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Insurer Accountability in the Next Generation of Health Reform

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INSURER ACCOUNTABILITY IN THE NEXT GENERATION OF HEALTH REFORM

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ABSTRACT

Democrats continue to debate how to extend health insurance coverage to the remaining uninsured and improve the affordability and quality of coverage and care. Prior intraparty debates—over whether to build upon the Affordable Care Act, create a public option, or expand the Medicare program to all (or more)—have centered on how to best accomplish these goals and whether health care delivery should be mediated through public versus private payers. These are worthwhile debates, but the history of health reform suggests that private health insurers are here to stay. This Article accepts the premise that future coverage expansions will likely rely on private insurers. Assuming so, I argue that more attention must be paid to holding these entities accountable for the government-subsidized benefits they offer. While the Affordable Care Act ushered in reforms that have addressed many historic insurance industry abuses, additional accountability measures are urgently needed to ensure access to care, increase affordability, and advance equity. This Article identifies several policy options that would help achieve these goals and could constitute part of an updated, post-Affordable Care Act patient bill of rights. Looking ahead, federal and state policymakers must pair coverage expansions with accountability mechanisms to maximize taxpayer value in subsidizing private coverage across a range of public programs.

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I. INTRODUCTION

The cost of health care remains a top concern for Americans.[1] This is unsurprising given ever-rising premiums, deductibles, and medical debt—to name just a few challenges.[2] Dysfunction in the health care system was on full display during the COVID-19 pandemic as we saw price gouging for testing,[3] sky-high bills for care,[4] surprise medical bills,[5] and a new wave of provider consolidation.[6] Given this dysfunction, it is no surprise that the United States outspends but lags behind other wealthy nations on access to care, administrative efficiency, and outcomes.[7] And even though the Affordable Care Act (ACA)

1. *See, e.g.*, Audrey Kearney et al., *Americans' Challenges with Health Care Costs*, KAISER FAM. FOUND. (Dec. 14, 2021), https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/ (describing the challenges that U.S. adults face in affording health care, filling prescriptions, and paying medical bills).

2. *See MITRE-Harris Poll Survey: 75% of Health-Insured Individuals in the U.S. Concerned About Medical Bills*, MITRE (Dec. 9, 2021), https://www.mitre.org/news/press-releases/mitre-harris-poll-survey-health-insured-individuals-concerned-medical-bills; Michael Karpman et al., *In the Years Before the COVID-19 Pandemic, Nearly 13 Million Adults Delayed or Did Not Get Needed Prescription Drugs Because of Costs*, URB. INST. (Dec. 1, 2021), https://www.urban.org/research/publication/years-covid-19-pandemic-nearly-13-million-adults-delayed-or-did-not-get-needed-prescription-drugs-because-costs; Gary Claxton et al., *2021 Employer Health Benefits Survey*, KAISER FAM. FOUND. (Nov. 10, 2021), https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf; A. Jay Holmgren et al., *The Increasing Role of Physician Practices as Bill Collectors: Destined for Failure*, 326 JAMA 695, 695 (2021); Raymond Kluender et al., *Medical Debt in the US, 2009-2020*, 326 JAMA 250, 251 (2021).

3. *See, e.g.*, Sarah Kliff, *This Lab Charges $380 for a Covid Test. Is That What Congress Had in Mind?*, N.Y. TIMES (Oct. 6, 2021), https://www.nytimes.com/2021/09/26/upshot/cost-of-covid-rapid-test-prices.html; *New Data Shows Continued Evidence of COVID-19 Testing Price Gouging*, AHIP (Jul. 20, 2021), https://www.ahip.org/new-data-shows-continued-evidence-of-covid-19-testing-price-gouging.

4. *See, e.g.*, Sarah Kliff, *Covid Killed His Father. Then Came $1 Million in Medical Bills*, N.Y. TIMES (May 21, 2021), https://www.nytimes.com/2021/05/21/upshot/covid-bills-financial-long-haulers.html; Joseph Goldstein, *She Survived the Coronavirus. Then She Got a $400,000 Medical Bill*, N.Y. TIMES (June 15, 2020), https://www.nytimes.com/2020/06/14/nyregion/coronavirus-billing-nyc.html.

5. *See, e.g.*, Sarah Kliff, *A $52,112 Air Ambulance Ride: Coronavirus Patients Battle Surprise Bills*, N.Y. TIMES (Oct. 22, 2021), https://www.nytimes.com/2020/10/13/upshot/coronavirus-surprise-medical-bills.html.

6. *See, e.g.*, Reed Abelson, *Buoyed by Federal Covid Aid, Big Hospital Chains Buy Up Competitors*, N.Y. TIMES (Oct. 22, 2021), https://www.nytimes.com/2021/05/21/health/covid-bailout-hospital-merger.html; Richard M. Scheffler & Laura Alexander, *Consolidation of Hospitals During the COVID-19 Pandemic: Government Bailouts and Private Equity*, MILBANK Q. OPINION (July 20, 2021), https://www.milbank.org/quarterly/opinions/consolidation-of-hospitals-during-the-covid-19-pandemic-government-bailouts-and-private-equity/.

7. *See* ERIC C. SCHNEIDER ET AL., COMMONWEALTH FUND, MIRROR, MIRROR 2021: REFLECTING POORLY – HEALTH CARE IN THE U.S. COMPARED TO OTHER HIGH-INCOME COUNTRIES 4 (2021) (comparing the performance of health care systems of eleven high-income

narrowed health disparities, underserved communities—such as people of color, low-income people, and LGBTQ people, among others—continue to face significant challenges and disparities in accessing coverage and care.[8]

Policymakers disagree on how to confront these multifaceted challenges. Despite several bipartisan laws enacted in 2020,[9] a significant divide remains between Democrats and Republicans when it comes to coverage policy.[10] Of course, disagreement *between* the two parties is not new—and sometimes masks disagreement *within* the two parties, which is the focus of this Article.

Debates over the future of health care reform dominated the Democratic primary ahead of the 2020 election—and continued as Congress considered the scope of the so-called Build Back Better Act.[11] These debates focus not on *whether* to improve upon the ACA and correct the law's perceived shortcomings—but on *how much* change to make and whether health care delivery should be mediated primarily through public or private payers.[12]

countries and concluding that the United States trails "far behind" other high-income countries on key measures).

8. *See, e.g.*, Roni Caryn Rabin, *Racial Inequities Persist in Health Care Despite Expanded Insurance*, N.Y. TIMES, https://www.nytimes.com/2021/08/17/health/racial-disparities-health-care.html (last updated Aug. 29, 2021); Nambi Ndugga & Samantha Artiga, *Disparities in Health and Health Care: 5 Key Questions and Answers*, KAISER FAM. FOUND. 5 (2021), https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/.

9. *See* Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, § 103, 134 Stat. 2758, 2797 (2020) (to be codified at 42 U.S.C. § 300gg111) (protecting patients from the most pervasive types of surprise out-of-network medical bills); Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, § 3201, 134 Stat. 366 (2020) (requiring insurers and group health plans to cover COVID-19 vaccines without cost-sharing); Families First Coronavirus Response Act, Pub. L. No. 116-127, § 6001, 134 Stat. 201 (2020) (requiring insurers and group health plans to cover COVID-19 testing without cost-sharing).

10. *Perspective: How U.S. Health Policy May Play Out Given Partisan Divide*, HARV. T.H. CHAN SCH. PUB. HEALTH, https://www.hsph.harvard.edu/news/hsph-in-the-news/perspective-how-u-s-health-policy-may-play-out-given-partisan-divide/ (last visited Feb. 24, 2022); John E. McDonough, *Republicans have Stopped Trying to Kill Obamacare. Here's What They're Planning Instead.*, POLITICO (Apr. 26, 2022, 4:30 AM), https://www.politico.com/news/magazine/2022/04/26/gop-obamacare-aca-health-care-00027585.

11. Nicole Rapfogel et al., *The Build Back Better Act Would Improve Health Care and Lower Costs*, CTR. AM. PROGRESS (Dec. 6, 2021), https://www.americanprogress.org/article/the-build-back-better-act-would-improve-health-care-and-lower-costs/ (summarizing the health care policies included in the House-passed version of the Build Back Better Act); *see* Dylan Scott, *The Real Differences Between the 2020 Democrats' Health Care Plans, Explained*, VOX (Dec. 19, 2019, 8:00 AM), https://www.vox.com/policy-and-politics/2019/12/19/21005124/2020-presidential-candidates-health-care-democratic-debate.

12. Jacob Pramuk, *'Medicare-for-All' vs. the Public Option: How Health Care Could Shape the Democratic Primary Race to Take on Trump in the 2020 Election*, CNBC (Mar. 10, 2019, 10:53 AM), https://www.cnbc.com/2019/03/06/2020-democratic-primary-candidates-weigh-medicare-for-all-public-option.html (noting that "[t]he differences on health care in the Democratic primaries essentially come down to how dramatically to build out the public Medicare and Medicaid

At one end of the spectrum is single-payer legislation. A single-payer system would severely limit private health insurance, which advocates argue is necessary to control costs, simplify the health care system, eliminate profit motivations, and ensure that health care is guaranteed.[13] Adding a public health insurance option—a policy embraced by President Biden—generally falls in the middle of the spectrum.[14] Most public option proposals would leverage Medicare or Medicaid to compete against private health insurance while preserving a multi-payer system. At the other end of the spectrum, expanding or bolstering the ACA marketplaces would rely entirely on private health insurance with no competition from a public payer, such as Medicare or Medicaid.

Democrats will continue to debate the role of public versus private insurance in the nation's health care system. This debate is important and should continue. But a shift to a fully public payer system may not be reconcilable, at least not in the near-term, with our current system that relies on a mix of public and increasingly private insurers to provide for health care benefits.[15] The debate over public versus private coverage often obscures this reality and assumes that little can be done to reform the practices of private insurers for the greater good. The ACA proves that this is not true but also shows how challenging it can be to hold private insurers accountable—even as we distribute billions in taxpayer dollars to subsidize their products.[16]

This Article first explains how Congress has repeatedly turned to private health insurers when expanding coverage. With an emphasis on reforms ushered in by the ACA, this Article describes how current law has banned or limited many historic insurance industry abuses while also identifying some of the ways that private insurers are failing to ensure access to care, increase affordability, and advance equity. These data suggest that additional accountability measures are needed to realize the goals of health reform and that policymakers could do more to protect consumers. Finally, this Article identifies a non-exhaustive list

programs"); *see* Scott, *supra* note 11 (noting that the "most pronounced difference between the Democratic health care plans" is whether care is financed through a single government program or a multi-payer system that includes private insurers).

13. LINDA J. BLUMBERG & JOHN HOLAHAN, THE PROS AND CONS OF SINGLE-PAYER HEALTH PLANS 3–5 (2019), https://www.urban.org/sites/default/files/publication/99918/pros_and_cons_of_a_single-payer_plan.pdf.

14. *See* Pramuk, *supra* note 12 (discussing the health care policies of Democratic presidential contenders and describing a public option as "a more incremental step" relative to single payer proposals).

15. *See* Bob Rosenblatt, *Healthcare History: How the Patchwork Coverage Came to Be*, L.A. TIMES (Jan. 3, 2013, 9:47 AM), https://www.latimes.com/health/la-he-health-insurance-history-20120227-story.html (chronicling the development of private health insurance and a multi-payer health care system in the United States).

16. *See* Joseph R. Antos & James C. Capretta, *The ACA: Trillions? Yes. A Revolution? No.*, HEALTH AFFS. (Apr. 10, 2020), https://www.healthaffairs.org/do/10.1377/forefront.20200406.93812/full/.

of new policies that federal and state officials should consider to ensure that taxpayer-subsidized private coverage meets the needs of enrollees and accomplishes broader health reform goals.

II. THE ROLE OF PRIVATE HEALTH INSURANCE IN HEALTH REFORM

Current debates about the role of private insurance underscore the complexity of the United States' fragmented health care system. This system—which was largely unplanned—consists of a patchwork of public and private health insurance programs.[17]

Private health insurance first emerged in the 1930s.[18] Thanks to a wage freeze and tax rulings during World War II, health insurance would soon become enshrined as a job-based benefit for millions of Americans—at least those who could secure higher-paying jobs.[19] Employer-sponsored health insurance soon became, and remains, the primary source of coverage in the United States[20] and is the nation's single largest tax expenditure.[21]

While many working-age people obtained private health insurance through their job, this left significant gaps for those outside of the workforce.[22] To fill some of these gaps, Congress created the Medicare and Medicaid programs in 1965 to provide coverage and care for older adults, low-income families, and those with disabilities.[23] While some presidents and members of Congress continued to champion a national health care system, these efforts failed,[24] and Congress adopted more incremental reforms throughout the 1990s and early

17. Rosenblatt, *supra* note 15.

18. TIMOTHY STOLTZFUS JOST, NAT'L ACAD. SOC. INS., THE REGULATION OF PRIVATE HEALTH INSURANCE 8 (2009) ("Health insurance in its contemporary form can be traced to the hospital prepayment plan offered by Baylor Hospital to the white public school teachers in Dallas, Texas in 1932.").

19. *See* Aaron E. Carroll, *The Real Reason the U.S. Has Employer-Sponsored Health Insurance*, N.Y. TIMES (Sept. 5, 2017), https://www.nytimes.com/2017/09/05/upshot/the-real-reason-the-us-has-employer-sponsored-health-insurance.html (tracing the history of employer-sponsored coverage).

20. KATHERINE KEISLER-STARKEY & LISA N. BUNCH, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2020 3 (2021), https://www.census.gov/content/dam/Census/library/publications/2021/demo/p60-274.pdf.

21. *Tax Expenditures*, U.S. DEP'T TREASURY, https://home.treasury.gov/policy-issues/tax-policy/tax-expenditures (last visited Feb. 25, 2022) (identifying the exclusion of employer contributions for medical insurance premiums and medical care as the largest tax expenditure at an estimated cost of $3,005,860,000,000 from fiscal year 2022 to 2031).

22. KEISLER-STARKEY & BUNCH, *supra* note 20, at 8.

23. 42 U.S.C. §§ 1395–96.

24. *See generally* JILL S. QUADAGNO, ONE NATION, UNINSURED: WHY THE U.S. HAS NO NATIONAL HEALTH INSURANCE 9–11 (Oxford Univ. Press ed., 2005).

2000s.[25] This was followed by the ACA, enacted in 2010.[26] Even after historic coverage gains under the ACA, about twenty-eight million people were uninsured in 2020.[27]

A. Blurring the Line Between Public and Private Coverage

The nation's health care system reflects a patchwork of public and private coverage sources.[28] But even our public coverage is increasingly dominated by private insurers,[29] blurring the line between public and private coverage. Indeed, most major coverage expansions from the past two decades have further entrenched the role of private insurers. Even when Congress has bolstered public coverage programs—by, say, creating the Medicare Part D program[30] or expanding the Medicaid program[31]—Congress (and those implementing the policy, such as states) have relied heavily on private insurers to deliver new benefits.

Private health insurers *already* play a significant role in many of our current public coverage programs. In programs like Medicare and Medicaid, federal and state officials contract with private insurers to provide health care coverage to beneficiaries.[32] In contrast to a fee-for-service model (where the government pays providers for health care claims), these arrangements are capitated, meaning the government pays private plans a fixed monthly amount per beneficiary.[33] This can incentivize private plans to manage beneficiary care efficiently and effectively, or it can lead private plans to limit care and expenditures to maximize profit.

Medicaid, the nation's single largest payer of health care services, is dominated by managed care companies, which are private insurers that contract

25. Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d; Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2874 (1997); Children's Health Insurance Program, § 1387aa–mm; Medicare Prescription Drug, Improvement, and Modernization Act of 2003, §§1395w-101–54.

26. §§ 18001–22.

27. KEISLER-STARKEY & BUNCH, *supra* note 20, at 2.

28. Rosenblatt, *supra* note 15.

29. *See* Karen Pollitz et al., *What's the Role of Private Health Insurance Today and Under Medicare-for-All and Other Public Option Proposals?*, KAISER FAM. FOUND. 3 (July 30, 2019), https://www.kff.org/health-reform/issue-brief/whats-the-role-of-private-health-insurance-today-and-under-medicare-for-all-and-other-public-option-proposals/ (explaining the role that private insurers play in providing health coverage under Medicare and Medicaid).

30. Thomas R. Oliver et al., *A Political History of Medicare and Prescription Drug Coverage*, 82 MILBANK Q. 283, 289–90 (2004).

31. Cynthia Cox et al., *Potential Costs and Impact of Health Provisions in the Build Back Better Act*, KAISER FAM. FOUND. (Nov. 23, 2021), https://www.kff.org/health-costs/issue-brief/potential-costs-and-impact-of-health-provisions-in-the-build-back-better-act/.

32. Pollitz et al., *supra* note 29.

33. *Id.* at 4.

with state Medicaid programs to serve Medicaid beneficiaries.[34] In 2019, more than two-thirds (sixty-nine percent) of all Medicaid beneficiaries were enrolled in comprehensive risk-based managed care.[35] All but ten states use managed care, and states increasingly use managed care to serve children, low-income adults, and more medically complex beneficiaries and to provide long-term services and supports.[36] In thirty-two states, about seventy-nine percent of children enrolled in the Children's Health Insurance Program (CHIP) in 2018 were enrolled in managed care.[37]

Private plans also play an increasingly outsized role in Medicare: in conjunction with traditional Medicare, as an alternative to traditional Medicare, and in the delivery of prescription drug benefits. Private plans were included at the onset of the Medicare program, but enrollment was uneven for the first several decades.[38] Enrollment only began to rise following enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which raised payments to Medicare Advantage plans and created new private plan options.[39]

Enrollment has risen steadily ever since: in 2021, forty-two percent of all Medicare beneficiaries—about 26.4 million people—were enrolled in private Medicare Advantage plans, and the Congressional Budget Office expects enrollment to rise to fifty-one percent by 2030.[40] Growth in Medicare Advantage

34. *Id.* at 3.

35. *Total Medicaid MCO Enrollment*, KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/ (last visited Feb. 27, 2022).

36. Elizabeth Hinton et al., *10 Things to Know About Medicaid Managed Care*, KAISER FAM. FOUND. (Oct. 29, 2020), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/; *see also Medicaid Managed Care Penetration Rates by Eligibility Group*, KAISER FAM. FOUND., https://www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/ (last visited Feb. 27, 2022) (showing that managed care provides ninety percent of coverage to Medicaid eligible children in twenty-six states, expansion adults in twenty-one states, the aged and disabled in seventeen states, and all other eligible adults in nineteen states).

37. *Medicaid & Children's Health Insurance Program (CHIP) Managed Care Final Rule – CMS-2408-F*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Nov. 9, 2020), https://www.cms.gov/newsroom/fact-sheets/medicaid-childrens-health-insurance-program-chip-managed-care-final-rule-cms-2408-f.

38. Yash M. Patel & Stuart Guterman, *The Evolution of Private Plans in Medicare*, COMMONWEALTH FUND (Dec. 8, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare.

39. *Id.*

40. Meredith Freed et al., *Medicare Advantage in 2021: Enrollment Update and Key Trends*, KAISER FAM. FOUND. (Jun. 21, 2021), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/ (citing current enrollment data and the Congressional Budget Office's baseline projections for 2020). Enrollment in Medicare Advantage is even greater among people of color: in 2018, about half of all Black and Hispanic beneficiaries, fifty and fifty-four percent, respectively, were enrolled in a Medicare Advantage plan, compared to only thirty-six percent of White beneficiaries. Nancy Ochieng et al., Racial and Ethnic Health

appears to be continuing in 2022.[41] Even those with traditional Medicare often purchase supplemental private coverage, generally known as a Medigap policy, to help reduce cost-sharing under Medicare Parts A and B and help provide some extra benefits.[42]

A major Medicare benefit—the coverage of outpatient prescription drugs—is delivered exclusively by private insurers.[43] The Medicare Part D program was established by the MMA during which "policymakers went to great lengths to ensure that the new prescription drug benefits will be administered principally by private companies and not by the federal government."[44] Medicare beneficiaries can enroll in a stand-alone private prescription drug plan under Medicare Part D or through a Medicare Advantage plan.[45] Enrollment in stand-alone Medicare Part D plans has fallen over time as enrollment in Medicare Advantage plans has increased.[46]

Congress prioritized private health insurance coverage in the ACA as well. Rather than overhaul the health care system, the ACA was purposely designed to minimize disruption, especially for the many millions of people with private coverage offered by larger employers.[47] Though far more disruptive to the individual and small group markets, the ACA relied on private insurers to offer marketplace coverage and then subsidized the costs of these private plans for low- and middle-income people.[48] A public option that would have competed

Inequities and Medicare, KAISER FAM. FOUND. (Feb. 16, 2021), https://www.kff.org/report-section/racial-and-ethnic-health-inequities-and-medicare-sources-of-coverage/.

41. Bob Herman, *The Big Medicare Advantage Players Keep Getting Bigger*, AXIOS (Jan. 19, 2022), https://www.axios.com/medicare-advantage-2022-enrollment-unitedhealth-humana-4e5557ba-6818-4fa9-aa99-68e7e95ed77f.html ("Six health insurers control roughly three-quarters of the fast-growing Medicare Advantage market, according to an Axios analysis of federal data.").

42. Wyatt Koma et al., *A Snapshot of Sources of Coverage Among Medicare Beneficiaries in 2018*, KAISER FAM. FOUND. (Mar. 23, 2021), https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries-in-2018/.

43. *Part D / Prescription Drug Benefits*, CTR. FOR MEDICARE ADVOC., https://medicareadvocacy.org/medicare-info/medicare-part-d/ (last visited Feb. 27, 2022).

44. Oliver et al., *supra* note 30, at 289–90.

45. *Id.* at 316–17.

46. *An Overview of the Medicare Part D Prescription Drug Benefit*, KAISER FAM. FOUND. (Oct. 13, 2021), https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/.

47. *See Weekly Address: President Obama Outlines Goals for Health Care Reform*, WHITE HOUSE: PRESIDENT BARACK OBAMA (June 5, 2009), https://obamawhitehouse.archives.gov/the-press-office/weekly-address-president-obama-outlines-goals-health-care-reform (noting the president's statement that individuals who liked their current plans would not be forced to change them under the ACA, minimizing disruption).

48. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1311, 1401, 1402, 124 Stat. 119, 173, 213, 220 (2010) (establishing health exchanges, premium tax credits, and cost-sharing for qualified plans, respectively); KAISER FAM. FOUND., FOCUS ON HEALTH REFORM: SUMMARY OF THE AFFORDABLE CARE ACT 1–2 (2013), https://files.kff.org/attachment/fact-sheet-summary-of-the-affordable-care-act.

alongside private insurers—heralded by advocates as both a counterweight to private insurers and a waystation on the transition towards a single-payer system—was considered during the debate over the ACA but ultimately left out of the final legislation due to political opposition by moderate Democrats.[49] In its most significant attempt to expand public coverage, the ACA extended eligibility for the Medicaid program to low-income adults; this expansion applied in every state but was ultimately made unenforceable (and thus optional) for states by the Supreme Court.[50] As noted above, most expansion enrollees are enrolled in Medicaid managed care, though this was not required by the ACA.[51]

B. Why Private Health Insurance?

There are practical and political reasons for why private health insurance has become so dominant, even in public programs. Practically, it may be more efficient for government officials to contract with private insurers rather than build their own capacity to manage significant new programs or grow existing programs. Leveraging private insurers to deliver public benefits requires less direct work by federal officials who may not have the staff, expertise, or other resources to develop provider networks, create new administrative processes, and hire new staff with appropriate expertise.[52]

Politically, there are strong lobbies in favor of private (over public) coverage.[53] This includes private health insurers themselves, as well as

49. Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFFS. 1117, 1117 (2010). The ACA also authorized Consumer Operated and Oriented Plans and Multi-State Plans as pseudo-alternatives to the public option, but both programs were unsuccessful at competing with private insurers. *See* Phil Galewitz, *Obamacare Co-Ops Down from 23 to Final '3 Little Miracles'*, KAISER HEALTH NEWS (Sept. 9, 2020), https://khn.org/news/obamacare-co-ops-down-from-23-to-final-3-little-miracles (noting only three ACA-authorized nonprofit health insurance co-ops remain); Jonathan Foley et al., *For Policy Makers Looking to Expand Coverage, Lessons from the Demise of the ACA's Multi-State Plan Program,* HEALTH AFFS. (Sept. 30, 2019), https://www.healthaffairs.org/do/10.1377/forefront.20190927.150599/full/ (discussing the decision to end the Multi-State Plan Program).

50. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 585 (2012); KAISER FAM. FOUND., *supra* note 48, at 1.

51. Hinton et al., *supra* note 36.

52. *See, e.g.*, Jeff Stein & Rachel Roubein, *White House Seeks to Speed Potential Medicare Dental Expansion in Face of Expected Delays*, WASH. POST (Sept. 1, 2021, 1:38 PM), https://www.washingtonpost.com/us-policy/2021/09/01/white-house-medicare-dental/. The authors described concerns raised by federal officials about implementation of a potential new dental benefit in Medicare and estimating that it could take three to five years to implement these changes. *Id.* Cited challenges include vetting thousands of new dentists for the Medicare system and devising a new pricing system for reimbursement of dentists. *Id.* To speed implementation of this new benefit, one option under consideration by policymakers was "working with private dental companies with access to better data." *Id.*

53. *See* Robert Pear, *Health Care and Insurance Industries Mobilize to Kill 'Medicare for All'*, N.Y. TIMES (Feb. 23, 2019), https://www.nytimes.com/2019/02/23/us/politics/medicare-for-all-

hospitals, physicians, and other providers that prefer the higher rates paid by private health insurers over lower public payer rates.[54] Capitation can also be an attractive model for policymakers in search of budget predictability, improved access to care, and cost control. Some policymakers also have an ideological preference for private coverage.[55]

Federal and state policymakers also tend to want to tweak existing policies or fill gaps in the current system as opposed to tearing down and starting anew. Even if starting anew would be more efficient or equitable, leaders are often reluctant to make changes that would disrupt the lives of their constituents.[56]

This history does not mean that expansions to public coverage are impossible or not worth pursuing. But private insurers may be enduring given their role in financing care for millions of people through job-based coverage, individual coverage, Medicaid, Medicare, and more.[57] If we assume, then, that private health insurers are here to stay, we must turn to better ways to hold these entities accountable for the government-subsidized benefits they offer.

III. INSURER ACCOUNTABILITY UNDER CURRENT LAW

The ACA dramatically improved the availability, affordability, and adequacy of private health insurance, especially for those who purchase coverage in the individual and small group markets.[58] Among its other changes, the law included new market reforms that set heightened standards for private insurers.[59] Many of these reforms—such as guaranteed access to coverage, a ban

lobbyists.html (noting extensive lobbying efforts by the health care and insurance industries to oppose public coverage options such as "Medicare for All").

54. *See* Adam Cancryn, *The Army Built to Fight 'Medicare for All'*, POLITICO (Nov. 25, 2019, 5:08 AM), https://www.politico.com/news/agenda/2019/11/25/medicare-for-all-lobbying-072110 (discussing how health insurance companies, hospitals, drugmakers, and physicians came together to lobby against "Medicare for All," in part due to the lower reimbursement rates they would receive under a public coverage option).

55. Alan C. Monheit, *Ideology, Politics, and Health Care Reform*, 44 INQUIRY: J. HEALTH CARE ORG., PROVISION, & FIN. 377, 377 (2007) (discussing how differences regarding health care reform are based on opposing ideologies).

56. *See* Sean Illing, *Two Eminent Political Scientists: The Problem with Democracy Is Voters*, VOX (June 24, 2017, 12:12 PM), https://www.vox.com/policy-and-politics/2017/6/1/15515820/donald-trump-democracy-brexit-2016-election-europe (noting how people blame politicians when their lives are disrupted, and they vote based on momentary feelings rather than views of how a policy will improve or hurt their life in the long-run); *see* Terry M. Moe, *The Politics of the Status Quo*, *in* OUR SCHOOLS AND OUR FUTURE . . . ARE WE STILL AT RISK? 177, 178 (Paul E. Peterson ed., 2003) (noting that most successful educational reforms maintain the status quo and do not create large disruptions to people's lives).

57. *See* Pollitz et al., *supra* note 29, at 2 (noting the majority of Americans have health coverage through a private insurer).

58. *See* KAISER FAM. FOUND., *supra* note 48, at 2, 3 (discussing how the cost-sharing and premium subsidies increased affordability for health insurance).

59. *See id.* at 1 (noting the new regulations on private health insurance plans).

on preexisting condition exclusions, a ban on lifetime and annual dollar limits, modified community rating, and the coverage of a minimum set of essential health benefits—were revolutionary and a stark departure from the relatively limited federal regulation of private health insurance up to that point.[60]

This Part does not describe every component of the ACA, but rather identifies key reforms to improve insurer accountability, and it provides a brief assessment of whether those reforms have met this goal. Several of these provisions were previously considered in Congress but not enacted until the ACA,[61] becoming part of the ACA known as the "patient's bill of rights," a set of policies that went into effect on September 23, 2010.[62] These reforms ended some of the insurance industry's most hated practices and remain some of the ACA's most popular provisions even today.[63]

A. Rescissions

The ACA banned rescissions, the retroactive cancellation of an enrollee's coverage once they became sick, except in the narrowest of circumstances.[64] Rescissions often followed a practice known as post-claims underwriting.[65]

60. *See* BERNADETTE FERNANDEZ, ET AL., CONG. RSCH. SERV., R45146, FEDERAL REQUIREMENTS ON PRIVATE HEALTH INSURANCE PLANS 3 (2018) (noting many of the federal regulations on private health insurance were either established by or expanded under the ACA); OFF. HEALTH POL'Y, U.S. DEP'T HEALTH & HUM. SERVS., THE REGULATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET, at 3, 24–28 (2008), https://aspe.hhs.gov/sites/default/files/private/pdf/75786/report.pdf (showing that prior to the ACA, most private individual health insurance plans were regulated primarily at the state level).

61. Most of these early market reforms were considered by prior congresses. *See* Katie Keith et al., *Implementing the Affordable Care Act: State Action on Early Market Reforms*, COMMONWEALTH FUND 10 n.2 (Mar. 2012), https://www.commonwealthfund.org/publications/issue-briefs/2012/mar/implementing-affordable-care-act-state-action-early-market (describing the history of many of the provisions that would become the ACA's patient bill of rights).

62. *See, e.g.*, Center for Consumer Info. & Ins. Oversight, *The Affordable Care Act's New Patient's Bill of Rights*, CTRS. MEDICARE & MEDICAID SERVS. (June 22, 2010), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca-new-patients-bill-of-rights ("The Affordable Care Act cracks down on the some of the most egregious practices of the insurance industry while providing the stability and the flexibility that families and businesses need to make the choices that work best for them."); Timothy Jost, *Implementing Health Reform: A Patient Bill of Rights*, HEALTH AFFS. (June 23, 2010), https://www.healthaffairs.org/do/10.1377/hblog20100623.005486/full.

63. Liz Hamel et al., *5 Charts About Public Opinion on the Affordable Care Act and the Supreme Court*, KAISER FAM. FOUND. (Dec. 18, 2020), https://www.kff.org/health-reform/poll-finding/5-charts-about-public-opinion-on-the-affordable-care-act-and-the-supreme-court/.

64. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2712, 124 Stat. 119, 131 (2010).

65. Insurers are prohibited from retroactively cancelling coverage except in the case of fraud or intentional misrepresentation of a material fact. *See, e.g.*, Gary Claxton et al., *Pre-Existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*,

After an enrollee needed care, their insurer would revisit their original application for coverage.[66] Insurers would pore over the details of the application to look for evidence that the consumer made a mistake on the application.[67] If a mistake was found, the insurer would argue that it never would have issued the policy in the first place and retroactively cancel the coverage, treating the patient as if they were never insured and leaving the patient liable for all medical bills dating back to the beginning of the policy.[68]

Rescissions were disruptive to care and financially devastating for families whose insurance did not work when they needed it most.[69] This practice received a significant amount of negative attention leading up to the ACA.[70] Congress held hearings and conducted investigations[71] while news outlets covered heartbreaking stories of patients whose life-saving care was denied after a rescission.[72]

The ban on rescissions created a bright-line rule and changed industry practice by prohibiting insurers from cancelling coverage just because an enrollee needed care. Combined with other ACA requirements for standardized enrollment processes and benefits, the ACA provision prohibiting rescissions has been effective at ending this practice and protecting consumers from arbitrary rescissions.[73]

KAISER FAM. FOUND. (Dec. 12, 2016), https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/.

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.* at 14.

70. *See* John Reichard, *Benefit 'Rescissions' Prompt Wider Waxman Probe of Insurers*, COMMONWEALTH FUND (Jul. 17, 2008), https://www.commonwealthfund.org/publications/newsletter-article/benefit-rescissions-prompt-wider-waxman-probe-insurers (describing patient stories, media coverage, and a congressional hearing on rescissions).

71. *E.g.*, *Termination of Individual Health Policies by Insurance Companies, Hearing Before Subcomm. on Oversight and Investigations of the Comm. on Energy and Com. H. R.*, 111th Cong. (2009); Reichard, *supra* note 70 (summarizing a 2008 hearing on rescissions before the House Oversight and Government Reform Committee).

72. *See, e.g.*, Julie Rovner, *Health Insurance Changes Come Too Late for Some*, NAT'L PUB. RADIO (Sept. 23, 2010, 7:55 AM), https://www.npr.org/templates/story/story.php?storyId=130040790; Murray Waas, *Insurer Targeted HIV Patients to Drop Coverage*, REUTERS (Mar. 17, 2010, 7:37 AM), https://www.reuters.com/article/us-insurers-idUSTRE62G2DO20100317; Alice Gomstyn, *Health Insurance Insider: 'They Dump the Sick'*, ABC NEWS (June 23, 2009, 3:39 PM), https://abcnews.go.com/Business/Health/story?id=7911195&page=1; Joanne Silberner, *Insurers Revoke Policies to Avoid Paying High Costs*, ST. LOUIS NAT'L PUB. RADIO (June 22, 2009, 12:01AM), https://www.npr.org/templates/story/story.php?storyId=105680875; Lisa Girion, *Anthem Blue Cross Sued over Rescissions*, L.A. TIMES (Apr. 17, 2008, 12:00 AM), https://www.latimes.com/business/la-fi-insure17apr17-story.html; Lisa Girion, *Health Net Ordered to Pay $9 Million After Canceling Cancer Patient's Policy*, L.A. TIMES (Feb. 23, 2008, 12:00 AM), https://www.latimes.com/business/la-fi-insure23feb23-story.html.

73. Claxton, *supra* note 65.

B. Appeals Processes

The ACA ensured that all enrollees have the right to appeal decisions made by their insurer. Though there were some appeals standards that predated the ACA, these requirements varied and had gaps.[74] The ACA created uniform standards for internal and external appeals processes that apply to all non-grandfathered health insurance plans.[75] Enrollees whose claims are denied can first file an internal appeal with their insurer.[76] If the insurer upholds their decision to deny payment, then the enrollee can appeal to an independent entity to review the insurer's determination.[77]

Denied claims are often reversed on appeal, but few consumers file an appeal.[78] Data from 2019 suggests that 119 marketplace insurers denied 40.4 million claims, and that consumers appealed fewer than 64,000 of these denials—an appeals rate of only 0.2%.[79] Of appealed denials, about forty percent were reversed in favor of the patient.[80] The data is even more sobering for external review: of the fifty-five marketplace insurers that reported data on external appeals from 2019, only thirty-one insurers had more than ten external appeals, suggesting that fewer than one in 20,000 denied claims are ever appealed to external review entities.[81]

The right to appeal is critical to vindicating consumer rights, but these data suggest that these rights are underutilized.[82] The low number of external reviews, in particular, may reflect the fact that not all denials are eligible for this process under regulations put in place by the Obama administration.[83] An initial interim final rule issued in 2010 permitted the appeal of any "adverse benefit

74. *Id.*

75. 42 U.S.C. § 300gg-19(a)(2)(A), (b)(2). The statute and implementing regulations include detailed requirements for standards for internal and external review processes, but those details are not discussed here.

76. Karen Pollitz, *Consumer Appeal Rights in Private Coverage*, KAISER FAM. FOUND. (Dec. 10, 2021), https://www.kff.org/private-insurance/issue-brief/consumer-appeal-rights-in-private-health-coverage/#.

77. *Id.*

78. *Id.*

79. Karen Pollitz & Daniel McDermott, *Claims Denials and Appeals in ACA Marketplace Plans*, KAISER FAM. FOUND. (Jan. 20, 2021), https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/.

80. *Id.*

81. *Id.*

82. *Id.*

83. *See* Timothy Jost, *Administration Finalizes Regulations Implementing ACA Insurance Reforms (Updated)*, HEALTH AFFS. (Nov. 14, 2015), https://www.healthaffairs.org/do/10.1377/hblog20151114.051786/full/ (noting that a final regulation on the appeals process narrowed the scope of review from any adverse benefit determination to only claims that involve medical judgment and rescission decisions).

determination" by an insurer.[84] But amendments to that rule in 2011 permanently narrowed external review to only claims that involve medical judgment and rescission.[85] As a result, claims may not be making it to external review because the scope of that process is unduly narrow.[86]

C. Medical Loss Ratio

The ACA requires insurers to spend a minimum amount of premium dollars towards health care or refund the difference to consumers.[87] This medical loss ratio (MLR) requirement was designed to help ensure that consumer premiums are spent by insurers on actual health care—rather than profit, bonuses, administrative expenses, or marketing.[88] Under Section 2718 of the Public Health Service Act, insurers must spend a certain percentage of their premium revenue—eighty percent in the individual and small group markets and eighty-five percent in the large group market—on health care claims or health care quality improvement expenses.[89] If insurers fail to meet this minimum MLR threshold, they must rebate the difference to their enrollees.[90]

Average MLRs and rebates in the group markets have been relatively stable since Section 2718 went into effect in 2011.[91] But the individual market has been far more volatile with average MLRs ranging from eighty to ninety percent

84. Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 43,329, 43,350–51 (July 23, 2010) (codified at 45 C.F.R. § 147.136, 29 C.F.R. § 2590.715-2719, 26 C.F.R. § 54.9815-2719T).

85. Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes, 76 Fed. Reg. 37,207, 37,216 (June 24, 2011) (codified at 26 C.F.R. § 54.9815-2719T, 29 C.F.R. § 2590.715-2719, 45 C.F.R. § 147.136) ("[T]his amendment suspends the broad scope of claims eligible for the Federal external review process and narrows the scope to claims that involve (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or (2) a rescission of coverage.").

86. Pollitz & McDermott, *supra* note 79, at 1. ("Of all denials with reasons reported for 2019, about 18% were denied because the claim was for an excluded service; about 9% were denied due to prior authorization or lack of referral, and less than 1% were denied based on medical necessity. The remaining plan-reported denials (72%) were denied for other reasons.").

87. *Explaining Health Care Reform: Medical Loss Ratio (MLR)*, KAISER FAM. FOUND. (Feb. 29, 2012), https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/. The ACA also imposed new MLR requirements on Medicare Advantage plans. *See* 42 U.S.C. § 1395w-27(e)(4). Plans that fail to meet an MLR of at least eighty-five percent must remit the difference to the federal government and could be barred from further enrollment or see their contracts cancelled if low MLRs persist. *Id.*

88. *Explaining Health Care Reform: Medical Loss Ratio (MLR)*, *supra* note 87.

89. 42 U.S.C. § 300gg-18(a)(1)–(2), (b)(1)(A)(i)–(ii).

90. *Id.* § 300gg-18(b)(1)(A).

91. Daniel McDermott & Cynthia Cox, *Data Note: 2021 Medical Loss Ratio Rebates*, KAISER FAM. FOUND. (Apr. 12, 2021), https://www.kff.org/private-insurance/issue-brief/data-note-2021-medical-loss-ratio-rebates/.

initially and then increasing dramatically beginning in 2014 when the ACA's broader reforms went into effect.[92] After peaking in 2015, average MLRs in the individual market fell in 2018 to seventy percent and rebounded slightly to seventy-four percent in 2020.[93] These low MLRs have led to record-high rebates beginning in 2019 when total rebates (across all markets) were $1.37 billion (with total individual market rebates of about $769 million).[94] This was followed by total rebates of $2.46 billion (including total individual market rebates of about $1.7 billion) in 2020[95] and total rebates of $2 billion (including total individual market rebates of about $1.3 billion) in 2021.[96]

While insurers struggled financially in the early years of the ACA, that is no longer the case. High individual market rebates are driven by exceptionally profitable years, which have continued during the pandemic.[97] In a comparison of MLRs across markets for 2018 to 2020, insurers offering individual market coverage have the lowest simple MLR when compared to coverage in the commercial group market, Medicare Advantage, and Medicaid managed care.[98] This profitability is likely attracting new insurers into the individual market and leading existing insurers to expand their footprint.[99]

Although popular, some evidence suggests that the MLR provision may not be working as intended. For one, Section 2718 relies on insurer self-reporting of data and there has generally been lax oversight.[100] One review of insurer MLR filings found that fourteen percent of insurers are strategically overstating their

92. *Id.*

93. *Id.*

94. Ctr. for Consumer Info. & Ins. Oversight, *2018 MLR Rebates by State*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 30, 2019), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2018-Rebates-by-State.pdf.

95. Ctr. for Consumer Info. & Ins. Oversight, *2019 MLR Rebates by State*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 16, 2020), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2019-Rebates-by-State.pdf.

96. Ctr. for Consumer Info. & Ins. Oversight, *2020 MLR* Rebates *by State*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 21, 2021), https://www.cms.gov/files/document/2020-rebates-state.pdf.

97. Daniel McDermott et al., *Health Insurer Financial Performance in 2020*, KAISER FAM. FOUND. (May 3, 2021), https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-in-2020/.

98. *Id.*

99. Ctr. for Consumer Info. & Ins. Oversight, *Plan Year 2022 Qualified Health Plan Choice and Premiums in HealthCare.gov States*, CTRS. FOR MEDICARE & MEDICAID SERVS 1, 2 (Oct. 25, 2021), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2022QHPPremiums ChoiceReport.pdf (documenting the increase in the number of qualified health plan insurers by county from plan year 2018 to 2022).

100. *See* McDermott & Cox, *supra* note 91.

claims to avoid rebates.[101] Though not a majority of insurers, this accounts for hundreds of millions of dollars that would have gone to consumers in the form of rebates but instead remain with insurers.[102] The Biden administration has also raised concerns about the quality of MLR reporting by insurers and adopted clarifications to promote compliance; these clarifications are expected to increase rebates for consumers by about sixty-two million dollars annually.[103] Others have concluded that the MLR provision has done little to hold down premiums as hoped and that insurers responded to the MLR incentive by paying for more care.[104] At a minimum, rebates that total billions of dollars suggest that federally-subsidized premiums are overpriced, contributing to a higher uninsured rate.[105]

D. Rate Review

Rate review—a process used to assess whether an insurer's proposed rate is based on accurate data and realistic assumptions and projections—should work in tandem with MLR requirements.[106] Robust rate review can also help control premium increases and address the underlying cost of health care.[107]

States have historically had exclusive authority to regulate private health insurance rates in the fully insured market and have taken divergent approaches to rate regulation over time.[108] But rate review capacity and legal authority varies significantly by state.[109] Some state officials conduct robust, comprehensive reviews of rates while others require only an actuarial certification that rates comply with state law (without requiring any additional

101. Evan Eastman et al., *Accounting-Based Regulation: Evidence from Health Insurers and the Affordable Care Act*, 96 ACCT. REV. (forthcoming), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3282300.

102. *Id.*

103. 87 Fed. Reg. 27,208, 27,348–53, 27,368 (May 6, 2022).

104. Steve Cicala et al., *Regulating Markups in U.S. Health Insurance*, 11 AM. ECON. J. APPLIED ECONS., Oct. 2019, at 73; Sandra Renfro Callaghan et al., *Health Insurers' Claims and Premiums Under the Affordable Care Act: Evidence on the Effects of Bright Line Regulations*, 87 J. RISK & INS. 67, 69 (2019).

105. *See* McDermott & Cox, *supra* note 91 (discussing trends in premiums and medical loss ratios while noting that high rebates are being driven by significant profits in 2018, 2019, and 2020 despite repeal of the individual mandate and decreases in average premiums).

106. Scott E. Harrington, *Medical Loss Ratio Regulation Under the Affordable Care Act*, 50 INQUIRY J. 9, 15 (2013).

107. *Id.* at 13.

108. Sabrina Corlette & Janet Lundy, *Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable*, KAISER FAM. FOUND. 3 (Dec. 2010), https://www.kff.org/wp-content/uploads/2013/01/8122.pdf.

109. *Id.*

documentation).[110] And some state regulators can disapprove rates before products are sold, while others have no pre-market control.[111]

The ACA included enhanced rate review requirements and funding for states to improve these processes with the goal of improving affordability and promoting transparency.[112] Under the ACA, each state—or the federal government on behalf of a state—is required to review proposed rate increases and assess whether those increases are unreasonable.[113] Rate filings or justifications must be publicly posted with an opportunity for the public to review and comment on proposed rate increases.[114] Federal officials must also designate whether a state has an "effective" rate review process, meaning state officials receive sufficient data to examine whether a proposed rate increase is unreasonable.[115] Most states now have an effective rate review program in at least one insurance market.[116]

Rate review improvements under the ACA helped achieve some savings, particularly in the early years of implementation.[117] However, it is not clear that rate review continues to have an impact on affordability. This is especially true given record high MLR rebates in recent years.[118] Rebates help safeguard against premium overpricing, but more effective rate review would help keep premiums low in the first place.

IV. TOWARDS A NEW PATIENT BILL OF RIGHTS

The ACA's reforms notwithstanding, data suggests that there is more work to be done to ensure that private insurers pay claims, ensure financial security, promote quality, improve health outcomes, and narrow disparities. Academic journals, white papers, and the media are replete with stories of how private insurance—whether in the commercial market, Medicare Advantage, or Medicaid managed care—may not be meeting these goals. [119] There are reports

110. *Id.* at 1.

111. *Id.* at 11.

112. Harrington, *supra* note 106, at 10.

113. 42 U.S.C. § 300gg-94(a) (2010).

114. *Id.*

115. 45 C.F.R. § 154.301(a)(1)–(3).

116. Ctr. for Consumer Info. & Ins. Oversight, *State Effective Rate Review Programs*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet (last visited Mar. 1, 2021).

117. CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., 2012 ANNUAL RATE REVIEW REPORT: RATE REVIEW SAVES ESTIMATED 41 BILLION FOR CONSUMERS (2012), https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/rate-review09112012a.

118. *See* McDermott & Cox, *supra* note 91 (discussing the link between high medical loss ratio rebates and premiums).

119. Patel & Guterman, *supra* note 38.

on inappropriate claims denials,[120] limited benefits,[121] high cost-sharing,[122] "ghost networks" and other network restrictions,[123] failure to manage care or fully communicate with members,[124] the gaming of risk adjustment,[125]

120. *See, e.g.*, OFF. INSPECTOR GEN., U.S. DEPT. HEALTH & HUM. SERVS., NO. OEI-09-16-00410, MEDICARE ADVANTAGE APPEAL OUTCOMES AND AUDIT FINDINGS RAISE CONCERNS ABOUT SERVICE AND PAYMENT DENIALS (2018) (finding that Medicare Advantage plans denied eight percent of claims in 2016, overturned seventy-five percent of denials on appeal from 2014 through 2016, and took enforcement action for inappropriate denials and providing incomplete or incorrect information).

121. *See* U.S. GOV'T. ACCOUNTABILITY OFF. GAO-21-482, MEDICARE ADVANTAGE: BENEFICIARY DISENROLLMENTS TO FEE-FOR-SERVICE IN LAST YEAR OF LIFE INCREASE MEDICARE SPENDING (Jun. 28, 2021), https://www.gao.gov/products/gao-21-482 (finding that beneficiaries in the last year of their life switched from Medicare Advantage plans to traditional Medicare at more than twice the rate of other Medicare Advantage enrollees, which stakeholders attributed to potential limitations in accessing specialized care through Medicare Advantage plans).

122. *See, e.g.*, MITRE, *supra* note 2 (finding that seventy-five percent of insured people have some level of concern about financial hardship due to medical bills and four-in-ten insured patients worried about a bill because their insurer did not cover as much as expected, their procedure was not covered, or their provider was out of network). Claxton et al., *supra* note 2, at 10 (finding that rising average deductibles in employer-sponsored health plans have increased the burden of deductibles by ninety-two percent across all covered workers over the past decade).

123. *See, e.g.*, Rebecca Pifer, *San Diego Sues Molina, Kaiser, Centene's HealthNet over Alleged 'Ghost Networks'*, HEALTHCARE DIVE (Jun. 28, 2021), https://www.healthcaredive.com /news/san-diego-sues-molina-kaiser-centenes-healthnet-over-alleged-ghost-netw/602494/ (summarizing a lawsuit filed by the City of San Diego against Kaiser Permanente, Molina, and HealthNet (a subsidiary of Centene) alleging that the insurers "failed to maintain accurate provider directories, misleading consumers with the so-called 'ghost networks' that are illegal under state and federal law" with overall error rates of nineteen percent, fifty-eight percent, and eighteen percent, respectively, in 2019).

124. *See, e.g.*, CTRS. FOR MEDICARE & MEDICAID SERVS., DISPARITIES IN HEALTH CARE IN MEDICARE ADVANTAGE ASSOCIATED WITH DUAL ELIGIBILITY OR ELIGIBILITY FOR A LOW-INCOME SUBSIDY viii (2021) (noting that low-income beneficiaries and dual eligibles "often received worse clinical care" through Medicare Advantage plans than other Medicare beneficiaries in 2018); Laura Dague et al., The Line Between Medicaid and Marketplace: Coverage Effects from Wisconsin's Partial Expansion (Nov. 29, 2021) (unpublished manuscript) (on file with the Duke U. Press) (concluding that traditional Medicaid expansion would have more effectively increased coverage in Wisconsin compared to relying on the ACA marketplace to cover certain low-income populations).

125. *See, e.g.*, OFF. INSPECTOR GEN, U.S. DEPT. HEALTH & HUM. SERVS., NO. OEI-03-17-00474, SOME MEDICARE ADVANTAGE COMPANIES LEVERAGED CHART REVIEWS AND HEALTH RISK ASSESSMENTS TO DISPROPORTIONATELY DRIVE PAYMENTS (2021) (finding that some Medicare Advantage companies—twenty of the total 162 Medicare Advantage companies—use chart reviews and health risk assessments to maximize risk-adjusted payments, resulting in an additional $9.2 billion in payments, and recommending additional oversight and monitoring of outlier companies).

overpricing or inadequate spending,[126] and conflicts of interest.[127] These behaviors persist at a time of record profits for many health insurers[128] and even though the government often pays *more* for private plans than traditional public coverage.[129] And, despite its popularity—and the $360 billion spent by Medicaid

126. *See, e.g.*, Eastman et al., *supra* note 101, at 3 (estimating that about fourteen percent of commercial insurers subject to the ACA's medical loss ratio requirement engage in strategic overestimates that result in underpayment of rebates to policyholders); Jeff Lagasse, *UnitedHealth, Anthem Medicare Advantage Plans Penalized for Inadequate Spending*, HEALTHCARE FIN. (Sept. 17, 2021), https://www.healthcarefinancenews.com/news/unitedhealth-anthem-medicare-advantage-plans-penalized-inadequate-spending (describing suspensions of four Medicare Advantage plans for 2022 because those plans failed to meet minimum medical loss ratios for three consecutive years).

127. *See, e.g.*, Paige Minemyer, *Centene to Pay $27.6M to Settle PBM Investigation in Kansas*, FIERCE HEALTHCARE (Dec. 7, 2021, 2:00 PM), https://www.fiercehealthcare.com/payer/centene-to-pay-27-6m-to-settle-pbm-investigation-kansas (describing one of several recent settlements between Centene and state governments over allegations that the company's pharmacy benefits manager subsidiary overcharged the state Medicaid program); David Jackson, *Illinois' $16 Billion Health Program Riddled with Industry Ties and Potential Conflicts of Interest*, MOD. HEALTHCARE (Nov. 12, 2021, 2:43 PM), https://www.modernhealthcare.com/medicaid/illinois-medicaid-program-riddled-industry-ties-and-conflicts-interest (discussing an investigation by the Better Government Association on potential conflicts of interest in the management of Illinois' Medicaid managed care program).

128. *See, e.g.*, Tara Bannow, *Goldman Sachs Projects Positive 2022 for Big Insurers*, MOD. HEALTHCARE (Dec. 14, 2021), https://www.modernhealthcare.com/insurance/goldman-sachs-projects-rosy-2022-unitedhealth-group-anthem-cvs (discussing a "rosy outlook" for publicly traded health insurers and describing "a significant profit opportunity in Medicare Advantage"); Bob Herman, *Health Insurers Still Aren't That Worried About the Coronavirus*, AXIOS (Nov. 5, 2021), https://www.axios.com/health-insurers-still-arent-that-worried-about-the-coronavirus-692675c3-ea33-4f28-80b1-2f796a57aaea.html ("Health insurers remain significantly more profitable today than they were before the pandemic, even after factoring in COVID costs."); Amanda Holpuch, *Pandemic Profits: Top U.S. Health Insurers Make Billions in Second Quarter*, GUARDIAN (Aug. 6, 2021, 6:00 AM), https://www.theguardian.com/us-news/2021/aug/06/us-healthcare-insurance-covid-19-coronavirus (summarizing the status of insurer profits in 2021 and noting a congressional investigation into insurer profits begun in 2020); Reed Abelson, *Major U.S. Health Insurers Report Big Profits, Benefiting from the Pandemic*, N.Y. TIMES (Aug. 5, 2020), https://www.nytimes.com/2020/08/05/health/covid-insurance-profits.html (summarizing the status of insurer profits in 2020 and noting that consumers are entitled to millions of dollars in medical loss ratio rebates).

129. *See, e.g.*, Jeannie Fuglesten Biniek et al., *Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges*, KAISER FAM. FOUND. (Aug. 17, 2021), https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/ (describing how spending on beneficiaries in Medicare Advantage plans is higher and growing faster per person for beneficiaries in traditional Medicare and the implications for total Medicare spending and beneficiary costs); Bob Herman, *Medicare Has Become More of a Private Marketplace—And It's Costly*, AXIOS (Aug. 11, 2021), https://www.axios.com/medicare-advantage-enrollment-spending-pandemic-risk-adjustment-d1a608ff-15eb-47bf-8952-0e1c5af097

on comprehensive managed care in 2020—research suggests that Medicaid managed care may not result in the lower costs, expanded access, or improved quality that its advocates often tout.[130]

Some might use the data cited above to argue that private insurers can *never* achieve the goals of health reform due to their inherent need to maximize profit; this, in turn, demands an expansion of truly public coverage. But, if we assume that private insurers will remain a core part of the nation's health care financing infrastructure and a key recipient of federal funds, the same data can be interpreted as a call to action for additional accountability measures and consumer protections.

Yet Congress has done little to pair recent coverage expansions with new accountability measures for private insurers. The pandemic relief packages adopted in 2020 made relatively few changes to coverage and did not include explicit accountability measures.[131] Neither did the American Rescue Plan Act, which temporarily expanded marketplace subsidies and fully subsidized private COBRA continuation coverage for laid-off workers.[132] In the Build Back Better Act, Congress may further expand private coverage by extending enhanced ACA subsidies and relying on (private) marketplace plans to fill the Medicaid coverage gap in the twelve states that have yet to expand this (public) program to low-income adults.[133] But, as with the pandemic relief packages, there are few, if any, accountability measures designed to change insurer practice to the benefit of consumers and taxpayers.

d5.html ("The federal government paid almost $350 billion to MA insurers for this year, a 10% increase from 2020.").

130. *See, e.g.*, *Has Medicaid Managed Care Delivered on Its Promise?*, TRADEOFFS (Nov. 4, 2021), https://tradeoffs.org/2021/11/04/medicaid-managed-care/ (summarizing literature reviews on the evidence that Medicaid managed care has led to lower costs and improved access and quality).

131. The legislation bolstered state Medicaid programs, required a wide range of public and private payers to cover COVID-19 testing and vaccines without cost-sharing, and authorized one billion dollars for the National Disaster Medical System to pay for COVID-19 testing for the uninsured. *See* Katie Keith, *Senate Passes COVID-19 Package #3: The Coverage Provisions*, HEALTH AFFS. BLOG (Mar. 26, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200326.765600/full/.

132. American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 9501(a)(3), 135 Stat. 4, 129 (2021).

133. Alice Miranda Ollstein, *Democrats Pitch Industry-Friendly Medicaid Workaround to Win Manchin's Support*, POLITICO (Oct. 26, 2021, 2:01PM), https://www.politico.com/news/2021/10/26/democrats-pitch-medicaid-workaround-manchin-517213. In a prior iteration of the Build Back Better Act considered by the U.S. House of Representatives, federal officials would have been required to contract with private Medicaid managed care companies to deliver benefits in non-expansion states. Katie Keith, *Unpacking the Coverage Provisions in the House's Build Back Better Act*, HEALTH AFFS. BLOG (Sept. 12, 2021), https://www.healthaffairs.org/do/10.1377/hblog20210912.160204/full/.

One narrow exception is in the Consolidated Appropriations Act of 2021 where Congress required private insurers to establish a new verification process to assess the accuracy of its provider directories every ninety days *and* hold harmless the patients who rely on inaccurate provider network information.[134] The challenges associated with accurate provider network directories are well-documented.[135] Under this recent law, consumers who rely on inaccurate provider network information cannot be forced to pay more in cost-sharing than they would have paid if the provider had actually been in their plan's network (as they expected).[136] The same is true if the insurer failed to provide the information at all.[137] It remains the enrollee's responsibility to check the network status of their provider.[138] But the new law assures that patients will not bear the brunt of negative consequences for relying on their insurer.[139]

These types of policies are, however, few and far between. This Part takes a first pass at identifying a non-exhaustive list of policies that federal and state officials could consider to better ensure that taxpayer-subsidized private coverage ensures patient access to care and protects consumers' financial security.

A. A New Baseline: Shifting the Burden of Proof to Private Insurers

Policymakers have long considered and debated the role of insurers in holding down costs, particularly by limiting access to care.[140] The negative experiences (or perceptions) associated with limits on provider choice have continued to inform payer decisions even now, with many employers unwilling to engage in limited networks even when doing so could reduce premiums and incentivize value-based care.[141] Instead, employers increasingly shift costs to

134. Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, § 116, 134 Stat. 1182, 2879 (2020).

135. *See, e.g.*, Abigail Burman, *Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories*, 40 YALE L. & POL'Y. REV. 78, 82 (2021); Jaclyn Kleban, *Countering Misinformation in the Health Care System: The Case for Stricter Regulations Within Health Insurance Provider Directories*, 41 CARDOZO L. REV. 1185, 1189 (2020).

136. § 116, 134 Stat. at 2880.

137. § 116, 134 Stat. at 2881.

138. *See* Burman, *supra* note 135, at 80.

139. § 116, 134 Stat. at 2880(1)(A).

140. *See, e.g.*, Thomas L. Greaney, *From Hero to Goat: Managed Care in the 1990s*, 47 ST. LOUIS U. L.J. 217, 217–19 (2003) (offering a history of managed care in the 1990s and citing the "large literature" on managed care backlash). Prof. Greaney's essay provided a foreword to an issue of the Saint Louis University Journal devoted to managed care based on the 2002 symposium, Looking Beyond A Patient Bill of Rights: The Future of Managed Care. *Id.* at 217.

141. *See, e.g.*, SABRINA CORLETTE ET AL., ASSESSING RESPONSES TO INCREASED PROVIDER CONSOLIDATION IN SIX MARKETS: FINAL REPORT 4 (2019); Gary Claxton et al., *Employer Strategies to Reduce Health Costs and Improve Quality Through Network Configuration*, PETERSON-KFF HEALTH SYS. TRACKER (Sept. 25, 2019), https://www.healthsystemtracker

employees and their families in the form of higher deductibles and other out-of-pocket costs.[142]

To help keep costs down, private insurers turn to other tools that limit or discourage care. These practices vary by insurer but often take the form of utilization management policies (such as prior authorization or step therapy) and restrictive medical necessity criteria (that leads to claims denials).[143] Proponents argue that these tools can hold down costs and prevent unnecessary care, while critics argue that these policies limit patient access and drive-up health care costs through administrative burdens.[144]

Utilization management and restrictive medical necessity criteria require providers and patients to take additional steps to secure prior authorization for care and to appeal claims denials.[145] In both instances, the patient's access to care is limited while paperwork is completed, and a waiting game begins to see if the insurer will challenge the treating provider's clinical judgment. Patients whose care is denied may simply go without care or are forced to pay out-of-pocket for care they expected to be covered. These burdens have been shown to discourage providers from seeing patients enrolled in certain programs. For instance, physicians lose seventeen percent of Medicaid revenue to billing

.org/brief/employer-strategies-to-reduce-health-costs-and-improve-quality-through-network-configuration/.

142. *See* CORLETTE ET AL., *supra* note 141, at 5 ("[T]he most widespread strategy among employers to constrain their health plan costs has been to shift them to employees, largely through higher deductibles.").

143. AM. SOC'Y ADDICTION MED., UTILIZATION MANAGEMENT FOR MEDICATIONS FOR ADDICTION TREATMENT TOOLKIT 3–4 (2021), https://pcssnow.org/wp-content/uploads/2021/07/Utilization-Management-Toolkit.pdf; Aaron L. Schwartz et al., *Measuring the Scope of Prior Authorization Policies: Applying Private Insurer Rules to Medicare Part B*, JAMA, May 28, 2021, at 2.

144. *See* Peter Orszag & Rahul Rekhi, *Real-Time Adjudication for Health Insurance Claims*, 1% STEPS FOR HEALTH CARE REFORM, https://onepercentsteps.com/policy-briefs/real-time-adjudication-for-health-insurance-claims/ (last visited Feb. 13, 2022) (estimating that claims administration and adjudication accounts for up to six percent of provider and payer revenue, which represents a significant administrative health care cost); *Prior Authorization and Step Therapy*, AM. ACAD. FAM. PHYSICIANS, 1–2 https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/BKG-PriorAuthorization.pdf (last updated Oct. 2021) (describing physician and patient concerns with prior authorization, including high time and cost burdens, delayed care, and negative outcomes); Jennifer Snow et al., *The Impact of Step Therapy Policies on Patients*, XCENDA AMERISOURCEBERGEN 1–2 (2019), https://www.xcenda.com/-/media/assets/xcenda/english/content-assets/white-papers-issue-briefs-studies-pdf/impact-of-step-therapy-on-patients_final_1019.pdf (summarizing the literature on the impact of step therapy policies on patients).

145. AM. SOC'Y ADDICTION MED., *supra* note 143, at 8; *Frequently Asked Questions: Medical Management and Prior Authorization*, AM. HEALTH INS. PLANS 3, https://www.ahip.org/documents/Prior-Authorization-FAQs.pdf (last visited Mar. 2, 2022).

problems, and physicians respond to billing problems by refusing to serve Medicaid patients in states with more severe billing hurdles.[146]

In contrast, traditional public payers typically do not apply the same care-limiting policies. Unlike Medicare Advantage, for instance, fee-for-service Medicare uses minimal prior authorization.[147] This distinction between the two types of payers for the same covered care has attracted calls for reform from federal policymakers.[148]

This Section argues that federal and state policymakers should consider a new framework for the provision of care by shifting the burden of *securing* care from patients and providers onto private insurers who would face the burden of *denying* care. Care recommended by an enrollee's in-network provider would be presumed valid unless the insurer shows that this recommendation is unreasonable. Put another way, insurers would be required to justify why a claim is being denied—rather than requiring providers and patients to seek permission for care, as is the current typical practice.

1. Prior Authorization

Currently, the burden of seeking and obtaining prior authorization—by showing that care should be covered and provided—rests on patients and providers.[149] The default is that care is *not* covered unless allowed by the insurer.[150] Policymakers could shift this burden to insurers, making them responsible for showing why care should be denied. This would create a presumption that a provider's medical recommendation is valid unless the insurer could show that the provider's recommendation is unreasonable.

As one important guardrail, the new default could apply only to care provided by in-network providers. Why? Because insurers should only be contracting with providers whose medical judgments they think are generally reasonable. Such a shift could also give insurers more leverage in negotiating

146. Abe Dunn et al., *A Denial A Day Keeps the Doctor Away, National Bureau of Economic Research* 26 (NBER Working Paper No. 29010), https://www.nber.org/papers/w29010.

147. Schwartz et al., *supra* note 143, at 1–2.

148. Jessie Hellmann & Nona Tepper, *Bipartisan Bill Would Revamp Medicare Advantage Prior Authorization*, MOD. HEALTHCARE (May 13, 2021, 2:25 PM), https://www.modernhealthcare.com/insurance/bipartisan-bill-would-revamp-medicare-advantage-prior-authorization (discussing proposed legislation in Congress that would require Medicare Advantage plans to disclose prior authorization policies in response to concerns from providers that prior authorization is overused, costly, and inefficient).

149. *See* AM. SOC'Y ADDICTION MED., *supra* note 143, at 1; Amanda DeMarzo, *What is Prior Authorization*, NAT'L BD. PRIOR AUTHORIZATION SPECIALISTS (Dec. 15, 2020), https://www.priorauthtraining.org/prior-authorization/.

150. *How U.S. Health Insurance Works*, STAN. UNIV. VADEN HEALTH SERVS., https://vaden.stanford.edu/insurance/health-insurance-overview/how-us-health-insurance-works (last visited Mar. 2, 2022).

network status with providers, many of whom could view relief from this administrative burden as an added benefit for being an in-network provider.

At least two states have already considered such a shift. Under proposed legislation in Connecticut, an insurer's clinical review team would be forced to show a lack of medical necessity before denying a claim.[151] In testimony in support of this part of the legislation, the Connecticut Office of the Healthcare Advocate stated that "[t]he default judgment should belong to the in-network treating physician or other provider who has examined the patient, not to the insurance company doctor or other reviewer in another state who has never examined or talked to the patient."[152] A similar bill was introduced in New Jersey and would have created a dedicated "carrier appeals program" for insurers to dispute a claim when care is not medically necessary or appropriate.[153]

2. Criteria for Medical Necessity Determinations

Similar burden shifts could be adopted for the criteria that private insurers use to determine whether a service is "medically necessary" or not. Medical necessity criteria are based on generally accepted standards of medical practice.[154] But critics note that "health plans are increasingly adopting formulaic rules that restrict when generally covered treatments will be paid for."[155] This "rulification" of medical necessity—through detailed clinical criteria—transforms plan determinations into "rules-based exercise[s]" that leave little room for medical judgment and undermine a patient's ability to successfully appeal a claims denial based on these "rulified" criteria.[156]

To address these challenges, policymakers could require all private insurers to use standard clinical criteria when assessing medical necessity. This would again shift the burden—in this case, of understanding and applying variable insurer policies—from providers and patients back onto insurers, who would be required to show why a given patient's care is inconsistent with generally accepted standards of medicine.

151. An Act Concerning Step Therapy, Adverse Determination and Utilization Reviews, and Health Insurance Coverage for Children, Stepchildren and Other Dependent Children, S.B. 1045, 2021 Gen. Assemb., Jan. Sess. (Conn. 2021) The legislation was passed by the Connecticut senate, but not the house.

152. *Testimony Before the Insurance and Real Estate Committee Re: S.B. 1045, Conn. Off. of the Healthcare Advoc.*, 2021 Gen. Assemb. (2021) (statement of Ted Doolittle, Healthcare Advocate, of Connecticut).

153. S.B. 558, 2022 Gen. Assemb., Reg. Sess. (N.J. 2022).

154. *How U.S. Health Insurance Works*, *supra* note 150.

155. Daniel Schwarcz & Amy B. Monahan, *Preserving Meaningful External Review Despite Insurers' Rulification of Medical Necessity*, HARV. L. BILL HEALTH (May 7, 2021), https://blog.petrieflom.law.harvard.edu/2021/05/07/medical-necessity-rules-external-review/.

156. *Id.*

Generally accepted standards of medical practice are, by definition, universal.[157] As such, consumers should not have to worry if the same care will be considered differently under different plans from different insurers. Short of requiring standardization, insurer medical necessity rules should be set aside by external reviewers, even when those rules are contained in insurance policies or formal health plan documents, under certain circumstances.[158]

3. Increased Standardization of Benefits, Cost-Sharing, and Exclusions

In addition to standardizing clinical criteria, policymakers could embrace standardization of other elements of plan design—especially consumer-facing elements such as covered benefits, cost-sharing, and exclusions. Doing so would build upon the ACA's reforms that required insurers in the individual and small group markets to cover the essential health benefits package. This led to *more* standardization among plans—which must now cover a minimum set of ten categories of essential health benefits and meet minimum actuarial value tiers for cost-sharing.[159] But there is still significant variation among plans in the benefits covered, cost-sharing for covered benefits, and plan exclusions.[160]

Much has been written about the benefits of plan standardization and improved plan choice architecture, especially given low levels of health insurance literacy and the complexity of health insurance.[161] In light of these benefits, several states have already embraced standardized plans.[162] At the federal level, the Obama administration adopted optional standardized plans for

157. Amy B. Monahan & Daniel Schwarcz, *Rules of Medical Necessity*, 107 IOWA L. REV. (forthcoming 2022) (manuscript at 3), https://ssrn.com/abstract=3777505.

158. *Id.* (manuscript at 59–60); Schwarcz & Monahan, *supra* note 155 ("[F]ederal regulations should make clear that the ACA requires external reviewers to apply traditional, standard-based, definitions of medical necessity when reviewing denials of coverage that are premised on medical judgments.").

159. *See, e.g.*, Petra W. Rasmussen & Erin A. Taylor, *What Can the Federal Government Learn from States About Health Insurance Plan Standardization?*, JAMA HEALTH F., Nov. 12, 2021, at 1; Ctr. for Consumer Info. & Ins. Oversight, *Information on Essential Health Benefits (EHB) Benchmark Plans*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb (last visited Mar. 2, 2022).

160. Rasmussen & Taylor, *supra* note 159.

161. *See, e.g.*, *id.*; Douglas Jacobs, *CMS' Standardized Plan Option Could Reduce Discrimination*, HEALTH AFFS. (Jan. 6, 2016), https://www.healthaffairs.org/do/10.1377/hblog20160106.052546/full/; *see also* Austin Frakt, *Why Consumers Often Err in Choosing Health Plans*, N.Y. TIMES (Nov. 1, 2015), https://www.nytimes.com/2015/11/02/upshot/why-consumers-often-err-in-choosing-health-plans.html.

162. Justin Giovannelli et al., *State Efforts to Standardize Marketplace Health Plans Show How the Biden Administration Could Improve Value and Reduce Disparities*, COMMONWEALTH FUND (Jul. 28, 2021), https://www.commonwealthfund.org/blog/2021/state-efforts-standardize-marketplace-health-plans.

the federal marketplace;[163] the Biden administration went further, requiring insurers to offer standardized plans, beginning with the 2023 plan year.[164]

Standardization of benefits, cost-sharing, and exclusions would shift some of the burden of pre-enrollment plan analysis from consumers to insurers. Consumers would still have some responsibility: many would need to check provider network directories and prescription drug formularies to see if their providers and drugs are in-network and covered. But additional standardization would reduce the guesswork for consumers by simplifying coverage comparisons and ensuring that patient care is covered by any subsidized private plan a consumer might select.

As just one example, Out2Enroll—a national initiative that connects LGBTQ people with coverage options under the ACA—publishes an annual analysis of the degree to which federal marketplace plans include transgender-specific health insurance exclusions.[165] This analysis (of hundreds and sometimes thousands of plans) takes a team of researchers several weeks to identify plans, locate underlying documents, and then assess the coverage language for each plan.[166] This data is then converted into state-specific enrollment guides for transgender consumers who use this information to understand their coverage options during annual and special enrollment periods.[167] This analysis is limited to only exclusions and does not assess cost-sharing, provider networks, or other important design elements that are equally important to transgender consumers.[168]

Additional standardization of plan exclusions across insurers would eliminate the need for this type of analysis, limit discriminatory benefit design, and help better ensure that transgender consumers have access to the care that they need. Instead of a multi-week analysis to uncover this information, transgender consumers could expect that medically necessary care would be covered. Recognizing the need for standardization and equal access, Colorado updated its essential health benefits benchmark to affirm and clarify insurer

163. Timothy Jost, *CMS Finalizes New Marketplace Payment Rule, Effective January 17, 2017*, HEALTH AFFS. BLOG (Dec. 18, 2016), https://www.healthaffairs.org/do/10.1377/forefront.20161218.058014/full/; *see also* Timothy Jost, *The Final 2018 Notice of Benefit and Payment Parameters (Part 2)*, HEALTH AFFS. (Dec. 18, 2016), https://www.healthaffairs.org/do/10.1377/hblog20161218.058022/full/.

164. 87 Fed. Reg. 27,310–22 (May 6, 2016).

165. *About Us*, OUT2ENROLL, https://out2enroll.org/about-us/ (last visited Mar. 2, 2022); *see also Summary of Findings: 2022 Marketplace Plan Compliance with Section 1557*, OUT2ENROLL 1 (2022), https://out2enroll.org/out2enroll/wp-content/uploads/2021/12/Report-on-Trans-Exclusions-in-2022-Marketplace-Plans.pdf [hereinafter Out2Enroll, Summary of Findings].

166. *See* Out2Enroll, Summary of Findings, *supra* note 165, at 1, 3.

167. *Plan Information for 2022*, OUT2ENROLL, https://out2enroll.org/2022-cocs/ (last visited Mar. 2, 2022).

168. *Id.*

coverage of gender-affirming care.[169] This is just one example of how standardization could better protect consumers.[170]

Standardization could also reduce reliance on intermediaries—such as agents, brokers, or navigators—who advise applicants on the various design features of each plan and some of whom have a financial interest in the plans in which enrollees select. In the absence of this type of assistance or unbiased third-party analysis, consumers face the daunting task of identifying, assessing, and selecting an insurance plan that will meet their needs. The complexity of this process, especially combined with the application process itself, can serve as a barrier to enrollment, contributing to higher uninsured rates.[171]

B. Improving Monitoring, Oversight, and Enforcement

Even if federal and state policymakers were to adopt the policies and reforms noted above, enforcement and oversight would likely remain a challenge. Why? Because current enforcement mechanisms are unlikely to provide complete protection for consumers.[172]

In the fully insured commercial market, federal and state oversight relies primarily on pre-market review (such as the review and approval of policy forms and rates) by state insurance departments or the federal Center for Consumer Information and Insurance Oversight followed by post-market complaints monitoring and market conduct exams.[173] There is even less oversight of group health plans, which are regulated almost entirely by the federal Department of Labor.[174] Federal officials at the federal Department of Health and Human

169. Katie Keith, *Unpacking Colorado's New Guidance on Transgender Health*, COMMONWEALTH FUND (Nov. 10, 2021), https://www.commonwealthfund.org/blog/2021/unpacking-colorados-new-guidance-transgender-health.

170. Similar challenges have been observed in access to information about prescription drugs. *See* Ed Silverman, *Just How Many Barriers Do Health Insurers Create to Fair Access to Medicines?*, STAT NEWS (Dec. 1, 2021), https://www.statnews.com/pharmalot/2021/12/01/health-insurance-prescription-drugs-access-icer/.

171. *See* ALLISON PERCY & KAREN STOCKLEY, CONG. BUDGET OFF., 56504, WHO WENT WITHOUT HEALTH INSURANCE IN 2019, AND WHY? 2, 18 (2020), https://www.cbo.gov/system/files/2020-09/56504-Health-Insurance.pdf ("[L]ack of information, confusion, and the complexity of applying for coverage are common barriers to enrollment.").

172. *See* Christine H. Monahan, *Private Enforcement of the Affordable Care Act: Towards An "Implied Warranty of Legality" in Health Insurance*, 126 YALE L.J. 1118, 1122–23, 1130 (2017) (explaining why "state public enforcement mechanisms are unlikely to provide consumers complete protection from violations" of the ACA).

173. *Id*. at 1129 n.49, 1130–32.

174. *See* U.S. GOV'T. ACCOUNTABILITY OFF. GAO-21-376, ENFORCEMENT EFFORTS TO PROTECT PARTICIPANTS' RIGHTS IN EMPLOYER-SPONSORED RETIREMENT AND HEALTH BENEFIT PLANS (2021) (describing the Department's enforcement tools, documenting declines in investigations over time, and noting that "fewer than 10 percent of investigations were referred for civil litigation" since fiscal year 2010); *Health Plans and Benefits*, U.S. DEP'T LAB., https://www.dol.gov/general/topic/health-plans (last visited Feb. 11, 2022).

Services are responsible for overseeing Medicare Advantage plans and Medicare Part D prescription drug plans while state officials manage contracts with Medicaid managed care companies.[175]

In general, regulators can investigate misconduct, ask for voluntary compliance, impose corrective action plans, and fine insurers.[176] Regulators can also terminate contracts or otherwise bar insurers from participating in the public program at issue (whether Medicaid, Medicare, or the marketplace).[177] While these can be effective tools, enforcement action is rarely invoked and often occurs after consumers have already been harmed.[178]

To the extent that federal officials continue to rely on administrative remedies, there is a significant need for ongoing monitoring and targeted enforcement of private insurer compliance with federal law.[179] Oversight and monitoring could be resource-intensive and would require a greater investment of federal dollars—or at least a prioritization of these efforts for current funding.[180] But such an investment is critical. It is past time to build the expertise

175. KAISER FAM. FOUND., COMPARISON OF CONSUMER PROTECTIONS IN THREE HEALTH INSURANCE MARKETS: MEDICARE ADVANTAGE, QUALIFIED HEALTH PLANS AND MEDICAID MANAGED CARE ORGANIZATIONS 23, 32 (2015), https://files.kff.org/attachment/report-comparison-of-consumer-protections-in-three-health-insurance-markets.

176. Monahan, *supra* note 172, at 1130.

177. *Id.*

178. *Part C and Part D Enforcement Actions*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions- (last visited Dec. 19, 2021). Comprehensive data on enforcement actions do not appear to be available for all programs, but the Centers for Medicare and Medicaid Services publishes program audits and audit results, as well as a list of civil monetary penalties, intermediate sanctions, and termination notices for its oversight of insurers participating in Medicare Part C and Part D. *Id.* As of December 19, 2021, federal officials identified seventy-eight enforcement actions since 2017. *Id.* (showing a complete list of audits published since 2017). The Center for Consumer Information and Insurance Oversight has a website dedicated to federal enforcement for marketplace plans but has posted only two federal market conduct examination final reports. *Compliance and Enforcement*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance (last visited Mar. 2, 2021).

179. John V. Jacobi et al., *Health Insurer Market Behavior After the Affordable Care Act: Assessing the Need for Monitoring*, *Targeted Enforcement, and Regulatory Reform*, 120 PENN ST. L. REV. 109, 113 (2015); Katie Keith et al., *Nondiscrimination Under the Affordable Care Act*, GEO. UNIV. HEALTH POL'Y INST., 16 (2013), https://chir.georgetown.edu/publications/#c_ea8c8c5836e4.

180. *See* ALLAN BAUMGARTEN, ROBERT WOOD JOHNSON FED'N., ANALYZING MEDICAID MANAGED CARE ORGANIZATIONS: STATE PRACTICES FOR CONTRACTING WITH MANAGED CARE ORGANIZATIONS AND OVERSIGHT OF CONTRACTORS 2, 15 (2020), https://www.rwjf.org/en/library/research/2020/08/analyzing-medicaid-managed-care-organizations—state-practices-for-contracting-with-managed-care-organizations-and-oversight-of-contractors.html ("Successful Medicaid managed care programs devote resources to ongoing oversight, auditing and evaluation of MCO performance."); *see also Has Medicaid Managed Care Delivered on Its Promise?*, *supra*

of federal officials to ensure that taxpayer-subsidized products work in a way that Congress intended and actually deliver health care to enrollees.

Taking ACA-regulated qualified health plans as an example, federal officials could begin by collecting, auditing, and using more federally mandated transparency data to better assess and publicize health plan performance and approve plans for sale through the marketplace.[181] As suggested above, there is a need for additional oversight on insurer MLR filings and improvements for rate review standards. Similar attention appears needed in other programs as well, with concerns raised about the gaming of Medicare Advantage star ratings and the risk adjustment program.[182]

Some have argued that administrative enforcement is, on its own, insufficient and that private enforcement is needed to protect consumers.[183] Indeed, private enforcement of the Medicaid Act by beneficiaries and providers has helped shape the Medicaid program and complemented federal oversight.[184] But similar causes of action may be of limited availability for other types of private insurance products, such as marketplace plans.[185]

note 130. For instance, several states are reorienting their contractual arrangements with Medicaid managed care organizations toward patient access and outcomes while also doing more to monitor performance and increase oversight over these private insurers.

181. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Title X, § 2715A, 124 Stat. 884 (2010) (codified at 42 U.S.C. § 300gg-15a) ("A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 1311(e)(3) of the Patient Protection and Affordable Care Act, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.").

182. *See, e.g.*, Lauren Flynn Kelly, *Recent MA Coding Complaints Signal DOJ's 'Evolving Expectations'*, MMIT: AIS HEALTH (Dec. 2, 2021), https://aishealth.mmitnetwork.com/blogs/radar-on-medicare-advantage/recent-ma-coding-complaints-signal-doj-s-evolving-expectations; Bob Herman, *The Lake Wobegon Effect in Medicare Advantage*, AXIOS: HEALTH (Oct. 11, 2021), https://www.axios.com/medicare-advantage-star-ratings-2022-c68929e2-82c7-4d8c-aea0-2df30361able.html; Allison K. Hoffman, *Federal Court Upholds Changes to Medicare Advantage Star Ratings During the COVID-19 Pandemic*, COMMONWEALTH FUND: TO THE POINT (Sept. 2, 2021), https://www.commonwealthfund.org/blog/2021/federal-court-upholds-changes-medicare-advantage-star-ratings-during-covid-19-pandemic.

183. Sara Rosenbaum et al., *Implementing Health Reform in an Era of Semi-Cooperative Federalism: Lessons from the Age 26 Expansion*, 10 J. HEALTH & BIOMEDICAL L. 327, 359 (2015); Sarah L. Grusin, *Holding Health Insurance Marketplaces Accountable: The Unheralded Rise and Imminent Demise of Structural Reform Litigation in Health Care*, 24 ANNALS HEALTH L. 337, 338 (2015).

184. *See* Grusin, *supra* note 183, at 350–51. There is no express or implied cause of action for private enforcement of the Medicaid Act, but plaintiffs have been able to sue because of the state's involvement in administering the Medicaid program. *Id.* at 350 ("[P]rivate enforcement is still viable in the Medicaid context despite the increased delegation of authority to private entities.").

185. *See id.* at 368.

To address this, some experts have called for an "implied warranty of legality" for ACA-regulated insurance products.[186] This would allow consumers to challenge insurer practice in state court by showing that their plan was subject to the ACA, that they assumed it complied with the law, that the insurer violated part of the ACA, and that the violation injured them. Allowing consumers to sue over health plan violations in this way would help "correct the power imbalance between consumers and insurers" and better incentivize compliance with legal requirements.[187]

V. CONCLUSION

Assuming future coverage expansions will rely on private insurers, policymakers must begin to pay more attention to holding these entities accountable for the government-subsidized benefits they offer. Doing so is vital to protecting enrollees and taxpayers who should receive the benefit of the government's bargain with private health insurers. Policymakers have several options available to them to ensure that taxpayer-subsidized private coverage accomplishes the goals of health reform—from building on the ACA's reforms, to shifting burdens from providers and patients, to improving monitoring, oversight, and enforcement. Regardless of the policies that federal and state leaders adopt, it will remain crucial to pair coverage expansions with accountability mechanisms to maximize taxpayer value in subsidizing private coverage across a range of public programs.

186. Monahan, *supra* note 172, at 1124.
187. *Id.* at 1179.