of physical complications of the mastectomy. Despite these protections, enforcement has been mixed and many of these laws do not apply uniformly to all types of health insurance. 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.

State standards. States have historically been the primary regulators of private health insurance and typically enforce requirements that apply to the fully insured market. 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. Despite these broad standards, researchers have identified few explicit prohibitions against discrimination based on race, religion, gender, and age. (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. 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.

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. Mandates, while common, often generate controversy about the appropriate balance between comprehensive coverage and affordability.

Despite existing protections, discrimination in private health insurance persists in the individual and small group markets. Women continue to be charged more for coverage, insurers in most states can deny or limit coverage based on health status, and consumers may face high cost-sharing for chronic diseases. 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. 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. 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.
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. 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.

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

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

*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.

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.

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.)

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.)

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. 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.

In implementing this requirement, HHS asked state officials to select a “benchmark plan” to serve as reference point for coverage of essential health benefits. 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. 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.

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. These requirements are enforced by the Office of Civil Rights within HHS and apply broadly to include, for example, the exchanges in every state. Although HHS released guidance to clarify that Section 1557 includes discrimination based on gender identity and sex stereotyping, federal regulators have not yet issued implementing regulations. This delay, however, has not prevented challenges to insurer and employer practices under this new protection.

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.
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

<table>
<thead>
<tr>
<th>Cost-sharing</th>
<th>Waiting periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical necessity definitions</td>
<td>Service areas</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Rating</td>
</tr>
<tr>
<td>Narrow networks</td>
<td>Visit limits</td>
</tr>
<tr>
<td>Drug formularies</td>
<td>Marketing of products</td>
</tr>
<tr>
<td>Benefit substitution</td>
<td>Utilization management</td>
</tr>
</tbody>
</table>

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 actuarily 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.

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**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.40 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.”41 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. 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), 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. 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.

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. 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
favored 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.

2 Ibid.

3 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).


6 Ibid.

7 Rosenbaum, *supra* note 1, at 6-7.


9 Rosenbaum, *supra* note 1, at 6-14.


12 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 (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.


18 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 “discrimination] 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”).

19 Ronen Avraham, Kyle D. Logue & Daniel Schwarz, 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).

20 Crossley, supra note 1, at 99-105, 110, footnote 54.


23 Ibid. at 72-73.


26 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).

27 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.


33 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
plan, HHS defined a “default” benchmark plan as the largest small group plan based on enrollment. 45 C.F.R. § 156.100(c).

34 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”).

35 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’”)


37 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).


40 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 limitations for benefits with specific characteristics”).

41 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 CCIIIO 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”).

42 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.


44 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”).

45 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).

46 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.