# The Affordable Care Act: Mandated Benefits Compliance Standards

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# INTRODUCTION

The Patient Protection and Affordable Care Act ("Act," or "ACA"),[1] popularly known as "Obamacare," has had an immense impact on the American system of health care and, perhaps more importantly, on health and medical insurance. The purpose of the law, as stated by its proponents, is to "ensure that all Americans have access to quality, affordable health care and [to] create the transformation within the health care system necessary to contain costs."[2] In particular, the law changes health insurance from being primarily a benefit provided by employers to employees[3] to being a responsibility to be "shared" between individuals, insurers, employers, and state and federal governments.[4] Individuals who do not receive coverage from an employer or other entity (*e.g.*, a union) are required to obtain coverage themselves. The coverage obtained must meet certain minimum requirements.

This white paper examines the minimum benefits that must be included in order for a health insurance policy to comply with the ACA. The first section discusses the background of the ACA, including prior federal legislation relating to health insurance. The second section deals with the coverage—the "essential minimum benefits"—a plan must afford persons covered by it. The third section addresses the regulatory and legal environment governing insurers' compliance with the ACA's minimum benefit requirements.

# I. BACKGROUND

## A. Historical Background

Health and medical insurance regulation has long been a matter of state law. Each state has been free to set out the parameters for health care policies. There was little federal involvement in the contents or operation of medical insurance.

Historically, such federal regulation as existed was focused mainly on medical insurance as a part of employee benefit plans. The practical effect of the federal laws was minimal. In 1959, Congress passed the Welfare and Pension Plans Disclosure Act (Act).[5] That law required sponsors of benefit plans (*e.g.*, employers or labor unions) to file financial statements and descriptions of the plans with the U.S.

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[1] Pub. L. 111-148, 124 Stat. 119 (2010)

[2] U.S. Senate Democratic Policy Committee, *The Patient Protection and Affordable Care Act—Detailed Summary, available at* http://www.dpc.senate.gov/healthreformbill/healthbill52.pdf (last visited Sep. 24, 2015). Opponents of the law take different views, frequently arguing that the law is meant as a way to introduce single-payer health insurance into the United States. *See, e.g.,* Robert W. Merry, *The Real Purpose of Obamacare,* Washington Times, Nov. 25, 2013, available at http://www.washingtontimes.com/news/2013/nov/25/merry-the-real-purpose-of-obamacare/.

[3] *See,* Peter Ubel, *Obamacare and the End of Employer-Based Health Insurance,* Forbes/Pharma & Healthcare (Nov. 14, 2013), *available at* http://www.forbes.com/sites/peterubel/2013/11/14/obamacare-and-the-end-of-employer-based-health-insurance/.

[4] U.S. Internal Revenue Service, *Questions and Answers on the Individual Shared Responsibility Provisions, available at* http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision (last visited Sep. 24, 2015).

[5] Pub. L. 85-836, 72 Stat. 997 (1959).

Department of Labor. The financial statements and plan descriptions were also to be made available to plan participants and beneficiaries.

While the law promoted transparency, it did not regulate the benefits that would be provided by covered plans. In addition, the law was weak: enforcement was originally left up to plan beneficiaries, who were required to bring a lawsuit to enforce the disclosure provisions. The Department of Labor did not have any real power to enforce the law until 1962, when the Department was given the authority to interpret the law and to investigate violations.

The situation began to change in the mid-1970s. In 1974, Congress passed the Employee Retirement Income Security Act (ERISA).[6] ERISA established a comprehensive framework of regulation of employee pension and retirement plans, and provided for federal regulation of health and welfare plans. The primary impetus behind the passage of ERISA was, however, the protection of pension plans and not the operation of health or medical insurance.[7]

After the passage of ERISA, Congress passed some additional legislation regarding health insurance. Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows some employees to keep their employer-provided health coverage after some event that would otherwise cause them to lose their coverage. A health plan provided by an employer must allow a person covered by the plan to continue coverage after death of the employee, termination of employment or a reduction in hours, divorce or legal separation, or a covered dependent child reaching the age of majority.[8] If an employer's plan does not do so, the employer must pay an excise tax. The employee or beneficiary who receives the continued coverage must pay the full premium him- or herself.[9]

Approximately ten years after the passage of COBRA, Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[10] HIPAA limited the restrictions that an insurer could place on the coverage of pre-existing conditions. The law also allowed individuals to enroll for coverage after losing coverage.[11] HIPAA included a number of provisions relating to patient privacy and the use and protection of data.[12]

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[6] 29 U.S.C. § 1001, *et seq.*

[7] Nat'l Assn. of Ins. Commissioners, *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (2004), *available at* http://www.naic.org/documents/prod_serv_legal_ers_om.pdf.

[8] *See, generally,* 26 C.F.R. 54.4980B-0, *et seq.*

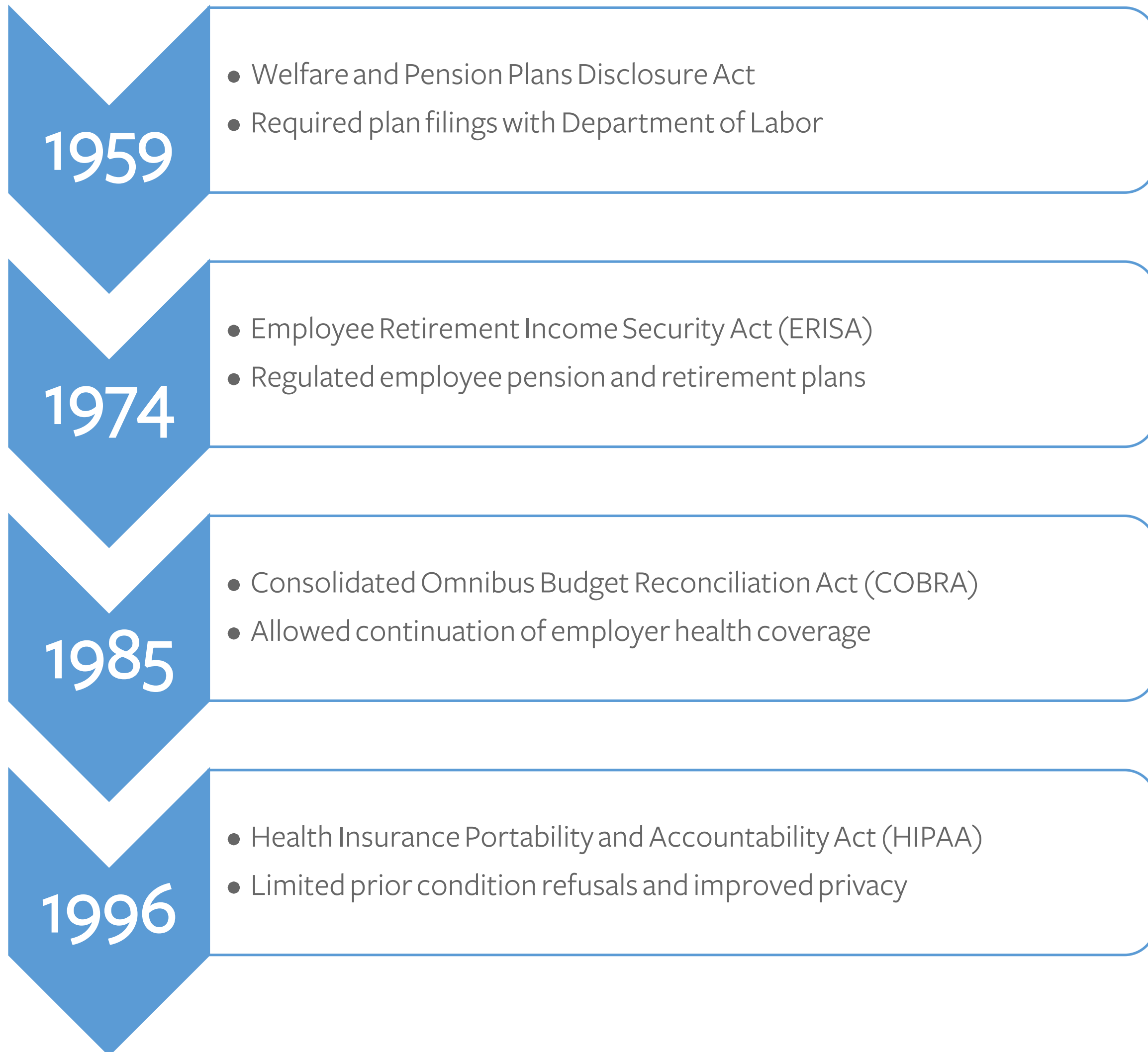
[9] Note that the COBRA continues the treatment of health insurance as something originating through an employer, even though the coverage that must be provided is paid for solely by the beneficiary.

[10] Pub. L. 104-191, 110 Stat. 1936.

[11] *See, generally,* U.S. Dept. of Labor, *Fact Sheet— The Health insurance Portability and Accountability Act* (Dec. 2004), *available at* http://www.dol.gov/ebsa/newsroom/fshipaa.html.

[12] *See, generally,* U.S. Dept. of Health and Human Services, *Summary of the HIPAA Privacy Rule* (May 2003), *available at* http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf.

Figure 1. Federal Legislative Background




## B. Universal Coverage

The federal laws enacted prior to the ACA did not attempt to expand medical insurance coverage. Although there was federal legislation to provide access to health care for the elderly and for the poor,[13] there seems to have been a tacit understanding that medical coverage for most people would typically be provided as a benefit of employment or group membership. Nevertheless, numerous attempts to provide health care coverage for all Americans have been made.

[13] *See,* Centers for Medicare and Medicaid Services, *History,* Sep. 4, 2015, *available at* https://www.cms.gov/About-CMS/Agency-Information/History/index.html?redirect=/History/.

Providing universal medical coverage was a goal of many reformers in the Progressive Era in the early 20th Century.[14] Early proposals were defeated by the combined opposition of medical associations, the insurance industry, business groups, and the American Federation of Labor (which regarded compulsory health insurance as an unnecessary paternalistic reform that would impose state supervision over people's health).[15] The issue remained dormant until the late 1930s, when Senator Robert Wagner of New York introduced legislation for a national health program. That bill failed, but versions of the same bill were reintroduced in every session of Congress for the next fourteen years.[16]

The enactment of Medicare and Medicaid in 1965 was a broad expansion of health coverage. Medicare, which provides coverage to the elderly, and Medicaid, which provides low-income people with coverage, were enacted as a part of President Johnson's Great Society program. Both programs were enacted over the strong opposition of the American Medical Association.[17]

In 1992, the election of President Clinton prompted new efforts at expanding health coverage. Five days after his inauguration, the President appointed First Lady Hillary Clinton to head a task force to develop a health care reform law. The task force developed a plan that provided universal coverage based on consumer choice among private health plans, with a cap on total spending.[18] The President's plan was rejected by Congress, due to strong opposition from business groups and a lack of strong support from the bill's proponents. The President's attention was also diverted by various foreign policy issues that prevented him from making a stronger case.[19]

## C. State Universal Coverage Legislation

A few states have enacted laws that attempt to expand health care coverage in the state. The first state to do so was Hawaii. The Prepaid Health Care Act[20] expands health insurance coverage by requiring employers to provide coverage to any employee who is paid at least 86.67 times the state's minimum hourly wage per month.[21] Employers are required to pay at least one-half of the premium for coverage.[22]

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[14] Karen S. Palmer, *A Brief History: Universal Health Care Efforts in the US,* talk given at the Spring 1999 meeting of Physicians for a National Health Program, *available at* http://www.pnhp.org/facts/a-brief-history-universal-health-care-efforts-in-the-us.

[15] *Id.*

[16] *Id.*

[17] *Id.*

[18] Paul Starr, *The Hillarycare Mythology,* The American Prospect (Oct. 2007), *available at* http://prospect.org/article/hillarycare-mythology.

[19] Adam Clymer, Robert Pear, and Robin Toner, *The Health Care Debate: What Went Wrong?,* The New York Times (Aug. 29, 1994), *available at* http://www.nytimes.com/1994/08/29/us/health-care-debate-what-went-wrong-health-care-campaign-collapsed-special-report.html?pagewanted=all.

[20] Haw. Rev. Stat. ch. 393.

[21] Haw. Rev. Stat. § 393.11. This threshold figure is usually simplified to say that employees who work at least twenty hours per week are covered. *See, e.g.,* Hawaii Department of Labor and Industrial Relations, *Highlights of the Hawaii Prepaid Health Care Law* (Aug. 2011 rev.), available at http://labor.hawaii.gov/dcd/files/2013/01/PHC-highlights.pdf.

[22] Haw. Rev. Stat. § 393.13.

Massachusetts adopted a law providing for broadly-based health care insurance in 2006.[23] This state law became the model for the federal ACA.[24] Under the Massachusetts provision, health care insurance is a shared responsibility between the individual, his or her employer, private insurers, and the state. All individuals age eighteen and over are required to obtain and maintain "creditable coverage," so long as that coverage is deemed affordable.[25] Formerly, employers who had eleven or more full-time equivalent employees were required to provide health insurance or pay a "Fair Share Employer Contribution."[26] Employers who neither offered insurance nor paid the Fair Share Contribution were required to pay a "Free Rider Surcharge," and their employees were covered by free state-provided insurance coverage.[27] The Massachusetts employer mandates were repealed in 2013 to avoid conflicts with the employer responsibility provisions of the ACA.[28]

Two other states—Maine and Vermont—adopted laws to expand health coverage, but have reversed themselves. In Maine, Dirigo Health partnered with a private insurer to offer coverage under the name DirigoChoice. Dirigo Health was funded by a tax on health insurance, and on soft drinks, wine, and beer. The program proved to be more expensive than expected, and did not provide coverage to as many previously uninsured people as expected.[29] The tax was repealed effective December 31, 2013.[30]

Vermont passed a law expanding access to health coverage in 2006.[31] That law was repealed in 2013, to be replaced with a statewide single-payer insurance plan.[32] In December of 2014, however, Governor Shumlin announced that his administration was dropping plans for single-payer coverage, stating that the cost would be higher than anticipated.[33]

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[23] Mass. Gen. Laws ch. 111M.

[24] Kaiser Family Foundation, *Massachusetts Health Care Reform: Six Years Later* (May 2012), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8311.pdf.

[25] Mass. Gen. Laws ch. 111M § 2. The determination of whether coverage is "affordable" is made by the Board of the Massachusetts Health Insurance Connector. *Id, see also 2014 Affordability Sheet, available at* https://betterhealthconnector.com/wp-content/uploads/Connector_Affordability_Tool_2014.pdf (last visited Sep. 24, 2015).

[26] Mass. Gen. Laws ch. 149 § 188, repealed effective 2013.

[27] Mass. Gen. Laws ch. 111G § 18b, repealed effective 2013.

[28] Matt Dunning, *Mass. Health Care Reform Law's Employer Mandate Repealed,* Business Insurance, July 17, 2013, *available at* http://www.businessinsurance.com/article/20130717/NEWS03/130719866/mass-health-care-reform-laws-employer-mandate-repealed?tags=%7C62%7C74%7C339%7C307%7C305.

[29] Jonathan McKane, *Dirigo Health—High Priced Lessons Learned,* Maine Wire, Jan. 20, 2014, available at http://www.themainewire.com/2014/01/dirigo-health-high-priced-lessons-learned/.

[30] Dirigo Health Agency website, http://www.dirigohealth.maine.gov/ (last visited Sep. 24, 2015)

[31] Vermont General Assembly Constituent Information Sheet, *2006 Health Care Reform Initiatives—The Details, available at* http://www.leg.state.vt.us/HealthCare/2006_Health_Care_Constituent_Information_Sheet.htm (last visited Sep. 24, 2015).

[32] Vt. Act 48 (2011).

[33] Paul Heintz, *In Striking Reversal, Shumlin Abandons Single-Payer Reforms,* Seven Days, Dec. 17, 2014, *available at* http://www.sevendaysvt.com/OffMessage/archives/2014/12/17/in-striking-reversal-shumlin-abandons-single-payer-reforms.

## D. Enactment of the Patient Protection and Affordable Care Act

Health care was a major issue in the 2008 presidential election. All of the candidates took different approaches to health care, with Republicans calling for market-oriented solutions, and Democrats advocating proposals that would call for more government intervention.[34]

Shortly after his inauguration, President Obama addressed a Joint Session of Congress and pledged action on health care reform. Congressional efforts on health care reform continued through 2009, and the Senate approved its version of the bill that would become the ACA on December 24, 2009. The House approved that version of the bill by a vote of 219-212 on March 21, 2010.[35]

Opposition to the ACA has continued since its enactment. The House of Representatives has voted to repeal the law many times.[36] There have also been a number of ultimately unsuccessful court challenges to the law. The U.S. Supreme Court upheld the constitutionality of the law in 2012.[37] The Supreme Court also rejected an interpretation of the ACA that many economists and policy experts believed would have allowed insurance premiums to increase dramatically, and that would have increased the number of Americans without insurance.[38]

## E. Essential Provisions of the ACA

The key (and most controversial) part of the Affordable Care Act is the requirement that all persons not otherwise exempt be covered by a health insurance plan that meets certain requirements.[39] There are two aspects to the insurance requirement: the individual mandate; and the employer mandate.

[34] Michelle Andrews, *Voters See Very Different Healthcare Plans from Obama, Clinton, and McCain,* U.S. News and World Report, Apr. 18, 2008, *available at* http://www.usnews.com/news/campaign-2008/articles/2008/04/18/voters-see-very-different-healthcare-plans-from-obama-clinton-and-mccain.

[35] NBCNews.com, *Health Care: A Timeline of the Overhaul Bill's Passage, available at* http://www.nbcnews.com/id/35986022/ns/politics-capitol_hill/t/health-care-timeline-overhaul-bills-passage/#.VgVnZ8tVhBc. More detailed accounts of the political efforts to pass the ACA may be found in the following sources: John Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History,* 105 Law Libr. J. 131 (spring 2013), *available at* http://www.aallnet.org/mm/Publications/llj/LLJ-Archives/Vol-105/no-2/2013-7.pdf; Vincent Frakes, *Partisanship and (Un)Compromise: A Study of the Patient Protection and Affordable Care Act,* 49 Harv. J. on Legis. 135 (2012), *abstract available at* http://heinonline.org/HOL/LandingPage?handle=hein.journals/hjl49&div=7&id=&page=; Norm Orenstein, *The Real Story of Obamacare's Birth,* The Atlantic, Jul. 6, 2015, *available at* http://www.theatlantic.com/politics/archive/2015/07/the-real-story-of-obamacares-birth/397742/;

[36] Deidre Walsh, *House Votes – Again – to Repeal Obamacare,* CNN Politics, Feb 3, 2015, *available at* http://www.cnn.com/2015/02/03/politics/obamacare-repeal-vote-house/.

[37] *National Federation of Independent Business v. Sebelius,* 567 U.S. ____, 132 S. Ct. 2566 (2012).

[38] *King v. Burwell,* 576 U.S. _____ (2015). For the potential effect of a contrary ruling in the case, *see* Jonathan Cohn, *Here's What the Supreme Court Could Do to Insurance Premiums in Your State,* The New Republic, Nov. 11, 2014, available at http://www.newrepublic.com/article/120233/king-v-burwell-how-supreme-court-could-wreck-obamacare-states. For a discussion of the recent "Hobby Lobby" case and the religious exemption requirement, *see infra.*

[39] 26 U.S.C. § 5000A.

### 1. Individual Mandate

The individual mandate may be satisfied if coverage is provided by any of the following:

- Employer-provided or individually purchased insurance;
- Medicare/Medicaid/CHIP;
- Veterans or TRICARE coverage;
- Refugee coverage;
- Self-funded college or university health coverage for students;
- A state high risk health insurance pool; or
- Other coverage approved by the Secretary of Health and Human Services.[40]

A person is required to have insurance coverage unless that person can prove she or he is entitled to an exemption. Exemptions are granted to a person who:

- Has a religious objection to any type of insurance;
- Is a member of a health care sharing ministry, defined as an organization that shares health care costs among individual members who have common ethical or religious beliefs;[41]
- Is an Alaska native or a member of a federally recognized Native American tribe, or is otherwise eligible to receive services from the Indian Health Service;
- Receives veteran's or TRICARE coverage;
- Receives Refugee Health Benefits;
- Has an income below the taxable threshold;
- Has a coverage gap of less than three months;
- Is unable to obtain coverage due to a hardship, defined as a life situation that prevents a person from obtaining coverage;
- Is unable to afford the premium for coverage;

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[40] 26 U.S.C. § 5000A (f); 26 C.F.R. § 1.5000A-2.

[41] In order to enable members to qualify for an exemption under this provision, the health care sharing ministry must have been in existence and paying claims continuously since December 1, 1999. 26 U.S.C. § 5000A (B) (ii) (IV).

- Is incarcerated; or
- Is an undocumented alien.[42]

A person who does not have coverage and who cannot prove eligibility for an exemption during the 2015 tax year must pay a fee of 2% of the person's yearly household income or $325 per person over age eighteen ($162.50 for children under 18) who does not have coverage, whichever is higher. The fee will be paid on the person's 2015 income tax return. For the 2016 tax year, the fee will increase to the higher of 2.5% of the yearly household income or $695 per person ($347.50 per child under 18). The fee will be adjusted for inflation in future years.[43] Coverage is reported, or an exemption claimed, on a person's individual income tax return.[44] In order to satisfy the requirements of the law, health insurance must provide "minimum essential coverage."

FIGURE 2. ACA FEE LIMITS

| If no coverage or exemption: | |
|---|---|
| **2015** | **The higher of:**<br>• **2% of yearly household income, *or***<br>• **$325 per person over 18, *plus***<br>• **$162.50 per person under 18** |
| **2016** | **The higher of:**<br>• **2.5% of yearly household income, *or***<br>• **$695 per person over 18, *plus***<br>• **$347.50 per person under 18** |
| **2017...** | **Adjusted for inflation from 2016 rates** |

[42] 26 U.S.C. § 5000A.

[43] *Id.* For the calculation of the penalty, *see* 26 C.F.R. § 1.5000A-4.

[44] 26 C.F.R. § 1.5000A-5.

Individuals may purchase coverage on a health insurance marketplace, or exchange. Marketplaces are either set up by each individual state or, if the state does not do so, by the U.S. Department of Health and Human Services.[45] Individuals or families with incomes less than four times the federal poverty level may receive subsidies to pay the premium.[46]

### 2. Employer Mandate

The employer mandate ("Employer Shared Responsibility") applies to employers who have at least 50 full-time employees, or a combination of full-time and part-time employees that is equivalent to 50 full-time employees. Employees who qualify for an exemption from the individual mandate are included in the count of employees. An employer who meets this requirement is required to offer affordable health coverage that provides a minimum level of coverage to full-time employees and their dependents.

If coverage is not offered, or if coverage is offered to fewer than 95% of full-time employees and their dependents, the employer may be subject to an Employer Shared Responsibility payment if at least one full-time employee receives a premium tax credit for purchasing individual coverage.[47]

## F. Other Provisions

The ACA also provided for federal funding to expand Medicaid coverage to include all those whose family income was at or below 133% of the federal poverty line. States that refused to do so would be penalized; however, that penalty was ruled unconstitutional.[48] As of March 2015, 22 states have declined to expand Medicaid.[49] Approximately 5.2 million people are uninsured due to their states' decisions not to expand Medicaid.[50]

## G. Impact of the ACA

The ACA's enactment decreased the number of Americans without health coverage. In 2013, 41.8 million were uninsured, but the number of uninsured fell to 33 million in 2014, after the law became

[45] 42 U.S.C. § 13031

[46] 42 U.S.C. § 18083.

[47] 26 U.S.C. § 4980H.

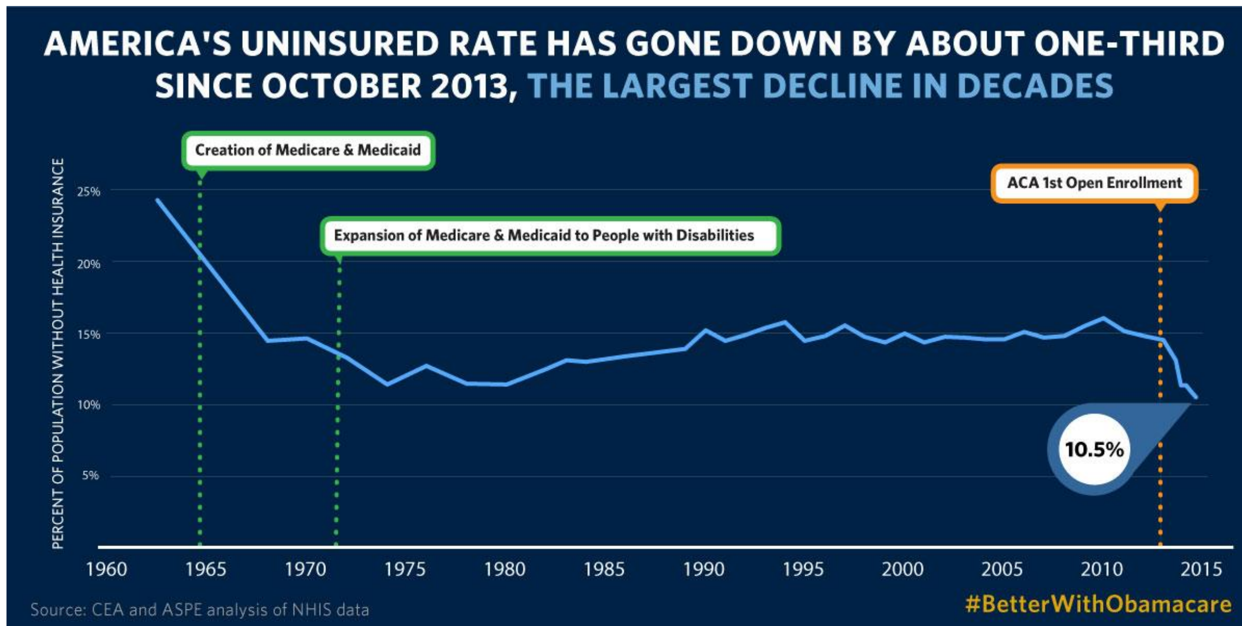
[48] *National Federation of Independent Business v. Sebelius, supra.*

[49] Rachel Garfield, Anthony Damico, Jessica Stephens, Saman Rouhani, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update,* Kaiser Family Foundation Health Reform, Apr. 17, 2015, available at http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/.

[50] *Id.*

fully operational.[51] The percentage of adults 18 to 25 who are uninsured fell from 26.5% in 2013 to 20.9% in the first three months of 2014.[52]

FIGURE 3. CHANGE IN INSURANCE RATES 1960-PRESENT




The ACA is also credited with contributing to slowing down the rate of increase in health care spending.[53] It is too early to determine the effect of the law on health care outcomes.

# II. ESSENTIAL HEALTH BENEFITS

## A. Benefits that Must be Provided

In order to be in compliance with the ACA, individuals must be covered by a health insurance plan that provides access to certain benefits. Those required benefits are categorized as "essential health benefits." The types of benefits that must be provided include:

- Ambulatory patient services;

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[51] Louise Radnofsky, *Percentage of Uninsured in U.S. Dropped in First Year of Obama's Health-Care Plan,* Wall Street Journal, Sep. 16, 2015, *available at* http://www.wsj.com/articles/percentage-of-uninsured-in-u-s-drops-in-2014-1442416629.

[52] U.S. Dept. of Health and Human Services National Health Interview Survey, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-March 2014*, Sep. 2014, *available at* http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201409.pdf.

[53] Bloomberg News, *Obamacare Effect Linked to Lower Medical Cost Estimates,* Sep. 5, 2014, *available at* http://www.bloomberg.com/news/articles/2014-09-05/obamacare-effect-linked-to-lower-medical-cost-estimates.

- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance abuse;
- Prescription drugs;
- Rehabilitative and habilitative services;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services.[54]

The Secretary of Health and Human Services is given the authority to ensure that the scope of the essential benefits offered "is equal to the scope of benefits provided under a typical employer plan."[55] To facilitate the determination of the scope of benefits under a "typical employer plan," the Department of Labor is directed to survey employer and multi-employer plans, and report on that survey to the Secretary of Health and Human Services.[56] In defining the essential health benefits, the Secretary of Health and Human Services must:

- Ensure that the essential health benefits reflect an appropriate balance among the categories, without giving undue weight toward any category;
- Not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals on the basis of age, disability, or life expectancy;
- Take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;
- Ensure that the benefits established as essential are not subject to denial to individuals against their wishes on the basis of age or life expectancy, or on the expected length of the individuals' present or predicted disability, degree of medical dependency, or quality of life;
- Provide that a plan will not be regarded as covering the essential health benefits unless coverage for emergency department services will be provided without imposing any prior authorization requirement or any limitation on coverage where the provider of services

[54] 42 U.S.C. § 18022 (b) (1).

[55] 42 U.S.C. § 18022 (b) (2).

[56] *Id.*

does not have a contractual relationship with the plan that is more restrictive than the requirements that apply to emergency department services providers who do have such a contractual relationship with the plan. If emergency services are provided out-of-network, the required copayment amount or coinsurance rate must be the same that would apply if such services were provided in-network;

- Provide that if a plan that provides stand-alone dental benefits plans is offered through an Exchange, another health plan offered through such Exchange will not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required; and

- Periodically review the essential health benefits and provide a report to Congress and the public assessing access to services and whether the list of essential services should be changed.[57]

Emergency services must be provided without imposing any requirement for prior authorization of services or any limitation on coverage for services by an out-of-network provider that is more restrictive than the requirements or limitations on emergency department services received in network.[58]

Prescription drug coverage must include coverage for at least one drug in every United States Pharmacopeia (USP) category and class, or the same number of prescription drugs in each category and class as the state benchmark plan (see *infra*), whichever is greater. Procedures must be in place to allow a covered individual to request and gain access to clinically appropriate medications not covered by the plan.[59] Alternately, a plan may submit its formulary drug list and, for plan years beginning on or after January 1, 2017, use a pharmacy and therapeutics (P & T) committee to establish and review the plan's formulary list.[60]

The term "preventive and wellness services" includes routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. The term also includes evidence-informed preventive care and screenings for infants, children, and adolescents as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Preventive and wellness services for women includes evidence-informed care and screenings as set out in binding guidelines issued by the Health Resources and Services Administration. All of these services must be covered without cost-sharing requirements (*e.g.* copayment, coinsurance, or a deductible). Coverage is also provided for evidence-based preventive and wellness items or services that have been given an A or B rating in the current recommendations of the United States Preventive Services Task Force. Cost-sharing requirements may be imposed for these services if they are billed separately from an office visit. An insurance plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for

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[57] 42 U.S.C. § 18022 (b) (4).

[58] 45 C.F.R. § 156.130 (g).

[59] 45 C.F.R. § 156.122.

[60] *Id.*

preventive or wellness services if not specified in the recommendation or guideline regarding that service.[61]

Preventive health services may include coverage for contraception. Religious employers may obtain an exemption from the requirement that they offer a plan that includes coverage for contraception if the employer is a non-profit organization that opposes contraception for religious reasons. The employer must hold itself out as a religious organization, and must certify that it is eligible for an exemption. Beneficiaries must be informed of the availability of separate payments for contraceptive services.[62] Private employers owned by individuals who have a religious objection to providing contraception may also be exempt from the requirement to provide a plan that covers contraception.[63] A state may elect to prohibit abortion coverage from qualified plans by enacting a law that prohibits such coverage.[64]

The covered pediatric services must include vision and dental care, even if not covered for adults under the plan.[65] Pediatric services are covered until the child turns 18. Dependent children of a beneficiary are covered until age 26.[66]

Coverage may not be made subject to any annual or lifetime dollar limits on the value of benefits provided to any beneficiary.[67] The Act does not preclude plans from covering services additional to the minimum level of coverage required.[68]

The specifics of the services in each category that are covered are not set out in either the ACA or the regulations interpreting the Act. The range of covered services within each of the categories of service depends first on the state in which the covered individual lives, and then on the medical services covered by that state's "base-benchmark plan." If the benchmark plan does not provide coverage for services in a required category of essential health benefits, the state must supplement the benefits package by adopting benefits from any other possible benchmark plan.[69]

The base-benchmark plan is used to define the scope of services to be covered by a plan that allows a covered individual to be in compliance with the ACA. The essential health benefits that must be offered by a complying plan are to be equivalent to the scope of benefits provided by a "typical employer plan."[70] The typical employer plan then becomes the benchmark for all other plans in the

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[61] 47 C.F.R. § 147.130.

[62] 45 C.F.R. § 147.131.

[63] *Burwell v. Hobby Lobby Stores, Inc.,* 573 U.S. ______, 134 S. Ct. 2751 (2014). In that case, the Supreme Court held that the federal government did not prove that the mandate to provide contraceptive services was the least restrictive means of furthering a compelling governmental interest, and therefore did not justify the substantial burden on the exercise of religion. In such a situation, the mandate violated the Religious Freedom Restoration Act, 42 U.S.C. §§ 2000bb – 2000bb-4.

[64] 42 U.S.C. § 18023 (a).

[65] 45 C.F.R. § 156.110.

[66] 42 U.S.C. § 300gg-14.

[67] 42 U.S.C. § 300gg-11.

[68] 42 U.S.C. § 18022 (b) (5).

[69] 45 C.F.R. § 156.110.

[70] 42 U.S.C § 18022 (b) (2) (A).

state. The benchmark plan in each state is selected by that state or, if the state does not select one, by the Secretary of Health and Human Services. The options for choosing a plan as the benchmark are the following:

- One of the three largest small group plans in the state;
- One of the three largest state employee health plans;
- One of the three largest federal employee health plan options; or
- The largest health maintenance organization (HMO) plan offered in the state's commercial market.[71]

The relative size of a plan is determined according to the number of people enrolled in the plan. If a state does not select a plan as its benchmark, the Secretary of Health and Human Services will select the plan in the state's small group market with the largest enrollment as the default.[72]

A plan that is in compliance with the ACA is not required to duplicate the coverage provided by the state benchmark plan, provided that the coverage offered is "substantially equal" to that provided by the benchmark plan.[73] The substantial equivalence description includes not only covered benefits, but limitations on the amount of covered benefits and their scope and duration. Prescription drug benefits must meet the same minimum requirements as the benchmark plan. Enrollees may not be excluded from any category of coverage except for pediatric services, and preventive health and habilitative services must be covered. [74]

An issuer of a plan that offers essential health benefits may substitute benefits, other than prescription drug benefits. The substituted benefits must be in in the same category as the benefits they replace, and must be actuarially equivalent. Actuarial equivalence means that the benefits offered in a given category of essential health benefits are of approximately the same value as those offered in that category by the benchmark plan.[75] Evidence of actuarial equivalence must be certified by a member of the American Academy of Actuaries. The analysis must have been performed "in accordance with generally accepted actuarial principles and methodologies" based on a standardized plan population, and done regardless of cost-sharing.[76]

A person who has insurance coverage through a "grandfathered plan" is considered covered, even if the plan does not meet all of the requirements other plans must follow.[77] A grandfathered plan is one that was in existence on March 23, 2010, and has not been changed in a way that would substantially cut benefits or increase costs for consumers. For purposes of the benefits that must be provided, the

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[71] 45 C.F.R. § 156.100.

[72] *Id.* A state-by-state listing of benchmark plans is found in Appendix A.

[73] 45 C.F.R. § 156.115 (a) (1).

[74] *Id.*

[75] 45 C.F.R. § 156.115 (b) (1).

[76] 45 C.F.R. § 156.115 (b) (2).

[77] 42 U.S.C. § 18011 (a).

difference between grandfathered plans and ACA compliant plans is that grandfathered plans are not required to provide free coverage for preventive care.[78]

## B. Non-required Coverage

A plan that is compliant with the ACA is not required to provide the following:

- Coverage provided by insurance not generally considered to be health insurance (*e.g.* motor vehicle insurance or workers' compensation insurance;[79]
- Limited benefits, such as adult vision or dental, long-term care, or nursing home care;[80]
- Non-coordinated benefits that cover a specific condition;[81] or
- Supplemental coverage that is provided by a separate policy.[82]

## C. Tiers of Compliant Plans

There are five categories, or "tiers," of compliant insurance plans under the ACA. An individual will be in compliance with the mandatory coverage provisions of the ACA if he or she is covered by a plan in any one of these tiers. Each category of plans must provide coverage for all essential health benefits. The distinctions between the plans rest on the percentages of the total costs of care each plan will cover.[83] This percentage will, in turn, determine how much the insured individual must pay for his or her medical care. The tiers are as follows:

- Bronze, covering 60% of costs on average;
- Silver, covering 70% of costs on average;
- Gold, covering 80% of costs on average;
- Platinum, covering 90% of costs on average;[84] and
- Catastrophic, covering less than 60% of costs on average. Catastrophic plans may be purchased only by individuals under 30 years of age, or who have a hardship

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[78] 45 C.F.R. § 147.140.

[79] *See* https://www.healthcare.gov/fees-exemptions/plans-that-count-as-coverage/ (last visited Sep. 28, 2015).

[80] 45 C.F.R. § 146.113

[81] *Id.*

[82] *Id.*

[83] 42 U.S.C. § 18022 (d).

[84] *Id.*

exemption from purchasing more expensive coverage. Catastrophic plans may be sold only in the individual market[85]

# III. REGULATORY AND LEGAL RISK

States have long been the primary enforcement authority over health insurers. The ACA did not change that, but provides an additional federal component to the regulation of health care market reforms. Under the ACA, states remain responsible for the regulation of health insurers within their state.[86] Now, in addition to ensuring compliance with state laws and regulations, insurance commissioners enforce compliance with ACA requirements. However, if a state does not have statutory authority to enforce the ACA mandates, or is "substantially failing to enforce" ACA requirements, HHS may step in to enforce compliance with the ACA.[87] Currently, five states—Alabama, Missouri, Oklahoma, Texas, and Wyoming—do not have the ability to enforce, or are choosing not to enforce, ACA requirements.[88] HHS is responsible for regulating ACA compliance in those "direct enforcement" states.[89] A state may also enter into a collaborative enforcement agreement with HHS.[90]

## A. State Enforcement

Traditionally, state insurance commissioners have utilized several enforcement mechanisms to enforce compliance with insurance laws, including the imposition of fines for violations of laws, the disapproval of plans that do not conform to state requirements, and market conduct examinations. Many states continue to regulate health insurers' ACA compliance in this manner. The majority of states conduct a rate review process, whereby the insurers must submit their proposed plans and rates to the insurance commissioner, who then approves or disapproves the plan.[91] Under this

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[85] 42 U.S.C. § 18022 (e).

[86] 42 U.S.C. §300gg-22(a)(1).

[87] 42 U.S.C. §300gg-22(a)(2); 45 CFR sections 150.207-219. *See also* Centers for Medicare and Medicaid Services, *FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces* (Feb. 20, 2015), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf (last visited Sep. 28, 2015).

[2] Centers for Medicare and Medicaid Services, *FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces* (Feb. 20, 2015), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf (last visited Sep. 28, 2015).

[89] *Id.*

[90] *See* Centers for Medicare and Medicaid Services, *Health Insurance Market Reforms Compliance*, *available at* http://www.cms.gov/CCIIO/Programsand-Initiatives/Health-Insurance-Market-Reforms/compliance.html (last visited Sept. 28, 2015).

[91] Centers for Medicare and Medicaid Services, *State Effective Rate Review Programs*, available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html (last visited Sep. 28, 2015). *See also* Mark C. Nielsen and Tamara S. Killion, *View From Groom: DOL and HHS Enforcement Activities Targeting Health Plans and Insurers* (Jan. 30, 2015), *available at* http://www.groom.com/media/publication/1531_View_from_Groom_DOL_and_HHS_Enforcement_Activities_Targeting_Health_Plans_and_Insurers.pdf (last visited Sep. 28, 2015).

proactive approach to enforcement, the insurance commissioner reviews the plans for compliance with both state laws and the ACA, and may disallow an insurer from marketing a non-compliant plan.

A recent consent order from Arizona provides an example.[92] In that matter, Respondent issued a disability policy that had not been submitted to and approved by the Insurance Department. The commissioner determined this was a violation of Arizona insurance law.[93] Respondent also violated the law by "issuing a contract, policy, certificate or evidence of coverage or otherwise transacting insurance if the coverage and benefits provided in the contract, policy, certificate or evidence of coverage are inconsistent with the applicable provisions of the Patient Protection and Affordable Care Act."[94] Accordingly, the state of Arizona suspended the respondent's certificate of authority "for the purposes of marketing or issuing any policy form to which the Affordable Care Act applies."[95]

Thus far, the states appear to be taking a cooperative approach to ensuring compliance with the ACA. Insurance commissioners have opted to disapprove rates or plans or disallow the sale of non-compliant plans, rather than levying significant fines or monetary penalties for failure to meet ACA standards. The relevant decisions are often in the form of a consent order that allows the insurer to gain approval if it makes specified changes to its plan.[96] A consent order from Florida illustrates this approach.[97] In that matter, the insurance commissioner examined respondent's policy in response to a complaint alleging that the insurer's coverage for HIV/AIDS prescriptions was discriminatory and did not satisfy ACA requirements.[98] In the order, the commissioner explicitly declined to determine if the coverage violated the ACA because the insurer agreed to change its formulary to comply with federal laws and regulations.[99] Thus, the state chose to work with the insurer and accepted a compliant policy from the insurer in lieu of exercising a more heavy-handed enforcement strategy.

This cooperative approach to enforcement is consistent with guidance issued by HHS. In a directive regarding Qualified Health Plan ("QHP") certification, HHS noted the enforcement policy in place during 2014, which was extended through 2015.[100] Pursuant to the good faith compliance policy established in 45 C.F.R. 156.800(c), HHS will not impose civil monetary penalties against issuers who

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[92] *See In the Matter of: United Healthcare Life Insurance Company (fka American Medical Security Insurance Company)*, No. 14A-012-INS (Nov. 19, 2014), *available at* http://www.floir.com/siteDocuments/CoventryHCFL162231-14-CO.pdf.

[93] *Id.*

[94] *Id.*

[95] *Id.*

[96] *See, e.g., Anthem Blue Cross and Blue Shield 2014 Individual Rate Filing for HealthChoice, HealthChoice Standard and Basic, HealthChoice HDHP, HMO Standard and Basic, and Lumenos Consumer Directed Health Plan Products Purchased by Members Before January 1, 2014* (Nov. 14, 2014), *available at* http://www.maine.gov/pfr/insurance/hearing_decisions/pdf/INS-14-1000.pdf. In this decision, the Maine Commissioner of Insurance disapproved the proposed rates, but provided specific guidelines which the insurer could follow to earn approval of the plan.

[97] *In the Matter of Coventry Health Care of Florida, Inc.*, Case No. 162231-14-CO (Nov. 14, 2014), *available at* http://www.floir.com/siteDocuments/CoventryHCFL162231-14-CO.pdf.

[98] *Id.*

[99] *Id.*

[100] Centers for Medicare and Medicaid Services, *FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces* (Feb. 20, 2015), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf (last visited Sep. 28, 2015).

do not meet marketplace requirements, if the issuer makes good faith efforts to comply with the requirements.[101] As part of this policy, issuers are expected to develop internal compliance monitoring programs and readily collaborate with HHS to remedy violations.[102] This good faith policy ends in 2015.[103]

Because the states often follow the lead of HHS, states are also likely to step up their enforcement efforts and may not be as likely to follow the good faith policy of previous years. As the agencies continue to provide further guidance and the parties become more familiar with the ACA, the rationale for a lighter touch on enforcement is less compelling.[104] Going forward, states may be more willing to impose fines or monetary penalties for non-compliant plans. Indeed, states have imposed rather large fines against insurers in other contexts, such as the marketing of plans with rates that were not approved by the commissioner.[105] While regulators may still give insurers the benefit of the doubt in some circumstances, insurers should be prepared for the possibility of tougher state enforcement in the future.

As HHS expects, insurers should create internal monitoring programs to ensure compliance with ACA requirements. Some states provide checklists to assist insurers when submitting documents for review and approval.[106] Where available, insurers should consult the checklists to aid development of a compliance program.

## B. Federal Enforcement

As noted above, the ACA vests HHS with authority to regulate market reforms in the absence of state action. HHS has adopted a rate review process similar to that used in the states for the approval of insurance rates and plans. Therefore, insurers in the five direct enforcement states must submit their plans directly to HHS for approval.[107]

HHS is also given the authority to determine whether a plan meets the eligibility standards to be a "qualified health plan" that may be offered on a state or federally-managed health care exchange.[108]

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[101] *Id.*; 45 C.F.R. 156.800(c).

[102] *Id.*

[103] *Id.*

[104] *Id.*

[105] *See, e.g.*, *In the Matter of Moda Health Plan, Inc.*, Order No. 15-0048 (Apr. 8, 2015), *available at* http://www.insurance.wa.gov/oicfiles/orders/2015orders/15-0048.pdf; *In the Matter of National Union Fire Insurance Company of Pittsburgh, PA*, Order No. 13-0091 (May 11, 2015), *available at* http://www.insurance.wa.gov/oicfiles/orders/2015orders/13-0091.pdf.

[106] *See, e.g.*, Illinois Dept. of Commerce, *Review Requirement Checklists*, *available at* http://insurance2.illinois.gov/LAH_HMO_IS3_Checklists/IS3_Checklists.asp.

[107] Centers for Medicare and Medicaid Services, *FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces* (Feb. 20, 2015), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf (last visited Sep. 28, 2015).

[108] 19 ACA section 1311(c).

HHS may issue penalties against insurers who do not meet certification requirements.[109] In this context, there is a dual enforcement scheme. Many states review plans to determine if they qualify for QHP status, and report their recommendations to HHS.[110] However, HHS is vested with final authority to determine who may obtain QHP status. Thus, HHS will review the certifications and recommendations provided by reviewing states, but may engage in some review of its own.[111] HHS will also conduct the review and certification process in those states that do not perform QHP review.[112]

Health insurers should also be aware of possible Department of Labor ("DOL") involvement in enforcement. The DOL is responsible for enforcing ERISA requirements, and the ACA amends and incorporates ERISA into its framework.[113] The DOL does not have authority to enforce ACA mandates directly against a health insurer, but does have authority over group health plans.[114] In that regard, the DOL may indirectly enforce reforms against a health insurer. If the DOL finds a violation in a group health plan, the plan is likely to inform the insurer, who may make corresponding changes to the plan.[115]

As part of its enforcement authority, HHS may conduct audits of an insurer.[116] These audits may be broad in scope, time consuming, and costly. Due to the dual nature of enforcement, HHS may audit an insurer or plan that is also subject to review by the state. HHS recognizes the possibility of duplication between state and federal oversight here, and has indicated that it is taking efforts to avoid redundant

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[109] 45 CFR section 156.805(a). HHS has the power to impose a civil monetary penalty up to a maximum penalty of $100 per day for each individual with respect to which such a failure occurs. *See also* 42 U.S.C. §300gg-22(b)(2)(C)(i).

[110] Centers for Medicare and Medicaid Services, *FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces* (Feb. 20, 2015), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf (last visited Sep. 28, 2015).

[111] *Id.*

[112] *Id.*

[113] Mark C. Nielsen and Tamara S. Killion, *View From Groom: DOL and HHS Enforcement Activities Targeting Health Plans and Insurers* (Jan. 30, 2015), *available at* http://www.groom.com/media/publication/1531_View_from_Groom_DOL_and_HHS_Enforcement_Activities_Targeting_Health_Plans_and_Insurers.pdf (last visited Sep. 28, 2015).

[114] 29 U.S.C. § 1132(b)(3); Mark C. Nielsen and Tamara S. Killion, *View From Groom: DOL and HHS Enforcement Activities Targeting Health Plans and Insurers* (Jan. 30, 2015), *available at* http://www.groom.com/media/publication/1531_View_from_Groom_DOL_and_HHS_Enforcement_Activities_Targeting_Health_Plans_and_Insurers.pdf (last visited Sep. 28, 2015).

[115] Mark C. Nielsen and Tamara S. Killion, *View From Groom: DOL and HHS Enforcement Activities Targeting Health Plans and Insurers* (Jan. 30, 2015), *available at* http://www.groom.com/media/publication/1531_View_from_Groom_DOL_and_HHS_Enforcement_Activities_Targeting_Health_Plans_and_Insurers.pdf (last visited Sep. 28, 2015).

[116] Some observers have noted an increase in the number of HHS audits of health plans. *See id.*

compliance efforts.[117] Nonetheless, even in states conducting a review process, an insurer should be prepared to respond to an HHS audit.[118] To do so, insurers are advised to take the following steps[119]:

1. **Maintain a file (both electronic and hard copy)** that includes:

- Plan documents (including insurance contracts), amendments, and resolutions
- Minutes from meetings discussing changes or potential changes to plan terms
- Summary Plan Descriptions (SPDs)
- Summary of Benefits and Coverage (SBCs)
- Service provider contracts
- Reports from benefit consultants or brokers discussing compliance issues
- Memoranda from legal counsel discussing legal requirements and compliance
- Participant disclosures required by the ACA and ERISA
- Stop-loss policies
- Fidelity bonds
- Fiduciary liability insurance

Insurers can also refer to the DOL Audit Compliance Checklist for a list of items routinely requested in health plan audits, which may shed light on the types of information needed in an HHS audit.[120]

2. **Perform internal compliance reviews on a periodic basis**, and correct any errors. Proactive action to fix problems could minimize possible penalties or negative findings. The DOL has also provided a self-

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[117] Centers for Medicare and Medicaid Services, *FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces* (Feb. 20, 2015), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf (last visited Sep. 28, 2015)

[118] The DOL may also perform audits under its enforcement authority. As noted above, the DOL does not have direct enforcement authority over health insurers. However, to the extent the DOL is auditing a group health plan, an insurer may be involved in providing information during the audit process.

[119] The following three steps are set forth in Mark C. Nielsen and Tamara S. Killion, *View From Groom: DOL and HHS Enforcement Activities Targeting Health Plans and Insurers* (Jan. 30, 2015), *available at* http://www.groom.com/media/publication/1531_View_from_Groom_DOL_and_HHS_Enforcement_Activities_Targeting_Health_Plans_and_Insurers.pdf (last visited Sep. 28, 2015). *See also* Todd Leeuwenburgh, *Penalties Await Plans That Ignore ACA's High-Litigation Risk* (Apr. 29, 2014), *available at* http://smarthr.blogs.thompson.com/2014/04/29/penalties-await-plans-that-ignore-acas-high-litigation-risks/ (last visited Sep. 29, 2015).

[120] U.S. Dept. of Labor, *Group Health Insurance Plan – Audit Compliance Checklist*, *available at* https://internal.nfp.com/webfiles/public/Links/DOL_AUDIT_COMPLIANCE_CHECKLIST.pdf (last visited on Sep. 29, 2015).

compliance tool for health care-related ERISA provisions, which should provide insight into the types of issues an audit may entail.[121]

3. **Work with counsel who is familiar with the ACA.**

## C. Private Rights of Action

The ACA does not create a private right of action for enforcement of health market reforms.[122] It does, however, incorporate the Employee Retirement Income Security Act, the Public Health Services Act (PHSA), the Fair Labor Standards Act (FLSA), and the Internal Revenue Code (IRS), which provide enforcement mechanisms for the different ACA sections.[123] ERISA authorizes a private right of action for health plan participants and beneficiaries to recover benefits or enforce rights under a health plan.[124] Thus, private plaintiffs may use the ERISA right of action to enforce ACA requirements in health plans in which they participate. These ERISA-based actions are limited to federal court and the recovery of unpaid benefits or equitable relief.[125] Commentators expect a significant amount of ERISA-based litigation in the coming years by private plaintiffs seeking to enforce ACA requirements in health plans.[126]

Where a statute does not create a private right of action, a court may, in some circumstances, find an implied right of action.[127] A 2012 GAO report determined that an implied private right of action was unlikely to be found in the ACA.[128] Nonetheless, interested parties will be closely monitoring the

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[121] U.S. Dept. of Labor, *Self-Compliance Tool for Part 7 of ERISA Health Care-Related Provisions*, *available at* http://www.dol.gov/ebsa/pdf/cagappa.pdf (last visited on Sep. 29, 2015).

[122] Neil H. Ekblom, *Finding a Private Right of Action in the Affordable Care Act*, *available at* http://www.leclairryan.com/files/Uploads/Documents/Finding%20a%20Private%20Right%20of%20Action%20in%20the%20Affordable%20Care%20Act.pdf (last visited on Sep. 29, 2015). *See also Dominion Pathology Laboratories, P.C. v. Anthem Health Plans of Virginia, Inc.*, 2015 WL 3830931, --- F.3d --- (June 19, 2015) (finding no private right of action under §2706 of the Affordable Care Act).

[123] Neil H. Ekblom, *Finding a Private Right of Action in the Affordable Care Act*, *available at* http://www.leclairryan.com/files/Uploads/Documents/Finding%20a%20Private%20Right%20of%20Action%20in%20the%20Affordable%20Care%20Act.pdf (last visited on Sep. 29, 2015); Mark C. Nielsen and Tamara S. Killion, *View From Groom: DOL and HHS Enforcement Activities Targeting Health Plans and Insurers* (Jan. 30, 2015), *available at* http://www.groom.com/media/publication/1531_View_from_Groom_DOL_and_HHS_Enforcement_Activities_Targeting_Health_Plans_and_Insurers.pdf (last visited Sep. 28, 2015).

[124] *Id.*

[125] Neil H. Ekblom, *Finding a Private Right of Action in the Affordable Care Act*, *available at* http://www.leclairryan.com/files/Uploads/Documents/Finding%20a%20Private%20Right%20of%20Action%20in%20the%20Affordable%20Care%20Act.pdf (last visited on Sep. 29, 2015).

[126] *Id. See also* Todd Leeuwenburgh, *Penalties Await Plans That Ignore ACA's High-Litigation Risk* (Apr. 29, 2014), *available at* http://smarthr.blogs.thompson.com/2014/04/29/penalties-await-plans-that-ignore-acas-high-litigation-risks/ (last visited Sep. 29, 2015).

[127] Neil H. Ekblom, *Finding a Private Right of Action in the Affordable Care Act*, *available at* http://www.leclairryan.com/files/Uploads/Documents/Finding%20a%20Private%20Right%20of%20Action%20in%20the%20Affordable%20Care%20Act.pdf (last visited on Sep. 29, 2015) (discussing the four *Cort v. Ash* factors considered by courts in determining whether an implied private right of action exists).

[128] Government Accounting Office, Causes of Action under the Patient Protection and Affordable Care Act, B-322525 (Mar. 23, 2012), available at http://www.gao.gov/products/P00407. *See also* Neil H. Ekblom, *Finding a Private Right of Action in the Affordable Care Act*, *available at*

courts for any case law developments suggesting a private right of action may be implied into the statute.

# CONCLUSION

The ACA is a hybrid. The broad outlines of the law are set by federal legislation, but some of the parts of the law that are most likely to affect the average person, especially in the areas of the benefits that must be provided and the establishment of exchanges, are left to the states. Federal regulators are involved only if the state, for whatever reason, takes no action. The provision of insurance coverage is left to private insurers.

The political battles over the ACA were hard-fought and contentious. The fight has continued, with court challenges and congressional votes to repeal, as well as campaign promises to repeal the law.[129] The opposition to the ACA comes not only from those opposed to federal involvement in health care, but from those who advocate replacing the ACA with single-payer health insurance.[130] Efforts to repeal the law will, in the views of some analysts, be complicated as the number of people insured continues to grow, and a constituency that supports continuation of the ACA begins to develop strength.[131] While the ACA is far from a perfect health care reform law, there is strong sentiment for fixing the flaws in the law, rather than repealing it outright.[132] The number of Americans who approve of the ACA is now slightly higher than the number who oppose it.[133]

While repeal of the ACA seems increasingly unlikely, some changes to the law will certainly be made. By one estimate, the law has already been "changed" over 50 times since it was enacted.[134] Proposals for reform include repealing the tax deduction for employer contributions for health insurance premiums,[135] or repealing the employer mandate and making health insurance solely an individual or

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http://www.leclairryan.com/files/Uploads/Documents/Finding%20a%20Private%20Right%20of%20Action%20in%20the%20Affordable%20Care%20Act.pdf (last visited on Sep. 29, 2015).

[129] Elizabeth Whitman, *2016 Republicans on Obamacare: For GOP, Repealing Affordable Care Act May Be Easier Said Than Done,* International Business Times, Apr. 16, 2015, *available at* http://www.ibtimes.com/2016-republicans-obamacare-gop-presidential-hopefuls-repealing-affordable-care-act-1885065.

[130] *See, e.g.,* Brent Budowsky, *Sanders Calls for Single-Payer Healthcare,* The Hill, June 29, 2015, available at http://thehill.com/blogs/pundits-blog/healthcare/246459-sanders-calls-for-single-payer-healthcare.

[131] *See, e.g.,* Sarah Kliff, *Obamacare's Final Test: It Survived the Supreme Court and it's Here to Stay*, Vox Policy & Politics, June 25, 2015, *available at* http://www.vox.com/2015/6/15/8779143/obamacare-repeal-dead-supreme-court.

[132] *In Our Opinion: Fix, Don't Repeal, Affordable Care Act,* Deseret News, Jan. 30, 2015, *available at* http://www.deseretnews.com/article/865620747/Fix-dont-repeal-Affordable-Care-Act.html?pg=all.

[133] Kaiser Family Foundation, *Kaiser Health Tracking Poll: The Public's View on the ACA, available at* http://kff.org/interactive/tracking-opinions-aca/#?response=Favorable--Unfavorable&aRange=twoYear (last visited Sep. 29, 2015). The poll shows that as of August 2015, 44% of adult Americans had a favorable opinion of the ACA, while 41% had an unfavorable opinion. In July of 2014, only 37% had a favorable opinion, with 53% having an unfavorable opinion.

[134] Grace-Marie Turner, *51 Changes to Obamacare . . . So Far,* Galen Institute, June 9, 2015, available at http://www.galen.org/newsletters/changes-to-obamacare-so-far/. The number of changes is open to dispute, as the author counts administrative actions and interpretations by the Executive Branch as 32 of the "changes" made in the law. The author also counts U.S. Supreme Court decisions as two of the changes. *Id.*

[135] The Economist, *How to Fix Obamacare,* Sep. 20, 2014, *available at* http://www.economist.com/news/leaders/21618788-americas-health-care-system-remains-dysfunctional-it-could-be-made-better-how-fix. According to the proponents of

family responsibility.[136] Proponents of eliminating the employer mandate argue that the mandate has driven employers to cut hours for employees, rather than expand coverage.[137] Either proposal would complete the transition of health care coverage from a benefit of employment to something acquired by the covered individual. Since the ACA has, arguably, started that transition, either proposal could be seen as just an inevitable incremental change. Advocates of eliminating the deduction for employer contributions base their proposal on the theoretical assumption that employers would raise wages in the absence of the tax benefit for employee medical coverage. On the other hand, advocates of eliminating the employer mandate focus on income preservation for affected workers, rather than on expanding or ensuring access to health care.

Most reform proposals tend to focus on things such as further expansion of Medicaid,[138] and on cost control.[139] Expansion of Medicaid may prove difficult, if not impossible, as states that have declined to do so are unlikely to rethink that decision for political reasons. Cost control, on the other hand, may prove to present a more politically expedient avenue for reform. Prescription drugs constitute a large, recurring medical expense even for families with good insurance coverage. The issue of drug pricing has been made even more prominent by news stories about the decision by Turing Pharmaceuticals to increase the price of its anti-infection drug Daraprim from $13.50 to $750 per tablet, an increase of over 5,000%.[140] One recent price control measure was put forth by presidential candidate Hillary Clinton. Her proposal would cap out-of-pocket expenses for prescription drugs at $250 per month.[141] While her proposal probably will face opposition from the pharmaceutical and biotechnology industries, it may resonate with a public that faces increasing bills for medication, and that is developing a mistrust of the pharmaceutical industry.[142]

Most of the list of essential health benefits covered by the ACA is not likely to change. One exception may be an expansion of the coverage for palliative care. Palliative care is provided to chronically ill

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the idea, employers who no longer have a tax incentive to provide health coverage will be able to pay employees higher wages, thus enabling them to obtain their own coverage. *Id.*

[136] David Frum, *Republicans Should Reform Obamacare, Not Repeal It,* The Atlantic, June 29, 2015, *available at* http://www.theatlantic.com/politics/archive/2015/06/republicans-obamacare-mandate-part-time-work/397199/.

[137] *Id.* For a contrary analysis, *see* Carlos Torres, *Economists See Little Effect on Hiring from U.S. Health-Care Law,* Bloomberg Business, Jan. 27, 2014, *available at* http://www.bloomberg.com/news/articles/2014-01-27/economists-see-little-effect-on-hiring-from-u-s-health-care-law.

[138] Brianna Ehley, *Four Ways to Help Fix Obamacare,* The Fiscal Times, Mar. 19, 2014, *available at* http://www.thefiscaltimes.com/Articles/2014/03/19/Four-Ways-Help-Fix-Obamacare.

[139] Jeffrey Young, *If Obamacare is Here to Stay, It's Going to Need Some Fixing. Here Are 5 Ways How,* Huffington Post Politics, July 8, 2015, *available at* http://www.huffingtonpost.com/2015/06/30/how-to-fix-obamacare_n_7691802.html.

[140] *Martin Shkreli Announces Turnaround on 5,000% Price Rise for Drug,* The Guardian, Sep. 23, 2015, available at http://www.theguardian.com/business/2015/sep/23/us-pharmaceutical-firm-to-roll-back-5000-price-hike-on-drug. Turing stated later that it would not increase the price as high as previously announced, but no details on the revised increase have been made public. Daraprim, or its generic version Pyrimethamine, is on the World Health Organization's list of essential medicines. *See, WHO Model List of Essential Medicines 18th List,* Apr. 2013, available at http://apps.who.int/iris/bitstream/10665/93142/1/EML_18_eng.pdf?ua=1.

[141] Amanda Becker, *Clinton Proposes $250 Monthly Cap on Prescription Drug Costs,* Reuters, Sep. 22, 2015, *available at* http://www.reuters.com/article/2015/09/23/us-usa-election-clinton-idUSKCN0RM08D20150923.

[142] David Knowles, *Hillary Clinton Fixes Sights on Ripe Target: Prescription Drug Prices,* Bloomberg Politics, Sep. 29, 2015, *available at* http://www.bloomberg.com/politics/articles/2015-09-29/hillary-clinton-fixes-sights-on-ripe-target-prescription-drug-prices.

patients, and is meant to make the patient comfortable and improve his or her quality of life. It sometimes is confused with hospice care, but while hospice care always includes palliative care, palliative care may be given to a patient at any stage of a condition, and with any diagnosis.[143] It addresses not only a patient's physical symptoms, but also considers the emotional and spiritual needs of the patient and the patient's family.[144] The ACA does not explicitly mention palliative care, although hospice care for the terminally ill is provided.[145] Palliative care is becoming more common, and patients who receive it tend to be very satisfied with their outcomes.[146] Addition of palliative care to the list of essential health benefits is foreseeable.

With the ongoing debate over the continued existence of the ACA, and with national elections coming in 2016, it may be too soon to speculate on how the ACA will change. However the debate proceeds, and whatever the result may be, it is certain that the enactment of the ACA has permanently changed the environment for American health care.

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[143] Debra Bradley Ruder, *An Extra Layer of Care--The Progress of Palliative Medicine*, Harvard Magazine, Mar.-Apr. 2015, *available at* http://harvardmagazine.com/2015/03/an-extra-layer-of-care.

[144] Mayo Clinic, *Palliative Care: Symptom Relief During Illness*, Jan. 10, 2013, *available at* http://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/palliative-care/art-20047525.

[145] 42 U.S.C. §1395f.

[146] Laura Landro, *Patients Turn to Palliative Care for Relief from Serious Illness*, Wall Street Journal, The Informed Patient, Dec. 22, 2014, *available at* http://www.wsj.com/articles/patients-turn-to-palliative-care-for-relief-from-serious-illness-1419288669.

# APPENDIX A

## State Benchmark Plans for Essential Health Benefits, 2014 - 2016

| State | Plan Issuer | Product Name | Plan Name |
|---|---|---|---|
| Alabama | Blue Cross Blue Shield of Alabama | 320 Plan | 320 Plan |
| Alaska | Premera Blue Cross Blue Shield of Alaska | Alaska Heritage Select Envoy | Heritage Select Envoy |
| Arizona | State of Arizona Self-Insured Plan, administered by United Healthcare | State Employee EPO Plan | Arizona Benefit Options EPO Plan, administered by United Healthcare |
| Arkansas | HMO Partners, Inc. | Open Access POS | HMO Partners, Inc. Open Access POS, 13262AR001 |
| California | Kaiser Foundation Health Plan, Inc. | Small Group HMO | Kaiser Foundation Health Plan Small Group HMO 30 ID 40513CA035 |
| Colorado | Kaiser Foundation Health Plan of Colorado | Deductible/Coinsurance HMO 1200D | Ded HMO 1200D |
| Connecticut | Connecticare, Inc. | HMO | Connecticare HMO |
| Delaware | Blue Cross Blue Shield of Delaware | Simply Blue EPO | Simply Blue EPO 100 500 |
| District of Columbia | Group Hospitalization and Medical Services, Inc. | BluePreferred | BluePreferred PPO Option 1 |
| Florida | Blue Cross and Blue Shield of Florida | BlueOptions | BlueOptions 5462 |
| Georgia | BCBS Healthcare Plan of Georgia, Inc. | POS | HMO Urgent Care 60 Copay |
| Hawaii | Hawaii Medical Service Association | Preferred Provider Plan 2010 | HMSA Preferred Provider Plan 2010 |
| Idaho | Blue Cross of Idaho Health Service Inc. | Preferred Blue | Preferred Blue |
| Illinois | Blue Cross Blue Shield of Illinois | BlueAdvantage Entrepreneur PPO | BlueCross BlueShield of Illinois BlueAdvantage |
| Indiana | Anthem Ins Companies Inc (Anthem BCBS) | PPO | Blue 5 Blue Access PPO Medical Option 6 Rx Option G |
| Iowa | Wellmark Inc. | Alliance Select | Copayment Plus |

| State | Plan Issuer | Product Name | Plan Name |
|---|---|---|---|
| Kansas | Blue Cross and Blue Shield of Kansas | Comprehensive Major Medical-Blue Choice | Comprehensive Major Medical Blue Choice GF 500 Deductible with Blue Rx card |
| Kentucky | Anthem Health Plans of KY (Anthem BCBS) | PPO | Anthem PPO |
| Louisiana | Blue Cross and Blue Shield of Louisiana | GroupCare PPO | GroupCare PPO |
| Maine | Anthem Health Plans of ME (Anthem BCBS) | PPO | Blue Choice 20 with Rx 10 30 50 50 |
| Maryland | CareFirst BlueChoice, Inc. | Blue Choice HMO HSA Open Access | Blue Choice HMO HSA Open Access |
| Massachusetts | Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. | HMO Blue With Deductible | HMO Blue 2000 Deductible |
| Michigan | Priority Health | PriorityHMO | 100 Percent Hospital Services Plan |
| Minnesota | HealthPartners, Inc. | Small Group Product | 500 25 Open Access |
| Mississippi | Blue Cross & Blue Shield of Mississippi | Network Blue | Network Blue |
| Missouri | Healthy Alliance Life Co (Anthem BCBS) | Blue Access Choice | Blue 5 Blue Access Choice PPO Medical Option 4 Rx Option D |
| Montana | Blue Cross and Blue Shield of Montana | Blue Dimensions | Blue Dimensions |
| Nebraska | Blue Cross and Blue Shield of Nebraska | Blue Pride | Blue Pride |
| Nevada | Health Plan of Nevada, Inc. | POS | Health Plan of Nevada Point Of Service Group 1 C XV 500 HCR |
| New Hampshire | Matthew Thornton Health Plan (Anthem BCBS) | Matthew Thornton Blue | Matthew Thornton Blue Health Plan |
| New Jersey | Horizon HMO | HMO | Horizon HMO Access HSA Compatible |
| New Mexico | Lovelace Insurance Company | Classic PPO | Lovelace Classic PPO |
| New York | Oxford Health Insurance, Inc. | EPO | Oxford EPO |
| North Carolina | Blue Cross and Blue Shield of NC | Blue Options | Blue Options |
| North Dakota | Sanford Health Plan | Sanford Health Plan HMO | Sanford Health Plan HMO |

| State | Plan Issuer | Product Name | Plan Name |
|---|---|---|---|
| Ohio | Community Insurance Company (Anthem BCBS) | PPO | Blue 6 Blue Access PPO Medical Option D4 Rx Option G |
| Oklahoma | Blue Cross Blue Shield of Oklahoma | BlueOptions PPO | RYB05 |
| Oregon | PacificSource Health Plans | Preferred CoDeduct Value | Preferred CoDeduct Value 3000 35 70 |
| Pennsylvania | Aetna Health Inc. (a PA corp.) | Aetna Health Maintenance Organization | PA POS Cost Sharing 34 1500 Ded |
| Rhode Island | Blue Cross & Blue Shield of Rhode Island | Vantage Blue | Vantage Blue BCBSRI |
| South Carolina | BlueCross BlueShield of South Carolina | Business Blue Complete | Business Blue Complete |
| South Dakota | Wellmark of South Dakota | Blue Select | Blue Select |
| Tennessee | BlueCross BlueShield of Tennessee | PPO | BCBST PPO |
| Texas | Blue Cross Blue Shield of Texas | BestChoice PPO | RS26 |
| Utah | Public Employee's Health Program | Utah Basic Plus | Utah Basic Plus |
| Vermont | The Vermont Health Plan, LLC | CDHP-HMO | BlueCare, The Vermont Health Plan, LLC, CDHP |
| Virginia | Anthem Health Plans of VA (Anthem BCBS) | PPO | KeyCare 30 with KC30 Rx Plan 10 30 50 OR 20 |
| Washington | Regence BlueShield | Regence Innova | Regence Blue Shield non-grandfathered small group product |
| West Virginia | Highmark Blue Cross Blue Shield West Virginia | Super Blue Plus 2000 | Super Blue Plus 2000 1000 Ded |
| Wisconsin | UnitedHealthcare Insurance Company | Choice Plus | Choice Plus Definity HSA Plan A92NS |
| Wyoming | Blue Cross Blue Shield of Wyoming | Blue Choice Network | Blue Choice Business 1000 80 20 |

Source: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services

# APPENDIX B

## Further Reading

### Statutes and Regulations

The official text of the Patient Protection and Affordable Care Act as enacted is available online at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf (PDF format) or https://www.congress.gov/bill/111th-congress/house-bill/3590 (HTML).

Regulations relating to the benefits that must be provided are located at 45 C.F.R. parts 147 – 156.

*Case Law*

*National Federation of Independent Business v. Sebelius,* 567 U.S. ____, 132 S. Ct. 2566 (2012).

*Burwell v. Hobby Lobby Stores, Inc.,* 573 U.S. ______, 134 S. Ct. 2751 (2014).

*King v. Burwell,* 576 U.S. _____ (2015).

### Comparative and Historical Analysis

The Commonwealth Fund, *International Profile of Health Care Systems, 2014*, Jan. 2015, *available at* http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v7.pdf.

Ezra Klein, *Unpopular Mandate*, The New Yorker, June 25, 2012, *available at* http://www.newyorker.com/magazine/2012/06/25/unpopular-mandate.

James A. Morone, *Presidents and Health Reform: From Franklin D. Roosevelt to Barack Obama,* Health Affairs, June 2010, *available at* http://content.healthaffairs.org/content/29/6/1096.full.

### Overview of ACA

Annie L. Mach, *Individual Mandate Under the ACA,* Congressional Research Service, May 13, 2015, *available at* http://fas.org/sgp/crs/misc/R41331.pdf.

C. Stephen Redhead, Hinda Chaikind, Bernadette Fernandez, Jennifer Staman, *ACA: A Brief Overview of the Law, Implementation, and Legal Challenges,* Congressional Research Service, July 3, 2012, available at http://fas.org/sgp/crs/misc/R41664.pdf.

Internal Revenue Service, *Legal Guidance for Group Health Plan Requirements*, Sep. 2, 2015, *available at* http://www.irs.gov/uac/Legal-Guidance-for-Group-Health-Plan-Requirements.

Jennifer A. Staman, *Enforcement of Private Health Insurance Market Reforms Under the Affordable Care Act (ACA).* Congressional Research Service, Jan. 8, 2014, *available at* https://www.hsdl.org/?view&did=749209.

## Essential Health Benefits

Centers for Medicare and Medicaid Services, *Information on Essential Health Benefits (EHB) Benchmark Plans*, *available at* https://www.cms.gov/cciio/resources/data-resources/ehb.html (last visited on Sep. 29, 2015).

Jean Marie Abraham, *How Might the Affordable Care Act's Coverage Expansion Provisions Influence Demand for Medical Care?,* Milbank Quarterly, Mar. 2014, available at http://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12041/full.

Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, *Implementing the Affordable Care Act: Revisiting the ACA's Essential Health Benefits Requirements,* The Commonwealth Fund, October 2014, *available at* http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/oct/1783_giovannelli_implementing_aca_essential_hlt_benefits_rb.pdf .

National Women's Law Center, *Women's Preventive Services in the Affordable Care Act: Frequently Asked Questions*, May 13, 2013, *available at* http://www.nwlc.org/resource/women%E2%80%99s-preventive-services-affordable-care-act-frequently-asked-questions.

## Economics of the ACA

Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act,* June 19, 2015, *available at* https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-Effects_of_ACA_Repeal.pdf.

National Rural Health Association, *Policy Brief—The Future of Rural Health*, Feb. 2013, *available at* http://www.ruralhealthweb.org/index.cfm?objectid=EAB2AE78-3048-651A-FE4CBFB6C083F34F.