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Article

Disparities in Private Health Insurance Coverage of Skilled Care

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Abstract: This article compares and contrasts public and private health insurance coverage of skilled medical rehabilitation, including cognitive rehabilitation, physical therapy, occupational therapy, speech-language pathology, and skilled nursing services (collectively, skilled care). As background, prior scholars writing in this area have focused on Medicare coverage of skilled care and have challenged coverage determinations limiting Medicare coverage to beneficiaries who are able to demonstrate improvement in their conditions within a specific period of time (the Improvement Standard). By and large, these scholars have applauded the settlement agreement approved on 24 January 2013, by the U.S. District Court for the District of Vermont in *Jimmo v. Sebelius* (*Jimmo*), as well as related motions, rulings, orders, government fact sheets, and Medicare program manual statements clarifying that Medicare covers skilled care that is necessary to prevent or slow a beneficiary's deterioration or to maintain a beneficiary at his or her maximum practicable level of function even though no further improvement in the beneficiary's condition is expected. Scholars who have focused on beneficiaries who have suffered severe brain injuries, in particular, have framed public insurance coverage of skilled brain rehabilitation as an important civil, disability, and educational right. Given that approximately two-thirds of Americans with health insurance are covered by private health insurance and that many private health plans continue to require their insureds to demonstrate improvement within a short period of time to obtain coverage of skilled care, scholarship assessing private health insurance coverage of skilled care is important but noticeably absent from the literature. This article responds to this gap by highlighting state benchmark plans' and other private health plans' continued use of the Improvement Standard in skilled care coverage decisions and identifying possible legal approaches for removing the Improvement Standard in private health insurance. This article also calls for scholars in health law, disability law, and insurance law, among other doctrinal areas, to evaluate the ethics and values associated with the continued use of the Improvement Standard in private health insurance.

Keywords: skilled care; Medicare; private health insurance; stigma; improvement; maintenance

This article compares and contrasts public and private health insurance coverage of skilled medical rehabilitation, including cognitive rehabilitation, physical therapy, occupational therapy, speech-language pathology, and skilled nursing services (collectively, skilled care). As background, prior scholars writing in this area have focused on Medicare¹ coverage of skilled care and have challenged coverage determinations limiting Medicare coverage to beneficiaries who are able to demonstrate improvement in their conditions within a specific period of time (the Improvement Standard).² By and large, these scholars have applauded the settlement agreement approved on

¹ See, e.g., (Lerch and Fischmann 2012, pp. 685, 698–703) (reviewing litigation alleging that the federal Department of Health and Human Services (HHS) illegally used an “Improvement Standard” in making Medicare coverage determinations).

² See, e.g., (Deford et al. 2010) (thoroughly explaining the demographic context in which the Improvement Standard is applied and describing the relevant Social Security Act provisions, federal regulations, program manual provisions, and other

24 January 2013, by the U.S. District Court for the District of Vermont in *Jimmo v. Sebelius (Jimmo)*,³ as well as related motions,⁴ rulings,⁵ orders,⁶ government fact sheets,⁷ and Medicare program manual statements⁸ clarifying that Medicare covers skilled care that is necessary to prevent or slow a beneficiary's deterioration or to maintain a beneficiary at his or her maximum practicable level of function even though no further improvement in the beneficiary's condition is expected. Scholars who have focused on beneficiaries who have suffered severe brain injuries, in particular, have framed public insurance coverage of skilled brain rehabilitation as an important civil, disability, and educational right.⁹

Given that approximately two-thirds of Americans with health insurance are covered by private health insurance¹⁰ and that many private health plans continue to require their insureds to demonstrate improvement within a short period of time to obtain coverage of skilled care,¹¹ scholarship assessing private health insurance coverage of skilled care is important but noticeably absent from the literature.¹² This article responds to this gap by highlighting state benchmark plans' and private health plans' continued use of the Improvement Standard in skilled care coverage decisions and outlining possible legal approaches for removing the Improvement Standard in private health insurance. This article also calls for scholars in health law, disability law, and insurance law, among other doctrinal areas, to evaluate the ethics and values associated with the continued use of the Improvement Standard in private health insurance.

1. A Skilled Care Hypothetical

Consider a drunk driver who hits a young adult while the latter is crossing the street on foot. Assume that the young adult, named Brian, sustains a severe traumatic brain injury as a result of the accident and is brought by an ambulance to the emergency department of a local hospital in critical

guidance to support patient advocates and litigators in challenging the Standard); *Papciak v. Sebelius*, 742 F.Supp.2d 765 (W.D. Pa. 2010) (agreeing with the plaintiff's argument that the Secretary of HHS failed to apply the correct legal standard and did not consider plaintiff's potential need for a rehabilitative maintenance program: "Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.").

³ See *Jimmo v. Sebelius*, 2011 WL 5104355 (D. Vt. 2011); *Fins et al. 2016* (noting that the *Jimmo* settlement "gives hope that coverage standards will be based on individualized assessment and the needs and conditions of specific patients" and concluding with policy recommendations designed to realize the aspirations of the *Jimmo* plaintiffs in the context of patients in the minimally conscious state in need of skilled care).

⁴ See *Jimmo v. Burwell*, No. 5:11-CV-17, 2016 WL 4401371 (D. Vt. 2016) (responding to plaintiffs' motion for resolution of HHS's noncompliance with the *Jimmo* settlement agreement).

⁵ *Id.* at *13 (granting the *Jimmo* plaintiffs' motion to enforce the portion of its settlement agreement with HHS relating to the Secretary's educational campaign obligations and directing the Secretary of HHS to propose corrective action for plaintiffs' consideration).

⁶ *Jimmo v. Burwell*, No. 5:11-CV-17, 2017 WL 462512, *7 (D. Vt. 2017) (ordering the Secretary of HHS to amend her corrective action plan to include a corrective statement and a national call that includes both the corrective statement as well as a court-required notice).

⁷ See U.S. Dep't Health & Human Servs., Ctrs. Medicare & Medicaid Servs., *Jimmo v. Sebelius* Settlement Agreement, Fact Sheet, 20 February 2014 ("The Medicare statute and regulations have never supported the imposition of an 'Improvement Standard' rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition."); *id.* ("A beneficiary's lack of restoration potential cannot, in itself, serve as the basis for denying coverage, without regard to an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question.").

⁸ See U.S. Dep't Health & Human Servs., Ctrs. Medicare & Medicaid Servs., *Jimmo v. Sebelius* Settlement Agreement Program Manual Clarifications Fact Sheet, 20 February 2014 (clarifying that "no 'Improvement Standard' is to be applied in determining Medicare coverage for maintenance claims in which skilled care is required").

⁹ See (*Wright and Fins 2016*) ("The right to rehabilitative technologies for the injured brain stems by analogy to the expectation of free public education for children and adolescents, and also by statute under the Americans with Disabilities Act and under Supreme Court jurisprudence . . .").

¹⁰ See Jessica C. Barnett & Marina S. Vornovitsky, U.S. Census Bureau, Health Insurance Coverage in the U.S.: 2015 at 7, tbl 2 (September 2016) (noting that 67.2% of Americans who had health insurance in 2015 had private health insurance).

¹¹ See *infra* Part III.

¹² See, e.g., *Wright & Fins, supra* note 9, at 277 ("We do not address all possible reforms to realize the right to rehabilitation, including how our argument intersects with the Affordable Care Act, as that is beyond the scope of this Article.").

condition. After physicians in the emergency department provide Brian with heroic, life-saving care, Brian is moved upstairs to the hospital's intensive care unit (ICU), where he remains in an unconscious state for two weeks. Thereafter, Brian slowly emerges to a state of wakeful unresponsiveness in which his eyes open but he remains unaware of himself and others and does not respond to commands. Further assume that, approximately ten days later, Brian's parents firmly believe they see some signs that Brian is regaining consciousness, including slight and occasional but definite movements towards them when they talk to him in the late morning as well as attempted verbalizations in the early afternoon.¹³ Because Brian is unable to reproduce these signs when his physicians and nurses examine him, however, Brian's health care providers believe Brian's parents are engaging in wishful thinking with respect to Brian's condition.

After Brian has been in the ICU for approximately one month, a hospital caseworker attempts to obtain consent from Brian's parents to discharge him to a local nursing home. The caseworker explains the attempted discharge in light of Brian's alleged inability to participate in any form of skilled care at the hospital, including physical therapy, occupational therapy, and speech-language therapy. With respect to his speech, however, Brian's parents believe that he is unable to talk because he has a tracheostomy, which forces air to bypass his vocal cords, and that he just needs a bit more time to improve and then he may be able to succeed in his verbalization attempts.

Brian's parents, who are well-to-do and politically connected, adamantly refuse the discharge to the nursing home and demand that Brian stay in the ICU until he can breathe on his own and be transferred to a top-ranked brain rehabilitation hospital in another state. Fortunately, Brian regains consciousness the following week and shortly thereafter is able to breathe on his own and to communicate with his health care providers and his family. Both the hospital and Brian's insurer agree that Brian's transfer to an inpatient brain rehabilitation facility is appropriate.

Not everyone is so lucky. Many individuals who suffer from severe brain injuries as well as other health conditions such as ALS, Alzheimer's disease, Multiple Sclerosis, paraplegia, Parkinson's disease, quadriplegia, and stroke need skilled nursing, physical, occupational, and/or speech therapy to maintain their current functioning and/or to slow their deterioration.¹⁴ Although their conditions may never dramatically improve like Brian's condition did, in part because we have not yet discovered cures for many chronic conditions, skilled care can help these individuals maintain the quality of their lives.¹⁵

To the extent that a public health care program, such as Medicare or Medicaid, or a private health plan limits coverage of skilled care to those individuals who demonstrate rapid improvement, individuals who have the potential to improve but do not improve fast enough as well as individuals with chronic conditions who may never improve may not receive the skilled care they need to live quality lives. Lacking coverage of skilled care, these individuals may be pushed towards custodial care settings, where they will receive little to no further assessment or rehabilitation.¹⁶

2. Medicare, the Improvement Standard, and *Jimmo*

Medicare beneficiaries with chronic conditions do have some relief as a result of recent clarifications regarding Medicare coverage of skilled care. As background, Congress has always prohibited Medicare from paying for health care items and services that are "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."¹⁷ Although the Social Security Act (Act) does not define the phrase

¹³ See, e.g., Fins et al., *supra* note 3, at 183 (describing a similar hypothetical).

¹⁴ See Deford, Murphy & Stein, *supra* note 2, at Part I (describing how individuals with chronic conditions frequently need one or more skilled therapies).

¹⁵ *Id.*

¹⁶ See, e.g., Joseph J. Fins, *Rights Come to Mind: Brain Injury, Ethics, and the Struggle for Consciousness* 5 (2015) ("Patients not 'showing progress' are discharged from rehabilitation programs to nursing homes where they linger without rehabilitation or diagnostic oversight.")

¹⁷ 42 U.S.C. § 1395y(a)(1)(A) (2017).

“reasonable and necessary,” the Act does identify broad categories of covered health care benefits¹⁸ as well as limitations and exclusions¹⁹ applicable to particular health care items and services.

The federal Department of Health and Human Services (HHS), not Congress, has the responsibility of determining when an advancement, innovation, or improvement of an item or service that does not fit into one of the statutory covered benefit categories is reasonable and necessary and therefore should be covered by Medicare.²⁰ Plaintiffs frequently challenge these HHS determinations. In *Jimmo v. Sebelius*, for example, six Medicare beneficiaries with a range of chronic conditions such as Alzheimer’s disease, cerebral palsy, multiple sclerosis, paralysis, and Parkinson’s disease joined together with seven national organizations to sue the Secretary of HHS (Secretary). The *Jimmo* plaintiffs alleged that HHS had adopted an “unlawful and clandestine” coverage standard that resulted in the wrongful termination, reduction, and/or denial of Medicare coverage for beneficiaries with medical conditions that were not expected to improve or that failed to demonstrate progress with treatment to date.²¹

In particular, the *Jimmo* plaintiffs argued that HHS denied coverage for skilled care, including skilled nursing care, home health care, and outpatient therapy, when beneficiaries needed “maintenance services,” or were described by their providers as “chronic,” “medically stable,” “not improving,” or “having plateaued.”²² The plaintiffs referred to HHS’s practice of denying coverage of items and services ordered for Medicare beneficiaries whose conditions had not improved or were not expected to improve as an “Improvement Standard.”²³ The plaintiffs argued that the Improvement Standard was contrary to the Act and its implementing regulations, the federal Administrative Procedure Act, the federal Freedom of Information Act, and the Due Process Clause of the Fifth Amendment.²⁴ On 25 October 2011, the U.S. District Court for the District of Vermont (Court) denied the Secretary’s motion to dismiss the plaintiffs’ lawsuit for failure to state a claim. The Court found “at least *some* evidence” of HHS’s use of illegal presumptions and improvement rules of thumb in its Medicare coverage determinations.²⁵

On 24 January 2013, the Court approved a settlement agreement (Agreement) between HHS and the *Jimmo* plaintiffs.²⁶ The Agreement required the Centers for Medicare & Medicaid Services (CMS) to issue clarifications to the Medicare Benefit Policy Manual and to develop and publicize new educational materials clarifying Medicare coverage of skilled care.²⁷ The goal of the Agreement was to ensure that Medicare coverage decisions would be made in accordance with existing Medicare policy and that Medicare beneficiaries would receive coverage of the skilled care to which they are entitled.²⁸

¹⁸ See, e.g., *id.* § 1395d (a) (listing categories of inpatient hospital, post-hospital extended care, home health, and hospice benefits covered by Medicare Part A); *id.* § 1395k(a) (listing categories of medical and other health services covered by Medicare Part B).

¹⁹ See, e.g., *id.* § 1395d(b) (establishing limitations on Medicare Part A benefits after such benefits have been provided for a certain amount of time); *id.* § 1395y(a) (excluding certain items and services from Medicare coverage).

²⁰ See, e.g., Health Care Financing Administration, Medicare Program; Procedures for Making National Coverage Decisions 64 FR 22,619 (27 April 1999) (announcing the process the former Health Care Financing Administration would use to make a national Medicare coverage decision (NCD) for a specific health care item or service); Centers for Medicare and Medicaid Services, Medicare Program; Revised Process for Making Medicare National Coverage Determinations, 68 Fed. Reg. 55,634 (26 September 2003) (revising the process CMS uses in making Medicare NCDs).

²¹ 2011 WL 5104355, *1 (D. Vt. 2011).

²² *Id.* at *1.

²³ *Id.* at *1.

²⁴ *Id.* at *2.

²⁵ *Id.* at *22 (“[T]he court cannot conclude as a matter of law that Plaintiffs’ Improvement Standard theory is factually implausible when it is supported by at least *some* evidence in each of the Individual Plaintiffs’ cases and where other plaintiffs have successfully demonstrated the use of illegal presumptions and rules of thumb much like Plaintiffs allege here.”) (italicized emphasis in original).

²⁶ See Proposed Settlement Agreement, *Jimmo v. Sebelius*, No. 5:11-CV-17-CR (16 October 2012); U.S. Dep’t Health & Human Servs., Ctrs. Medicare & Medicaid Servs., *Jimmo v. Sebelius* Fact Sheet [hereinafter Fact Sheet] (stating that, “On 24 January 2013, the U. S. District Court for the District of Vermont approved a settlement agreement in the case of *Jimmo v. Sebelius*, in which the plaintiffs alleged that Medicare contractors were inappropriately applying an ‘Improvement Standard’ in making claims determinations for Medicare coverage involving skilled care . . .”).

²⁷ Fact Sheet, *supra* note 26, at 1.

²⁸ *Id.*

The Agreement did not resolve the plaintiffs' concerns, however. Three years later, on 1 March 2016, the *Jimmo* plaintiffs filed with the Court a motion in which they argued that the Secretary failed to comply with the Agreement.²⁹ On 17 August 2016, the Court granted the plaintiffs' motion to enforce the portion of the Agreement relating to the Secretary's educational campaign obligations and directed the Secretary of HHS to propose corrective action for plaintiffs' consideration.³⁰ The Court explained that the Secretary "failed to fulfill the letter and spirit of the Settlement Agreement with respect to at least one essential component of the Educational Campaign."³¹ The Court further explained that the plaintiffs provided "persuasive evidence that at least some of the information provided by the Secretary in the Educational Campaign was inaccurate, nonresponsive, and failed to reflect the maintenance coverage standard."³²

Most recently, on 1 February 2017, the Court ordered the Secretary to amend the corrective action plan to include the following corrective statement (Corrective Statement):

The Centers for Medicare & Medicaid Services reminds the Medicare community of the *Jimmo* Settlement Agreement (January 201[3], which clarified that the Medicare program will pay for skilled nursing care and skilled rehabilitation services when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the *Jimmo* Settlement adopted a "maintenance coverage standard" for both skilled nursing and therapy services:

Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.

Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. The *Jimmo* Settlement may reflect a change in practice for many providers, adjudicators, and contractors, who may have erroneously believed that the Medicare program pays for nursing and rehabilitation only when a beneficiary is expected to improve. The Settlement correctly implements the Medicare program's regulations governing maintenance nursing and rehabilitation in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and maintenance nursing and rehabilitation in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide. These regulations are set forth in the Medicare Benefit Policy Manual.³³

The Court also required HHS to include the Corrective Statement on HHS's *Jimmo* webpage, in HHS's publicly available answers to frequently asked questions (FAQs) about the Agreement, and in the written materials and oral statements that the Secretary agreed to publicize as part of the corrective action plan.³⁴

²⁹ See *Jimmo v. Burwell*, No. 5:11-CV-17, 2016 WL 4401371 (D. Vt. 2016) (responding to plaintiffs' motion for resolution of HHS's noncompliance with the *Jimmo* settlement agreement).

³⁰ *Id.* at *13.

³¹ *Id.* at *10.

³² *Id.* at *11.

³³ *Jimmo v. Burwell*, No. 5:11-CV-17, 2017 WL 462512, *6 (D. Vt. 2017).

³⁴ *Id.*

3. Private Health Insurance Coverage of Skilled Care

Although judicial enforcement of the *Jimmo* Agreement should improve the ability of Medicare beneficiaries to obtain coverage of skilled care, the case does not impact private health insurance coverage of skilled care. Given that approximately two-thirds of Americans with health insurance are covered by private health insurance,³⁵ scholarship assessing private health insurance coverage of skilled care is important but noticeably absent from the literature.³⁶ The remainder of this article responds to this gap by highlighting state benchmark plans' and private health plans' continued use of the Improvement Standard in skilled care coverage decisions and by offering legal approaches for removing the Improvement Standard in private health insurance.

A. *The Improvement Standard in Private Health Insurance before the ACA*

Before President Obama signed the Affordable Care Act (ACA) into law, private health plans also contained Improvement Standards much like the one opposed by the *Jimmo* plaintiffs. Although many of these plans are no longer in effect, the terms of their incorporated Improvement Standards are available in cases involving plaintiffs who suffered severe brain injuries as well as plaintiffs with a range of other chronic conditions who sued their insurers to obtain coverage of requested care.

The 1999 case of *Moore v. Blue Cross and Blue Shield of National Capital Area* is illustrative.³⁷ *Moore* involved a fifteen-year-old named Alistaire Moore who was a passenger in a chauffeured automobile when the driver lost control while driving through New York City.³⁸ Alistaire suffered a severe traumatic brain injury as a result of the car crash that followed.³⁹ One of the issues in *Moore* was the interpretation of two health maintenance organization (HMO) provisions Alistaire's parents believed should be read to cover the skilled home health services and outpatient rehabilitation and physical therapy services Alistaire's parents requested.⁴⁰ The HMO provision covering home health services limited coverage for individuals with conditions that, in the judgment of the HMO, would significantly improve within a period of ninety days.⁴¹ The HMO provision covering outpatient rehabilitation and physical therapy services likewise limited services to individuals with conditions that, in the judgment of the HMO, would significantly improve within a period of ninety days.⁴²

The 1990 case of *McGee v. Equicore-Equitable HCA Corporation* is also illustrative of pre-ACA Improvement Standards. In *McGee*, the U.S. District Court for the District of Kansas was charged with interpreting an ERISA-governed health plan that contained an Improvement Standard.⁴³ *McGee* involved the interpretation of an HMO provision the plaintiff claimed covered the long-term rehabilitative needs of the plaintiff's daughter, who suffered a brain injury during an automobile accident.⁴⁴ The disputed provision covered short-term rehabilitation services if, in the judgment of the HMO physician, the patient's condition could be expected to significantly improve within two months.⁴⁵ Because a physician made a predetermination that substantial improvement would occur in the daughter's condition in two months if she was transferred to a particular hospital, the court in

³⁵ See Jessica C. Barnett & Marina S. Vornovitsky, U.S. Census Bureau, Health Insurance Coverage in the U.S.: 2015 at 7, tbl 2 (September 2016) (noting that 67.2% of Americans who had health insurance in 2015, the most recent year for which data are available, had private health insurance).

³⁶ See, e.g., *supra* note 12.

³⁷ *Moore v. Blue Cross & Blue Shield*, 70 F.Supp.2d 9, 13 (D.D.C. 1999).

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.* at 14.

⁴¹ *Id.* at 33 (noting that Alistaire's HMO's would cover "Short term physical therapy for conditions which, in the judgment of CapitalCare, are subject to significant improvement within a period of 90 days").

⁴² *Id.* (also noting that Alistaire's HMO would cover "Short term rehabilitation services and physical therapy (for conditions which CapitalCare determines are subject to significant improvement within a period of 90 days).").

⁴³ *McGee v. Equicore-Equitable HCA Corp.*, 1990 WL 37932 (D. Kan. 10 April 1990) (unpublished).

⁴⁴ *Id.* at *1.

⁴⁵ *Id.* at *1 (quoting the disputed provision, which limited rehabilitation to that "which in the judgment of the Plan Physician, can be expected to result in significant improvement of the Member's condition within a period of two months."); *id.* at

McGee actually required the defendant to cover the first two months of rehabilitation at that hospital.⁴⁶ The patient in McGee was lucky, just like Brian in the skilled care hypothetical outlined above.

B. *The Improvement Standard in Private Health Insurance after the ACA*

When I give talks regarding the *Jimmo* Agreement, Medicare beneficiaries and other stakeholders will frequently tell me how pleased they are that *Jimmo* ended the use of the Improvement Standard in all forms of health insurance and that the ACA placed the final nail in the Improvement Standard coffin. At this point, I must explain that *Jimmo* only impacts Medicare coverage of skilled care. I also must explain that the ACA has not curtailed the use of the Improvement Standard in a range of private health insurance contexts, including the private individual, small group, and large group markets.

As background, President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (as consolidated, the Affordable Care Act (ACA)) into law in late March 2010.⁴⁷ Best known for its still controversial individual health insurance mandate,⁴⁸ the ACA requires certain health plans to provide ten sets of benefits called essential health benefits (EHBs).⁴⁹ Specifically, the ACA requires individual and small group health plans,⁵⁰ exchange-offered qualified health plans,⁵¹ state basic health plans,⁵² and Medicaid benchmark plans⁵³ to offer “rehabilitative and habilitative services and devices” in addition to nine other categories of EHBs.⁵⁴ Unfortunately, not every individual with private health insurance will benefit from these EHBs because the ACA exempted grandfathered health plans, large group health plans (through the beginning of 2017), and self-insured health plans from the requirement to provide the ten sets of EHBs.⁵⁵ In some states, such as Nevada, only ten percent of residents are covered by a health plan that must comply with the ACA’s EHBs, leaving the vast majority of residents without mandatory rehabilitation benefits.⁵⁶

3 (“Short-term rehabilitation services are limited to those services which, in the judgement of the Plan Physician, can be expected to result in significant improvement of the Member’s condition within a period of two months.”).

⁴⁶ Id. at *15.

⁴⁷ See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.) [hereinafter ACA].

⁴⁸ Id. § 5000A, 124 Stat. at 244 (adding the following to the Internal Revenue Code: “An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month”).

⁴⁹ See ACA § 1302(b)(1)(A)–(J).

⁵⁰ See ACA § 1201(2)(A) (noting amendments to the Public Health Service Act § 2707(a)) (codified at 42 U.S.C. § 300gg-6(a)).

⁵¹ Id. § 1301(a)(1)(B) (adding new 42 U.S.C. § 18021(a)(1)(B)).

⁵² Individuals eligible for state basic health plan coverage include individuals who are not eligible for Medicaid and whose household income falls between 133% and 200% of the federal poverty line for the family involved as well as low-income legal resident immigrants. Id. § 1331(e).

⁵³ Id. § 2001(c)(3) (adding new 42 U.S.C. § 1396u-7(b)(5)–(6)).

⁵⁴ Id. § 1302(b)(1)(A)–(J).

⁵⁵ See Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538, 34,562 (17 June 2010) (to be codified at 29 C.F.R. pt. 2590) (adopting 29 C.F.R. § 2590.715-1251(a), which defines “grandfathered health plan coverage” as “coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on 23 March 2010”); id. at 34,559 (explaining that Public Health Service Act § 2707 does not apply to grandfathered health plans); id. at 34,567–68 (adopting 29 C.F.R. § 2590.715-1251(c)(1), which states that “the provisions of PHS Act section[] . . . 2707 . . . do not apply to grandfathered health plans”); U.S. Dep’t Labor, Application of the New Health Reform Provisions of Part A of Title XXVII of the PHS Act to Grandfathered Plans 1 (2010) (explaining that ACA’s essential benefit package requirement is not applicable to grandfathered plans); Inst. of Med., Essential Health Benefits: Balancing Coverage and Cost 19 (2012) (listing the health plan settings to which ACA’s EHB requirement do not apply); Commonwealth Fund, The Essential Health Benefits Provisions of the Affordable Care Act: Implications for People with Disabilities 3 (2011) (“The act exempts large-group health plans, as well as self-insured [Employee Retirement Income Security Act] plans and ERISA-governed multiemployer welfare arrangements not subject to state insurance law, from the essential benefit requirements”).

⁵⁶ See e-mail from Glenn Shippey, Nev. Div. of Ins., to Stacey Tovino, Univ. of Nev., Las Vegas (8 April 2016, 3:33 PM PT) (“Please note that fewer than 10% of Nevadans are covered under an individual or small group policy in the state, and large employers are not required to provide coverage for essential health benefits”) (on file with author) [hereinafter Shippey E-mail].

For those health plans that must provide benefits within the ten EHB categories, the statutory EHB requirements were unclear as to whether particular benefits, such as inpatient brain rehabilitation benefits, were included and, if so, the extent to which they were required to be covered. As a result, HHS issued its first set of final regulations implementing the ACA's EHB requirements on 25 February 2013 (2013 Final Regulations).⁵⁷ The 2013 Final Regulations required states to select (or be defaulted into) a benchmark plan⁵⁸ that provided coverage for the ten EHB categories, including rehabilitation services,⁵⁹ and that served as a reference plan for health plans in each state. According to the 2013 Final Regulations, health plans in the state to which the EHB requirements applied were required to provide health benefits substantially equal to those provided by the state's benchmark plan, including the benchmark plan's covered benefits and excluded benefits.⁶⁰ Thus, the question of whether a particular health insurance policy or plan was responsible for providing (between 2014 and 2016) particular skilled care required an analysis of the applicability of the ACA's EHB provision to the policy or plan, the content of the state's current, selected benchmark plan, and the similarity between the particular policy or plan and the benchmark plan.

Since I am on faculty at the University of Nevada, Las Vegas, I will use the State of Nevada's first benchmark plan to illustrate the application of these rules. Nevada's first benchmark plan was the Health Plan of Nevada Point of Service Group 1 C XV 500 HCR Plan (Nevada's First Benchmark Plan).⁶¹ If, as written on 31 March 2012, Nevada's First Benchmark Plan included particular rehabilitation benefits without those benefits being subject to an Improvement Standard, then individual, small group, and other ACA-covered health plans in Nevada were responsible for providing substantially similar benefits in the years 2014, 2015, and 2016.⁶² On the other hand, if Nevada's First Benchmark Plan did not include coverage of particular rehabilitation benefits on 31 March 2012, then those benefits were not considered EHBs in Nevada and individuals who needed those benefits did not have coverage in 2014, 2015, and 2016 unless their health plans voluntarily included such benefits⁶³ or unless they accessed separate state funds (only available in some states) for relevant treatments and services.⁶⁴

In regulations published on 27 February 2015, HHS required states to select a new benchmark plan effective for the 2017 plan year (Second Benchmark Plan).⁶⁵ The deadline for states to select a Second Benchmark Plan was 1 June 2015.⁶⁶ Nevada, for example, selected the Health Plan of Nevada (HPN) Solutions Health Maintenance Organization Platinum 15/0/90% Plan as its Second Benchmark Plan.⁶⁷ Section 6.12 of the Second Benchmark Plan explains that, with respect to short-term rehabilitation therapy, covered services include speech therapy, occupational therapy, and physical therapy on an inpatient or outpatient basis when ordered by the member's primary care physician

⁵⁷ Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834 (25 February 2013) (to be codified at 45 C.F.R. pts. 147, 155, and 156).

⁵⁸ Id. at 12,866 (adopting 45 C.F.R. § 156.100).

⁵⁹ Id. (adopting 45 C.F.R. § 156.110(a)(7)).

⁶⁰ Id. at 12,867 (adopting 45 C.F.R. § 156.115(a)).

⁶¹ See Ctrs. for Medicare & Medicaid Servs., Nevada EHB Benchmark Plan. <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/nevad-ehb-benchmark-plan.pdf> (accessed on 1 September 2017) [hereinafter Nevada's First Benchmark Plan]; see also Letter from Scott J. Kipper, Comm'r, Div. of Ins., Dep't of Bus. & Indus., State of Nev., to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. 2 (14 December 2012) (identifying Nevada's Benchmark Plan selection).

⁶² See Shippey E-mail, *supra* note 56 (explaining the application of the EHB requirements in the State of Nevada).

⁶³ See (Cassidy 2013), at 2 (noting that HHS has indicated that the benchmark plan approach may be changed in 2016 and in future years based on evaluation and feedback).

⁶⁴ See, e.g., (Bernhard and John 2012) (discussing, for example, problem gambling treatments that are partially or fully supported by the State of Nevada).

⁶⁵ See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,812 (27 February 2015).

⁶⁶ See, e.g., (Volk 2015) (referencing the 1 June 2015, deadline for states to select an EHB benchmark for small employer and individual coverage available in 2017); Nev. Div. of Ins., Dep't Bus. & Industry, Essential Health Benefits, <http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Essential-Health-Benefits/> (last visited 1 September 2017) [hereinafter Nevada's Second Benchmark Plan] (identifying Nevada's benchmark plan selection for 2017).

⁶⁷ See Health Plan of Nevada, Small Business Evidence of Coverage, available under Nevada 2017 EHB Benchmark Plan Information at <https://www.cms.gov/cciio/resources/data-resources/ehb.html#Nevada> (accessed on 1 September 2017).

(PCP) and authorized by HPN's managed care program.⁶⁸ Nevada's Second Benchmark Plan also clarifies, however, that "Benefits for rehabilitation therapy are limited to services given for acute or recently acquired conditions that, in the judgment of the Member's PCP and HPN's Managed Care Program, are subject to significant improvement through Short-Term therapy."⁶⁹ Nevada's Second Benchmark Plan, which is currently in effect under the ACA, thus contains an Improvement Standard much like the Standard challenged by the *Jimmo* plaintiffs.

Nevada is not the only state whose Second Benchmark Plan contains an Improvement Standard. Alaska's Second Benchmark Plan, which is the Premera Blue Cross Blue Shield of Alaska Heritage Select Envoy plan,⁷⁰ explains that, with respect to inpatient and outpatient rehabilitation therapy services, covered services include only those services necessary to "restore and improve" a bodily or cognitive function that was "previously normal but was lost as a result of an accidental injury, illness, or surgery."⁷¹

Similarly, Hawaii's Second Benchmark Plan, which is the Hawaii Medical Service Association's Preferred Provider Plan 2010, explains, with respect to rehabilitation therapy, that covered short-term services include only those that will "improve or restore" neurological or musculoskeletal function.⁷² The Hawaii plan further clarifies that, "Therapy beyond this is considered long-term and is not covered. Maintenance therapy, defined as activities that preserve present functional level and prevent regression, are not covered."⁷³

Likewise, Georgia's Second Benchmark Plan also expressly excludes "custodial care and maintenance care."⁷⁴ The Georgia plan defines "custodial care" as "services you require that are primarily to maintain, and are not likely to improve, your condition"⁷⁵ and "maintenance care" as "services and supplies furnished mainly to...[m]aintain, rather than improve, a level of physical or mental function."⁷⁶

Idaho's Second Benchmark Plan is the Blue Cross of Idaho Health Service, Inc. Preferred Blue PPO Small Group Plan.⁷⁷ Through recent amendments, the Idaho plan specifically adds "maintenance care" to the services that are excluded from the list of covered physical therapy, occupational therapy, and speech therapy services.⁷⁸ The same amendments further specify that, with respect to physical therapy, occupational therapy, and speech therapy, there must be a "reasonable expectation that the services will produce measurable improvement in the Insured's condition in a reasonable period of time."⁷⁹

As a final illustrative, non-exhaustive, example of an EHB plan that contains an Improvement Standard similar to that opposed by the *Jimmo* plaintiffs, Colorado's Second Benchmark Plan is the Kaiser Foundation Health Plan of Colorado State LG A230 Employee Health Plan.⁸⁰ With respect to physical, occupational, and speech therapy as well as multidisciplinary rehabilitation services

⁶⁸ Id. at 17, § 6.12.

⁶⁹ Id.

⁷⁰ See Alaska, 2017 EHB Plan Information, <https://www.cms.gov/ccio/resources/data-resources/ehb.html#Alaska> (last visited 1 September 2017).

⁷¹ See Premera Blue Cross Blue Shield of Alaska, Heritage[®] Select Envoy, at 19, Available online: <https://www.cms.gov/ccio/resources/data-resources/ehb.html#Alaska> (accessed on 1 September 2017).

⁷² See Hawaii Medical Service Association, Preferred Provider Plan 2010, at 30, <https://www.cms.gov/ccio/resources/data-resources/ehb.html#Hawaii> (accessed on 1 September 2017).

⁷³ Id.

⁷⁴ See Humana Employers Health Plan of Georgia, Inc., Georgia HMO Premier 14, Copay Option 22, at 81, <https://www.cms.gov/ccio/resources/data-resources/ehb.html#Georgia> (accessed on 1 September 2017).

⁷⁵ Id. at 119.

⁷⁶ Id. at 128.

⁷⁷ See Idaho 2017 EHB Benchmark Plan Information, <https://www.cms.gov/ccio/resources/data-resources/ehb.html#Idaho> (accessed on 1 September 2017).

⁷⁸ See Blue Cross of Idaho Health Service, Inc., Preferred Blue PPO Small Group, Amendments, at 4, <https://www.cms.gov/ccio/resources/data-resources/ehb.html#Idaho> (accessed on 1 September 2017).

⁷⁹ Id. at 3–4.

⁸⁰ See Colorado 2017 EHB Benchmark Plan Information, <https://www.cms.gov/ccio/resources/data-resources/ehb.html#Colorado> (accessed on 1 September 2017).

provided in either the inpatient or outpatient settings, the Colorado plan requires a plan physician to determine that “*significant improvement is achievable within a two-month period*” in order for the services to be covered.⁸¹

In summary, the ACA is both historically significant and frustratingly limited at the same time in terms of skilled care and rehabilitation benefits. In terms of its significance, the ACA does require some health plans to provide essential rehabilitation benefits. Thus, after decades without express recognition in federal health law, some individuals with severe brain injuries and chronic conditions who need skilled care—at least in theory and pursuant to the terms of the brief ACA EHB provision—have essential rehabilitation benefits.

In terms of its limitations, however, the ACA does not expressly state that individuals who have insurance through a plan that must comply with the EHB provisions must have access to skilled care without an Improvement Standard. In fact, many state benchmark plans, including those of Nevada, Alaska, Colorado, Georgia, Hawaii, and Idaho, expressly reject coverage of individuals who need rehabilitation to maintain, rather than improve, their conditions.

In addition, the ACA’s EHB requirements still do not help out the tens of millions of Americans who are enrolled in grandfathered health plans, large group health plans, and self-insured health plans.⁸² As discussed above, less than ten percent of residents in some states are enrolled in a plan that must comply with the ACA’s EHB mandate, leaving the vast majority of some state residents without mandatory skilled care and rehabilitation benefits.⁸³

4. Conclusions

This article has compared and contrasted Medicare and private health insurance coverage of skilled care and has shown that some private health plans continue to require their members to demonstrate improvement in order to be eligible for coverage of skilled care. Operational and legal options for remedying this disparity are straightforward. First, private health plans could voluntarily remove from their plans any language containing an Improvement Standard. Second, state legislatures could amend existing, or enact new, mandatory rehabilitation insurance benefits statutes. These state statutes could require health insurers and health plans offering insurance to residents of the state to remove any plan provisions that contain an Improvement Standard and/or to require coverage of skilled care that is necessary to help maintain or prevent deterioration of a resident’s condition. Third, Congress could enact a federal rehabilitation parity statute that requires health plans that cover skilled care to cover such care for individuals whose conditions could be maintained with such care. This federal rehabilitation parity statute could be modeled after existing mental health parity statutes, such as the federal Mental Health Parity Act of 1996 and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which require parity between the insurance benefits provided to individuals with physical health conditions and individuals with mental health conditions. That is, a new federal law could require parity between the insurance benefits provided to individuals whose conditions can improve with skilled care and individuals whose conditions can be maintained with skilled care.

Although operational and legal approaches for remedying the disparity between public and private health insurance coverage of skilled care are straightforward, convincing health plan executives and state and federal lawmakers to adopt these approaches will be more difficult. This is where research and advocacy by scholars in health law, disability law, and insurance law may be useful. For example, additional research is needed to show how many states have selected Second Benchmark Plans that

⁸¹ See Kaiser Foundation Health Plan of Colorado State LG A230 Employee Health Plan, <https://www.cms.gov/cciiio/resources/data-resources/ehb.html#Colorado>, at 29 (accessed on 1 September 2017) (italicized emphasis added).

⁸² See sources cited at *supra* note 55.

⁸³ See Shippey E-mail, *supra* note 77 (“Please note that fewer than 10% of Nevadans are covered under an individual or small group policy in the state, and large employers are not required to provide coverage for essential health benefits”).

expressly or impliedly contain an Improvement Standard for skilled care. In states that have Second Benchmark Plans that expressly or impliedly contain an Improvement Standard for skilled care, how many ACA-covered plans in those jurisdictions voluntarily cover skilled care even when the insured is not expected to improve but could maintain his or her condition or not further deteriorate with skilled care?

Moreover, for insured and self-insured plans that continue to cover skilled care benefits subject to an Improvement Standard, why do they do so? Do these plans believe that individuals with brain injuries and other chronic conditions are not, somehow, worthy of skilled care? Or, perhaps that skilled care is too expensive to cover relative to the likelihood that the individual will improve? Have these plans assessed the cost of custodial care relative to the cost of skilled care in the context of individuals with brain injuries and individuals with chronic conditions and, if so, what is the difference? Should the difference be considered when making coverage determinations for individuals whose conditions are no longer improving? If so, why?

Along the same lines, does stigma against individuals with physical and mental disabilities in general, or with severe brain injuries and other chronic conditions in particular, play a role? As a normative matter, should skilled care without an Improvement Standard—and to that level of specificity—be an EHB in the United States? If so, should we amend the ACA to clarify that essential rehabilitation benefits shall not be subject to an Improvement Standard, much the same way HHS has in the Medicare context through *Jimmo*? Although efforts by President Trump to repeal and replace the ACA have failed thus far, how will any future repeal and replacement of the ACA affect the above analysis? It is my hope that this article will encourage scholars in health law, disability law, and insurance law to consider these and other practical and normative questions involving insurance coverage of skilled care.⁸⁴

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⁸⁴ See, e.g., Stacey A. Tovino, *A Right to Brain Rehabilitation* (in progress).