ESSAY

Requiring Meaning for the Affordable Care Act's Prohibition on Annual Limits

*Matthew Thrasher**

ABSTRACT

The Patient Protection and Affordable Care Act, commonly known as "Obamacare," includes a provision that prohibits insurers from setting annual or lifetime limits to the "dollar value" of coverage for essential health benefits. This element of the law was meant to protect patients with chronic or catastrophic conditions from facing bankruptcy despite having—seemingly—robust health insurance. Notwithstanding this provision, the agencies responsible for implementing the law have informally stated that insurers may convert the statutorily prohibited dollar caps into frequency or duration limitations on benefits. These new forms of benefit limits have the potential to be worse for those with chronic conditions than the simpler dollar caps, and will distort the market in perverse ways. Additionally, these new limits are contrary to the statutory language and purpose. This Essay challenges the agencies' guidance on this issue as an improper interpretation of the statute, and furthermore, bad policy. Part I explains the law's provision on annual and lifetime limits and then describes the current implementation of these provisions. Part II describes the negative real-world effects this implementation is having on those beneficiaries whom the law was meant to help. Part III looks

* J.D., May 2014, The George Washington University Law School; B.A., 2006, Tulane University; Lieutenant in the U.S. Navy (and attended law school through the U.S. Navy's Law Education Program). All views expressed are the author's own. I would like to thank Grace and Henry Thrasher for their inspiration, Caitlin Thrasher for her support, numerous others for their comments, and the staff of *The George Washington Law Review* for their editorial work, especially Elizabeth French for her critical eye, which I greatly needed.

at the statutory interpretation of the provision and analyzes the amount of deference a court would give to the agency interpretation of this issue. Part IV calls on the responsible agencies to issue a bright-line rule in accordance with the statute that would prohibit all annual or lifetime limits to essential health benefits, or else to conduct a more thorough and transparent process to address the topic. Until this occurs, insurers will perversely be free to apply more restrictive annual limits to the sickest beneficiaries because of an interpretation of a statute that was meant to end such limits outright.

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INTRODUCTION

Cari Brown,[1] like many Americans, ensured that she and her family had proper medical coverage so that if they needed costly treat-

1 For more on Cari, and other families' struggle with this issue, see, e.g., Maddie Garrett, *Parents Protesting New Insurance Rules for Autism Therapy*, KOAA NEWS 5 (Dec. 2, 2013, 11:44 PM), http://www.koaa.com/news/parents-protesting-new-insurance-rules-for-autism-therapy/. Cari also has a blog, in which she discusses the fight to get her son coverage. Cari Brown, WE

ments they could receive them without draining their bank account. Unfortunately, after her son was diagnosed with autism, she learned that the amount of treatment he received was not going to be dictated by their doctor's prescription, but by cost-based annual limits that insurers have placed on his benefits.[2] Similar scenes occurred throughout the country as individuals and families facing chronic conditions found out that their insurance benefits were capped when they needed them most, leaving them scrambling to pay bills or relying on public benefits. In 2011, however, people in this predicament had reason to be hopeful because of the passage of the Patient Protection and Affordable Care Act ("PPACA").[3] The President had promised that after the passage of the PPACA insurers would not "be able to place lifetime limits or restrictive annual limits on the amount of care they can receive."[4] For families like Cari Brown's this change was vitally important. It meant that as long as they paid the insurance premiums, they would receive the treatments prescribed by the doctor.

This response was not limited just to people dealing with autism. Some 17,948,000 people were subjected to annual limits in their insurance plans as of 2009.[5] Although the incidence of people reaching their plan's annual—or lifetime—limits is relatively rare compared to the total population, "[t]hese limits particularly affect people with high-cost conditions, which are typically very serious,"[6] and reaching the limit is devastating for these most vulnerable patients.[7] For example, according to a survey, ten percent of cancer patients reach their plan's annual limit, and twenty-five percent of cancer patients or their family members reported extraordinary financial burdens resulting from treatment costs, all while dealing with a debilitating illness.[8]

CELEBRATE THE SMALL STUFF, http://celebratesmallstuff.blogspot.com (last visited Sept. 19, 2014).

2 *See* Garrett, *supra* note 1.

3 Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in sections of 25, 26, 29, and 42 U.S.C.).

4 Remarks on Signing the Patient Protection and Affordable Care Act, 1 PUB. PAPERS 400 (Mar. 23, 2010).

5 Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37,188, 37,204 (June 28, 2010) [hereinafter Annual Limits Rule].

6 *Id.* at 37,204–05 (footnote omitted).

7 *See id.* at 37,205 (citing KAISER FAMILY FOUNDATION ET AL., NATIONAL SURVEY OF HOUSEHOLDS AFFECTED BY CANCER (2006), *available at* http://www.kff.org/kaiserpolls/upload/7591.pdf; Robert W. Seifert & Mark Rukavina, *Bankruptcy Is the Tip of a Medical-Debt Iceberg*, 25 HEALTH AFF. w89 (2006), *available at* http://content.healthaffairs.org/content/25/2/w89.full.html).

8 *See id.*

Unfortunately for Cari, this promise of healthcare reform has been taken away. Instead of getting rid of annual limits to her son's care, the agencies implementing the PPACA are allowing insurers to make the limits even more restrictive. In many cases, the old dollar limits have been changed into restrictive frequency or duration limits,[9] dictating that a patient can only receive a limited number of treatments per year, often fewer treatments even than a patient could have purchased under the old dollar caps.[10]

As this Essay will show, people like Cari had good reason to be hopeful for the law's elimination of annual limits on care, and they are justified in being angry now. Proceeding in four parts, this Essay argues that the PPACA's prohibition on annual and lifetime limits is not being implemented in accordance with the law, and it calls on the responsible agencies to look at this issue more closely and ultimately to promulgate clearer guidance through an open process. Part I provides background on the PPACA's prohibition on annual limits and how the responsible agencies have opened the door for insurers to use frequency and duration limits on benefits to achieve the same ends as the prohibited dollar caps. Part II describes some of the practical issues with the current administrative implementation of the provision and the problems this is creating for patients with the greatest need. Part III highlights the incongruence between the statute's purpose and plain meaning and the informal guidance being issued by the agencies. Further, Part III describes how the administrative agencies' informal interpretation of the statute will not receive a great deal of deference if reviewed by a federal court. Finally, Part IV calls on the agencies to look at this subject more closely and issue a reasoned and justified interpretation of the statute that gives purpose to the text of the law.

I. THE PURPORTED END OF ANNUAL AND LIFETIME LIMITS ON COVERAGE

A. *The Patient Protection and Affordable Care Act*

The passage of the PPACA into law on March 23, 2010,[11] changed the landscape of health care in the United States. An infamously complex[12] and controversial law, the PPACA instituted some major

9 These limits are also referred to colloquially as "visit limits."

10 *See, e.g.*, Maddie Garrett, *New Insurance Rules Creating Gap in Autism Coverage*, KOAA NEWS 5 (Nov. 4, 2013, 11:31 AM), http://www.koaa.com/news/new-insurance-rules-creating-gap-in-autism-coverage/#_.

11 PPACA, Pub. L. No. 111-148, 124 Stat. 119 (2010).

12 *See, e.g.*, Paul Krugman, *Why Is Obamacare So Complicated?*, N.Y. TIMES CONSCIENCE

changes to the American health care system including bolstered patient protections, the set-up of state health insurance exchanges, expansion of existing federal health care coverage programs like Medicaid, and the individual and employer mandates.[13]

1. *Prohibition on Limits to the Annual Dollar Value of Benefits*

In the overwhelmingly controversial PPACA,[14] the patient protections are consistently among the most popular components, primarily because they directly benefit consumers.[15] These federal directives include ending exclusions based on pre-existing conditions, allowing young adults to stay on a parent's plan until age twenty-six, and ending lifetime or annual limits on benefits.[16] Through these provisions, Congress changed the baseline rules for many insurance plans within the country and moved into a field previously occupied mainly by state laws and the Employee Retirement Income Security Act of 1974 ("ERISA").[17]

For example, many states in recent years have mandated certain types of health insurance coverage, but have included annual limits to those mandated benefits as a compromise to insurers' fears of lost profitability.[18] A good example of this is in state-based autism therapy mandates, which states began passing in the early 2000s in order to require coverage that insurers were largely rejecting.[19] For patients

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OF A LIBERAL BLOG (Oct. 26, 2013, 9:58 AM), http://krugman.blogs.nytimes.com/2013/10/26/why-is-obamacare-complicated/?_r=0.

13 *See generally* PPACA, 124 Stat. 119. Admittedly, the PPACA is more complex than a single essay could possibly cover; this article will thus focus on the patient protection feature of ending annual limits.

14 *See* Frank Newport, *No Clear Mandate from Americans on Healthcare Reform*, GALLUP (Nov. 9, 2009), http://www.gallup.com/poll/124202/No-Clear-Mandate-Americans-Healthcare-Reform.aspx; Lydia Saad, *Verdict on Healthcare Reform Bill Still Divided*, GALLUP (June 22, 2010), http://www.gallup.com/poll/140981/Verdict-Healthcare-Reform-Bill-Divided.aspx.

15 *See* Jeffrey M. Jones, *Americans' Approval of Healthcare Law Declines*, GALLUP (Nov. 14, 2013) (reporting the most prevalent reasons citizens cited for supporting the PPACA include "Makes healthcare accessible to more people," "Fair/Right that everyone should have health insurance," and "Covers people with pre-existing conditions"), http://www.gallup.com/poll/165863/americans-approval-healthcare-law-declines.aspx.

16 42 U.S.C. §§ 300gg-3, 300gg-14 (2012).

17 Employee Retirement Income Security Act (ERISA) of 1974, Pub. L. No. 93-406, 88 Stat. 829; *see generally* Mallory Jensen, *Is ERISA Preemption Superfluous in the New Age of Health Care Reform?*, 2011 COLUM. BUS. L. REV. 464, 503 (2011) (discussing ERISA preemption and issues of federalism after the passage of the PPACA).

18 *See* CTR. FOR INFO. & INS. OVERSIGHT, DEP'T OF HEALTH AND HUMAN SERVS., ESSENTIAL HEALTH BENEFITS BULLETIN 7–9 (2011) [hereinafter EHB BULLETIN], *available at* http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

19 *See* EHB BULLETIN, *supra* note 18 at 7; *see also* LORRI SHEALY UNUMB & DANIEL R.

seeking care under these state mandates after the PPACA, the law's provision ending annual limits,[20] which preempts the previous limits set by states,[21] seemed like a great advance.

Specifically, as passed, the PPACA mandates that a "group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish" after January 1, 2014, "annual limits on the dollar value of benefits for any participant or beneficiary."[22] As the PPACA further clarifies, this prohibition only applies to those benefits considered to be "essential health benefits" as defined by the PPACA.[23]

This specific element of the law, presumably because of its popularity, has been a political selling point for the Obama administration. For example, at an event in the run-up to the 2012 election, the Secretary of Health and Human Services ("HHS") touted the law saying "the health care law signed a year ago by President Obama, will help ease the financial burden that often comes with treating and caring for people with ASD [Autism Spectrum Disorder]. . . . Insurers will . . . no longer be allowed to . . . set arbitrary lifetime or annual limits on benefits."[24]

2. *Essential Health Benefits*

The PPACA does not purport to end annual limits for all types of coverage, but only for those aspects of coverage labeled "essential health benefits" ("EHBs").[25] EHBs are core treatments that the PPACA requires insurers to cover in order to be included in new state-based exchanges.[26] Congress listed in the PPACA ten categories

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UNUMB, AUTISM AND THE LAW: CASES, STATUTES, AND MATERIALS 49–50, 62 (2011) (discussing the grassroots push for state insurance mandates for autism).

20 42 U.S.C. § 300gg-11(a)(1)-(2) (2012). Note that section 10101 in Title X of the PPACA supersedes the provision in Title I of the same act. While both appearing in the text of the Public Law, the language in Title X is the language codified, and is the controlling language. *Compare* PPACA § 10101, Pub. L. No. 111-148, 124 Stat. 119, 883 (2012), *with id.* § 2711, 124 Stat. at 131.

21 *See* CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH AND HUMAN SERVS., FREQUENTLY ASKED QUESTIONS ON ESSENTIAL HEALTH BENEFITS BULLETIN (2012) [hereinafter FAQs ON EHB].

22 42 U.S.C. § 300gg-11(a)(2) (2012). The law allowed for a phasing in of the prohibition prior to January 1, 2014, after which the limits are prohibited.

23 *Id.* (referencing "essential health benefits" requirements of PPACA § 1302, codified at 42 U.S.C. 18022).

24 Press Release, U.S. Dep't of Health & Human Servs., Statement by Secretary Sebelius on National Autism Awareness Month (Apr. 1, 2011), *available at* http://wayback.archive-it.org/3926/20140108162226/http://www.hhs.gov/news/press/2011pres/03/20110401a.html.

25 42 U.S.C. § 300gg-11(a)(2).

26 *Id.* § 18022(b). It should be noted that the essential health benefits are also required to

of benefits that must be included in all plans meeting the "essential health benefits" definition: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) 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.[27] Beyond these ten categories, section 1302 of the PPACA generally allows the Secretary of HHS some discretion in further defining areas to be included as EHBs. Congress provided guidelines to shape the Secretary's determination, and mandated that prior to any final decision she "provide notice and an opportunity for public comment."[28]

HHS has chosen to define EHBs, including the core ten categories, through a loose scheme of deference to states and insurers, providing them with maximum flexibility. Despite the ten enumerated categories in the PPACA, states have been allowed to define "essential health benefits" by choosing their own preexisting insurance plans, "benchmark plans," that all other insurers within the state have to match.[29] For things like autism coverage, which varied widely state-to-state, this means that some states include it as an EHB, while others do not.[30] Although this decision benefits states and insurers, many advocates and members of Congress see this scheme as undercutting the intent of the law's ten baseline categories to set up a consistent nationwide minimum of insurance coverage.[31]

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be included in non-grandfathered individual and small group plans offered outside of the exchanges beginning in 2014, and states expanding Medicaid must provide essential health benefits as well. *See* EHB BULLETIN, *supra* note 18, at 1; FAQS ON EHB, *supra* note 21.

27 42 U.S.C. § 18022(b).

28 *Id.* § 18022(b)(3).

29 *See* 45 C.F.R. § 156.100 (2013).

30 *See* AUTISM SPEAKS, THE AFFORDABLE CARE ACT AND AUTISM: ESSENTIAL HEALTH BENEFITS, INCLUDING APPLIED BEHAVIOR ANALYSIS, *available at* http://www.autismspeaks.org/sites/default/files/docs/gr/ehb.10.31de_0.pdf (noting at time of publication that twenty-four states did not include the coverage as an essential health benefit) (last visited Sept. 19, 2014). While this decision may, or may not, be outside the legal discretion of the Secretary, it is outside the scope of this Essay.

31 *See, e.g.*, Letter from Senator Robert Menendez to Sec'y Kathleen Sibelius, Dep't of Health and Human Servs. (Jan. 31, 2012) (arguing that the law's inclusion of "mental health and substance use disorder services, including behavioral health treatment" was specifically added to include coverage for autism therapies as an EHB (internal quotation marks omitted)) [hereinafter Menendez Letter]; *see also* Letter from Interagency Autism Coordinating Comm. to Sec'y Kathleen Sibelius, Dep't of Health and Human Servs. (Mar. 25, 2012) [hereinafter IACC Letter].

B. *Agencies Implementing the Prohibition on Annual Limits*

Although the text of the PPACA is itself vast, the regulations implementing it are even more voluminous. Spread across multiple federal agencies, including the Departments of Health and Human Services, Labor ("DOL"), and Treasury,[32] the final implementing regulations and guidance span well over ten thousand pages.[33]

1. *Regulatory Guidance on Essential Health Benefits and Annual Limits*

Despite the volumes of regulations concerning the PPACA, the main rule in the Federal Register specifically addressing annual limits to EHBs is the interim final rule ("IFR") published on June 28, 2010.[34] The IFR covers a number of the patient protection features of the PPACA, including the ban on rescissions and exclusions based on preexisting conditions, and the prohibition of lifetime and annual limits to coverage.[35] The operative language in the IFR tracks closely with the statutory language in that applicable insurers "may not establish any annual limit on the dollar amount of benefits for any individual."[36] Taking a close look at the language, however, reveals that it does not exactly mirror the statute's wording. In the statute, the annual limit is on "dollar *value* of benefits,"[37] but in the IFR the prohibition is on annual limits to the "dollar *amount* of benefits."[38] It is unclear whether this difference in language is intentional or not. No explanation or justification as to why the language differs appears in the IFR; in fact, there is no acknowledgment in the regulation's discussion of the annual limits provision that its language is different from that in the statute.[39]

Outside of this difference, the IFR generally emphasizes the importance of eliminating annual limits on benefits for reducing overall

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32 *See* Annual Limits Rule, 75 Fed. Reg. 37,188 (June 28, 2010).

33 *See id.; see also* Glenn Kessler, *The Fact Checker: How Many Pages of Regulations for "Obamacare"?*, WASH. POST (May 15, 2013, 6:00 AM), http://www.washingtonpost.com/blogs/fact-checker/post/how-many-pages-of-regulations-for-obamacare/2013/05/14/61eec914-bcf9-11e2-9b09-1638acc3942e_blog.html.

34 Annual Limits Rule, 75 Fed. Reg. 37,188 (June 28, 2010). Though the IFR was subsequently codified in various parts of the C.F.R., citation to the complete rule as it appeared in the Federal Register has been maintained for clarity.

35 *See id.* at 37,190, 37,192.

36 *Id.* at 37,223.

37 42 U.S.C. § 300gg-11 (emphasis added). The law allows for a phasing in of the prohibition prior to January 1, 2014, after which the limits are prohibited. *Id.*

38 Annual Limits Rule, 75 Fed. Reg. at 37,223 (emphasis added).

39 *See id.*

medical costs and improving access to medical care,[40] discusses the effect this elimination will have on premiums,[41] and explicitly excludes certain types of plans (Flexible Savings Accounts, Medical Savings Accounts, and Health Reimbursement Arrangements) from the prohibition.[42] What the IFR does not do is give guidance on how to implement the prohibition, or discuss whether frequency or duration limits are permissible under the law, although the discussion on the need for the prohibition on annual limits seems to presume that after the law goes into effect the problems presented by annual limits to benefits will be alleviated and not simply shifted to other forms.[43]

2. *Informal Guidance Creating a Gap in the Statute*

Informal guidance from the federal agencies does not significantly clarify the issue, but does open the door to insurers and states seeking to circumvent the seemingly broad application of the annual limits prohibition. Much of the consumer-facing guidance is vaguer than the statute or the IFR. For instance, Healthcare.gov, the central hub of the PPACA exchanges, states in its discussion of "health coverage rights and protections" under a sub-heading entitled "Ending Lifetime & Yearly Limits," that "[n]o yearly dollar limits on essential health benefits are allowed for plan years starting January 1, 2014."[44] Furthermore, in the portion of the discussion explaining exceptions to this end of limits, frequency or duration caps on the value of a benefit are not mentioned.[45]

Additionally, HHS published a bulletin on EHBs, which lays out the department's general approach to the topic.[46] The bulletin discusses state mandates, such as those for autism coverage,[47] but does not directly address the prohibition on annual limits. One element that the bulletin does discuss, which is especially confusing to the issue of annual limits, is the idea of benefit substitution. As the bulletin describes, states are to choose benchmark plans that effectively define

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40 *See id.* at 37,205.

41 *See id.* at 37,191.

42 *See id.* at 37,190.

43 *See id.* at 37,205 ("By prohibiting lifetime limits and restricting annual limits, these . . . regulations will help families and individuals experiencing financial burdens due to exceeding the benefit limits of their insurance policy.").

44 U.S. CTRS. FOR MEDICARE AND MEDICAID, *Ending Lifetime & Yearly Limits*, HEALTHCARE.GOV, https://www.healthcare.gov/how-does-the-health-care-law-protect-me/lifetime-and-yearly-limits/ (last visited Sept. 19, 2014).

45 *See id.*

46 *See* EHB BULLETIN, *supra* note 18.

47 *See id.* at 5–7.

EHBs for all participating insurers within the state.[48] As a means to provide added flexibility in meeting the state benchmark plan, the bulletin explains that insurers need not exactly match the benchmark plan's coverage, but must "offer benefits that are 'substantially equal' to the benefits of the benchmark plan selected by the State."[49] The bulletin makes no claim, though, that this type of regulatory substitution supersedes the statutory patient protections, such as the prohibition on annual limits, or the end to discrimination against pre-existing conditions.

While the bulletin itself does not directly address annual limits, a *Frequently Asked Questions on Essential Health Benefits Bulletin* ("FAQ") published by HHS addresses the issue.[50] In question eight, HHS is asked: "Can scope and duration limitations be included in the EHB?"[51] In answering that scope and duration limits are indeed authorized, HHS echoes the bulletin by saying that substitution is generally allowable: "Under the intended approach, a plan must be substantially equal to the benchmark plan, in both the scope of benefits offered and any limitations on those benefits such as visit limits."[52] The answer continues on to say: "However, any scope and duration limitations in a plan would be subject to . . . [section 1001 of the PPACA, which] prohibits imposing annual and lifetime dollar limits on EHB."[53]

The next question in the FAQ again addresses the issue of state mandates and frequency limits. Question nine asks: "State-mandated benefits sometimes have dollar limits. How does the intended EHB policy interact with the annual and lifetime dollar limit provisions of the Affordable Care Act?"[54] As in the previous question, HHS gives a somewhat confusing, bifurcated answer. It starts by saying that the ACA "does not permit annual or lifetime dollar limits on EHB. Therefore, if a benefit, including a State-mandated benefit, included within a State-selected EHB benchmark plan was to have a dollar limit, that benefit would be incorporated into the EHB definition without the dollar limit."[55]

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48 *See id.* at 8–9.

49 *See id.* at 12.

50 *See* FAQs ON EHB, *supra* note 21.

51 *Id.*

52 *Id.*

53 *Id.*

54 *Id.*

55 *Id.*

Despite this statement, the answer goes on to discuss benefit substitutions for EHBs, stating: "[B]ased on the Bulletin describing our intended approach, plans would be permitted to make actuarially equivalent substitutions within statutory categories. Therefore, plans would be permitted to impose non-dollar limits, consistent with other guidance, that are at least actuarially equivalent to the annual dollar limits."[56]

This seems to say that non-dollar limits, such as frequency limits, somehow bypass the law's prohibition against limiting the "dollar value of benefits"[57] if they are converted through the use of actuarial equivalency, even though such new limits would be, by design and valuation, the same as a dollar cap to the benefit.

Finally, in another document discussing how to implement EHB benchmark plans, the Centers for Medicare and Medicaid Services states that "EHB-benchmark plans displayed may include annual and/or lifetime dollar limits; however, in accordance with 45 CFR 147.126, these limits cannot be applied to the essential health benefits. Annual and lifetime dollar limits can be converted to actuarially equivalent treatment or service limits."[58] Again, the guidance is internally inconsistent. It correctly states that annual limits to the dollar value of coverage for EHBs are not allowed under the PPACA, but also says that those illegal limits can be permitted if converted into other forms of equal dollar value.

HHS's choice to use benchmark plans to define EHBs necessitated benefit substitution so that insurance companies would have flexibility in plan design, but this choice should not be able to alter the statute's patient protections. Despite this, the informal guidance on benchmark plans seems to be grafting the HHS-created concept of allowable benefit substitution onto the separate statutory patient protection that prohibits annual limits on the dollar value of benefits. In effect, this guidance creates a way for insurers to enact an annual limit to benefits through substitution simply by swapping prohibited dollar limits for a frequency limit of equal dollar value. It is unclear if this is really the reasoned official position of the cognizant agencies, or

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56 *Id.* For a precise definition of actuarial equivalency as used in the health insurance industry see AM. ACAD. OF ACTUARIES, CRITICAL ISSUES IN HEALTH REFORM: ACTUARIAL EQUIVALENCE (2009), *available at* http://www.actuary.org/pdf/health/equivalence_may09.pdf.

57 42 U.S.C. § 300gg-11(a)(1) (2012).

58 CTR. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH AND HUMAN SERVS., GUIDE TO REVIEWING ESSENTIAL HEALTH BENEFITS BENCHMARK PLANS [hereinafter GUIDE TO EHB BENCHMARK PLANS], *available at* http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/ehb-benchmark-review-guide.pdf (last visited Sept. 20, 2014).

rather the result of questions being asked about one area of the law (annual limits) but being answered in the narrower context of another area of the same law (EHB). This, intentionally or not, has created a gap within the implementation of the law that does not exist in the PPACA itself.

II. Issues Surrounding the Implementation of the Prohibition on Annual Limits

Although it is unsettled what limitations on EHBs, if any, are still allowable under the PPACA, state regulators, insurers, and patients have to move forward while trying to comply with the law.

A. States and Insurers Filling the Gap

With the opening provided by the informal guidance discussed above, insurers and state regulators are predominantly converting annual dollar limits into frequency limits. For example, UnitedHealthcare, a division of the largest single health carrier in the United States,[59] states that under the PPACA "frequency limits are generally acceptable."[60] This is typical of the information put out by many large insurers.[61] In other words, from the insurers' perspective, the PPACA's prohibition has become merely a procedural hurdle, not a substantive change to insurance practice. This construction of the provision allows insurers to continue to limit the dollar value of benefits per year, in much the same way as before the PPACA was passed, as long as that limit is not expressed or applied explicitly in dollar terms but rather in end use terms (i.e., number of treatments, visits, etc.).

State regulators are also moving forward under a permissive interpretation of the statute, often by converting dollar amount limits into equally valued frequency limits.[62] For example, a Colorado De-

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59 *See About Us*, UnitedHealthcare, http://www.uhc.com/about_us.htm (last visited Sept. 20, 2014).

60 *Annual Limits: Frequently Asked Questions*, UnitedHealthcare, http://www.uhc.com/united_for_reform_resource_center/health_reform_provisions/annual_limits.htm (last visited Sept. 20, 2014) (basing this view on informal Department of Labor comments).

61 *See, e.g.*, *Informed on Reform: Frequently Asked Questions*, Cigna, http://www.cigna.com/health-care-reform/faqs#a-b (last visited Sept. 20, 2014) ("The PPACA does allow some limits. There can be a limit on the cost per visit per hour and on the number of visits over a period of days. For example, a person can be limited to three annual visits, but with no cost limits per visit.").

62 *See, e.g.*, Colo. Dep't of Regulatory Agencies, Bulletin No. B-4.51: Actuarial Equivalent Service Limits for Certain Essential Health Benefits (2013), *available at* http://cdn.colorado.gov/cs/Satellite/DORA-DI/CBON/DORA/1251623061723 (follow "4 Life, Accident and Health" hyperlink); Justin M. Kindy, Aon Hewitt, Silver State Health In-

partment of Regulatory Agencies bulletin explicitly lays out how the pre-PPACA dollar caps for benefits are to be converted directly into frequency limits.[63]

B. Practical Problems of Allowing Frequency Limits

For beneficiaries with a chronic medical condition, an interpretation of the law that continues to allow these types of artificial limits to care is no protection at all— in fact, it is worse than the old dollar caps. Additionally, these limits will likely exacerbate the rise in cost of care because they incentivize providers and beneficiaries to charge as much as possible per visit—or per usage—knowing that the frequency of care is artificially limited.

Take, for example, the effect of frequency limits on a primary therapy prescribed by doctors for autism, applied behavior analysis ("ABA").[64] ABA is generally delivered in a tiered model, whereby the highest trained and highest paid provider, the Board Certified Behavior Analyst ("BCBA" or "BCBA-D"),[65] oversees implementation of the therapy delivered by a less qualified technician.[66] Under the pre-PPACA dollar caps, providers and beneficiaries were often able to keep costs low and maximize the hours of therapy a child would receive by tailoring the therapy delivery and holding down the costs of technicians by utilizing those training to become BCBAs who may be willing to work for lower wages.[67]

If the now prohibited dollar caps are converted into frequency caps, this beneficiary flexibility disappears. Doctors will prescribe a set amount of ABA therapy for a child,[68] and that child will only receive whatever fraction of the prescription is available under the insurer's frequency caps. For example, under the original PPACA

SURANCE EXCHANGE: SERVICE LEVEL EQUIVALENTS FOR AUTISM AND MEAL REPLACEMENT DOLLAR THRESHOLDS (2012), *available at* http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Meetings/Service_Level_Equivalents.pdf. "Actuarial equivalency," discussed in greater detail *infra* Part III.A, is a process by which different insurance benefits are compared to determine their basic dollar value equivalence.

63 COLO. DEP'T OF REGULATORY AGENCIES, *supra* note 62.

64 *See* AM. ACAD. OF PEDIATRICS, UNDERSTANDING AUTISM SPECTRUM DISORDERS (ASDs) 24 (2006), *available at* www.aap.org.

65 *See* BEHAVIOR ANALYST CERTIFICATION BD., GUIDELINES: HEALTH PLAN COVERAGE OF APPLIED BEHAVIOR ANALYSIS TREATMENT FOR AUTISM SPECTRUM DISORDER 38–40 (2012) (explaining the qualifications for a BCBA or BCBA-D).

66 *See id.* at 24–25.

67 *See id.* (describing the use of supervised behavioral technicians as a cost-effective way to ensure sufficient expertise, appropriate supervision, and appropriate case management).

68 *See generally id.* at 19–25 (describing the development of treatment plans for patients with autism spectrum disorders).

implementing regulations in Colorado, a child diagnosed with autism around age two or three could only receive about eighteen percent of his prescribed care covered by insurance, with little flexibility to work around this cap, and less than six percent of the prescription once the child was nine or older.[69] Colorado, when confronted with this incongruence between the PPACA statute and federal regulatory guidance, as well as with its drastic practical impacts, adopted emergency regulations attempting to fix some of these issues.[70] Without federal regulatory implementation though, families in other states will likely not be as lucky, and will face diminished coverage despite what the law says.

Given the nature of autism, and the fact that intensive early intervention has been shown to drastically improve outcomes,[71] a family facing benefit limits will be left with the choice between massive financial strain to pay for the treatment or a significantly diminished prognosis for the beneficiary. As a public policy, in the case of autism coverage the cap on benefits shifts the costs from insurance companies and insurance premiums onto tax payers, who will pay greater amounts over the course of the child's life for special education, Medicaid, lost productivity of the child and his caregivers, and future disability services.[72] This public-to-private shift of costs, as well as the

69 COLO. DEP'T OF REGULATORY AGENCIES, *supra* note 62. The figure of 18% results from dividing Colorado's ABA coverage minimum of 550 sessions per year into the 25-minute increments specified under the regulation (550 x 25 minutes = 13,750 minutes per year) by the 25-hours per week typically prescribed by physicians (25 x 60 minutes x 52 weeks = 78,000 minutes per year), rounded up from 17.628%. *See* COLO. CODE. REGS. § 702-4:4-2-47 (2014) (setting forth the ABA coverage minimums); UNUMB & UNUMB, *supra* note 19, at 10 (stating that ABA treatments for children typically involve prescriptions starting at 25 hours per week). The figure of 6% results from performing the same calculation using Colorado's minimum of 185 sessions for children nine and above. Per the Colorado minimum, a child under the age of 9 would only receive roughly 4.4 hours of therapy each week (calculated by dividing the 13,750 minutes provided per year by 52 weeks and 60 minutes).

70 *See* Colo. Code. Regs. § 702-4:4-2-47 (2014) ("In the event that five hundred fifty (550) annual ABA sessions for a child from birth through age eight (8) does not provide the same coverage for ABA therapy as would have been required prior to May 13, 2013, all carriers with health benefit plans subject to this regulation shall increase the number of visits or sessions in order to provide the equivalent of the minimum number of visits or sessions as would have been required prior to May 13, 2013.").

71 *See* Howard Cohen et al., *Early Intensive Behavioral Treatment: Replication of the UCLA Model in a Community Setting*, 27 J. DEVELOPMENTAL & BEHAV. PEDIATRICS S145, S152–54 (2006); O. Ivar Lovaas, *Behavioral Treatment and Normal Educational and Intellectual Functioning in Young Autistic Children*, 55 J. CONSULTING & CLINICAL PSYCHOL. 3, 8 (1987); *see also* MARC LAMBRIGHT, OLIVER WYMAN, ACTUARIAL COST ESTIMATE: NEBRASKA LEGISLATIVE BILL 1129, at 22 (2012) (collecting studies that report better outcomes for children with autism spectrum disorder who receive intensive treatment rather than less intensive treatment).

72 *See* LAMBRIGHT, *supra* note 71, at 2 (describing that the costs savings through increased wages and taxes of the individual with ASD and their family, and the decrease in future costs of

long-term cost savings of early intervention, are two reasons why so many states had previously instituted mandates for coverage of chronic conditions like autism, and why such coverage was included in the EHBs under the PPACA.[73] This effect will likely be seen with other essential health benefits that continue to face restricted annual and lifetime limits even after the PPACA purported to end them.

III. GIVING THE STATUTORY PROHIBITION MEANING

The interpretation of the statute under which some states and insurers are operating is bad policy and unlikely to withstand legal challenge. The legal validity of allowing frequency limits after the PPACA's statutory prohibition on "annual limit[s] on the dollar value of benefits" is a question of statutory interpretation.[74] Agencies have issued some guidance on these issues;[75] therefore, principles of administrative law will also determine how much deference a court gives to an agency's interpretations. To avoid further complication and litigation of the issue altogether, the responsible agencies should promulgate a more formal interpretation of the PPACA that is in line with the text and purpose of the law.

A. Interpreting the Statute

In interpreting this section of the PPACA, a court would first look to "its textual plain meaning, as gleaned from ordinary usage, dictionaries, grammar, and linguistic canons (plain meaning sources)."[76] The relevant portion of the PPACA, codified as 42 U.S.C. § 300gg-11, states, "[a] group health plan and a health insurance issuer offering

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disability services, special education, and unemployment could make the bill mandating therapy coverage a net positive for the state's finances); *see also* ABT ASSOCS., INC., AUTISM SPECTRUM DISORDERS MANDATED BENEFITS REVIEW PANEL REPORT: EVIDENCE SUBMITTED CONCERNING PENNSYLVANIA HB 1150, at 36 (2008) (citing a Pennsylvania Department of Public Works study finding an estimated savings of $89.3 million over four years just accounting for the savings in Medicaid expenditures due to a decrease in those with private insurance being forced to utilize Medicaid to cover ABA); Laura C. Hoffman, *Health Care for the Autistic Child in the U.S.: The Case for Federal Legislative Reform for ABA Therapy*, 46 J. MARSHALL L. REV. 169, 210–216 (2012) (discussing various aspects of the costs of healthcare for ASD).

73 UNUMB & UNUMB, *supra* note 19, at 49–50 (discussing the grassroots movement for state insurance mandates for autism); *see also* IACC Letter, *supra* note 31 (discussing the importance of including ABA therapy as an EHB under the PPACA); Menendez Letter, *supra* note 31 (noting that by denying coverage, health insurance companies have created a barrier to early intervention treatments that can improve outcomes and is contrary to the law's intent).

74 42 U.S.C. § 300gg-11 (a)(2) (2012).

75 *See supra* Part II.A.

76 William N. Eskridge, Jr., *No Frills Textualism*, 119 HARV. L. REV. 2041, 2042 (2006) (reviewing ADRIAN VERMEULE, JUDGING UNDER UNCERTAINTY (2006)).

group or individual health insurance coverage may not establish . . . except as provided in paragraph (2), annual limits on the dollar value of benefits for any participant or beneficiary."[77] The exception in paragraph (2) applies to plan years beginning prior to 2014, when the limits take full effect.[78] Subsection (b) clarifies that this prohibition only applies to EHBs as defined by the PPACA.[79]

The key portion of the text for interpretive purposes is that insurers "may not establish . . . annual limits on the dollar value of benefits for any participant or beneficiary."[80] From this text one can see that the prohibition, whatever its scope, is a hard prohibition because the applicable insurers are directed that they "*may not* establish"[81] a limit. There is no reasonableness standard or other ambiguous guidance on the prohibition; therefore, the remaining question concerns the scope of the hard prohibition.

Looking to basic grammatical structure, "dollar value" modifies "benefits" and narrows what the law is prohibiting. Additionally, the use of the term "dollar value," as opposed to "dollar limit" or "dollar amount," widens the meaning of the prohibition somewhat. The definition of "value" clarifies this widening effect. *Merriam-Webster's Dictionary* defines "value" as "the amount of money that something is worth" or the "usefulness or importance" of a thing.[82] This concept of importance or worth goes beyond the simpler concept of amount. Although the term "dollars" colloquially incorporates an inherent concept of value, a narrower legal understanding of the term is possible when the modifier of "value" is absent. An example of similar usage of these terms from another section of the U.S. Code confirms this interpretation. When Congress set out to define the military's ready reserve income insurance, it set a basic benefit of one thousand dollars per month, but then also set up a scheme whereby the military service's secretary was to adjust the dollar amount in the future so as "to maintain the constant dollar value of the benefit."[83]

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77 42 U.S.C. § 300gg-11(a)(1) (2012).

78 *Id.* § 300gg-11(a)(2).

79 *Id.* § 300gg-11(b) (referencing "essential health benefits" provision of PPACA § 1302, codified at 42 U.S.C. 18022).

80 *Id.* § 300gg-11(a)(1).

81 *Id.* (emphasis added).

82 *Value Definition*, MERRIAM-WEBSTER.COM, http://www.merriam-webster.com/dictionary/value (last visited Sept. 20, 2014).

83 10 U.S.C. § 12525(a), (d)(1) (2012).

From the context surrounding the provision on annual limits within the PPACA,[84] the prohibition is meant to be a substantive protection to beneficiaries rather than a procedural limit on how caps to benefits can be expressed.[85] First, and perhaps most obvious, is the fact that the statute itself is entitled the "Patient Protection and Affordable Care Act."[86] Additionally, Subtitle A, under which the annual limits prohibition is detailed, is entitled "Immediate Improvements in Health Care Coverage for All Americans."[87] These titles suggest a purpose to the statutory text of improving health coverage for the beneficiary and providing additional patient protection, rather than simply changing the procedural norms of the insurance industry.

Furthermore, and somewhat uniquely because of how the PPACA was passed,[88] one can see within the text of the law as passed some of the earlier iterations of language considered, and then rejected, by Congress. For example, compare the rejected language in Title I, which only prohibited "unreasonable" annual limits, with the final operative language in Title X, which prohibits all annual limits to the dollar value of benefits.[89] This shows at least some consideration of how far to take the prohibition, and demonstrates that the final result was the broader prohibition of all annual limits.[90] This supports the view that the prohibition was meant to be substantive and that a less expansive prohibition was considered and rejected by a large segment of Congress.

In addition, the phase-in of the prohibition over the course of three years under 42 U.S.C. § 300gg-11(a)(2) provides insight into the purpose of the statute and the intended scope of the prohibition.[91]

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84 *See* PPACA § 2711(a)(2), Pub. L. No. 111-148, 124 Stat. 119, 131 (2010).

85 *Cf.* FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 132–33 (2000) (stating that a canon of statutory construction is analyzing a phrase in its context and looking to Congress's "core objectives" in passing the statute in order to determine the statute's meaning); Davis v. Mich. Dep't of Treasury, 489 U.S. 803, 809 (1989) (asserting that statutory language should not be "construed in a vacuum," but rather should reflect the context of the interpreted phrase).

86 PPACA, 124 Stat. at 119.

87 *Id.*

88 *See* John Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105 LAW LIBR. J. 131, 143–59, 161 (2013).

89 *Compare* PPACA § 1001(5), 124 Stat. at 131 (original language), *with* PPACA § 10101(a), 124 Stat. at 883 (amending the § 1001 language). For a procedural explanation of why the original language and amendment language both appear in the law, see Cannan, *supra* note 88, at 161.

90 *See* PPACA § 10101(a), 124 Stat. at 883.

91 42 U.S.C. § 300gg-11 (a)(2) (2012).

Under that subsection, "restricted annual limit[s]" are allowed in plan years beginning before 2014.[92] The statute specifically delegates authority to HHS to define what a "restricted annual limit" is during the three-year phase-in, but instructs her that "[i]n defining the term 'restricted annual limit' for purposes of the preceding sentence, the Secretary shall ensure that *access to needed services* is made available with a *minimal impact on premiums*."[93]

This demonstrates that although the statutory purpose of the prohibition on annual limits is to expand the "access to needed services,"[94] the benefit expansion is expected to drive up costs and premiums.[95] If the prohibition were merely a procedural prohibition on expressing limits to benefits in terms of dollar amounts and insurers could still cap their costs through restrictive frequency limits, then the balancing mandated during the three-year phase-in, and indeed the existence of a phase-in period itself, would be unnecessary.[96] The interpretation adopted in the informal guidance discussed above will lead to no substantive difference in cost to insurers or to premiums, because the new frequency caps have been designed to limit the expected dollar value of benefit exactly. As such, a phase-in period that is concerned about the sudden rise in costs associated with ending annual limits to benefits would make no sense.

Moreover, the PPACA limits the scope of the prohibition to EHBs by stating that it "shall not be construed to prevent [insurers] from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits."[97] This is a major limitation on the scope of the prohibition. As such, it lends credence to the view that the prohibition was meant to have a meaningful impact on a beneficiary's ability to receive essential health care services, and was recognized to likely have a negative impact on an insurer's bottom-line, or to lead to an increase in premiums. Once again, if the statute meant only that insurers had to convert dollar limits into frequency limits through "actuarial[ ] equivalen[ce]" there would be, by

92 *Id.*

93 *Id.* (emphasis added).

94 *Id.*

95 The Interim Finale Rule on Annual limits reflects this concern. *See* Annual Limits Rule, 75 Fed. Reg. 37,188, 37,196 (June 28, 2010) ("These patient protections are expected to expand coverage for children with preexisting conditions and individuals who face rescissions, lifetime limits, and annual limits as a result of high health care costs.").

96 *See* Sutton v. United Air Lines, Inc., 527 U.S. 471, 481–87 (1999) (finding that the agency's interpretation "conflict[ed] with the plain meaning" of the statute by nullifying a major criteria that was originally in the statute to serve the beneficiaries of the law).

97 42 U.S.C. § 300gg-11(b) (2012).

definition, little added costs to insurers or premiums, and very little added benefit to beneficiaries.[98] As such, the statutory language limiting the prohibition and phasing in the effect of the provision would be unnecessary.

Statements made during the passage of the PPACA and shortly thereafter also support the general view that the annual limits prohibition was meant to protect patients by excluding cost-driven annual limitations to care. For example, when signing the bill into law, President Obama stated that "[insurers] won't be able to place lifetime limits or restrictive annual limits on the amount of care they can receive."[99] This "amount of care" construction is noticeably at odds with a view that frequency limitations are still allowed to limit the amount of care provided in a given year. The Secretary of HHS has consistently repeated this claim about the law ending "limits on benefits,"[100] and floor speeches in the Senate prior to passage also echo this interpretation of the prohibition on annual limits.[101] Taken together, these statements support the view that the purpose of the prohibition on annual limits is to protect patients from cost-driven annual limits to key essential health benefits.

B. *The Informal Guidance Will Receive Little Deference from the Courts*

At a practical level, an interpretation of the annual limits provision of the PPACA only really matters if a court will enforce such a reading. In determining that converting illegal dollar caps to benefits into frequency or duration caps of equal dollar value is permissible even after the PPACA, insurers and state regulators are relying primarily on the IFR and the informal guidance from the agencies, namely the publication on EHB benchmark plans and the two answers in the

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98 *Id.* § 18022(d)(1)(A)–(D).

99 Remarks on Signing the Patient Protection and Affordable Care Act, 1 PUB. PAPERS 400 (March 23, 2010).

100 *See, e.g.*, Press Release, U.S. Dep't of Health and Human Servs., Secretary Sebelius To Deliver Remarks on How the Affordable Care Act Benefits Women and Families (June 24, 2010), *available at* http://wayback.archive-it.org/3926/20131018160721/http://www.hhs.gov/news/press/2010pres/06/20100624a.html (stating that "the new law . . . ends lifetime limits on benefits; and phases out annual limits on benefits").

101 *See, e.g.*, 111 CONG. REC. S13,720 (daily ed. Dec. 22, 2009) (statement of Sen. Max Baucus) (stating that with passage of the law "annual limits, the lifetime limits will have been repealed"); 111 CONG. REC. S13,597 (daily ed. Dec. 20, 2009) (statement of Sen. Tom Harkin) (stating that the law will "prohibit insurers from imposing lifetime limits on benefits, and we impose and restrict the use of annual limits").

FAQ on EHBs, for justification.[102] When a court reviews this particular interpretation of the statute, prior to reaching the substance of the statutory interpretation discussed above, it will have to first determine the proper amount of deference that should be shown toward the agency's interpretation.

At a general level, the question of how much deference a court should give to an agency's interpretation of the law depends on many factors. For instance, although "[i]t is emphatically the province and duty of the judicial department to say what the law is,"[103] it may be that Congress desires that an agency employ its presumably greater expertise in a given area to define the scope or application of a particular law.[104] As the Supreme Court stated in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, "[i]f Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority" to interpret or make law.[105]

Courts often apply *Chevron* deference to agency regulations.[106] *Chevron* deference means that a court will give "controlling weight" to an agency's interpretation of an ambiguous law unless that interpretation is arbitrary, capricious, or manifestly contrary to the statute.[107] Even under the *Chevron* test, the most deferential to agency interpretations, it is unlikely that the agency's guidance would be upheld in this case. Applying the first step of *Chevron*, it is unlikely that a court will read the language of the prohibition and find ambiguity.[108] The statute states that insurers "may not establish" annual limits to the "dollar value of benefits."[109] This statement has a clearly defined meaning, so a court, even under *Chevron*, could apply the statute with no deference to the agency's interpretation.[110]

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102 *See supra* Part I.B.2.

103 Marbury v. Madison, 5 U.S. (1 Cranch) 137, 177 (1803).

104 *See, e.g.*, Chevron, U.S.A., Inc., v. Natural Res. Def. Council, Inc., 467 U.S. 837, 865 (1984).

105 *Id.* at 843–44.

106 *See* Cooley R. Howarth, Jr., United States v. Mead Corp.*: More Pieces for the* Chevron/Skidmore *Deference Puzzle*, 54 ADMIN. L. REV. 699, 710–11 (2002).

107 *See Chevron*, 467 U.S. at 843–44.

108 *See id.* at 842–43 (holding that the first step is to determine if Congress has spoken directly on the question, and if the intent of Congress is clear then the "unambiguously expressed intent" must be honored by the agency and the courts).

109 42 U.S.C. § 300gg-11(a) (2012).

110 *See Chevron*, 467 U.S. at 843 n.9 ("If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect.").

Even if a court moved on to step two of a *Chevron* analysis to determine if the agency's interpretation is "arbitrary, capricious, or manifestly contrary to the statute,"[111] frequency limits would not be permitted. Furthermore, because an interpretation of "dollar value of benefits" that allows an insurer to convert dollar amounts into the equally valued frequency limits goes directly against the statute's plain meaning, the agency interpretation would fail this step of *Chevron* as well.[112]

Although *Chevron* is the most commonly applied level of deference to agency interpretations, the Supreme Court has carved out numerous situations where less deference should be shown.[113] Many of these lesser levels of deference could apply to this issue. For example, one of the simplest ways to view the informal guidance is to see it as interpreting the IFR's language, rather than the statute's. Normally, in such a case, an agency receives deference in interpreting their own regulations, presumably based on expertise and familiarity with the regulations.[114] The Court has rightly ruled, however, that this deference does not apply when informal guidance is interpreting a regulation that merely repeats a statute's language.[115] This is just such a case; the IFR does little more than repeat the statutory text,[116] and as such little deference would be due.[117]

Another alternative to *Chevron* analysis is found in *INS v. Cardoza-Fonseca*.[118] In that case, the Supreme Court held that "pure question[s] of statutory construction [are] for the courts to decide,"[119] applying no deference. The question of whether frequency limits for EHBs are allowed under the PPACA can certainly be seen as one of pure statutory interpretation. Furthermore, the Supreme Court has ruled that *Chevron* deference does not apply to less formal agency

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111 *Id.* at 844.

112 *See* MCI Telecomms. Corp. v. AT&T Co., 512 U.S. 218, 229 (1994) (stating that "[a]n agency's interpretation of a statute is not entitled to deference when it goes beyond the meaning that the statute can bear").

113 *See e.g.*, Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944) (holding that informal agency interpretations, though not granted controlling deference, are "entitled to respect").

114 Gonzales v. Oregon, 546 U.S. 243, 255 (2006) ("An administrative rule may receive substantial deference if it interprets the issuing agency's own ambiguous regulation." (citing Auer v. Robbins, 519 U.S. 452, 461–63 (1997))).

115 *See id.* at 257 (rejecting *Auer* deference when the regulation merely parrots the statute).

116 *Compare* Annual Limits Rule, 75 Fed. Reg. 37,188, 37,236 (June 28, 2010), *with* 42 U.S.C. § 300gg-11(a).

117 *See Gonzales,* 546 U.S. at 257.

118 INS v. Cardoza-Fonseca, 480 U.S. 421 (1987).

119 *Id.* at 446.

actions such as opinion letters, "policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law";[120] instead, these agency actions are "entitled to respect" under *Skidmore v. Swift & Co.*[121] The informal guidance at issue in this case could also fall within the realm of *Skidmore*.

Under *Skidmore*, the level of deference owed is related to the agency's "power to persuade."[122] This "power to persuade" is broken down into four general factors: "the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade . . . ."[123] In this case, the factors of the Skidmore test generally point to a standard of little or no deference.

The first factor, thoroughness, would likely cut against giving deference because neither the EHB bulletin nor the FAQ answers show any kind of thorough review of the whether allowing frequency or duration limits is in line with the annual limits provision. No public comment period or transparent examination of the issues was involved, nor have the agencies even appeared to consider the statutory text or any context surrounding the meaning of "dollar value of benefits."[124] Additionally, the guidance found in the FAQ shows some confusion as to which part of the statute is being interpreted, and similarly does not discuss any consideration of the prohibition on annual dollar limits.[125] In fact, all the informal guidance is given in documents primarily concerned with the EHBs, and the agencies have provided no discussion of reasoning behind an interpretation to permit frequency limitations.

The second factor, the validity agency reasoning, is even more damning for an agency or insurance company seeking deference to the agencies' informal guidance under *Skidmore*. The informal guidance being given shows very little explanation or reasoning. For example, the *Guide to Reviewing Essential Health Benefits Benchmark Plans* ("EHB Guide") simply states that illegal caps can be converted to "actuarially equivalent treatment or service limits" without any at-

120 Christensen v. Harris Cnty., 529 U.S. 576, 587 (2000).

121 Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944); *see also* United States v. Mead Corp., 533 U.S. 218, 234–35 (2001) (finding that tariff classification rulings could warrant *Skidmore* deference, but not *Chevron*, because they are more akin to policy statements or enforcement guidelines); *Christensen*, 529 U.S. at 587 (applying lesser *Skidmore* deference to a Department of Labor opinion letter).

122 *See Skidmore*, 323 U.S. at 140.

123 *Id.*

124 *See, e.g.*, GUIDE TO EHB BENCHMARK PLANS, *supra* note 58.

125 *See* FAQs ON EHB, *supra* note 21.

tempt at justification.[126] Due to the absence of reasoning presented, a court would simply have to use its own judicial tools to assess the implied reasoning of the conclusion, which cuts against the agency's "power to persuade."[127]

Finally, the informal guidance's lack of "consistency with earlier and later pronouncements"[128] also weakens an argument for deference. The officials' public statements and the public facing guidance on annual limits all support a broad prohibition of lifetime and annual limits; meanwhile, the FAQ and EHB Guide expressly go against these prior statements.[129] Taken together, all the *Skidmore* factors indicate that a court should give little to no deference to the agencies' interpretation of the statue, assuming these informal communications actually reflect the agency's view.

All told, even under the highest level of deference accorded to agency regulation, *Chevron*, the promulgated informal guidance is not likely to withstand legal challenge. Under lower levels of deference, this would be an even easier case. To avoid this issue completely, the agencies should reconsider the informal guidance given thus far and address this issue directly and openly.

IV. NEW GUIDANCE THAT IS BASED ON THE STATUTE IS NEEDED

The current state of affairs is untenable. Many beneficiaries will soon be, or are already, dealing with restrictive frequency limits after being told that these limits no longer applied.[130] States are already attempting to institute changes to preempted dollar caps based on minimal guidance from the federal agencies,[131] and insurers are operating in an uncertain environment where they may be open to future litigation.[132] The current IFR, issued without a notice and comment period due to determination that such a delay would be "impractica-

126 *See, e.g.*, GUIDE TO EHB BENCHMARK PLANS, *supra* note 58.

127 *See Skidmore*, 323 U.S. at 140.

128 *Id.*

129 *Compare* Press Release, U.S. Dep't of Health & Human Servs., HHS Secretary Kathleen Sebelius Statement on LGBT Pride Month (June 3, 2013), *available at* http://www.hhs.gov/news/press/2013pres/06/20130603a.html ("Insurers can no longer impose lifetime dollar limits on health insurance coverage, and annual limits will be phased out in 2014."), *with* GUIDE TO EHB BENCHMARK PLANS, *supra* note 58 (stating that EHBs can still be limited through frequency or duration caps to the dollar value of benefits).

130 *See, e.g.*, Garrett, *supra* note 1.

131 *See, e.g.*, COLO. DEP'T OF REGULATORY AGENCIES, *supra* note 62.

132 *See supra* Part III.

ble, unnecessary, or contrary to the public interest,"[133] is inadequate. A simple answer to this problem exists: the responsible agencies should issue clarifying guidance that conforms to the statutory text and explains the rationale and justification for whatever interpretation is selected. This solution would implement the purpose of the PPACA provision, while also giving all parties more clarity and certainty and potentially avoiding costly lawsuits.

If the agencies involved decide to reconsider the informal guidance and reject the actuarial equivalency method of converting dollar limits into frequency limits, there are two potential solutions. First, the agencies could explain how frequency limits or duration limits can justifiably be implemented in accordance with the law. This position would require an explanation of what types of limits transcend into prohibited restrictions on the dollar value of benefits. The second option would be for the agencies to provide a bright-line rule that applies an interpretation that all annual or lifetime limits to essential health benefits are illegal under the law.

If the agencies decided to still allow frequency limits, the regulation—in order to give the statute a meaning the text will bear[134]—must explain the difference between the allowable limitation and a cap on the "dollar value of benefits."[135] If an insurer or a state arrives at a frequency limit by looking at end result cost savings or at a previous dollar cap, and converts those numbers into frequency limits, then this method should be prohibited if it will be, by design, a limit on the "dollar value of benefits."[136] Therefore, the agencies should define the precise bounds of what is allowable, and how allowable caps could be determined and still meet the legal requirement of not limiting the "dollar value of benefits."[137]

While the agencies may be able to craft a detailed explanation and justification for why some benefit limits could still be implemented in accordance with the law, it would be better policy to simply promulgate a bright-line rule against all caps. As the agencies describe in the preamble to the current IFR, the increased premiums resulting from abolished annual limits to care will likely be minimal,[138]

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133 Annual Limits Rule, 75 Fed. Reg. 37,188, 37,195 (June 28, 2010) (citing the Administrative Procedure Act § 553(b)).

134 *See* MCI Telecomms. Corp. v. AT&T Co., 512 U.S. 218, 229 (1994).

135 42 U.S.C. § 300gg-11 (2012).

136 *Id.*

137 *Id.*

138 *See* Annual Limits Rule, 75 Fed. Reg. at 37,191 ("The restricted annual limits provided

while the care received by the most vulnerable patients will be critical.[139]

A bright-line rule against all forms of annual caps is most in line with the statutory language and purpose.[140] As a bright-line rule, it will require less administrative burden on the agencies to promulgate or to police. In fact, because of its simplicity it could be done in a less formal and less exhaustive fashion than attempting to distinguish allowable from illegal annual limits, which would require extensive explanation and clarification. Additionally, this bright-line approach will provide insurers, and the insurance marketplace as a whole, with a simpler and more predictable framework in which to operate.[141] Finally, this option would likely result in less litigation between parties contesting whether a limit is permissible or not, and will lower administrative costs on insurers trying to tailor policies within an otherwise ambiguous rule.

CONCLUSION

Regardless of whether the agencies decide to carve out some allowable non-dollar value limits, or if they opt for a bright-line rule barring all limits to EHBs, all parties involved need clarity. Currently, beneficiaries are being told by the President and the Secretary of HHS that the PPACA "ends lifetime limits on benefits; and . . . annual limits on benefits,"[142] but are not seeing this promise in action. In many cases beneficiaries are facing the perverse reality that their limits to care post-PPACA are more restrictive than those that existed before the law. This undermines the very intention of the PPACA's scheme, and harms the sickest, most vulnerable patients. The failure to clearly interpret the PPACA provision also injects the probability of costly litigation, and undermines public support for the law. Therefore, the responsible agencies should respect the statute's promise for the most vulnerable among us and issue thoughtful guidance in line with the statute's text and purpose.

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in these interim final regulations are designed to ensure, in the vast majority of cases, that individuals would have access to needed services with a minimal impact on premiums.").

139 *Id.* at 37,197 ("These new protections ensure that patients are not confronted with devastating health costs because they have exhausted their health coverage when faced with a serious medical condition.").

140 *See supra* Part III.

141 *See supra* Part II.B.

142 Press Release, U.S. Dep't of Health & Human Servs., *supra* note 100.