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The Picture Begins to Assert Itself: 
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Wendy K. Mariner *

I. INTRODUCTION

Joan Miró described his artistic method as moving from free expression to more detailed execution: “I begin painting and as I paint, the picture begins to assert itself. . . The first stage is free, unconscious. The second stage is carefully calculated.”1 Like Miró, the drafters of the Affordable Care Act (“ACA”)2 might resist being labeled Surrealists, but the product of their efforts is a large canvas on which a new picture of health insurance is emerging. In broad strokes, the ACA lays out a vision for financing access to comprehensive, affordable health care, thus changing the nature of health insurance. No longer the subject of an ordinary, voluntary commercial transaction – because almost everyone must obtain some form of coverage – health insurance is becoming a form of social insurance.3

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3. See Paul Starr, Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform 241 (2011) (“The Affordable Care Act restructures health insurance so as to achieve for all Americans the aims it has been serving only for some—to provide access to health care and protection against the risk of being bankrupted by medical costs.”); Wendy K. Mariner, Health Insurance Is Dead: Long Live Health Insurance, 40 Am. J.L. & Med. 195, 201 (2014) [hereinafter Mariner, Long Live Health Insurance] (“[T]he ACA cemented a broader social function for health insurance, employing it to serve the goal of access to affordable healthcare for all.”). The ACA’s future depends on somewhat unpredictable political support for some of its elements. See David Nather, Health Care Torch Passed . . . to Nobody, Politico (Dec. 7, 2014, 8:29 PM), http://www.politico.com/story/2014/12/health-care-democrats-113379.html.
While private, commercial insurance remains a critical element of this system, it is now subject to extensive regulations intended to achieve the ACA's dual goals of comprehensive coverage and affordability. Health insurers who sell policies in the individual and small group markets, including through health insurance exchanges or marketplaces, must comply with ACA requirements for issuance, renewal, coverage, and actuarial value for a significant segment of the health insurance market.

This shift in the nature of health insurance creates some challenges for the law governing the interpretation of health insurance policies. Insurance policies are typically viewed as a specific category of contract, such that traditional rules of contract construction apply to ascertain the meaning of an insurance policy. A substantial body of scholarship has refined these rules to fit the particular quirks of insurance, especially covered benefits and exclusions in standard form insurance policies. Yet, considerable debate remains over which rules are justified and which should apply in which circumstances. Many rules of construction do not seamlessly fit health insurance policies. Health insurance itself has long been a bit of an


5. See, e.g., 42 U.S.C.A. § 300gg-1 (West, WestlawNext through P.L. 113-296, excluding P.L. 113-235, 113-287, and 113-291) (guaranteed issuance of insurance); § 300gg-11 (no lifetime or annual limits); § 300gg-14 (extension of dependent coverage); see also 45 C.F.R. Pt. 153 (2014) (provisions for risk adjustments, risk corridors, and reinsurance); Pt. 156 (requirements for offering qualified health plans on exchanges); Pt. 158 (medical loss ratio requirements).


9. See infra Parts IV-V.
anomaly in the insurance field. The history of health insurance includes examples of courts struggling with whether to classify health plans as service contracts or as insurance for purposes of state insurance regulation. With health insurance operating as a federally regulated industry to finance health care, rather than offering only voluntary contracts to accept certain risks, conventional rules of construction have diminishing relevance. The question of how to interpret coverage governed by the ACA becomes more acute as federal and state governments implement the new regulatory scheme. The challenge is to move from the broad strokes of the ACA canvas to more deliberate details.

This article attempts to take a first step in that direction, without – it must be said – completing the picture. The article explores which rules of interpretation should apply to one specific line of insurance – health insurance policies, primarily qualified health plans, sold to individuals and small groups through the exchanges and private markets governed by the ACA. The ACA requires such plans to cover Essential Health Benefits, described in Part II, but both the statute and the regulations speak in broad categorical terms, leaving considerable discretion to insurers to decide what to cover in particular health plans and in individual cases. This raises the question of which rule – or rules – of construction should be used to make coverage decisions and resolve coverage disputes.

Two possibilities are explored here. First, the doctrine of reasonable expectations, described in Part III, holds some promise. Part IV examines whether that doctrine is suited to making ex post decisions about what health care is covered within the meaning of Essential Health Benefits.

11. See, e.g., id. at 444 (describing health insurance as including elements of both conventional insurance and service contracts); Jordan v. Group Health Ass’n., 107 F.2d 239 (D.C. Cir. 1939). See also Jerry & Richmond, supra note 7, at 24 (noting that in “the health care arena, the line between an ordinary service contract and an insurance contract is more elusive.”).
12. See Mariner, Long Live Health Insurance, supra note 3, at 214 (concluding, “[T]he ACA has taken the first step in the process to provide general standards for health insurance coverage. The next step is to reevaluate the normative standards in insurance law that govern what insurers must do for insureds at the level of patient care.”).
13. The article does not address state Medicaid expansion programs, including those permitted pursuant to a waiver under Social Security Act § 1115, that are allowed to establish benchmark equivalent coverage, which is similar to Essential Health Benefits. See 42 U.S.C. § 1396u-7(b)(2).
governed by the ACA. Since Essential Health Benefits are a statutory requirement, Part V considers the need for rules of statutory interpretation. These could compensate for a disadvantage of the doctrine of reasonable expectations – the likely absence of specific expectations by the parties. The article concludes that courts, insurers, and policyholders would be well served by adopting a functional combination of both approaches, which might be called reasonable statutory expectations, to carry out the regulatory and financing functions of ACA plans. As noted in Part VI, this is a modest conclusion, given the circumscribed scope of private health plans currently subject to ACA requirements. It adds only slightly more definition to the picture. Nonetheless, such a functional approach to interpreting ACA plans could play a positive role and inform a growing number of health plans.

II. THE AFFORDABLE CARE ACT AND ESSENTIAL HEALTH BENEFITS

The goal of the Affordable Care Act is to increase access to health care by enabling individuals and small groups to purchase affordable health insurance in the private market, including through web-based marketplaces (called Exchanges in the Act). This goal is bolstered in part by the individual mandate, and tax credits and subsidies to enable low-income individuals to purchase insurance. To ensure the availability of insurance, the Act requires private health insurers that offer qualified health plans to individuals or small groups through a marketplace exchange or in the regular private market to comply with specific requirements. The majority of those who purchased coverage through an exchange are eligible for subsidies currently, since the IRS interpreted §§ 1311 and 1321 of the ACA to permit subsidies to those who purchased through the federal website. Consequently, most grandfathered plans will ultimately be replaced by self-insured plans or plans that must meet ACA requirements. E.g., 42 U.S.C.A. §§ 18031, 18041 (West, WestlawNext through P.L. 113-296, excluding P.L. 113-235, 113-287, and 113-291) (defining qualified health plans); § 18022 (defining qualified health plans); §18022 (outlining the essential health benefit requirements). The number of grandfathered plans has been declining. Sarah Barr, FAQ: Grandfathered Health Plans, KAISER HEALTH NEWS (Nov. 13, 2013), http://kaiserhealthnews.org/news/grandfathered-plans-faq/. Consequently, most grandfathered plans will ultimately be replaced by self-insured plans or plans that must meet ACA requirements. E.g., 42 U.S.C.A. §§ 18031, 18041 (West, WestlawNext through P.L. 113-296, excluding P.L. 113-235, 113-
include guaranteed issue and prohibitions on exclusions based on pre-existing conditions and health risks, prohibitions on lifetime and annual benefit limits, as well as requirements for plan actuarial values, medical loss ratios, risk adjustments, and data reporting. The exchanges may be established or operated by a state, the federal government, or a federal-state cooperative arrangement of various types. This article refers to the ACA plans required to meet these conditions as “ACA plans,” whether they are offered through an exchange or in the ordinary insurance market.

To assure consistency in benefit design, the ACA requires ACA plans to cover ten categories of health services, called Essential Health Benefits (“EHB”). The Act defines EHB as ten broad categories of benefits:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitation and habilitation services;
8. Mental health and substance use disorder treatment services, including behavioral health treatment;
9. Substance use disorder treatment services, including behavioral health treatment;
10. Preventive and wellness services and preventive health services.

§ 18022(b)(1).
(7) Rehabilitative and habilitative services and devices;
(8) Laboratory services;
(9) Preventive and wellness services and chronic disease management; and
(10) Pediatric services, including oral and vision care.\(^{21}\)

To complicate matters, the ACA also requires that four general “considerations” be taken into account in designing coverage of EHB. First, the EHB categories must be balanced, without undue weight given to any single category.\(^{22}\) Second, coverage must not discriminate on the basis of age, disability, or life expectancy.\(^{23}\) Third, the needs of diverse groups, including women, children, and people with disabilities, should be taken into account.\(^{24}\) And finally, benefits should not be denied on the basis of age, life expectancy, present or predicted disability, degree of medical dependency, or quality of life.\(^{25}\)

The ACA charged the Secretary of Health and Human Services (“HHS”) with the task of defining EHB.\(^{26}\) The Secretary, however, initially allowed the states to flesh out the actual benefit package for their own markets, within some broad parameters.\(^{27}\) States could select a “benchmark” plan as the template for EHB.\(^{28}\) Benchmark plans that did not include all ten EHB categories needed to add the missing categories to qualify.\(^{29}\) This allowed the states and the health insurance industry to use existing policies, often with little modification, as benchmarks to meet eligibility requirements in the rapid gear-up to the first plan year of the ACA’s operation, beginning on or after January 1, 2014.\(^{30}\)

\(^{21}\) Id. The HHS regulations repeat the same unannotated list of benefits. See 45 C.F.R. § 156.110 (West, WestlawNext through Apr. 9, 2015; 80 Fed. Reg. 19,036).

\(^{22}\) Id. at § 18022(b)(4)(A).

\(^{23}\) See id. at § 18022(b)(4)(B) (“[T]he Secretary shall . . . 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.”).

\(^{24}\) Id. at § 18022(b)(4)(C).

\(^{25}\) Id. at § 18022(b)(4)(D).

\(^{26}\) Id. at § 18022(b)(1).


\(^{29}\) See id. (“[W]hen designing plans that are substantially equal to the EHB-benchmark plan, beginning in 2014, issuers may need to conform plan benefits, including coverage and limitations, to comply with [ACA] requirements and limitations.”).

\(^{30}\) See id. For a summary of each state’s benchmark plan, see Consumer Information
The ostensible purpose of specifying EHB for ACA plans was to offer people in the individual and small group market a set of benefits that were comparable to the more robust benefits covered by employer-sponsored plans, while maintaining affordable premiums. However, reliance on existing health plans as benchmarks meant that benefits would not necessarily be uniform across the states. Indeed, anecdotal evidence suggests that benefits vary somewhat within a single state, since different insurance carriers use different definitions of what specific services count as a benefit within the same category.
The ACA requires the Secretary of HHS to develop standards for insurers to use in preparing a summary of benefits and coverage. The current standards (or template) focus on costs to the policyholder, including premiums, deductibles, co-insurance, co-payments, and out-of-pocket limits. The template lists terms for services in generic language, like emergency room services, urgent care, prenatal and postnatal care, rehabilitation services, and hospice services. A glossary presents brief definitions of basic terms like balance billing, deductible, and durable medical equipment, without identifying specific services. For example, the term “medically necessary” is defined as “health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.” Standard terminology should facilitate plan comparisons, so consumers should find these definitions helpful. However, the summaries do not—and probably cannot—describe precisely what services will be provided to...


35. 42 U.S.C.A. § 300gg-15 (West, Westlaw through P.L. 113-296, excluding P.L. 113-235, 113-287, and 113-291) (“[T]he Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees, and policyholders or certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage” and the explanation is to include a description of the coverage for each of the EHB categories, as well as exceptions, reductions, and limits on coverage).


37. Id. at 2-3.


39. Id. at 3.

40. See Daniel Schwarcz, Transparently Opaque: Understanding the Lack of Transparency in Insurance Consumer Protection, 61 UCLA L. Rev. 394, 423-24 (2014) (suggesting that the ACA requirements could be a model for property/casualty and other lines of insurance to enable consumers to compare policy terms in a standardized format).
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anyone in need of future medical care. In any event, the templates are not intended to prescribe the particular services that an ACA plan must cover, and should not be interpreted as doing so. It is the insurer that chooses the services it will cover within EHB categories to comply with ACA requirements.

The variation in EHB will not necessarily be smoothed over in subsequent plan years, for at least four reasons. First, there are so many different insurers, each with multiple plans, that it is unrealistic to expect that they would all define coverage in exactly the same way. Second, it is impossible to specify everything that is or should be covered. This is why health plans have traditionally listed categories of services, such as inpatient hospital services or mental health services, rather than particular drugs, diagnostic tests, surgical procedures, or similar treatments. The services are too numerous to catalog in an insurance policy. A comprehensive list could run thousands of pages. Moreover, as scientific and medical knowledge advances, new services should be added, and perhaps currents ones dropped. Third, insurers are free to use their own formulas to calculate the actuarial value of their plans. This may encourage valuing costs or adding or omitting particular services within each EHB category to achieve the minimum actuarial value required for ACA plans.

Finally, at the level of patient care, it is impossible to predict precisely what care should be covered (apart from routine preventive services and highly standardized therapies, such as setting a broken leg) until an

41. See supra text accompanying notes 33 and 34. Participants in employee group health plans are entitled to receive a summary plan description (although not the actual group health plan, which can be quite lengthy, unless requested) with descriptions similar to the HHS summary described. See Employee Income Security Retirement Act, 29 U.S.C. §§ 1022, 1024. Employee benefit plans and summaries also generally describe benefits in categories, rather than particular services; and while details are sometimes provided for controversial conditions like infertility or items like durable medical equipment, services for general medical conditions, such as heart disease or rheumatoid arthritis, are rarely mentioned. Copies on file with author. See generally, Wendy K. Mariner, Business vs. Medical Ethics: Conflicting Standards for Managed Care, 23 J. L. Med. & Ethics 236, 241 (1995); Ira Mark Ellman & Mark A. Hall, Redefining the Terms of Insurance to Accommodate Varying Consumer Risk Preferences, 20 Am. J. L & Med. 187 (1994); Mark A. Hall & Gerald F. Anderson, Models of Rationing: Health Insurers’ Assessment of Medical Necessity, 140 U. Pa. L. Rev. 1637 (1992).

42. See Alan M. Garber, Evidence-Based Coverage Policy, 20 Health Aff. 62, 79-80 (2001) (providing that in practice, health insurers often rely on guidelines generated internally or based on medical specialty recommendations for best practices to determine what services are appropriate for particular medical conditions).

43. See 45 C.F.R. §156.135 (requiring HHS to provide an actuarial value (AV) calculator for insurers to calculate the actuarial value of their plans, but also allowing the use of alternative AV calculators subject to HHS requirements and state-specific standard populations subject to HHS approval).
individual actually needs care. What care is appropriate often depends on the medical condition and circumstances of the individual who seeks care. For example, even if liver transplantation is expressly listed as a covered service, it would be inappropriate for policyholders with medical contraindications to receive such a transplant. This means that what counts a covered benefit often cannot be specified \textit{ex ante} in the policy when it is issued, but must be decided \textit{ex post} if and when a person seeks care.

The \textit{ex post} nature of benefit coverage determinations suggests that policyholders typically will not know what services an ACA plan will cover unless there is consistency in interpreting EHB when people need health care. When disputes arise over coverage, consistency may be achieved only through the application of remedial principles, those that govern the interpretation of coverage.

III. THE DOCTRINE OF REASONABLE EXPECTATIONS

The breadth and generality of EHB categories, enhanced by the “considerations” with which they should be balanced and fleshed out, offer a nearly blank canvas for benefit determinations. Still, it may be possible to add a little paint to the canvas by considering just how EHB coverage should be interpreted.

The generality of EHB categories suggests that the doctrine of reasonable expectations may hold some promise as a rule of construction. The doctrine of reasonable expectations occupies a somewhat unsettled place in disputes over insurance coverage.\textsuperscript{44} Despite an impressive pedigree and acceptance by most insurance law scholars,\textsuperscript{45} it has not been


\textsuperscript{45} See Peter Nash Swisher, \textit{A Realistic Consensus Approach to the Insurance Law Doctrine of Reasonable Expectations}, 35 Tort & Ins. L.J. 729, 729-732 (2000) (stating that a reasonable expectations analysis would help to assist “academic scholars, jurists, and insurance law practitioners alike” if the theory is interpreted properly); \textit{see also} Robert H. Jerry, II, \textit{Insurance, Contract, and the Doctrine of Reasonable Expectations}, 5 Conn. Ins. L.J. 21, 22-23 (1998) (discussing the history of the doctrine of reasonable expectations); Mark C. Rahdert, \textit{Reasonable Expectations Revisited}, 5 Conn. Ins. L.J. 107, 111, 150 (1998) [hereinafter Rahdert, \textit{Revisited}] (describing four ways that the concept of reasonable expectations is used and rejecting criticisms of each use); Jeffrey W. Stempel, \textit{Unmet Expectations: Undue Restriction of the Reasonable Expectations Approach and the Misleading Mythology of the Judicial Role}, 5 Conn. Ins. L.J. 181, 206-10 (1998) [hereinafter Stempel, \textit{Unmet Expectations}] (discussing scholarly reactions to the reasonable expectations theory and noting that scholars support the doctrine more than do courts); Stephen J. Ware, A
defined or applied entirely consistently. Critics, including insurers, practitioners and some judges, have resisted its appeal. In contrast to more formal rules of contract construction, the doctrine calls for enforcing the policyholder’s objectively reasonable expectations even if the policy provisions negate such coverage. Some, though not all, of this divergence in opinion may stem from the assumption that the doctrine’s viability depends upon its relevance and application to all insurance disputes, or at least those in all lines of consumer insurance.

Professor (later Judge) Keeton formulated the principle of honoring

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Critique of the Reasonable Expectations Doctrine, 56 U. Chi. L. Rev. 1461, 1461 (1989) (stating that “[academic] commentary almost uniformly supports the reasonable expectations doctrine”); Mark C. Rahdert, Reasonable Expectations Reconsidered, 18 Conn. L. Rev. 323, 323-324 (1986) [hereinafter Rahdert, Reconsidered] (providing that the reasonable expectations doctrine was initially very popular with more than one hundred insurance cases in the court system referencing the doctrine, comprising nearly half of the states); Kenneth S. Abraham, Judge-Made Law and Judge-Made Insurance: Honoring the Reasonable Expectations of the Insured, 67 Va. L. Rev. 1151, 1152-153 (1981) [hereinafter Abraham, Judge-Made Law] (discussing the history and application of the reasonable expectations principle).

46. Roger C. Henderson, The Doctrine of Reasonable Expectations in Insurance Law After Two Decades, 51 Ohio St. L.J. 823, 824 (1990); see Randy Maniloff & Jeffrey Stempel, The Reasonable Expectations Approach to Insurance Policy Interpretation, in General Liability Insurance: Key Issues in Every State (3rd ed. forthcoming 2015) (manuscript on file with author) (describing court decisions in all states that accepted and rejected the reasonable expectations doctrine or one of its variants); see also Abraham, Judge-Made Law, supra note 45, at 1153 (stating that the reasonable expectations principle is “not a monolithic one”, as it has been applied in a variety of circumstances, including “cases where the insured’s expectation of coverage was probably real and reasonable. . .where an expectation of coverage was less probable, but the policy’s denial of coverage seemed unfair. . .where an expectation of coverage was improbable and the denial of coverage would not appear unfair.”); Jeffrey E. Thomas, Reasonable Expectations Doctrine, 1-5 APPLMAN ON INSURANCE AND LAW PRACTICE §5.05[3] (2015) [hereinafter Thomas, Appleman on Insurance] (analyzing four approaches to the reasonable expectations doctrine); see also infra Part IV discussion.

47. See Jeffrey E. Thomas, An Interdisciplinary Critique of the Reasonable Expectations Doctrine, 5 Conn. Ins. L.J. 295, 300-301 (1998) [hereinafter Thomas, An Interdisciplinary Critique] (arguing that the doctrine is internally inconsistent); see also Susan M. Popik & Carol D. Quackenbos, Reasonable Expectations after Thirty Years: A Failed Doctrine, 5 Conn. Ins. L.J. 425, 426, 432 (1998) (arguing that the doctrine lacked clear standards, was inconsistently applied, and raised insurance costs); Ware, A Critique of the Reasonable Expectations Doctrine, supra note 45 at 1461-1462 (arguing that the doctrine should be abandoned, because the inequality of bargaining power and standard form contracts the doctrine purports to remedy can promote economic efficiency).

48. Stempel, Unmet Expectations, supra note 45, at 183.

49. See James M. Fischer, The Doctrine of Reasonable Expectations is Indispensable. If We Only Knew What For?, 5 Conn. Ins. L.J. 151, 152 (1998) [hereinafter Fischer, Reasonable Expectations] (discussing the value of the doctrine of reasonable expectations as a “methodology used to import ‘fairness’ into the loss distribution system” of insurance in general).
reasonable expectations to account for judicial decisions that favored an insurance policyholder despite policy language that appeared to exclude or limit coverage – decisions that could not be explained by existing interpretive rules. Policing doctrines, such as fraud, misrepresentation, concealment, duress, mistake, impracticability, and supervening frustration, did not apply in such decisions. Likewise, the decisions did not involve issues of warranty or estoppel. Professor Keeton’s goal was to offer a principle that could impose order on decisions that might otherwise seem arbitrary.

Professor Keeton stated his reasonable expectations principle as follows: “The objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations.” Keeton’s initial justification for the judiciary’s use of such a principle was the disadvantage placed on policyholders who must buy a standard form contract. Then, as now, “[i]nsurance contracts continue to be contracts of adhesion.”

52. As used in practice, however, the reasonable expectations doctrine sometimes resembles principles of unconscionability and estoppel. Thomas, Appleman on Insurance, supra note 46; Jerry, supra note 45, at 36; see Rahdert, Revisited, supra note 45, at 127–28 (stating that “[t]he essential function of this facet of the reasonable expectations idea is to secure the basic fairness of policy terms and procedures).
53. See Keeton, Part One, supra note 44, at 961 (arguing that is possible to find some “currents of principle” in the decisions).
54. Id. at 967. The reasonable expectations principle was Keeton’s second principle. Id. at 961-62. Keeton’s first principle of unconscionable advantage has rarely been controversial, manifesting, as it does, a more general rule against enforcing unconscionable provisions in contracts in general: “An insurer will not be permitted an unconscionable advantage in an insurance transaction even though the policyholder or other person whose interests are affected has manifested fully informed consent.” Id. at 963; see Restatement (Second) of Contracts § 208 (1981) (stating that a court may refuse to enforce a contract or a certain term that is found to be “unconscionable”). A third principle of detrimental reliance is uncontroversial and is of little relevance to the issues considered here. It provides: “A policyholder or other person intended to receive benefits under an insurance policy is entitled to redress against the insurer to the extent of detriment he suffers because he or another person justifiably relied upon an agent’s representation incidental to his employment for the insurer.” Keeton, Part One, supra note 44, at 977–78.
circumstances, Keeton argued, it is appropriate for courts to interpret or “regulate” insurance contract language “as laymen would understand it and not according to the interpretation of sophisticated underwriters.”

Although considered revolutionary in some respects, the doctrine could also be considered a fair adaptation of conventional rules of contract interpretation to insurance disputes. As Professor Jerry notes, the essence of a contract is a meeting of the minds, so that “the reasonable expectations of the parties are fundamental to the formation of a contractual obligation.” Where coverage disputes concerning standard form language in consumer policies arise, it makes some sense to consider the consumer’s reasonable expectations of coverage.

The reasonable expectations doctrine gained notice during the 1970s. It became generally accepted, if sparsely and inconsistently applied in practice, in the 1980s. Since then, the doctrine has suffered retrenchment, with some courts limiting its application to cases in which policy language was ambiguous and other courts rejecting it entirely. Scholars and courts have subjected the doctrine to criticism.

57. Keeton, Part One, supra note 44, at 967; accord Kessler, supra note 56, at 637 (“In dealing with standardized contracts courts have to determine what the weaker contracting party could legitimately expect by way of services according to the enterpriser’s ‘calling,’ and to what extent the stronger party disappointed reasonable expectations based on the typical life situation.”). There exists understandable hesitation to apply the reasonable expectations doctrine to policies that have been carefully negotiated by so-called “sophisticated policyholders” who, unlike ordinary consumers, may have sufficient knowledge or bargaining power to negotiate a carefully tailored policy rather than accept a standard form policy. See Eagle Leasing Corp. v. Hartford Fire Ins. Co., 540 F.2d 1257, 1261 (5th Cir. 1976) (suggesting that the principle of construing ambiguous policy provisions against the drafter might not apply where the policy was negotiated by a “sophisticated” commercial company and the insurer who drafted the resulting policy). See generally Jeffrey W. Stempel, Stempel on Insurance Contracts § 4.11 (2009) (describing the sophisticated policyholder concept and its application); Jeffrey W. Stempel, Reassessing the “Sophisticated” Policyholder Defense in Insurance Coverage Litigation, 42 Drake L. Rev. 807 (1993) (noting that courts have begun to recognize that some parties are more sophisticated than others).

58. See Jerry & Richmond, supra note 7, at 142–45; see also Roger C. Henderson, The Formulation of the Doctrine of Reasonable Expectations and the Influence of Forces Outside Insurance Law, 5 Conn. Ins. L.J. 69, 74 (1998) (noting that the doctrine was influenced by the § 211 of the Restatement (Second) of Contracts, which addressed situations in which standard form contract terms can be ignored).

59. Jerry, supra note 45, at 29.

60. See Abraham, Judge-Made Law, supra note 45, at 1153; see also Stempel, Unmet Expectations, supra note 45, at 184; Jerry, supra note 45, at 22.

61. See Maniloff & Stempel, supra note 46 (forthcoming) (listing state by state rules).

62. Id. See generally Abraham, Distributing Risk, supra note 7 (explaining how public policy relates to interpretation of insurance contracts).

63. See, e.g., Fischer, Reasonable Expectations, supra note 49, at 172 (arguing that the
reevaluation, and reconciliation. As a result, Keeton’s original principle has spawned several variations. Most prominent are a strong (pure) form and a weak form. The strong form follows Keeton’s original formulation, allowing the policyholder’s reasonable expectations to control, even though the policy’s text precludes coverage. The weak version differs little from the general principle of contra proferentem, which construes ambiguous contract language against the drafter. Indeed, it is questionable whether this weak version should be considered a variation on

discipline fails to offer meaningful criteria for determining reasonable expectations); Thomas, An Interdisciplinary Critique, supra note 47 (arguing that the doctrine fails to achieve its goals); Popik & Quackenbos, supra note 47 (arguing that the doctrine is plagued with problems like indefiniteness and unpredictability); Ware, supra note 45 (arguing for abandonment of the doctrine).

64. See, e.g., Rahdert, Revisited, supra note 45 (defending the doctrine against critiques); Rahdert, Reconsidered, supra note 45 (updating his views of the importance of the reasonable expectations doctrine); Abraham, Judge-Made Law, supra note 45 (analyzing applications of variations of the reasonable expectations doctrine).

65. See, e.g., Swisher, supra note 45 (discussing how the doctrine of reasonable expectations is a “middle ground” synthesis of traditional, objective, and contractually based reasonable expectations principles”).

66. See Jerry & Richmond, supra note7, at 145-151 (describing the doctrine of reasonable expectations and its variations); see also Stempel, supra 45, at 192–93 (describing seven court reactions: (1) strong or pure Keeton version; (2) construction in favor of insured where contrary text is hidden, surprising or contravenes the essence of the contract; (3) mandated coverage to accomplish the purpose of the policy; (4) estoppel against insurer because of insurer’s actions; (5) construction of ambiguous text in favor of insurer’s expectations; (6) rejection of policyholder’s expectations; and (7) rejection of policyholder’s unreasonable expectations or expectations that contravene basic insurance principles, such as moral hazard, adverse selection or fortuity); Rahdert, Revisited, supra note 45, at 115, 126, 136, 140 (finding four applications of the doctrine in cases of (1) ambiguous policy language, (2) unconscionable policy provisions, (3) making the policy work for its intended purpose, and (4) protecting policyholders from catastrophic loss).

67. See Jerry & Richmond, supra note 7, at 146 (describing the strong form of the reasonable expectations principle); see also Stempel, supra note 45, at 192 (explaining that this strong form is the most favorable to policyholders).

68. See Restatement (Second) of Contracts § 206 (1981) (explaining that standard contract terms are construed against the drafter); see also Rahdert, Revisited, supra note 45, at 112 (explaining that the “ambiguity principle” invokes contra proferentem – a maxim that the courts apply to interpret ambiguous insurance policy language). This weaker form and variations that apply only in the presence of ambiguous language fit within traditional rules of contract interpretation. Id. Professor Jerry describes how noted scholars of contract foreshadowed the reasonable expectations doctrine. See Jerry, supra note 45, at 42-50. Among the antecedents Jerry cites are Kessler, supra note 56, Karl Llewellyn, The Effect of Legal Institutions Upon Economics, 15 Am. Econ. Rev. 665 (1925), Spencer L. Kimball, Insurance and Public Policy: A Study in the Legal Implementation of Social and Economic Public Policy, Based on Wisconsin Records 1835-1959 (1960), and Alan Schwartz, Karl Llewellyn and the Origins of Contract Theory, in The Jurisprudential Foundations of Corporate and Commercial Law (Jody S. Krauss & Stephen D. Walt, eds., 1999).
the doctrine at all.\textsuperscript{69}

The scholarly debate produced limited consensus on how best to define and apply the doctrine.\textsuperscript{70} The twenty-first century has seen only a smattering of scholarly contributions that even relate to the idea of reasonable expectations.\textsuperscript{71} One possible reason for the continuing unease may be that scholars have not found consensus on a principle that can apply to all lines of insurance without disrupting the predictability of the meaning of contract terms. Universality, while desirable, is not a necessary quality for a principle of interpretation or construction. Some principles may fit only certain types of contracts. It is at least worth examining whether the doctrine does fit one particular context – health insurance policies that must cover the EHB required by the ACA.

IV. DOES THE DOCTRINE OF REASONABLE EXPECTATIONS SUIT EX-POST INTERPRETATIONS OF ESSENTIAL HEALTH BENEFITS?

Commercial health insurance policies occupy a somewhat unusual space among lines of insurance.\textsuperscript{72} They cross the boundary between conventional insurance and service contracts, because they cover both fortuitous losses, like accidental injuries and heart attacks, and predictable “losses,” such as preventive services.\textsuperscript{73} The ACA has pushed health insurance even farther away from the conventional insurance model and toward becoming a method of financing health care.\textsuperscript{74} Conventional rules of contract construction may be inadequate to interpret the terms of these new ACA health plans in light of the ACA’s requirement for coverage of

\begin{itemize}
  \item \textsuperscript{69} See Randall, supra note 6, at 109-110 (arguing that some courts apply \textit{contra proferentem}, while characterizing it as a reasonable expectations approach).
  \item \textsuperscript{70} See Fischer, supra note 49, at 153 (noting the doctrine’s “profund influence both in our conception of what insurance law is and how insurance law is implemented in the courts,” despite its adoption by only a minority of states).
  \item \textsuperscript{72} See Mariner, supra note 10, at 441-47 (discussing characteristics of health insurance before the ACA took effect).
  \item \textsuperscript{73} See \textit{id.} at 438.
  \item \textsuperscript{74} See Mariner, supra note 10, at 196-201 (noting that the ACA eliminated most insurance techniques of risk selection and underwriting for health plans subject to ACA requirements).
\end{itemize}
EHB and its elimination of traditional methods of selecting and underwriting risks.

ACA plans do have the characteristics of insurance policies that make the doctrine of reasonable expectations a potentially useful rule of construction. First, and most obviously, ACA plans are contracts of adhesion – standard form contracts for consumer insurance – the type of insurance contract that the doctrine of reasonable expectations fits best. As Keeton noted, “the insured is left little choice beyond electing among standardized provisions offered to him, even when the standard forms are prescribed by public officials rather than insurers.” The standardized form may still offer some value to the extent that it provides uniform terms in compliance with ACA requirements and approved by state insurance regulators. However, insurers, rather than regulators, typically prepare the plan language, so terminology is not necessarily uniform. Moreover, as long as the Secretary and state regulators allow insurers to draft their own ACA plans, variation in policy language is likely to remain. In these circumstances, the ACA’s goal of ensuring a reasonably uniform package of benefits may not be attained without a reasonably uniform principle for interpreting EHB policy language.

Second, ACA plans may be more “adhesive” than ordinary insurance policies, because individuals must buy a policy or face a penalty. Like consumers who purchase other types of insurance, purchasers of ACA plans have little bargaining power. However, this is not the typical take-it-or-leave-it situation most consumers confront with standard form contracts. While ordinary insurance purchasers may have little or no choice of an automobile insurance policy, for example, they can refuse to buy a car (at least in theory) and thereby avoid having to buy insurance without losing any money. Persons obligated to obtain minimum coverage under the ACA

75. See Abraham, Policy Interpretation, supra note 7, at 540.
76. Keeton, Part One, supra note 44, at 966.
77. Where basic coverage terms are standard, consumers may be better able to compare other terms that may be important to them, such as premium rates, cost sharing, and participating providers. Standard forms have other recognized advantages, such as defining terms uniformly, reducing the transaction costs of negotiating individual agreements with numerous similarly situated individuals, and avoiding the need for individualized underwriting. See Slawson, supra note 55. The ongoing development of rules for web-based Summaries of Benefits and Coverage offers some promise here, although perhaps not enough to clarify EHB. See supra text accompanying notes 35–40.
78. This is not unique to health insurance, of course. See Keeton, Part One, supra note 44, at 966–67.
79. See supra text accompanying notes 29-32.
81. See Schwarcz, supra note 40; see Daniel D. Barnhizer, supra note 71.
do not have that option. They must “take” a policy, because they cannot “leave it” without penalty.

Third, those who purchase through a marketplace exchange have no one to bargain with. They log on to the state or federal website and choose from a list of plans. The information about plans on these websites is typically limited to a list of the general categories of covered benefits (e.g., emergency care, hospital care, maternity benefits), premiums, cost sharing amounts, some service limits, and perhaps a list of participating provider networks. The website may advise applicants to seek more information from each insurer, but insurer websites contain little more information than the exchange, suggesting that those who buy directly from an insurer are likely to learn no more than those who buy through an exchange marketplace.

ACA plan purchasers have few, if any, sources of independent information about plan coverage. There is some evidence that independent insurance brokers offer limited advice about different plans, perhaps because brokers themselves know little more than what consumers find on websites or are not forthcoming with everything they do know. Insurance regulators have not traditionally provided health insurance information directly to consumers. The ACA’s requirement for standardized Summaries of Benefits is a step in the right direction, but should not be expected to offer detailed coverage explanations.

ACA plan purchasers typically cannot read a policy before buying it. Most policyholders never receive a copy of the policy at all, until after the contract has been made. Of course, few consumers read any insurance policy in detail, if at all, and insurers do not expect them to do so.
Llewellyn famously called consumer consent to standard form contract terms a fiction. And consumers who do read a policy are likely to find it incomprehensible, despite recent efforts to prepare readable text. Important details may be hard to find, such as coverage exclusions tucked into the definition of terms. Such textual vagaries give some courts reason to interpret insurance policy provisions to favor the policyholder.

Fourth, and of special importance for ACA plans, the full policy rarely answers the questions a consumer may want or need to know. Some scholars have recommended more specific disclosure of plan terms to compensate for the disadvantages consumers face in purchasing almost any type of insurance. But disclosure of ACA plan terms is not enough. There is evidence that consumers have trouble understanding or using standard disclosures in many contexts. ACA plans present the more difficult problem that the plan itself cannot fully disclose everything that will (or will not) be covered. As noted above, the description of EHB categories is so broad and vague that, apart from a few dental and vision services, the policy itself cannot make explicit all covered benefits or exclusions. Thus, it is impossible to assume that had the consumer read the policy she would have recognized the limits of coverage. Furthermore,

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91. Some versions of the reasonable expectations doctrine are applied where exclusionary language is found to be hidden, obscure, or misleadingly drafted. See Stempel, supra note 45, at 192; John Dwight Ingram, The Insured’s Expectations Should Be Honored Only If They Are Reasonable, 23 Wm. Mitchell L. Rev. 813, 822 (1997).  
93. See Omri Ben-Shahar & Carl E. Schneider, More Than You Wanted to Know: The Failure of Mandated Disclosure 14–31, 26–32, 69 (2014) (summarizing research finding that required disclosures are not necessarily read, understood or used by consumers to make decisions).
neither insurers nor regulators are likely to be able to compensate for the
consumer’s lack of information at the time the policy is purchased, because
they cannot predict ex ante an individual’s future needs.
This brings us to the fifth and most significant reason why the
reasonable expectations doctrine may suit ACA plan coverage decisions.
Covered EHB in an ACA plan are necessarily determined ex post – when
the consumer becomes a patient and seeks insurance coverage for health
care. With inevitably vague EHB coverage terminology, decisions about
what medical services the insurer will pay for necessarily arise only when
the policyholder becomes a patient and seeks health care.94 At that point,
the insurer and the patient each may have different ideas – or expectations –
of what EHB coverage includes.
These different ideas cannot be attributed to the policyholder failing to
read the policy, or even misunderstanding its text.95 The difference is
invited by the vague description of EHB coverage in the policy.
Conventional contract interpretation rules cannot resolve the difference,
because they do not address this problem. They simply do not fit. The
rationale for enforcing the terms of a standard form contract that the
policyholder merely failed to read is inapplicable here.96 The terms
themselves could not specify what should be enforced. The principle that
hidden terms should not be enforced against the policyholder is similarly
inapplicable where specific terms are not hidden, because they are not
included in the contract at all.97 The rule against enforcing unconscionable
terms is similarly inapplicable.98 Most policing doctrines are not likely to
apply to disputes over EHB coverage. Unless the insurer has led the
policyholder to believe that a specific medical service would be covered,

94. There are, of course, important exceptions to this scenario. Some exclusions, such
   as custodial care or experimental therapies, may be clearly set forth in the policy, while
   others might be inferred from the text. Here, the focus is on the more common circumstance
   in which the determination must be made solely on the basis of what counts as part of EHB.
95. See Wendy K. Mariner, Can Consumer-Choice Plans Satisfy Patients? Problems
   with Theory and Practice in Health Insurance Contracts, 69 Brook. L. Rev. 485, 515–18
   (2004) (arguing that different rules may apply to ex ante purchases and ex post treatment
decisions, because “consumers choose health plans, while patients choose medical care”).
96. See generally Robert A. Hillman & Jeffrey J. Rachlinski, Standard-Form
   Contracting in the Electronic Age, 77 N.Y.U. L. Rev. 429 (2002); see generally W. David
   Slawson, Standard Form Contracts and Democratic Control of Lawmaking Power, 84 Harv.
   L. Rev. 529 (1971).
97. See Stempel, supra note 45, at 184–93 (describing judicial refusal to enforce
   coverage exclusions hidden in unexpected places in the contract or couched in unusual
   language, such that consumers would not necessarily notice them).
98. Keeton, supra note 44, at 963 (Keeton’s first principle forbids allowing insurers to
   take advantage of unconscionable provisions.).
fraud, misrepresentation, or estoppel is not likely to apply.99 The insurer is also unlikely to have made any warranty with respect to coverage of general EHB services.100

The rule that ambiguities in the policy should be construed against the drafter – the insurer – might seem to have a place here.101 However, EHB categories are not so much ambiguous as they are vague. There is a difference between ambiguity and vagueness.102 Ambiguous terms are subject to more than one objectively reasonable interpretation.103 Under the general contract rule, ambiguities are construed in favor of the policyholder’s expectations, especially where the policyholder was not in a position to know what the insurer meant.104 Strict application of such a rule to permit coverage of whatever a policyholder wants, however, can put insurers at an unfair disadvantage if the policyholder’s expectation is unreasonable.105 Moreover, such a strict application would not necessarily serve the purpose of an ACA plan.106

The weak form of the reasonable expectations doctrine ameliorates this drawback somewhat by limiting coverage to what would be reasonable for policyholders to expect.107 However, even the weak form does not address

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100. Exceptions might be found where the insurer and insured have an ongoing relationship, such as coverage of specific services for a chronic disease. See Stempel, Swisher, & Knutsen, supra note 8, at 129; see also Jay M. Feinman, Relational Contract and Default Rules, 3 S. Cal. Interdisc. L.J. 43, 54–55 (1993); see generally John Aloysius Cogan Jr., Readability, Contracts of Recurring Use, and the Problem of Ex Post Judicial Governance of Health Insurance Policies, 15 Roger Williams U. L. Rev. 93 (2010); see generally Ian R. Macneil, Contracts: Adjustment of Long-Term Economic Relations Under Classical, Neoclassical, and Relational Contract Law, 72 Nw. U. L. Rev. 854 (1978).

101. See Stempel, supra note 45, at 206; see also Rahdert, Revisited, supra 45, at 116–18; see also Abraham, Policy Interpretation, supra note 7, at 531 (“[I]nsurance policy provisions are in a sense always ambiguous.”); see also Eyal Zamir, The Inverted Hierarchy of Contract Interpretation and Supplementation, 97 Colum. L. Rev. 1710, 1712 (1997) (“No contract can fully and unequivocally address every question that may arise regarding its performance or nonperformance.”).

102. See Farnsworth, Contracts, supra note 51, at § 7.8 (distinguishing vagueness from ambiguity in contracts).

103. See Stempel Swisher & Knutsen, supra note 8, at 131.

104. See Restatement (Second) of Contracts § 201 (1981).


106. See infra Part V.

107. Most courts construe the rule to permit coverage only where coverage is an
the core problem in ACA plans. The problem is not that the insurer uses ambiguous terms, or even that the policyholder interprets those terms differently. Rather, the insurer cannot wholly describe the coverage and the policyholder cannot form concrete expectations. The problem is the vague nature of coverage.

Vague terms present a more difficult problem than do ambiguous terms. Professor Farnsworth defined vague language as terms that are imprecise in marginal applications. However, EHB categories are vague in almost all their applications, not only in marginal ones. Indeed, EHB categories are so general as to be nearly meaningless. They offer only generic boundaries with little hint as to their specific content. A policyholder can only learn exactly what illnesses, injuries, and therapies an insurer includes in these categories at the time – or shortly

\[objectively\] reasonable expectation, considered in light of permissible extrinsic evidence. Stempel, Swisher & Knutsen, supra note 8, at 131; Restatement (Second) of Contracts § 206 (1981); Rahdert, Revisited, supra note 45, at 116–17 (discussing the ambiguity rule in the context of insurance).


109. See Stempel, supra note 45, at 264 (“Many insurance policy provisions, even those routinely enforced by courts, simply are not clear unless one understands the nature of the insurance product and the background of the specific contract.”).


before – that service is sought. At that point, of course, the policyholder and insurer may have quite different expectations about what should be covered.

To be sure, many insurers include provisions stating that they will cover only medically accepted therapies that are recommended by a recognized medical specialty organization or Medicare guidelines, which gives a modicum of substance to the categories. However, the therapies themselves are not listed. More generally, insurers typically limit coverage to “medically necessary” or “appropriate” services and items. While these terms add some limits to the general categories, the services that will be covered remain unspecified. Typically, the insurer reserves the contractual right to determine what is medically necessary in any individual case. Thus, coverage remains unpredictable ex ante by the policyholder and often also by the insurer.

It would be the rare policyholder who is familiar enough with health insurance practices to be able to anticipate the range of healthcare services that will be covered. The ordinary consumer would have to possess a strong imagination to dream up the “losses” for which she seeks coverage ex ante. For the vast majority, no expectation of specific coverage arises until a physician or other health professional recommends a particular course of therapy. In today’s health plans, insurers “satisfy” claims by paying the provider, not the policyholder. The policyholder gets the services the insurer decides are covered ex post.

112. See generally Wendy K. Mariner, Patients’ Rights after Health Care Reform: Who Decides What Is Medically Necessary?, 84 Am. J. Pub. Health 1515 (1994). Some services may seem obvious, such as hospitalization for a stroke, but whether to give the patient tissue plasminogen activator (tPA), for example, depends upon the patient’s circumstances. See id.

113. See id.

114. See id.

115. See id.


117. See Rosenbaum et al., supra note 116, at 229–30. Similarly, health plans often require prior authorization of coverage for particular services for the purpose of determining whether particular services are medically necessary for an individual patient. For example, while a plan may indeed cover the category of behavioral health services, specific services, such as inpatient therapy, may not be covered and paid for without a plan determination that it is actually medically necessary. And ongoing utilization management practices may require periodic determinations that continued therapy is medically necessary. MAHP Letter to Massachusetts Division of Insurance re Special Session on Treatment for Opioid Addiction (Sept. 26, 2014) (on file with author).
Parties to ACA plans cannot realistically agree fully on EHB coverage *ex ante*, because of the unpredictability of any policyholder’s future medical needs and the impossibility of individualized negotiation of terms. In these circumstances, disputes over an ACA plan’s EHB coverage seem all but inevitable. The reasonable expectations doctrine seems well-suited to the task of interpretation, especially in its original strong form. This is because the strong form requires the policyholder’s expectations to be “objectively reasonable.” Insistence on an objective view of reasonableness makes sense where, at the time of purchase, the policyholder did not or could not anticipate what the plan might cover. In that case, when the policyholder needs care, she may “expect” coverage of the course of therapy that she and her physician now think best, regardless of cost.

The doctrine’s focus on expectations, however, may give us pause. If it is nearly impossible to form concrete expectations *ex ante*, how can one use the concept of reasonable expectations to determine coverage *ex post*? A possible answer lies in focusing less on “expectations” and more on what is “reasonable.” The reasonable expectations doctrine, applied to disputes over coverage, could be understood to ask what an insurance policy of this particular sort should reasonably cover. But, one might object, isn’t this the same kind of question that arises with ordinary (non-ACA) health insurance plans? After all, such plans typically describe coverage in generic categories, much like the EHB categories, and present problems of determining what that category includes.

The difference between ACA plans and their predecessor commercial health insurance policies lies in the ACA’s requirements for coverage of all the EHB categories, which takes much of the discretion to select services...
and impose limits out of the insurer’s hands. Moreover, the insurer is not free to select risks for ACA plans, but must ensure balanced coverage under the “considerations,” all while keeping premiums affordable. Thus, what might be reasonable for a pre-ACA health insurance policy may not be reasonable for an ACA plan.

The ACA alters the expectations of both insurer and insured. In the context of ACA plans, the doctrine could ask what therapy or service an ACA plan should reasonably be expected to cover in light of the ACA’s goal of ensuring that ACA plans cover a comprehensive set of benefits – EHB – for a premium that is affordable to the population required to obtain coverage.

V. REASONABLE EXPECTATIONS OF ACA PLANS AND RULES OF STATUTORY INTERPRETATION

The ACA creates legislative expectations for ACA plans. These can be easily inferred from the statutory requirements for ACA plan coverage (including EHB), guaranteed issue and renewal, no dollar caps on coverage, nondiscrimination on the basis of health factors, actuarial values, medical loss ratios, risk adjustments, and reinsurance, to name only a few. ACA plans are almost entirely creatures of the federal statute. This suggests that a fair interpretation of ACA plan terms necessarily depends on understanding – and interpreting – the statutory provisions governing ACA plans.

Rules of statutory interpretation are likely to be necessary in considering how EHB coverage should be construed. Professor Stempel compares the function of standard form insurance policies to that of legislation, arguing that canons of statutory construction could prove useful

125. See supra notes 17–18.
126. Id.
in interpreting policy content.\textsuperscript{128} Professor Randall argues that state “statutory and regulatory control of insurance relationships should displace judicial reliance on contract principles.”\textsuperscript{129} ACA plans are not merely analogous to statutes; their design and marketing are almost entirely governed by legislation and implementing regulations. Federal law dominates the regulatory framework for ACA plans, despite preservation of many state insurance licensure and rate-setting functions.\textsuperscript{130} Indeed, the scope of federal requirements make ACA plans look rather like part of a more traditional federal benefit program, such as Medicare Part B, administered by third party insurers.\textsuperscript{131}

To properly construe the purpose, function, and terms of an ACA plan, it may be impossible to avoid interpreting the statute itself. As Professor Randall suggests, this shifts the starting point for interpretation from contract to statutory rules of construction.\textsuperscript{132} If, as argued above, specific benefits covered by EHB cannot be discerned from the plan text and the parties have no \textit{ex ante} specific intent respecting particular benefits coverage, then contract-based rules of construction offer little guidance. While the doctrine of reasonable expectations suggests searching for what would be reasonable for a health plan of this type, it begs the question of what counts as reasonable in such a plan. If one adds – or begins with – the presumption that ACA plans are intended to function as means of financing affordable health care, then courts may be able to resolve disputes by focusing on the purpose that ACA plans are to serve.\textsuperscript{133}

The ACA can be seen as a remedial statute – one enacted to remedy the market failures that made health insurance unaffordable or unavailable to more than eighteen percent of the population in 2010.\textsuperscript{134} ACA remedial

\textsuperscript{130} See Randall, supra note 6, at 126–36. (for a summary of the variation in often limited regulatory authority of state insurance departments even before the ACA).
\textsuperscript{131} See \textsc{Barbara S. Klees et al.}, \textit{Brief Summaries of Medicare & Medicaid} 11–13 (Nov. 1, 2014) (for a description of Medicare Part B, which combines federal payments with beneficiary premium payments).
\textsuperscript{132} See Randall, supra note 6, at 108, 135–36. This suggests a question beyond the scope of this article: whether ACA plans should be considered to be contracts of adhesion to the extent that the statute and regulations serve to represent the interests of the consumer.
\textsuperscript{133} See Stempel, supra note 128, at 230 (“Particular applications of the policy to unanticipated future disputes may not have been foreseen, but the general goals of the policy provisions are ascertainable with reasonable certainty.”); Robert Katzmann, \textit{Judging Statutes} 31–34 (2014).
\textsuperscript{134} See generally \textsc{Inst. of Med.}, \textit{America’s Uninsured Crisis: Consequences for Health
provisions eliminate most of the prerogatives heretofore enjoyed by individual and small group health insurance carriers under state statutes and common law.\(^{135}\) The maxim that remedial statutes should be liberally construed seems particularly relevant here.\(^{136}\) This rule argues against relying solely on contract rules of construction, particularly those that are limited to the text of an insurance policy’s coverage provisions, and in favor of interpreting ACA plan coverage in light of legislative intent or goals. Arguably, then, the ACA’s requirement for EHB coverage should be liberally construed. At the same time, the ACA goal of affordability argues against a construction so liberal that it would jeopardize the solvency of the health insurance industry.

Some might argue that the ACA could be considered a statute in derogation of the common law. Such statutes were traditionally construed narrowly,\(^{137}\) but that rule may hold little sway today.\(^{138}\) ACA provisions governing insurance do not expressly abrogate common law rules for interpreting insurance policies. Yet, the ACA does impose federal rules on activities – designing, pricing, and selling health insurance policies – that were already regulated in part at both the state and federal level.\(^{139}\) The more persuasive view of the ACA is a remedial statute that expands federal regulation to remedy the market failures remaining under pre-existing laws.

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138. See Scott, supra note 136, at 402 (finding that twenty states rejected the rule that statutes in derogation of the common law should be strictly construed); see also Pound, supra note 137, at 387 (arguing that the principle that statutes in derogation of the common law should be strictly construed was already an anachronism in 1908, because “no statute of any consequence dealing with any relation of private law can be anything but in derogation of the common law”).
Assuming that the ACA is a remedial statute, however, does not automatically answer the question of how EHB should be construed. What exactly should be construed expansively? One might argue that EHB categories should be construed expansively to permit coverage of most, if not all, services that fall within the category. But that would have the same disadvantages that construing coverage to favor the policyholder’s expectations would have, especially if expectations are not limited to objectively reasonable expectations.

Here, the canons of statutory construction may help. The text of the EHB section of the ACA is too vague to offer a plain meaning for designing coverage or making individual patient care determinations. Although the EHB requirements are not precisely ambiguous in the sense used in interpreting insurance policies, they should qualify as ambiguous for purposes of statutory interpretation and therefore be subject to the more contextual rules of construction, legislative intent in particular.

The meaning of EHB appears to depend importantly on its context – the overall goal and function of the ACA. Recall that the ACA’s goal is twofold: to expand access to care by enabling individuals to obtain health insurance coverage, and to keep premiums affordable. One cannot read the statute itself or the limited legislative history without recognizing both objectives. Thus, the ACA itself incorporates the tension inherent in many insurance relationships between the policyholder’s desire for coverage and the insurer’s desire (or need) to limit expenditures. But the ACA does not lean to one or the other. By making both objectives clear, the ACA

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140. See Duncan v. Walker, 533 U.S. 167, 172 (2001) (to find the meaning of a statute, the court begins with its language).

141. See Katzmann, supra note 133, at 35; Kent Greenawalt, Statutory and Common Law Interpretation 140 (2013) (there is “no neat categorization” or hierarchy of factors that apply to statutory interpretation of ambiguous terms). They may also be subject to interpretation by the Departments of Health and Human Services, Labor, and Treasury, the federal agencies charged with issuing regulations to implement the ACA. See Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 843–844 (1984).


recognizes – indeed, requires – balancing the scope of coverage with its cost. This suggests that within EHB categories, insurers must cover necessary and medically acceptable services (and providers), but need not include expensive services where safe and effective alternatives are less costly.

One might be concerned that courts today could be reluctant to engage in this type of functional analysis. Both the reasonable expectations doctrine and the statutory intent canon fall on the functional side of rules of interpretation. That is, each interprets the meaning of policy and statutory language, respectively, in light of its function and purpose, rather than relying on the text alone (unless the text is ambiguous or unclear). But reliance on text alone is not likely to resolve disputes over the meaning of EHB coverage, at least in most cases. Thus, a rule based on function or purpose seems inevitable. The idea that ACA plans serve a remedial statutory function only reinforces this conclusion.

Resistance to the rule of function comes most often from scholars and courts that prefer the formal approach to contract interpretation credited to Professor Williston. This approach resists consideration of any extrinsic evidence outside the “four corners” of the contract unless the text is unclear. The text is presumed to state the parties’ intention, so that the “plain meaning” of the text must be enforced. Courts in the majority of jurisdictions view themselves as bound by their role as interpreters to avoid making judgments that could be considered rewriting the contract between the parties. Judges who are uncomfortable trying to interpret a contract

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146. Fischer, supra note 49, at 180 (The doctrine of reasonable expectations “needs to shed its disguise of policyholder expectations and sustain itself on its true grounding of insurance as a public good and the corollary that coverage decisions should be based on public policy.”).

147. Samuel Williston, A Treatise on the Law of Contracts (1961); see Swisher, supra note 45, at 1047 (comparing formalist and functionalist approaches to interpreting insurance policies).

148. See Randall, supra note 6, at 110–11.

149. See Restatement (First) of Contracts (1932) (presenting the formal rule of construction); Restatement (Second) of Contracts § 211(3) (1981) (reflecting a somewhat more functional approach) (“Where the other party [insurer] has reason to believe that the party [policyholder] manifesting such assent [to a standard form contract] would not do so if he knew that the writing contained a particular term, the term is not part of the agreement.”).

150. See Stempel, Unmet Expectations, supra note 45, at 252–53; see also John E.
without hanging their hat on a contract term may fall back on limiting their analysis to the text of the contract. The rule also supports predictability in judicial decisions; if the contract’s text is clear, it will be enforced without resort to other evidence. Such predictability can save an insurer both administrative and litigation expenses and thereby reduce premium increases.

However, the formal rule does not work for EHB disputes. To the extent that enforcing clear policy language is intended to encourage the parties to expressly agree on their specific intended bargain, the parties to ACA plans simply cannot comply. They do not bargain together, and they cannot adequately specify what they expect from coverage in advance. There is not always a plain meaning. Acceptance of formal interpretation rules only exacerbates the disadvantages of standard form contracts while offering few, if any, of its advantages. While formal policy interpretation may lessen the burden of judges and insurers, it is not a credible method of identifying the intent of the parties in ACA plans. As Professor Fischer argues, “If reading the policy is essentially useless, it is difficult to support use of policy structure or language complexity as a basis for determining reasonable expectations, or any expectations for that matter.”

Professor Stempel argues that the judiciary has little reason to revere the idea of judicial restraint when interpreting any type of insurance policy. There is even less reason to do so in the case of ACA plans. Most obviously, the meaning of contract terms is a matter of law for the court to decide. The terms of ACA plans must also meet statutory
requirements, and statutory interpretation is also a matter for the judiciary. Basing decisions solely on the text of an ACA plan is to pretend to find the meaning of words without admitting the pretense. Since ACA plan provisions on EHB are likely to offer only general descriptions, courts have little choice but to interpret their terms in light of the statutory purpose that such plans are intended to implement. To do otherwise risks overstepping the boundary between Congress and the judiciary.

Furthermore, ex post EHB coverage determinations are individualized decisions, where there is less pressure for the application of a uniform rule. The issue is whether an insurer is bound to pay for a particular course of therapy for one individual, not a search for the plain meaning of a text applicable to all policyholders. What may be reasonable and necessary for one patient may not be for another, and decision-making takes place in the context of limited resources. Courts could consider the cost to the insurer of covering that therapy for the proportion of policyholders who are predicted to need it and compare that cost with premiums. Surely insurers could provide some actuarial support for the assumptions underlying the premium rate. Insurers should be expected to pay for what the policyholder reasonably needs and nothing more, in order to ensure the availability of funds to cover every policyholder’s reasonable needs. In essence, interpreting EHB coverage in individual cases is analogous to deciding whether the insurer is acting in good faith, a doctrine that courts have few qualms applying, despite its independence from the text of a contract.

To be sure, the judicial task of dispute resolution under this analytic framework may be complex. Nonetheless, it may be more honest and acceptable to all parties than attempts to force ACA plan generalities into ill-fitting contract rules of construction. Courts need not resort to fictions like the intent of the parties or ambiguous text, but can focus on identifying appropriate services within the constraints of available resources.

158. The same could be said of judicial conclusions about a policyholder’s expectations. See Fischer, supra note 49, at 164 (“The expectations of the policyholder are defined by the judge’s perception of what constitutes a fair and just bargain.”).
161. See Randall, supra note 6, at 136.
162. For examples of studies of efforts to identify cost-effective health services, see Niteesh K. Choudhry et al., Five Features Of Value-Based Insurance Design Plans Were Associated With Higher Rates Of Medication Adherence, 33 Health Aff. 3493 (2014); Matthew L. Maciejewski et al., Value-Based Insurance Design Program in North Carolina Increased Medication Adherence But Was Not Cost Neutral, 33 Health Aff. 300 (2014). For
Moreover, to the extent that insurers and consumers gain experience with the scope and limits of ACA plan coverage and affordability, regulatory agencies should be able to develop more detailed rules or guidance for specific types of EHB categories, as the Centers for Medicare and Medicaid Services have done for Medicare benefits.\textsuperscript{163}

It may not matter whether one characterizes this approach as a reasonableness standard or as statutory interpretation.\textsuperscript{164} In the case of ACA plans, they are two sides of the same coin.\textsuperscript{165} The approach might be called reasonable statutory expectations. The reasonable expectations of the parties cannot diverge significantly from Congressional intent, because all parties are bound by the statutory framework. Moreover, the ACA itself probably inspires its own expectations among insureds and insurers. Thus, the rule of construction should ask what services a reasonable health plan would cover to comply with the EHB requirements in light of ACA’s goal of comprehensive and affordable coverage.

VI. CONCLUSION

A functional approach to ACA plan interpretation could move us farther down the path to a more “carefully calculated” picture of ACA plan coverage. Since the ACA has altered the concept of insurance in the context of health insurance, it stands to reason that insurance law applied to ACA plans should adapt itself to the ends that the ACA seeks to achieve. Traditional rules of construction for insurance policies do not easily fit the individualized determinations of health services covered as part of EHB.

an analysis of health insurers responses to ACA requirements, see Michael J. McCue & Mark Hall, Health Insurers’ Financial Performance and Quality Improvement Expenditures in the Affordable Care Act’s Second Year, 72 Med. Care Res. & Rev. 113 (2015) (to meet ACA requirements, insurers increased medical loss ratios, decreased median administrative expenses and most increased quality of care expenditures in 2012). Although still too early to predict, some uses of accountable care organizations may encourage more value for money. See, e.g., Arnold M. Epstein, et al., Analysis of Early Accountable Care Organizations Defines Patient, Structural, Cost, and Quality-Of-Care Characteristics, 33 Health Aff. 95 (2014).

163. Although Medicare uses private carriers to administer claims, which can result in some variation in coverage determinations, it also issues National Coverage Determinations to be applied nationally. See Dep’t of Health & Hum. Servs., Ctrs for Medicare & Medicaid Servs., Medicare Coverage – General Information, CMS.GOV, www.cms.gov/Medicare/Coverage/CoverageGenInfo/index.html (last visited Apr. 15, 2015). State insurance regulators may also have discretion to make EHB content more concrete, depending on their state statutory authority. See Stempel, Insurance Policy, supra note 128, at 246.


165. See Fischer, supra note 49, at 163–64 (noting that reasonableness standards import public policy into private law).
Without explicit, individualized content in the definition of EHB, the language of the plan itself can offer no text, ambiguous or otherwise, on which courts might pin their decisions. In the absence of specific \textit{ex ante} expectations about particular health services for a particular person, coverage determinations cannot rely on the intent of the parties or their expectations.

Yet the purpose of ACA plans is clear. They should provide reasonably necessary care at an affordable price. This two-part goal offers a framework for a functional analysis of EHB – reasonable statutory expectations. Decision-makers, both insurers and courts, would be well served by beginning an analysis of EHB coverage that is consistent with the ACA’s two-part goal. In so doing, decision-makers can apply well-established rules of statutory construction, which necessarily apply to health plans that are created and governed by federal law. Where such rules do not resolve conflicting interpretations, decision-makers can look to what can be reasonably expected of a comprehensive, but affordable, ACA plan.

This is a modest conclusion, one that does not pretend to solve all controversies over ACA plans, much less other insurance policy interpretations. It addresses only the interpretation of EHB in ACA plans marketed to individuals and small groups. Thus, it does not challenge the coverage exclusions permitted by the ACA, for example.\textsuperscript{166} Neither does it address plans governed by the Employee Retirement Income Security Act nor any public benefit programs such as Medicare or Medicaid. Moreover, it may not affect ACA plans that include mandatory arbitration provisions, although arbitrators could – and, I would argue, should – apply the same principles in their proceedings.\textsuperscript{167} It could be used in both internal and external review processes for claims determinations.

The proportion of the population currently enrolled in ACA plans is small—less than five percent of eligible individuals.\textsuperscript{168} Nevertheless, the symbolic value of ACA plans far exceeds the number of people they enroll. And, barring a collapse of federal tax credits, that number may grow over


time. ACA plans are an essential piece of the picture of health benefits for all Americans.

A functional approach to interpreting ACA plans may move us toward a more realistic view of health insurance in general. It may also move insurance law toward a more principled conception of highly regulated insurance policies. At the very least, a rule of construction based on the legislative purpose of ACA plans is a step toward achieving fairness both across populations and in individual cases. Decisions that are consistent with ACA goals may foster trust among consumers and patients that their health insurance is serving their most basic needs, even if it does not pay for all their hearts’ desires. This is, after all, the end that the ACA seeks to achieve.

169. King v. Burwell, 759 F.3d 358 (4th Cir. 2014), cert. granted, 190 L. Ed. 2d 355 (2014) (challenging the authority of the Internal Revenue Service to issue tax credits to individuals who purchase health insurance through the federal exchange or a federal-state partnership exchange); see supra note 15.

170. See Abraham, supra note 6, at 670 (describing the ACA as the strongest example of treating health insurance as a heavily regulated industry heavily akin to a public utility).