

## Anti-Discrimination Law Comes to Health Benefit Design: Is HHS Getting the Rules Right?

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Is providing coverage for special services for developmentally disabled children that is not made available to all members of a health plan discrimination? That is what the Department of Health & Human Services (HHS) declared in recent guidance on the essential health benefits (EHB) rules.<sup>1</sup> According to HHS, when insurers limit coverage of special services like hearing aids to young children, they are “circumventing coverage of medically necessary benefits” for adults, which amounts to discrimination prohibited under the rules.<sup>2</sup>

This new guidance is only part of HHS’ reworking of little-known provisions in the EHB rules found in 42 U.S.C. § 18022(b)(4) (the “Section (b)(4) Rules”). While health insurers subject to the EHB rules have been focused on conforming their plans to state benchmarks and the metal tiers, HHS’ new guidance could require even further changes in benefit design. And HHS has warned that state benchmarks may not conform to the Section (b)(4) Rules—but that it still expects issuers to comply.<sup>3</sup>

HHS also recently released proposed rules for Section 1557 of the Affordable Care Act (ACA)<sup>4</sup> that appear to further complicate, or at least do little to clarify, the issue. Section 1557 is a separate, but overlapping, statutory provision that applies four pre-existing federal laws that prohibit discrimination on the basis of race, color and national origin, sex, disability, and age to entities that operate health programs that receive federal financial assistance. HHS says the statute covers qualified health plans (QHPs) that are offered on the exchanges.<sup>5</sup> QHPs also are subject to the EHB rules. On the one hand, the proposed rules forbid health plan cost-sharing terms and benefit designs that discriminate based on race, sex, disability and age; but on the other hand, they incorporate prior HHS regulations providing that special programs for children and the aged are nondiscriminatory.<sup>6</sup>

How are insurers to respond to these contradictory directives? And does HHS’ guidance further or frustrate Congress’ goals?

### The Section (b)(4) Rules in Context

The EHB rules were written to target health coverage sold to individuals that consumer advocates labeled “junk insurance.” Advocates claimed that while this insurance might offer affordable premiums, it had coverage gaps, such as exclusions for prescription drugs and maternity care, or it only paid a small percentage of costs, because of low annual and lifetime dollar limits or high cost sharing.<sup>7</sup>

The ACA addressed these concerns by empowering HHS to define an “essential health benefits” package that non-grandfathered individual and small group health insurance

coverage—exchange and non-exchange—must provide.<sup>8</sup> To eliminate coverage gaps, plans must cover ten categories of services, including oft-omitted benefits such as prescription drugs and maternity and mental health care.<sup>9</sup> To ensure plans pay a significant portion of health care costs, the ACA eliminates annual and lifetime limits, and the EHB rules cap cost sharing.<sup>10</sup> Under the “metal tier” rules, plans must pay for a minimum percentage of the average member’s health care costs—for example, 70% for a silver plan.<sup>11</sup> These rules of course can increase premiums, but federal subsidies defray this increase to some extent for most consumers who buy coverage through the exchanges, and for a smaller percentage of employers in the small group market.

While the EHB rules require plans to cover services in ten listed categories, they do not require plans to cover all possible services. Rather, the rules provide the “limitation” that benefits should be “equal to the scope of benefits provided under a typical employer plan.”<sup>12</sup> But the rules also list several “required elements for consideration” that plans must take into account in designing EHBs. These Section (b)(4) Rules include that:

- (A) benefits “reflect an appropriate *balance*” among the ten EHB categories;
- (B) plans “not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that *discriminate* against individuals because of their age, disability, or expected length of life”;
- (C) plans “take into account the health care needs of *diverse segments* of the population, including women, children, persons with disabilities, and other groups”;
- (D) “health benefits established as essential not be subject to *denial* to individuals against their wishes on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life.”

This list of elements, however, leaves key terms undefined. Perhaps most important is the prohibition on discrimination in “design[ing] benefits” in Rule (B). Does benefit design encompass only such things as the services covered and cost-sharing terms? Or does it include things like provider network design? The elements also seem to pull in opposite directions. Rules (B) and (D), on the one hand, say that plans can’t discriminate or limit coverage based on age, disability, and length and quality of life (although notably, they fail to mention discrimination based on race or sex). Rule (C), on the other hand, tells plans to

take the diverse needs of “women, children and persons with disabilities” into account in designing benefits. This rule appears to instruct plans to offer special benefits to these groups.

## HHS’ Reworking of the Section (b)(4) Rules

### The Section (b)(4) Rules in the context of civil rights law

Some have hailed the Section (b)(4) Rules as reversing decades of court decisions holding that discrimination laws did not reach health plan design.<sup>13</sup> In fact, federal age and disability discrimination laws often have been held to not reach health plan terms.<sup>14</sup> The Supreme Court has held that the Rehabilitation Act, which prohibits discrimination based on disability in programs that receive federal financial assistance, only required plans such as Medicaid programs to offer the disabled “meaningful access” to whatever benefits the state program offered. But the Act permitted plans to provide different benefits and treatment limits for different conditions—such as fewer days of coverage of inpatient treatment for mental versus physical disorders.<sup>15</sup> Multiple federal circuits have stated that the Americans with Disabilities Act (ADA) does not require employers to offer the same benefits for all disabilities and—taking it further still—generally does not regulate the contents of insurance policies.<sup>16</sup> The ADA has been held not to prohibit an employer from offering a plan that limited benefits for mental disabilities to two years, while providing unlimited benefits for physical disabilities; not to prevent insurers from imposing \$20K and \$100K lifetime limits on AIDS treatments not applied to other conditions; and not to require insurers to cover hearing aids for the deaf.<sup>17</sup> The reach of the Age Discrimination in Employment Act (ADEA) to benefit design also has been limited.<sup>18</sup>

### HHS’ read-out of the “diverse segments” rule

In its recent guidance, HHS appears to assume that the purpose of the Section (b)(4) Rules is to counter this precedent. In its November 2014 *Notice of Benefit and Payment Parameters for 2016* proposed rule, HHS stated that it read *all four* of the Section (b)(4) Rules as a simple ban on discrimination:

Section 1302(b)(4) of the Affordable Care Act directs the Secretary to address certain standards in defining EHB, including elements related to *balance*, *discrimination*, the needs of *diverse sections* of the population, and *denial* of benefits. *We have interpreted this provision as a prohibition on discrimination* by issuers providing EHB.<sup>19</sup>

The guidance then stated that the HHS regulation “which implements these provisions,” 45 C.F.R. § 156.125, thus provides that “*an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.*”<sup>20</sup> Significantly, the

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text of this regulation combined elements of the “discrimination” and “no denial” provisions in Section (b)(4) Rules (B) and (D), and seemingly ignored the “diverse needs” provision in Rule (C).<sup>21</sup>

HHS’ example applying this guidance made its interpretation even more explicit:

We caution both issuers and States that age limits are discriminatory when applied to services that have been found clinically effective at all ages. For example, it would be arbitrary to limit a hearing aid to enrollees who are 6 years of age and younger since there may be some older enrollees for whom a hearing aid is medically necessary. . . . [I]ssuers should not attempt to circumvent coverage of medically necessary benefits by labeling the benefit as a “pediatric service” thereby excluding adults.<sup>22</sup>

But does HHS’ read-out of the “diverse segments” mandate get it right?

Advocates have long claimed that health plans historically have failed to include special types of benefits needed by women, children, and the disabled.<sup>23</sup> Simply requiring equal coverage for all will not cure these prior deficits.<sup>24</sup> Hearing aids may be a perfect example of the potential problems caused by HHS’ rework of the rules. Some studies have found that hearing-impaired children have an especially crucial need for hearing aids and cochlear implants, because when provided at an early age these devices significantly aid speech and language acquisition.<sup>25</sup> But hearing aids and cochlear implants can be expensive. According to the National Institutes of Health, two to three in 1,000 children are born with some hearing loss.<sup>26</sup> By

# Analysis

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contrast, more than 50% of adults over age 50 and 75% of adults over age 60 have diminished hearing.<sup>27</sup> While it may be affordable for a plan to provide coverage of hearing aids or cochlear implants for the fairly small group of children who are hearing impaired, extending that coverage to adults may be prohibitively expensive. A young child with diminished hearing is more likely to face debilitating speech-language consequences without hearing aids or cochlear implants than an adult. The question then becomes whether congressional intent was to deny coverage for services that are critically needed by developmentally disabled children in instances where a plan cannot afford to cover similar services for adults?

Under the canons of statutory construction, it is assumed that Congress intended all of the words in a statute to be applied. In the “diverse segments” element of the Section (b)(4) Rules, Congress indicated that plans must take affirmative steps to cover the special needs of children, women, and the disabled. And, the rest of the EHB rules and the ACA do not seem to evince congressional intent to eliminate all age, sex, and disability differences in benefits.<sup>28</sup> For example, one of the ten general EHB categories—“pediatric services—including oral and vision care”—is restricted to children,<sup>29</sup> while another—maternity services—is limited to women.<sup>30</sup>

In comments on the HHS guidance, the National Association of Insurance Commissioners noted that state regulators do not consider age limits for benefits to be inherently discriminatory and that both state and federal laws commonly set age limits for certain benefits.<sup>31</sup> For example, the Social Security Act includes an entire slate of benefits known as Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) that state Medicaid plans are only required to cover for children, but not adults over 21. This includes many services that could be medically necessary for adults, such as hearing aids.<sup>32</sup> And, HHS’ own regulations for the Age Discrimination Act, which prohibits discrimination in programs that receive federal financial assistance, permits age discrimination where a program provides special benefits for the elderly or children.<sup>33</sup>

Instead of a strict ban on any coverage that is limited to specific age, gender, or disability classes, a balancing test likely would better reflect the directives of Section (b)(4). Under this test, a plan could limit coverage to a member segment by showing that the limited coverage meets a special need of the segment and that restricting benefits is actuarially justified by affordability factors.

### HHS’ read-in of the QHP anti-discouragement rule

In addition to the EHB rules, the ACA contains additional standards for certification of QHPs that are sold on the exchanges. Among these standards is the following:

a plan shall, at the minimum . . . meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs.<sup>34</sup>

The statute focuses on marketing practices, but HHS has used the “anti-discouragement” provision to challenge a wide range of practices by QHPs and other EHB plans.

Although the anti-discouragement rule is only found in the QHP certification standards, HHS has long applied it to all other EHB plans.<sup>35</sup> HHS abandoned an earlier proposal to expressly include it in the EHB regulations, but the agency’s November 2014 guidance for the Section (b)(4) Rules effectively reads-in the rule by deeming discouragement to be a form of discrimination.<sup>36</sup>

Since we finalized § 156.125, we have become aware of benefit designs that we believe would *discourage enrollment* by individuals based on age or based on health conditions, *in effect making those plan designs discriminatory*, thus violating this prohibition.<sup>37</sup>

While the authority for this move is questionable, the larger issue is that the anti-discouragement rule as written leaves much undefined: What is the test for “discouragement of enrollment”? And who are “individuals with significant health needs”? Making the rule even more open-ended, HHS’ reading of the rule appears to state a disparate impact standard, because a violation can occur if “the *effect of*” a benefit design is deemed to discourage enrollment, regardless of whether the plan *intended* to discriminate.

HHS’ application of the anti-discouragement rule shows the difficulties caused by this vagueness. In its November 2014 guidance, HHS gave two examples of coverage policies it deemed to discourage enrollment and hence be discriminatory:

[I]f an issuer refuses to cover a single tablet drug regimen or extended-release product that is customarily prescribed and is just as effective as a multi-tablet regimen, we

believe that, absent an appropriate reason for such refusal, such a plan design effectively discriminates against, or discourages enrollment by, individuals who would benefit from such innovative therapeutic options. . . . [I]f an issuer places most or all drugs that treat a specific condition on the highest cost tiers, we believe that such plan designs effectively discriminate against, or discourage enrollment by, individuals who have those chronic conditions.<sup>38</sup>

These examples reflect two of the rule's interpretive problems:

First, these examples conclude, without showing, that the challenged plan terms actually *discourage enrollment*. It is questionable that these cost-sharing terms would discourage members with serious diseases from purchasing health coverage. The EHB rules limit member out-of-pocket costs, so members with serious diseases are likely to incur covered health care costs that far exceed these out-of-pocket limits, and hence to receive significant plan benefits.<sup>39</sup> When all their benefits for medical services and drugs are considered, members with serious diseases should receive far more in benefits from their plans than they pay in premium dollars—providing a strong incentive for enrollment.

HHS' isolation of individual plan terms, without consideration of how the totality of the plan affects a member, also is questionable. A plan may have significant coinsurance for specialty tier drugs, but lower deductibles for prescription drugs than for medical/surgical services. So a member with high usage of drugs in specialty tiers can actually have lower total cost sharing than a member with high medical/surgical costs.

Second, these examples interpret the "have the effect of" language in the statute as requiring that members incur equal charges for the services they obtain, regardless of the cost to the health insurer. Generic drug manufacturers and governmental payers have contended that single-tablet regimen drugs are often just patented combinations of off-patent drugs, and can cost more than the individual drugs they replace without providing greater efficacy.<sup>40</sup> So a plan's refusal to cover a combination drug may arguably reflect its efforts to control health care costs. And HHS' regulations specifically permit plans to use reasonable medical management techniques.<sup>41</sup>

Drug tiering also is based on manufacturer pricing for drugs. When drug costs are considered, plan members often pay a lower percentage of the cost of drugs in higher tiers (which use percentage coinsurance) than in lower tiers (which use fixed copays). While members may pay out more in total dollars for drugs in higher tiers, this is often because their prescriptions cost more money, or because they use higher-cost brand-name rather than generic drugs.

Individuals with serious medical conditions would be expected to incur higher health care costs. But the ACA specifically permits cost sharing. So it does not appear that Congress intended to completely shield health plan members from the costs associated with their medical conditions. In its February

2015 guidance for the Section (b)(4) Rules, HHS stepped back from this "equality of results" analysis and stated that cost can be taken into account in benefit design:

The examples provided in the proposed rule are potentially discriminatory if there is no appropriate non-discriminatory reason for the noted practice. Having a specialty tier is not on its face discriminatory; however, placing most or all drugs for a certain condition on a high cost tier without regard to the actual cost the issuer pays for the drug may often be discriminatory when looking at the totality of the circumstances, and therefore prohibited.<sup>42</sup>

However, this latest guidance shows that HHS also is having difficulty in defining the "persons with significant health needs" who are covered by the anti-discouragement rule. In its February 2015 guidance, as a new example of "discouragement," HHS cites the practice by some plans of making certain drugs only available via mail order. HHS contends that this might prevent transients or persons with privacy concerns from obtaining prescriptions and thus discourage them from enrollment.<sup>43</sup> While plans can still use cost sharing to encourage use of lower-cost mail order pharmacies, the guidance indicates that they must provide members with other means to obtain drugs.

In earlier guidance, HHS had stated that persons with significant health needs were those with "high cost health care needs."<sup>44</sup> Its latest guidance assumes that all health care services are significant, regardless of cost. The effect is that HHS may have transformed the anti-discouragement rule into a general tool to ban any practice that in theory prevents any plan member from accessing benefits. If HHS does move in that direction, it raises the question of whether HHS' application of the statute reflects congressional intent.

### HHS' read-in of prohibitions on race and sex discrimination

The HHS regulations implementing the QHP certification standards also include a requirement that issuers not "discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation."<sup>45</sup> Since 2012, HHS regulations have required all other EHB plans to comply with this rule as well.<sup>46</sup> HHS, however, has provided little guidance on how this rule is to affect EHB plans or adds to the discrimination rules described above.

The *Federal Register* preamble introducing this regulation did not specify its statutory basis.<sup>47</sup> Prior federal civil rights laws prohibiting sex discrimination historically have not been applied to all individual or small group health plans.<sup>48</sup> The Section (b)(4) Rules include prohibitions on discrimination based on age and disability, but not sex or race.

HHS may have based this regulation largely on ACA Section 1557, which applies four pre-existing laws prohibiting

discrimination on the basis of race, color and national origin, sex, age, and disability to health programs and activities that receive federal financial assistance or that are administered by an entity established under Title I the ACA.<sup>49</sup> But such a statutory basis is problematic. While Section 1557 may apply to QHPs, it does not apply to other EHB plans.

## The Effect of ACA Section 1557 on EHB Plans

While Section 1557 may apply to QHPs, it does not necessarily apply to other EHB plans. HHS' proposed rules, which it issued on September 8, 2015, state that Section 1557 covers QHPs because they receive federal funds in the form of premium tax credits and cost-sharing reductions.<sup>50</sup> The rules add that if an insurer receives federal funds for part of its health programs, then Section 1557 applies to all of the insurer's operations, including its services as a third-party administrator.<sup>51</sup> If an insurer only operates individual or small group plans that do not receive federal funds, it should not be subject to Section 1557—but would still need to comply with the EHB rules.

The proposed rules contain general discrimination provisions that apply to all covered entities, as well as specific provisions for health plans. The specific rules provide that plans may not “limit . . . health coverage” or “employ . . . benefit designs” that discriminate based on race, color, national origin, sex, age or disability.<sup>52</sup> The meaning of these rules is unclear. Prior cases on Section 504 of the Rehabilitation Act, one of the four statutes incorporated into Section 1557, have held that Section 504 does not require covered health benefit plans to provide equal benefits to all classes of persons and that it is not actionable discrimination for plans to impose greater numerical and dollar limits on coverage for some conditions than on others.<sup>53</sup>

This specific health plan discrimination rule also needs to be harmonized with the general provisions in the proposed rules. The general provisions incorporate HHS' prior rules for the four civil rights laws referenced in Section 1557, which prohibit exclusion of individuals from participation in programs based on race, color and national origin, sex, disability, or age.<sup>54</sup> And they also incorporate the exceptions to the prior rules—at least for race, disability, and age discrimination.<sup>55</sup> These include an exception to the prohibition on age discrimination where a covered entity “provides special benefits to the elderly or to children.”<sup>56</sup> This would appear, for example, to authorize a health plan to provide coverage of hearing aids that is restricted to children. The proposed rules do not incorporate HHS' prior exceptions on sex discrimination, but the preamble states that some sex-based distinctions might be appropriate, such as a women-only health clinic or a counseling program limited to victims of domestic violence.<sup>57</sup> This suggests that there may be room for health plans to cover special services that are limited based on sex, which would seem consistent with the “diverse segments” provision in the EHB rules.

## Conclusion

Enforcement of the EHB standards is the province of both HHS, through the Centers for Medicare & Medicaid Services, and state regulators,<sup>58</sup> while the HHS Office for Civil Rights is responsible for enforcement of Section 1557. HHS' rulemaking and guidance for both statutes appears unsystematic and perhaps driven by complaints from advocates or its compliance reviews. This can produce unwarranted enforcement actions, including by state regulators, who may take cues from HHS. It can also lead to confusion for judges, who often defer to agency direction. It may be time for HHS to reconsider both its EHB regulations and Section 1557 proposed rules, as well as its guidance, to make them more systematic, complete, and predictable and to ensure they reflect congressional intent, including making health plan coverage affordable. **C**

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## Endnotes

- 1 This guidance was included in the Notice of Benefit and Payment Parameters for 2016 Proposed Rule. See 79 Fed. Reg. 70674, 70723 (Nov. 26, 2014). It was repeated in the Center for Consumer Information and Insurance Oversight's (CCIIO's) Final 2016 Letter to Issuers in Federally-facilitated Marketplaces (Feb. 20, 2015) at pp. 36-37.
- 2 79 Fed. Reg. at 70723.
- 3 80 Fed. Reg. 10750, 10822 (Feb. 27, 2015).
- 4 42 U.S.C. § 18116.
- 5 The proposed rules state that QHPs are covered by Section 1557 because they receive federal financial assistance in the form of premium tax credits and cost-sharing reduction payments. 45 C.F.R. pt. 92, Nondiscrimination in Health Programs and Activities; Proposed Rule, 78 Fed. Reg. 54172, 54195 (Sept. 8, 2015).
- 6 See 45 C.F.R. § 91.17 (incorporated in proposed 45 C.F.R. § 92.191(b)(2)(i)) and proposed 45 C.F.R. § 92.207(b)(1) and (2).
- 7 ConsumerReports.org, *Hazardous health plans* (May 2009), available at [www.consumerreports.org/content/cro/en/health/insurance/hazardous-health-plans.print.html](http://www.consumerreports.org/content/cro/en/health/insurance/hazardous-health-plans.print.html) (visited June 29, 2015).
- 8 42 USC § 300gg-6(a); § 300-91(b)(2); 42 U.S.C. § 18011. See also 80 Fed. Reg. 10763 (“Section 2707(a) of the PHS Act, which is effective for plan or policy years beginning on or after January 1, 2014, extends the coverage of the EHB package to non-grandfathered individual and small group coverage, irrespective of whether such coverage is offered through an Exchange.”); *id.* at 10827 (“Employer-sponsored plans in the large group market and self-insured employers continue to have flexibility in designing their plans. They are not required to cover all EHB.”). Transition rules can extend the compliance dates for some individual and small group plans to policy years beginning after September 30, 2016. CCIIO, *Insurance Standards Bulletin Series—Extension of Transitional Policy through October 1, 2016* (Mar. 5, 2015).
- 9 42 U.S.C. § 18022(b)(1).
- 10 42 U.S.C. § 300gg-11; 42 U.S.C. § 18022(c); 26 U.S.C. § 223(c)(2)(A)(ii).
- 11 42 U.S.C. § 18022 (d)(1)(B).

- 12 42 U.S.C. § 18022(b)(2)(a).
- 13 See, e.g., Sara Rosenbaum and Joel Teitelbaum, *A Lost Opportunity for Persons with Disabilities? The Final Essential Health Benefits Rule*, HEALTH AFFAIRS BLOG (Mar. 11, 2013), available at <http://healthaffairs.org/blog/2013/03/11/a-lost-opportunity-for-persons-with-disabilities-the-final-essential-health-benefits-rule/> (visited July 30, 2015).
- 14 See Sharona Hoffman, *AIDS Caps, Contraceptive Coverage, and the Law: And Analysis of the Federal Anti-Discrimination Statutes' Applicability to Health Insurance*, 23 CARDOZO L. REV. 1315-62 (2002); Sara Rosenbaum, *Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law and Federal Reform Options*. 37 J.L. MED. & ETHICS 103 (2009).
- 15 *Alexander v. Choate*, 469 U.S. 287 (1985); see also *Traynor v. Turnage*, 485 U.S. 535 (1988); *Moderno v. King*, 82 F.3d 1059 (D.C. Cir. 1996); *Rogers v. Dep't of Health and Environ. Control*, 174 F.3d 431 (4th Cir. 1999).
- 16 *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674 (8th Cir. 1996); *Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3d Cir. 1998); *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999); *McNeil v. Time Ins. Co.*, 205 F.3d 179 (5th Cir. 2000); *EEOC v. Staten Island Savings Bank*, 207 F.3d 144 (2d Cir. 2000); but cf. *CarParts Distribution Ctr., Inc. v. Automotive Wholesaler's Ass'n of New England*, 37 F.3d 12 (1st Cir. 1994).
- 17 *Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006 (6th Cir. 1997); *Doe v. Mutual of Omaha*, 179 F.3d 557 (7th Cir. 1999); *Micek v. City of Chicago*, 1999 WL 966970 (N.D. Ill. 1999).
- 18 *Public Employee Retirement Sys. of Ohio v. Betts*, 493 U.S. 158 (1989) (prior version of ADEA); 29 U.S.C. § 623(f)(2)(B)(i) (current version of ADEA).
- 19 79 Fed. Reg. at 70722.
- 20 *Id.*
- 21 The "balance" requirement is included at Section 156.110(e).
- 22 79 Fed. Reg. 70723; 80 Fed. Reg. 10822-23 (reaffirming guidance).
- 23 See Aimee M. Grace, et al., *The ACA's Pediatric Essential Health Benefit Has Resulted in a State-By-State Patchwork of Coverage with Exclusions*, HEALTH AFFAIRS, 33:12:2136-43 (2014); Kyla Davidoff, *Time to close the Gap: Women in the Individual Health Insurance Market Deserve Access to Maternity Coverage*, 25 WISC. J. L., GENDER & SOC'Y 393, 397-98 (2010).
- 24 CMS' tests for QHP compliance, which look for cost-sharing outliers, reductions in benefits, and plan exclusions, reflect HHS' focus on equality rather than the goal of meeting the needs of diverse population segments. See CMS, Final 2016 Letter to Issuers in Federally-facilitated Marketplaces (Feb. 20, 2015), at 36-40.
- 25 J. Bruce Tomblin, *The Influence of Hearing Aids on the Speech and Language Development of Children With Hearing Loss*, JAMA OTOLARYNGOL HEAD NECK SURG. 403-409 (2014); Timothy M. Markman, et al., *Language development after cochlear implantation: an epigenetic model*, J. NEURODEVELOP. DISORD. 3:388-404 (2011).
- 26 National Institutes of Health, National Institute on Deafness and Other Communication Disorders, Quick Statistics, available at [www.nidcd.nih.gov/health/statistics/pages/quick.aspx](http://www.nidcd.nih.gov/health/statistics/pages/quick.aspx) (visited July 30, 2015).
- 27 Yuri Agrawal, et al., *Prevalence of Hearing Loss and Differences by Demographic Characteristics Among US Adults*, ARCH. INTERN. MED., 168(14):1522-1530 (2008).
- 28 National Ass'n of Insurance Commissioners (NAIC), comment letter on Notice of Benefit and Payment Parameters for 2016 (Dec. 18, 2014), at 4.
- 29 42 U.S.C. § 18022(b)(1)(J).
- 30 *Id.* at § 18022(b)(1)(D).
- 31 NAIC, *supra* note 28. According to a report by the American Speech-Language Hearing Association, 17 states require insurers to cover hearing aids or cochlear implants for children, but do not extend this mandate to adults. ASHA, *State Insurance Mandates for Hearing Aids*, available at [www.asha.org/advocacy/state/issues/ha\\_reimbursement/](http://www.asha.org/advocacy/state/issues/ha_reimbursement/) (visited Sept. 1, 2015).
- 32 CMS, *EPSDT-A Guide for States* (June 2014) available at [www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT\\_Coverage\\_Guide.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf) (visited Sept. 1, 2015) at p. 15. See also Hearing Loss Assn. of America, *Medicaid Regulations*, available at [www.hearingloss.org/content/medicaid-regulations](http://www.hearingloss.org/content/medicaid-regulations) (visited Sept. 1, 2015) (listing state Medicaid plans that do not cover hearing aids for adults).
- 33 45 C.F.R. § 91.17.
- 34 42 U.S.C. § 18031(c)(1)(A).
- 35 HHS' QHP regulations include one implementing this statute. 45 C.F.R. § 156.225(b).
- 36 In its November 2012 *Federal Register* Notice on its proposed rules for the EHBs, HHS proposed including a requirement to comply with the anti-discouragement rule in its EHB regulations. 77 Fed. Reg. 70644, 70653, 70670 (Nov. 26, 2012). The agency ultimately did not adopt this proposal and the requirement does not appear in the current version of the EHB discrimination regulation. See 45 C.F.R. § 156.125.
- 37 79 Fed. Reg. 70722.
- 38 *Id.* at 70723.
- 39 For example, a recent study found that health care costs for multiple sclerosis (MS) range from \$8,528 to \$54,244 per year. G. Adelman, *The cost burden of multiple sclerosis in the United States; a systematic review of the literature*, J. MED. ECON., 16:5:639-47 (2013). The out-of-pocket maximum for EHB plans in 2015 is \$6,600, and can be reduced if the member qualifies for cost-sharing-reductions. See [HealthCare.gov](http://www.healthcare.gov), *Out of Pocket Costs*, available at <https://www.healthcare.gov/choose-a-plan/out-of-pocket-costs/> (visited July 22, 2015). Most individuals with MS should receive a substantial net benefit after premiums from purchasing health insurance.
- 40 Roger Peabody, *Treatment outcomes no better with single tablet regimens than individual tablets*, Apr. 23, 2015, available at [www.aidsmap.com/print/Treatment-outcomes-no-better-with-single-tablet-regimens-than-individual-tablets/page/2964131/](http://www.aidsmap.com/print/Treatment-outcomes-no-better-with-single-tablet-regimens-than-individual-tablets/page/2964131/) (visited July 16, 2015). Of course, there are studies finding just the opposite—that single-tablet regimen drugs increase patient compliance and hence are more effective.
- 41 45 C.F.R. § 156.125(c).
- 42 Notice of Benefit and Payment Parameters for 2016, Final Rule, 80 Fed. Reg. 10750, 10823 (Feb. 27, 2015).
- 43 *Id.* at 10821.
- 44 77 Fed. Reg. 70644, 70653 (Nov. 26, 2012).
- 45 45 C.F.R. § 156.200(e).
- 46 *Id.* at § 156.125(b). Some argue that Section 156.125(b) only requires EHB plans to comply with Section 156.200(e) for QHPs. But cf., 77 Fed. Reg. 70653.
- 47 76 Fed. Reg. 41866, 41897 (July 15, 2011).
- 48 See Lisa Codispoli, Brigette Courtot and Jen Swedish, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women*, National Women's Law Center (2008), available at [www.nwlc.org/sites/default/files/pdfs/NWLCReport-NowhereToTurn-81309w.pdf](http://www.nwlc.org/sites/default/files/pdfs/NWLCReport-NowhereToTurn-81309w.pdf) (visited July 30, 2015); Kyla Davidoff, *supra* note 23, at 391-415; Sara Rosenbaum, *Insurance Discrimination*, *supra* note 14.
- 49 42 U.S.C. § 18116. The classes covered in the HHS regulation generally are the same classes covered by the civil rights statutes incorporated in Section 1557. The HHS regulation also adds the categories "gender identity and sexual orientation." This is consistent with recent policy statements from the HHS Office for Civil Rights on Section 1557. See July 12, 2012 letter from HHS, OCR to Maya Rupert, National Center for Lesbian Rights, available at <https://www.nachc.com/client/OCRLetterJuly2012.pdf> (visited July 29, 2015).
- 50 80 Fed. Reg. 54172, 54194-95.
- 51 Proposed 45 C.F.R. § 92.207(b); 80 Fed. Reg. at 54189.
- 52 Proposed 45 C.F.R. § 92.207(b)(1), (2). See 80 Fed. Reg. 54172, 54219.
- 53 See *supra* note 15. It is possible that HHS included these provisions to harmonize the regulations here with its EHB regulations, such as the anti-discouragement rule discussed above. While this might pose less of a problem for QHPs, which are subject to both the EHB and Section 1557 rules, it could pose a problem for benefit plans that are not subject to the EHB rules.
- 54 Proposed 45 C.F.R. § 92.101(b); 80 Fed. Reg. 54218.
- 55 Proposed 45 C.F.R. § 92.101(b); 80 Fed. Reg. 54218.
- 56 45 C.F.R. § 91.17.
- 57 80 Fed. Reg. 54181.
- 58 See 42 U.S.C. § 300gg-22(a), (b); 80 Fed. Reg. 10823.