

Summer 2015

The Picture Begins to Assert Itself: Rules of Construction for Essential Health Benefits in Health Insurance Plans Subject to the Affordable Care Act

Wendy K. Mariner
Boston University School of Law

Follow this and additional works at: https://scholarship.law.bu.edu/faculty_scholarship

 Part of the [Health Law and Policy Commons](#)

Recommended Citation

Wendy K. Mariner, *The Picture Begins to Assert Itself: Rules of Construction for Essential Health Benefits in Health Insurance Plans Subject to the Affordable Care Act*, 24 *Annals of Health Law* 437 (2015).

Available at: https://scholarship.law.bu.edu/faculty_scholarship/351

This Article is brought to you for free and open access by Scholarly Commons at Boston University School of Law. It has been accepted for inclusion in Faculty Scholarship by an authorized administrator of Scholarly Commons at Boston University School of Law. For more information, please contact lawlessa@bu.edu.



The Picture Begins to Assert Itself: Rules of Construction for Essential Health Benefits in Health Insurance Plans Subject to the Affordable Care Act

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

* Edward R. Utey Professor of Health Law, Boston University School of Public Health, Professor of Law, School of Law, Professor of Socio-Medical Sciences, School of Medicine. My thanks to Professors George J. Annas, Leonard H. Glantz, and Jeffrey W. Stempel, and Michael E. Cannella, Health Law & Bioethics Fellow, BU School of Public Health, for insightful comments and suggestions. Errors remain my own.

1. Susie Hodge, *Why Your Five-Year-Old Could Not Have Done That: Modern Art Explained* 63 (2012) (quoting Miró). My thanks to Professors Stempel and Annas for inspiring this metaphor.

2. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010).

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.⁴ 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.⁵

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.⁶ 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.⁷ Yet, considerable debate remains over which rules are justified and which should apply in which circumstances.⁸ Many rules of construction do not seamlessly fit health insurance policies.⁹ Health insurance itself has long been a bit of an

4. See Starr, *supra* note 3 (The ACA “seeks the more limited goal of making health care and health insurance ‘affordable.’”). Health insurance, whether public or private, finances most health care services in the United States. *National Health Expenditures by Type of Service and Source of Funds, Calendar Years 1960-2013*, Ctrs. for Medicare & Medicaid Servs., <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> (follow the hyperlink labeled “National Health Expenditures by type of service and source of funds, CY 1960-2013”) (last modified Dec. 9, 2014, 6:26 AM).

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).

6. Kenneth S. Abraham, *Four Conceptions of Insurance*, 161 U. Pa. L. Rev. 653, 657-58 (2013) [hereinafter Abraham, *Four Conceptions of Insurance*]. See generally Susan Randall, *Freedom of Contract in Insurance*, 14 Conn. Ins. L.J. 107, 107-35 (2008).

7. See Robert H. Jerry, II & Douglas R. Richmond, *Understanding Insurance Law* 125-64 (5th ed. 2012); see also Kenneth S. Abraham, *Distributing Risk: Insurance, Legal Theory, And Public Policy* 118-119, 175-87 (1986) [hereinafter ABRAHAM, *DISTRIBUTING RISK*] (discussing reformation of contracts, breaches of contract, and measures of damages). See generally Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 Mich. L. Rev. 531 (1996) [hereinafter Abraham, *Policy Interpretation*]; James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context*, 24 Ariz. St. L.J. 995 (1992); Spencer L. Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 Minn. L. Rev. 471 (1961).

8. See Jeffrey W. Stempel et al., *Principles of Insurance Law* 103-38 (4th ed. 2012) (discussing the legal system and methods by which it assesses insurance policies and determines coverage).

9. See *infra* Parts IV-V.

anomaly in the insurance field.¹⁰ 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.¹¹ 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.¹² 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.¹³ The ACA requires such plans to cover Essential Health Benefits,¹⁴ 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

10. See Wendy K. Mariner, *Health Reform: What's Insurance Got to Do With It? Recognizing Health Insurance as a Separate Species of Insurance*, 36 Am. J.L. & Med. 436, 438 (2010) [hereinafter Mariner, *What's Insurance Got to Do With It?*] (describing ways in which health insurance differs from conventional insurance).

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).

14. 42 U.S.C.A. § 18022(b) (West, WestlawNext through P.L. 113-296, excluding P.L. 113-235, 113-287, and 113-291); 42 U.S.C.A. § 300gg-6(b) (West, WestlawNext through P.L. 113-296, excluding P.L. 113-235, 113-287, and 113-291).

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).¹⁵ This goal is bolstered in part by the individual mandate, and tax credits and subsidies to enable low-income individuals to purchase insurance.¹⁶ 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.¹⁷ These

15. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2580 (2012) ("The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care."); see 26 C.F.R. § 1.5000A-2 (2014) (West, WestlawNext through Apr. 9, 2015; 80 Fed. Reg. 19,036) (explaining minimum essential coverage).

16. See 26 U.S.C.A. § 5000A (West, WestlawNext through P.L. 111-148, 111-152, 111-159, and 111-173); see also 26 C.F.R. § 1.5000A-2 (West, WestlawNext through Apr. 9, 2015; 80 Fed. Reg. 19,036); 26 U.S.C.A. § 36B (West, WestlawNext through P.L. 113-296, excluding P.L. 113-235, 113-287, and 113-291) (discussing premium assistance tax credits). 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. See 26 C.F.R. § 1.36B-2 (West, WestlawNext through Apr. 9, 2014; 80 Fed. Reg. 19,036) (detailing a taxpayer's eligibility for premium assistance).

17. 42 U.S.C.A. § 18021 (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.¹⁸ The exchanges may be established or operated by a state, the federal government, or a federal-state cooperative arrangement of various types.¹⁹ 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”).²⁰ 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;

287, and 113-291) (establishing the Exchanges and noting that these requirements do not apply to large group plans or employer-sponsored self-insured or grandfathered plans).

18. 45 C.F.R. Pt. 155 (2014) (establishing the exchanges); 45 C.F.R. Pt. 156 (2014) (listing the requirements for insurers offering qualified health plans on exchanges); 42 U.S.C.A. § 300gg (prohibiting discriminatory premium rates); § 300gg-1 (requiring health insurance issuers to accept every employer and individual that applies for coverage); § 300gg-3 (prohibiting preexisting condition exclusion); § 300gg-2 (guaranteeing that health insurance coverage is renewable); § 300gg-5 (requiring non-discrimination in health care); § 300gg-11 (prohibiting establishment of annual/lifetime limits on the dollar value of benefits); § 300gg-13 (requiring minimum coverage for preventive health services and prohibiting cost sharing in various situations); § 300gg-14 (allowing dependent children to stay on their parents health plan until 26 years of age); § 300gg-19 (requiring an effective internal appeals process); 42 U.S.C.A. § 18061 (West, WestlawNext through P.L. 113-296, excluding P.L. 113-235, 113-287, and 113-291) (providing a transitional reinsurance program); 42 U.S.C.A. § 18062 (establishing a program of risk corridors); 42 U.S.C.A. § 18063 (establishing criteria and methods for low and high actuarial risk plans); 42 U.S.C.A. § 18071 (implementing income-based cost sharing reductions). ACA plans meeting the conditions can be approved as “qualified plans” that can be sold through the marketplace exchanges. § 18031(c) (establishing criteria for qualified health plans).

19. *State Health Insurance Marketplace Types, 2015*, KAISER FAM. FOUND., <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/> (last visited Apr. 13, 2015); Sarah J. Dash & Amy Thomas, *New State-Based Marketplaces Unlikely in 2015, but Technology Challenges Create More Shades of Gray*, THE COMMONWEALTH FUND BLOG (May 1, 2014), <http://www.commonwealthfund.org/publications/blog/2014/may/new-state-based-marketplaces-unlikely-in-2015>; accord Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 Yale L.J. 534 (2011) (discussing variations in exchanges and Medicaid programs as examples of evolving conceptions of federalism).

20. § 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. § 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).

27. 45 C.F.R. § 156.100 (West, WestlawNext through Apr. 19, 2015; 80 Fed. Reg. 19,036). *See generally* Inst. of Med. of the Nat’l Acad., *Essential Health Benefits: Balancing Coverage and Cost* 79-102 (Cheryl Ulmer et al. eds., 2012) (providing recommendations as to the process for defining EHB in terms of a typical small employer health insurance plan, without specifying content).

28. *Additional Information on Proposed State Essential Health Benefits Benchmark Plans*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html> (last visited Apr. 15, 2015).

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,³¹ while maintaining affordable premiums.³² However, reliance on existing health plans as benchmarks meant that benefits would not necessarily be uniform across the states.³³ 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.³⁴

and Insurance Oversight, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/ccio/index.html> (last visited Apr. 15, 2015).

31. § 18022(b)(2) (providing that EHB should be “equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary” without distinguishing between plans offered by large and small employers); see INST. OF MED. of the Nat’l Acad., *supra* note 27, at 80-94 (noting that the IOM recommended using small employer plans as a benchmark, because individuals and small groups are the market for plans offered on an exchange and such plans had lower premiums and actuarial values than large employer plans).

32. See DEP’T OF HEALTH & HUMAN SERVS., HEALTH PLAN CHOICE AND PREMIUMS IN THE 2015 HEALTH INSURANCE MARKETPLACE 1-3 (2015), available at <http://aspe.hhs.gov/health/reports/2015/premiumreport/healthpremium2015.pdf> (discussing affordable premiums).

33. See JUSTINE GIOVANNELLI ET AL., THE COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: REVISITING THE ACA’S ESSENTIAL HEALTH BENEFITS REQUIREMENTS 1-2 (2014), available at http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/oct/1783_giovannelli_implementing_aca_essential_hlt_benefits_rb.pdf (discussing how 2014 and 2015 federal regulations did not create “a single, nationally uniform package of health services” and how states tailored “benefit standards to reflect state priorities”); see also Aimee M. Grace et al., *The ACA’s Pediatric Essential Health Benefit has Resulted in a State-By-State Patchwork of Coverage with Exclusions*, 33 HEALTH AFF. 2136, 2139-141 (2014) (examining the benchmark plans in all fifty states and noting how they differ in relation to pediatric services).

34. See Robert Weisman, *Demand for Expensive Hepatitis C Drug Strains Insurers*, BOSTON GLOBE, June 1, 2014, <http://www.bostonglobe.com/business/2014/05/31/costly-new-hepatitis-treatments-curing-patients-but-straining-health-care-system-finances/SmBE9NoUESxjfgphfqvXKL/story.html> (reporting that Sovaldi, a new drug to treat Hepatitis C, is priced incredibly high which significantly increases expenses for insurers who cover them; as a result, one insurer in the state of Massachusetts, Neighborhood Health, created its own criteria to qualify patients for coverage of the drug and other insurers plan to develop a “gated” approach to pay doctors and hospitals); see also Andrew Pollack, *Lawmakers Attack Cost of New Hepatitis Drug*, N.Y. TIMES, Mar. 21, 2014, http://www.nytimes.com/2014/03/22/business/lawmakers-attack-cost-of-new-hepatitis-drug.html?_r=0 (reporting that with regards to Sovaldi “some insurers say the system cannot absorb the \$84,000 price for a 12-week course of treatment – or \$1,000 a daily pill” and that some health plans are limiting treatment to the sickest patients). New drugs to treat the Hepatitis C Virus, such as Olysio (simeprevir) and Sovaldi (sofosbuvir), can often cure the chronic condition in more patients with certain genotypes in less time and with fewer side effects than previously used drugs alone, such as Interferon, Ribavirin, and either Incivek or Victrelis. *Advances in Medications to Treat Hepatitis C*, AM. LIVER FOUND.,

The ACA requires the Secretary of HHS to develop standards for insurers to use in preparing a summary of benefits and coverage.³⁵ The current standards (or template) focus on costs to the policyholder, including premiums, deductibles, co-insurance, co-payments, and out-of-pocket limits.³⁶ The template lists terms for services in generic language, like emergency room services, urgent care, prenatal and postnatal care, rehabilitation services, and hospice services.³⁷ A glossary presents brief definitions of basic terms like balance billing, deductible, and durable medical equipment, without identifying specific services.³⁸ 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.”³⁹ Standard terminology should facilitate plan comparisons, so consumers should find these definitions helpful.⁴⁰ However, the summaries do not—and probably cannot—describe precisely what services will be provided to

<http://hepc.liverfoundation.org/treatment/the-basics-about-hepatitis-c-treatment/what-medications-are-used-to-treat-hepatitis-c/> (last updated Apr. 2015). Another example is variation in substance abuse treatment. The Massachusetts Association of Health Plans (MAHP) noted that commercial health plans cover most of six FDA-approved medications to treat opioid addiction, but not Methadone. See Letter from the Mass. Ass’n of Health Plans to the Mass. Div. of Ins. (Sept. 26, 2014) (on file with author) (discussing treatment for opioid addiction). See also MASS. ASS’N. OF HEALTH PLANS, OPIOID ADDICTION TREATMENT: EVIDENCE BASED MEDICINE, POLICY, AND PRACTICE, II ON POINT: HEALTH POLICY BRIEF 2-5 (2015), available at http://www.ma hp.com/unify-files/MAHPOnPoint_March2015_Opioid.pdf (arguing that opioid addiction treatment should include a full range of therapies, including medication, in addition to more costly inpatient therapy, which is most often recommended).

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).

36. *Summary of Benefits and Coverage Template*, Ctrs. for Medicare & Medicaid Servs. 1-2, available at <http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/sbc-template-accessible.pdf>.

37. *Id.* at 2-3.

38. *Glossary of Health Coverage and Medical Terms*, Ctrs. for Medicare & Medicaid Servs. 1-2, available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Uniform-Glossary-12-19-14-FINAL.pdf>.

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).

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.⁴¹ 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 current ones dropped.⁴² Third, insurers are free to use their own formulas to calculate the actuarial value of their plans.⁴³ 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 as a covered benefit often cannot be specified *ex ante* in the policy when it is issued, but must be decided *ex post* if and when a person seeks care.

The *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.⁴⁴ Despite an impressive pedigree and acceptance by most insurance law scholars,⁴⁵ it has not been

44. See Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 Harv. L. Rev. 961, 969-977 (1970) [hereinafter Keeton, *Part One*] (introducing the reasonable expectations principle); see also *Insurance Law Rights at Variance with Policy Provisions: Part Two*, 83 Harv. L. Rev. 1281, 1285 (1970) [hereinafter Keeton, *Part Two*] (arguing that the reasonable expectations principle could fruitfully apply to the interpretation of warranties in insurance policies).

45. See Peter Nash Swisher, *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); see also Robert H. Jerry, II, *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, *Reasonable Expectations Revisited*, 5 Conn. Ins. L.J. 107, 111, 150 (1998) [hereinafter Rahdert, *Revisited*] (describing four ways that the concept of reasonable expectations is used and rejecting criticisms of each use); Jeffrey W. Stempel, *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, *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.⁴⁶ Critics, including insurers, practitioners and some judges, have resisted its appeal.⁴⁷ 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.⁴⁸ 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.⁴⁹

Professor (later Judge) Keeton formulated the principle of honoring

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 APPLEMAN 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.⁵⁰ Policing doctrines, such as fraud, misrepresentation, concealment, duress, mistake, impracticability, and supervening frustration, did not apply in such decisions.⁵¹ Likewise, the decisions did not involve issues of warranty or estoppel.⁵² Professor Keeton’s goal was to offer a principle that could impose order on decisions that might otherwise seem arbitrary.⁵³

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.”⁵⁴ 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.⁵⁵ Then, as now, “[i]nsurance contracts continue to be contracts of adhesion.”⁵⁶ In such

50. Keeton, *Part One*, *supra* note 44, at 961-62.

51. See E. Allan Farnsworth, *Contracts* §§ 4.1 – 4.20 (4th ed. 2004) (discussing policing doctrines).

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.

55. Keeton, *Part One*, *supra* note 44, at 966–67. For a seminal discussion of standard form contracts, see generally W. David Slawson, *The New Meaning of Contract: The Transformation of Contracts Law by Standard Forms*, 46 U. Pitt. L. Rev. 21 (1984).

56. Keeton, *Part One*, *supra* note 44, at 966; accord Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 Harv. L. Rev. 1173, 1176–77 (1983) (defining a contract of adhesion); Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 Colum. L. Rev. 629, 631–32 (1943) (using insurance contracts as

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.”⁵⁷

Although considered revolutionary in some respects, the doctrine could also be considered a fair adaptation of conventional rules of contract interpretation to insurance disputes.⁵⁸ 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.”⁵⁹ 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.⁶⁰ It became generally accepted, if sparsely and inconsistently applied in practice, in the 1980s.⁶¹ 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.⁶² Scholars and courts have subjected the doctrine to criticism,⁶³

key examples of contracts of adhesion).

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,⁶⁴ and reconciliation.⁶⁵ As a result, Keeton's original principle has spawned several variations.⁶⁶ 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.⁶⁷ The weak version differs little from the general principle of *contra proferentem*, which construes ambiguous contract language against the drafter.⁶⁸ Indeed, it is questionable whether this weak version should be considered a variation on

doctrine 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* note 7, 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 insured'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 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.⁶⁹

The scholarly debate produced limited consensus on how best to define and apply the doctrine.⁷⁰ The twenty-first century has seen only a smattering of scholarly contributions that even relate to the idea of reasonable expectations.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.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.⁷³ The ACA has pushed health insurance even farther away from the conventional insurance model and toward becoming a method of financing health care.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

69. See Randall, *supra* note 6, at 109-110 (arguing that some courts apply *contra proferentem*, while characterizing it as a reasonable expectations approach).

70. See Fischer, *supra* note 49, at 153 (noting the doctrine’s “profound 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).

71. See, e.g., Arthur J. Park, *What to Reasonably Expect in the Coming Years from the Reasonable Expectations of the Insured Doctrine*, 49 Willamette L. Rev. 165 (2012); W. David Slawson, *Contractual Discretionary Power: A Law to Prevent Deceptive Contracting by Standard Form*, 2006 Mich. St. L. Rev. 853; David Horton, *Flipping the Script: Contra Proferentem and Standard Form Contracts*, 80 U. Colo. L. Rev. 431 (2009); Dudi Schwartz, *Interpretation and Disclosure in Insurance Contracts*, 21 Loy. Consumer L. Rev. 105 (2008); Randall, *supra* note 6; Wayne R. Barnes, *Toward a Fairer Model of Consumer Assent to Standard Form Contracts: In Defense of Restatement Subsection 211(3)*, 82 Wash. L. Rev. 227 (2007); Daniel D. Barnhizer, *Inequality of Bargaining Power*, 76 U. Colo. L. Rev. 139 (2005).

72. See Mariner, *supra* note 10, at 441-47 (discussing characteristics of health insurance before the ACA took effect).

73. See *id.* at 438.

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).

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.⁷⁵ 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.”⁷⁶ 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.⁷⁷ However, insurers, rather than regulators, typically prepare the plan language, so terminology is not necessarily uniform.⁷⁸ 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.⁷⁹ 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.⁸⁰ Like consumers who purchase other types of insurance, purchasers of ACA plans have little bargaining power.⁸¹ 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.

80. 26 U.S.C. § 5000A (2015).

81. See Schwarcz, *supra* note 40; see Daniel D. Barnhizer, *supra* note 71.

do not have that option⁸². 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.⁸³ 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.⁸⁴ 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.⁸⁵ Insurance regulators have not traditionally provided health insurance information directly to consumers.⁸⁶ 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.⁸⁷ Of course, few consumers read any insurance policy in detail, if at all, and insurers do not expect them to do so.⁸⁸

82. Persons exempt from the minimum coverage requirement or penalty include undocumented aliens, 26 U.S.C. § 5000A(d)(3); persons with certain religious objections, *id.* at § 5000(d)(2); prisoners, *id.* at § 5000A(d)(4), and persons below certain income thresholds, *id.* at § 5000A(e).

83. See, e.g., HealthCare.gov, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., www.healthcare.gov (last visited Apr. 15, 2015) (federal); Access Health CT, www.ct.gov/hix/site/default.asp (last visited Apr. 15, 2015) (Connecticut); Get Covered Illinois, <https://getcoveredillinois.gov/> (last visited Apr. 15, 2015) (Illinois); Kentucky’s Healthcare Connection, KYNECT, <https://kynect.ky.gov/> (last visited Apr. 15, 2015) (Kentucky).

84. See generally, Schwarcz, *supra* note 40 (arguing that the Consumer Financial Protection Bureau should encompass consumer protection in insurance markets).

85. See Daniel Schwarcz, *Reevaluating Standardized Insurance Policies*, 78 U. Chi. L. Rev. 1263, 1267, 1322, 1329-1331 (2011) (presenting findings from a study of homeowners policies).

86. *Id.* at 1323–25.

87. Keeton, *supra* note 44, at 968; see Schwarcz, *Transparently Opaque*, *supra* note 39, at 421; Deborah Stone, *Promises and Public Trust: Rethinking Insurance Law Through Stories*, 72 TEX. L. REV. 1435, 1438 (1994).

88. See Rakoff, *supra* note 56, at 1179; Michelle Boardman, *Insuring Understanding*:

Llewellyn famously called consumer consent to standard form contract terms a fiction.⁸⁹ And consumers who do read a policy are likely to find it incomprehensible, despite recent efforts to prepare readable text.⁹⁰ Important details may be hard to find, such as coverage exclusions tucked into the definition of terms.⁹¹ 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.⁹² But disclosure of ACA plan terms is not enough. There is evidence that consumers have trouble understanding or using standard disclosures in many contexts.⁹³ 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,

The Tested Language Defense, 95 Iowa L. Rev. 1075, 1077 (2010); Restatement (Second) of Contracts § 211 cmt. b. (1981) (“A party who makes regular use of a standardized form of agreement does not ordinarily expect his customers to understand or even to read the standard terms.”).

89. Karl. N. Llewellyn, *The Common Law Tradition: Deciding Appeals* 370 (1960).

90. See Schwarcz, *supra* note 85, at 1327; see generally Tesa Wilkinson-Ryan, *A Psychological Account of Consent to Fine Print*, 99 Iowa L. Rev. 1745 (2014); Russell Korobkin, *Bounded Rationality, Standard Form Contracts, and Unconscionability*, 70 U. Chi. L. Rev. 1203 (2003); see also Melvin Aron Eisenberg, *The Limits of Cognition and the Limits of Contract*, 47 Stan. L. Rev. 211, 213 (1995); see also Michael I. Meyerson, *The Efficient Consumer Form Contract: Law and Economics Meets the Real World*, 24 Ga. L. Rev. 583, 595 (1990).

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).

92. See Rakoff, *supra* note 56; Edith R. Warkentine, *Beyond Unconscionability: The Case for Using “Knowing Assent” as the Basis for Analyzing Unbargained-for Terms in Standard Form Contracts*, 31 Seattle U. L. Rev. 469, 512 (2008). See also, Melissa T. Lonegrass, *Finding Room for Fairness in Formalism – The Sliding Scale Approach to Unconscionability*, 44 Loy. U. Chi. L.J. 1, 29–34 (2012) (describing literacy, lack of familiarity with the subject matter, time, psychological and other barriers that make actual consumer assent to standard form contract terms unrealistic).

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

99. See generally Eugene R. Anderson & Nadia V. Holober, *Preventing Inconsistencies in Litigation with a Spotlight on Insurance Coverage Litigation: The Doctrines of Judicial Estoppel, Equitable Estoppel, Quasi-Estoppel, Collateral Estoppel, "MEND the Hold," "FRAUD on the Court" and Judicial and Evidentiary Admissions*, 4 Conn. Ins. L.J. 589 (1997–1998).

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).

105. See Michael B. Rappaport, *The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should Not Be Construed against the Drafter*, 30 Ga. L. Rev. 171, 189–91 (1995); but see Horton, *supra* note 71, at 473 (arguing that strict liability contra proferentem “promotes uniformity of meaning in standard-form contracts”).

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.¹⁰⁸ 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.¹⁰⁹ They offer only generic boundaries with little hint as to their specific content.¹¹⁰ Consider the EHB categories of ambulatory patient services, hospitalization, maternity and newborn care, and rehabilitative and habilitative services and devices.¹¹¹ 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).

108. See E. Allan Farnsworth, ‘Meaning’ in the Law of Contracts, 76 Yale L.J. 939, 952–55 (1967) (identifying three types of imprecise contract language: vague terms; ambiguous terms; and ambiguous syntax); see also Jerry & Richmond, *supra* note 7, at 126–67.

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.”).

110. See *id.* Four EHB categories have been somewhat more fully defined. Most specific are Federal regulations requiring coverage of preventive services recommended by the U.S. Preventive Services Task Force. See *Recommendations for Primary Care Practice*, U.S. PREVENTIVE SERVS. TASK FORCE (Oct. 2014), <http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>. Some contraceptive services listed met with considerable controversy. See *Exemption and Accommodations in Connection with Coverage of Preventive Health Services*, 45 C.F.R. § 147.131(a) (2013); see also *Burwell v. Hobby Lobby Stores, Inc.*, 134 S.Ct. 2751, 2759 (2014). Mental health and substance use services are less well articulated in regulations. Many insurers have specified pharmaceutical formularies or tiers and pediatric oral and vision services. See generally state health insurance exchange websites: *Regulations*, CAL. HEALTH BENEFIT EXCH., <http://hbex.coveredca.com/regulations/> (last visited Apr. 15, 2015); *Summary of Benefits and Coverage (SBC)*, KY. HEALTH BENEFIT EXCH., [http://healthbenefitexchange.ky.gov/Pages/Summary-of-Benefits-and-Coverage-\(SBC\).aspx](http://healthbenefitexchange.ky.gov/Pages/Summary-of-Benefits-and-Coverage-(SBC).aspx) (last visited Apr. 15, 2015); *Rules & Regulations*, MASS. HEALTH CONNECTOR, <https://www.mahealthconnector.org/about/policy-center/rules-regulations> (last visited Apr. 15, 2015).

111. *Essential Health Benefits*, HEALTHCARE.GOV, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.healthcare.gov/glossary/essential-health-benefits/> (last visited Apr. 15, 2015).

before – that service is sought.¹¹² At that point, of course, the policyholder and insurer may have quite different expectations about what should be covered¹¹³.

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.¹¹⁴ However, the therapies themselves are not listed.¹¹⁵ More generally, insurers typically limit coverage to “medically necessary” or “appropriate” services and items.¹¹⁶ 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.¹¹⁷ 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.*

116. Alan M. Garber, *Cost-Effectiveness and Evidence Evaluation as Criteria for Coverage Policy*, 23 Health Aff. 284, 285 (2004); Harriette B. Fox & Margaret A. McManus, *A National Study of Commercial Health Insurance and Medicaid Definitions of Medical Necessity: What Do They Mean for Children?*, 1 Ambulatory Pediatrics 16 (2001); Sara Rosenbaum et al., *Who Should Determine When Health Care Is Medically Necessary?*, 340 New Eng. J. Med. 229, 230 (1999); Mariner, *supra* note 112, at 1516–17.

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."¹¹⁸ 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.¹¹⁹

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*?¹²⁰ A possible answer lies in focusing less on "expectations" and more on what is "reasonable."¹²¹ 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.¹²² 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

118. See Keeton, *supra* note 44, at 967;

In our view, the reasonable-expectations doctrine does not automatically mandate either pro-insurer or pro-insured results. It does place a burden on insurance companies to communicate coverage and exclusions of policies accurately and clearly. It does require that expectations of coverage by the insured be reasonable under the circumstances. Neither of those requirements seems overly burdensome. Properly used, the doctrine will result in coverage in some cases and in no coverage in others.

Atwater Creamery Co. v. Western Nat'l Mut. Ins. Co., 366 N.W.2d 271, 278 (Minn. 1985).

119. See Ingram, *supra* note 91, at 826–32.

120. See Thomas, *supra* note 47, at 324–25 (noting that court conclusions about policyholder expectations are often a fiction); see also Rahdert, *Revisited*, *supra* note 45, at 136.

121. See Fischer, *supra* note 49, at 163 (arguing that reasonableness may be used where the contract is silent "as to the level and degree of required specificity").

122. See *id.* at 164–65 (arguing that courts claiming to honor the policyholder's expectations are actually interpreting the contract to serve its social policy purpose).

and impose limits out of the insurer's hands.¹²³ 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.¹²⁴ 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.¹²⁵ ACA plans are almost entirely creatures of the federal statute.¹²⁶ 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.¹²⁷ Professor Stempel compares the function of standard form insurance policies to that of legislation, arguing that canons of statutory construction could prove useful

123. Mariner, *supra* note 10, at 439–40.

124. NAT'L ASS'N OF INS. COMM'RS, ADVERSE SELECTION ISSUES AND HEALTH INSURANCE EXCHANGES UNDER THE AFFORDABLE CARE ACT 2–4 (2011), available at <http://www.naic.org/store/free/ASE-OP.pdf>.

125. *See supra* notes 17–18.

126. *Id.*

127. For general treatments of statutory analysis, see Frank B. Cross, *The Theory and Practice of Statutory Interpretation* (2009); William N. Eskridge, Jr. et al., *Cases and Materials on Legislation: Statutes and the Creation of Public Policy* (4th ed. 2007 & Supp. 2010); Norman J. Singer & J.D. Shambie Singer, *Sutherland on Statutes and Statutory Construction* (2007); Peter L. Strauss, *Legislation: Understanding and Using Statutes* (2006); William D. Popkin, *Statutes in Court: The History and Theory of Statutory Interpretation* (1999); *see also* Abbe R. Gluck & Lisa Schultz Bressman, *Statutory Interpretation from the Inside—An Empirical Study of Congressional Drafting, Delegation, and the Canons: Part I*, 65 *Stan. L. Rev.* 901, 965 (2013) (finding that legislative staff viewed legislative history as second only to statutory text as the most important tool for interpreting legislation).

in interpreting policy content.¹²⁸ Professor Randall argues that state “statutory and regulatory control of insurance relationships should displace judicial reliance on contract principles.”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.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.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.¹³² If, as argued above, specific benefits covered by EHB cannot be discerned from the plan text and the parties have no *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.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 2010.¹³⁴ ACA remedial

128. See Jeffrey W. Stempel, *The Insurance Policy as Statute*, 41 McGeorge L. Rev. 203, 215 (2010) [hereinafter Stempel *Insurance Policy*].

129. Randall, *supra* note 6, at 107; see also James Davey, *Fracturing and Bundling Risks: The Coverage Expectations of the “Real” Reasonable Policyholder*, 11 Rutgers J.L. & Pub. Pol’y 118, 135–38 (2013) (discussing an English case in which the court aligned contract interpretation with statutory interpretation).

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).

131. See BARBARA S. KLEES ET AL., 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).

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.

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, *Judging Statutes* 31–34 (2014).

134. See generally Inst. of Med., *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.

and Health Care (Feb. 2009), available at <http://www.iom.edu/~media/Files/Report%20Files/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care/Americas%20Uninsured%20Crisis%202009%20Report%20Brief.pdf>; see PAUL FRONSTIN, EMP. BENEFIT RES. INST., SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED: ANALYSIS OF THE MARCH 2011 CURRENT POPULATION SURVEY 7 (Sept. 2011), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-2011_No362_Uninsured1.pdf (for data on the numbers of uninsured in 2010).

135. Mariner, *supra* note 10, at 439–40.

136. See Jacob Scott, *Codified Canons and the Common Law of Interpretation*, 98 Geo. L.J. 341, 402, (2010) (concluding that nineteen states have codified this rule as a method of interpreting their state statutes).

137. See Roscoe Pound, *Common Law and Legislation*, 21 Harv. L. Rev. 383, 386 (1908).

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”).

139. See, e.g., Employee Retirement Income Security Act, 29 U.S.C.A. §§ 1001 (West, WestlawNext through P.L. 113-296 (excluding P.L. 113-235, 113-287, and 113-291)); Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 29 & 42 U.S.C.); Americans with Disabilities Act, 42 U.S.C.A. §§ 12101 (West, WestlawNext through P.L. 113-296 (excluding P.L. 113-235, 113-287, and 113-291)); Genetic Information Nondiscrimination Act of 2008, Pub. L. 110-233, 122 Stat. 881 (codified as amended in scattered sections of 29 & 42 U.S.C.).

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.¹⁴⁰ 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.¹⁴¹

The meaning of EHB appears to depend importantly on its context – the overall goal and function of the ACA.¹⁴² 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.¹⁴³ 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

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).

142. See *Bond v. U.S.*, 134 S. Ct. 2077, 2088 (2014) (“Part of a fair reading of statutory text is recognizing that ‘Congress legislates against the backdrop’ of certain unexpressed presumptions,” citing *EEOC v. Arabian Am. Oil Co.*, 499 U.S. 244, 248 (1991)); *Nat'l Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 666 (2007) (words may become meaningful only when read in context); *Food and Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 132–33 (2000) (“A court must . . . interpret the statute as a symmetrical and coherent regulatory scheme, and fit, if possible, all parts into a harmonious whole.”); see also William N. Eskridge, Jr., *Dynamic Statutory Interpretation* 9 (1994) (discussing dynamic statutory interpretation, which accepts that meaning often only becomes clear when applied to “concrete circumstances”).

143. MORGAN DOWNEY & CHRISTOPHER D. STILL, *THE AFFORDABLE CARE ACT'S IMPACT ON PERSONS WITH OBESITY 2* (2013), available at <http://www.downeyobesityreport.com/wp-content/uploads/The-Affordable-Care-Act2.pdf>.

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.¹⁴⁴ Both the reasonable expectations doctrine and the statutory intent canon fall on the functional side of rules of interpretation.¹⁴⁵ 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).¹⁴⁶ 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.¹⁴⁷ This approach resists consideration of any extrinsic evidence outside the “four corners” of the contract unless the text is unclear.¹⁴⁸ The text is presumed to state the parties’ intention, so that the “plain meaning” of the text must be enforced.¹⁴⁹ 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.¹⁵⁰ Judges who are uncomfortable trying to interpret a contract

144. See, e.g., Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* (2012) (arguing for a textualist interpretation); William N. Eskridge, Jr., *The New Textualism and Normative Canons*, 113 Colum. L. Rev. 531, 532–33 (2013) (describing conceptions of textualism); Richard A. Posner, *Reflections on Judging* 178–235 (2013) (arguing that there is no principled hierarchy of canons of construction).

145. See Peter N. Swisher, *Judicial Rationales in Insurance Law: Dusting Off the Formal for the Function*, 52 Ohio St. L.J. 1037, 1052–53 (1991).

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 145, 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.¹⁵¹ The rule also supports predictability in judicial decisions; if the contract's text is clear, it will be enforced without resort to other evidence.¹⁵² Such predictability can save an insurer both administrative and litigation expenses and thereby reduce premium increases.¹⁵³

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.¹⁵⁴ 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."¹⁵⁵

Professor Stempel argues that the judiciary has little reason to reverse the idea of judicial restraint when interpreting any type of insurance policy.¹⁵⁶ 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.¹⁵⁷ The terms of ACA plans must also meet statutory

Murray, *Contract Theories and the Rise of Neoformalism*, 71 *Fordham L. Rev.* 869, 870 (2002); see also Wayne Barnes, *The Objective Theory of Contracts*, 76 *U. Cin. L. Rev.* 1119, 1120 (2008).

151. See Thomas, *supra* note 47.

152. See Randall, *supra* note 6, at 110–11. Of course, some judges may incorrectly assume that their understanding of the meaning of a contract term is the universal understanding. See generally Lawrence Solan, Terri Rosenblatt & Daniel Osherson, *False Consensus Bias in Contract Interpretation*, 108 *Colum. L. Rev.* 1268 (2008) (discussing ways in which judges find meaning in contract provisions).

153. See Rappaport, *supra* note 105, at 244–45.

154. Swisher, *supra* note 145, at 1073 (arguing that decisions sometimes draw on both approaches, either in the same decision or in different decisions, in what he calls a "clash" between formalism and functionalism); see Lonegrass, *supra* note 92, at 54–56; Michael I. Meyerson, *The Reunification of Contract Law: The Objective Theory of Consumer Form Contracts*, 47 *U. Miami L. Rev.* 1263, 1273 (1993).

155. Fischer, *supra* note 49, at 169.

156. See Stempel, *Unmet Expectations*, *supra* note 45, at 292–93; Stempel, *Insurance Policy*, *supra* note 128, at 230–31 (purpose-oriented methods of analysis are only a short step from identifying the goals of an insurance policy).

157. See, e.g., *Boatner v. Atlantic Specialty Ins. Co.*, 115 F.3d 1248, 1251 (5th Cir. 1997); Restatement (Second) of Contracts § 212 cmt. d (1981).

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.¹⁵⁸ 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.¹⁵⁹ 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.¹⁶⁰

To be sure, the judicial task of dispute resolution under this analytic framework may be complex.¹⁶¹ 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.¹⁶²

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.").

159. See Deborah A. Stone, *Promises and Public Trust: Rethinking Insurance Law Through Stories*, 72 TEX. L. REV. 1435, 1440–45 (1994).

160. See Kenneth S. Abraham, *Liability for Bad Faith and the Principle Without a Name (Yet)*, 19 Conn. Ins. L.J. 1 (2012/2013); Robert H. Jerry, II, *Bad Faith at Middle Age: Comments on Abraham, "Liability for Bad Faith and the Principle without a Name (Yet)"*, 19 Conn. Ins. L.J. 13 (2012/2013).

161. See Randall, *supra* note 6, at 136.

162. For examples of studies of efforts to identify cost-effective health services, see Nitesh 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.¹⁶³

It may not matter whether one characterizes this approach as a reasonableness standard or as statutory interpretation.¹⁶⁴ In the case of ACA plans, they are two sides of the same coin.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.

164. See Bailey H. Kuklin, *The Plausibility of Legally Protecting Reasonable Expectations*, 32 *Val. U. L. Rev.* 19 (1997).

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 *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.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.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.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

166. See, e.g., Natali L. Regoli, *Insurance Roulette: The Experimental Treatment Exclusion & Desperate Patients*, 22 *Quinnipiac L. Rev.* 697 (2004).

167. See Susan Randall, *Mandatory Arbitration in Insurance Disputes: Inverse Preemption of the Federal Arbitration Act*, 11 *Conn. Ins. L.J.* 253 (2004/2005); Richard C. Reuben, *Democracy and Dispute Resolution: The Problem of Arbitration*, 67 *Law & Contemp. Prob.* 279 (Winter/Spring 2004); Jeffrey W. Stempel, *Forgetfulness, Fuzziness, Functionality, Fairness, and Freedom in Dispute Resolution: Serving Dispute Resolution Through Adjudication*, 3 *Nev. L. J.* 305 (2002/2003).

168. DEP’T OF HEALTH & HUM. SERVS., ASPE ISSUE BRIEF HEALTH INSURANCE MARKETPLACE: SUMMARY ENROLLMENT REPORT FOR THE INITIAL ANNUAL OPEN ENROLLMENT PERIOD 1 (2014), available at http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf.

time.¹⁶⁹ 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.¹⁷⁰ 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.¹⁷¹

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).

171. Susie Hodge, *Why Your Five-Year-Old Could Not Have Done That: Modern Art Explained* 63 (2012) (quoting Miró). My thanks to Professors Stempel and Annas for inspiring this metaphor.