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Nicholas Bagley

*University of Michigan Law School, [nbagley@umich.edu](mailto:nbagley@umich.edu)*

Helen Levy

*University of Michigan Institute for Social Research, [hlevy@umich.edu](mailto:hlevy@umich.edu)*

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## Essential Health Benefits and the Affordable Care Act: Law and Process

Nicholas Bagley\*  
Helen Levy\*\*

### 1. Introduction

The Affordable Care Act (ACA) creates a host of new programs, each of which requires some kind of implementation at the agency level. By and large, the regulations governing these new programs have been promulgated through relatively formal notice-and-comment procedures and subjected to review coordinated by the Office of Information and Regulatory Affairs (OIRA). But the federal agencies implementing the ACA have at times shied away from notice-and-comment rulemaking even where it might have seemed appropriate. They have instead announced a number of critically important policies through subregulatory guidance documents—a broad category that encompasses bulletins, memoranda, and letters to state officials. These guidance documents are typically published not in Federal Register notices, but on agency websites.

This implementation strategy raises the question, a perennial in administrative law, of whether the substitution of subregulatory guidance for notice-and-comment rulemaking is a good thing. Does it reflect the zealous pursuit of good policy by government officials reluctant to get bogged down in a ritualistic bureaucratic exercise? Or does it represent an autocratic effort to avoid the rough-and-tumble of public deliberation over the merits of particular rules?

We consider this question in the context of a case study. Beginning in 2014, the ACA will require private insurance plans sold in the individual and small-group markets to cover a roster of “essential health benefits.” Precisely which benefits should count as essential, however, was left to the discretion of the Department of Health and Human Services (HHS). The matter was extraordinarily delicate. An expansive bundle of mandatory services would assure comprehensive coverage, but it would also raise the cost of insurance and could impede efforts to achieve near-universal coverage. Whatever HHS eventually decided, its choice would “influence the nature of coverage available to millions of people in the United States.”<sup>1</sup>

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\* Assistant Professor of Law, University of Michigan Law School. This draft book chapter is set to appear in a University of Chicago Law School conference volume in connection with the October, 2012 Conference on the Future of Health Care Reform in the United States.

\*\* Research Associate Professor, Institute for Social Research, University of Michigan.

<sup>1</sup> INSTITUTE OF MEDICINE, PERSPECTIVES ON ESSENTIAL HEALTH BENEFITS: WORKSHOP REPORT 17 (2011) (quoting Sherry Glied, Assistant Secretary for Planning and Evaluation at HHS).

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In December 2011, HHS released its first official communication on essential health benefits: a 13-page bulletin posted on its website stating that it would allow each state to define essential benefits for itself by choosing a “benchmark” plan modeled on existing plans in the state. The benefits included in that benchmark plan (subject to some adjustments) would be considered essential within the state. On both substance and procedure, the move was surprising. The benchmark approach departed from the uniform, federal standard that the statute appears to anticipate and that many informed observers expected HHS to adopt. And announcing the policy through an internet bulletin arguably allowed HHS to sidestep orthodox administrative procedures, including notice and comment, OIRA review, and pre-enforcement review in the courts—notwithstanding the ACA’s command that HHS “provide notice and an opportunity for public comment” on the definition of essential health benefits.<sup>2</sup> By the time HHS actually initiated a full-dress rulemaking process in November 2012, the deadline for states to submit their proposed benchmark plans to the agency was almost two months in the past.

What are we to make of this? The story of essential health benefits offers useful insight into the merits of subregulatory guidance; it is also interesting in its own right, both because of the importance of the policy question and the unexpected decision from HHS. In this chapter, we explore two questions. First, is the benchmark approach a lawful exercise of HHS’s authority under the ACA? Although we conclude that the approach likely will (and, in our view, should) be upheld in the event of a challenge, HHS may have brushed up against the limits of its discretionary authority. Second, did HHS’s announcement of the benchmark approach through an internet bulletin allow the agency to avoid the very administrative procedures that typically serve to constrain the exercise of agency discretion? The answer here is a flat no. The agency’s adroit use of guidance documents instead resulted in a process that was *more* open to public scrutiny and external oversight than conventional rulemaking would have been.

## 2. Background.

### *a. What does the statute say about essential health benefits?*

The ACA requires new health insurance plans in the individual and small-group markets to cover a minimum set of services that the ACA terms “essential health benefits” starting in 2014.<sup>3</sup> This requirement applies to plans sold on state health insurance exchanges and also to individual and small-group plans sold outside the

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<sup>2</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, §1302(b)(3) (2010) [hereinafter “ACA”].

<sup>3</sup> Large-group plans, such as those provided by large employers, are not required to provide essential health benefits, although they are subject to a different set of requirements governing the actuarial value of coverage.

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exchanges. The statute enumerates ten different categories of services that essential health benefits must, at a minimum, include:<sup>4</sup>

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.
10. Pediatric services, including oral and vision care.

Many of these inclusions are significant—for example, prescription drugs and pediatric dental care might have been excluded had Congress taken a bare-bones approach toward essential health benefits—but the list, by design, leaves much detail to be specified by subsequent regulation. For example, does “habilitative services” include behavioral treatment for autism, an expensive therapy with mixed evidence of effectiveness?<sup>5</sup> What do “preventive and wellness services” encompass beyond the ones that another provision of the ACA requires all plans to cover without cost-sharing?<sup>6</sup>

Sensitive to the need for greater detail, the ACA instructs the Secretary of HHS to flesh out the definition of essential health benefits. Specifically, the statute directs her to “ensure that the scope of the essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.” Congress also instructed the Secretary of Labor to survey insurance plans “to determine the benefits typically covered by employers” and report back to the Secretary of HHS.<sup>7</sup> The statute further directs that “[i]n defining the essential health benefits . . . and in revising the benefits . . . the Secretary shall provide notice and an opportunity for public comment.”<sup>8</sup>

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<sup>4</sup> ACA, §1302(b)(1).

<sup>5</sup> See Brian Reichow, *Overview of Meta-Analyses on Early Intensive Behavioral Intervention for Young Children with Autism Spectrum Disorders*, 42 J. AUTISM & DEVELOPMENTAL DISORDERS 512 (2012).

<sup>6</sup> ACA, Sec. 1001, §2713.

<sup>7</sup> ACA, §1302(b)(2)(A)

<sup>8</sup> ACA, §1302(b)(3)

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In the normal course of regulatory events, HHS might have been expected to launch an orderly rulemaking process not long after the ACA's enactment. It's hard to say exactly what a reasonable timeframe for this might have been, but the ACA required states to demonstrate to HHS by January 2013 that they would have health insurance exchanges up and running the following year. That demonstration in turn depended on states knowing well in advance about the scope of benefits that plans on the exchanges would cover. Working backward, a notice of proposed rulemaking would probably have had to issue by the end of 2011, followed by a final rule in mid-2012, to have any hope of giving states the certainty they needed to create their exchanges. That's not, however, what happened.

*b. The roles of the Institute of Medicine and the Department of Labor.*

As its first move out of the gate, HHS turned to the Institute of Medicine (IOM) for “advice on a process and considerations the Department needs to take into account in its initial establishment of [essential health benefits] and in updating them over time.”<sup>9</sup> In other words, HHS asked IOM not to define essential benefits, but to offer suggestions on how HHS might do so. The IOM report was expected to be complete in the fall of 2011. This bought HHS time during which it might reasonably do nothing. Assuming the agency was prepared to issue a notice of proposed rulemaking shortly after the release of the IOM report, the formal rulemaking process could proceed on a time frame that would allow for meaningful interaction with states and other interested parties—including insurers, health care providers, and consumer advocacy groups—before bumping into deadlines for health insurance exchanges.

IOM tackled its assignment with dispatch. It rapidly convened an expert panel to write a report recommending methods for determining and updating essential benefits. It also invited members of the public to submit comments online, and held two public consensus conferences, one in Washington, DC in January 2011 and another in Costa Mesa, California in March 2011. These consensus conferences featured presentations by an impressive range of experts and stakeholders, and were summarized in a volume released by IOM.<sup>10</sup>

Meanwhile, in April 2011, the Department of Labor (DOL) delivered its report on employer-sponsored coverage to HHS.<sup>11</sup> The report could offer little guidance on the hard questions facing HHS because the DOL surveys on which the report was based lacked sufficiently detailed information about the scope of coverage for specific

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<sup>9</sup> Sherry Glied, *Testimony to the IOM Committee on the Determination of Essential Health Benefits*, Jan. 13, 2011 (cited in INSTITUTE OF MEDICINE, *ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST* (2011)).

<sup>10</sup> See INSTITUTE OF MEDICINE, *PERSPECTIVES ON ESSENTIAL HEALTH BENEFITS: WORKSHOP REPORT* (2011).

<sup>11</sup> See *SELECTED MEDICAL BENEFITS: A REPORT FROM THE DEPARTMENT OF LABOR TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES*, Apr. 15, 2011, <http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf>.

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services. This was not entirely DOL’s fault: the “summary plan descriptions” that employers provide their workers (and on which the DOL analysis was based) are relatively sparse and uninformative. The report therefore gave HHS little to go on; it certainly provided no useful guidance on whether, say, a “typical” employer plan covered behavioral treatment for autism.

IOM did considerably better. On October 6, 2011, the expert panel released a 256-page report recommending a method for determining essential benefits.<sup>12</sup> Somewhat controversially, the report proposed a “premium target” approach in which a single national package of essential benefits would be tied to the cost of a typical benefits package in the small group market. That national package would then be updated over time to reflect innovation and public deliberation.

Following the release of the IOM report, HHS had little excuse for further delay. The agency announced that it would hold a series of “listening sessions” around the country. These sessions—two-hour meetings at which members of the public could share their opinions with HHS officials—were conducted in each of ten HHS-defined regions. The final listening session occurred in San Francisco on the Monday before Thanksgiving, November 21, 2011. For the next three and a half weeks, HHS was silent on the subject of essential health benefits.

*c. The bulletin.*

Then, on December 14, 2011, reports circulated that HHS intended to release a “prerule” on essential health benefits, although the term “prerule” created confusion. “Not even the most seasoned Washingtonians seem to know what it means,” according to *Politico*.<sup>13</sup> Two days later, the prerule was posted on HHS’s website with the title “Essential Health Benefits Bulletin.”<sup>14</sup>

Although the medium may have created some confusion, the bulletin’s message was both concise and surprising. Rather than specify a uniform national benefits package, the bulletin proposed to allow states to choose a “benchmark plan” to define essential health benefits. This approach was modeled on a policy introduced into Medicaid by the Deficit Reduction Act of 2005. Under the Medicaid version of the benchmark approach, states were allowed to offer a modified set of benefits, linked to a state-selected benchmark, to some groups of adult Medicaid enrollees. Only ten states

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<sup>12</sup> See INSTITUTE OF MEDICINE, *ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST* (2011).

<sup>13</sup> J. Lester Feder & Jason Millman, *Guidance by Any Other Name*, *POLITICO PRO*, Dec. 15, 2011.

<sup>14</sup> See Center for Consumer Information and Insurance Oversight, Department of Health and Human Services, *Essential Health Benefits Bulletin*, Dec. 16, 2011, [http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf) [hereinafter “EHB Bulletin”].

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have used this approach, and even then only for narrowly defined populations (e.g., individuals with diabetes).<sup>15</sup>

Adapting the benchmark approach for essential health benefits, the bulletin proposed permitting each state to choose a “benchmark plan” from a menu of options, including the three largest insurance plans in the state’s small-group market and the three largest plans available to state employees.<sup>16</sup> The default benchmark, for states that failed to select one, would be the largest small-group plan in the state.<sup>17</sup> Subject to adjustments to assure their conformity with the ACA’s list of coverage requirements, these benchmark plans would define essential benefits within the states.

The benchmark approach was front-page news, described by the *New York Times* as a “major surprise.”<sup>18</sup> As we explore in greater detail below, the ACA seems to have been drafted with a single national definition of essential health benefits in mind, not a different definition in each state. Most expert observers had not seriously considered a state-specific benchmark prior to the bulletin. The Congressional Budget Office scored the ACA on the assumption that HHS would establish a single, uniform standard.<sup>19</sup> And the IOM report never mentioned the benchmark approach that the bulletin ultimately proposed (although it did offer a limited endorsement for the idea that states might deviate from the national definition of essential benefits, subject to approval by HHS).<sup>20</sup>

Why did HHS take such an unanticipated approach to essential health benefits? Politics certainly played a role. Instead of imposing a uniform federal mandate that some states would inevitably dislike, the benchmark approach affords states greater flexibility to tailor their essential health benefits package along the lines they think best. What’s more—and although we lack the space here to thoroughly examine the question—smart politics probably made for smart policy. Because most health insurance plans “do not differ significantly in the range of services they cover” and “generally cover health care services in virtually all of the 10 statutory categories,”<sup>21</sup> no state can select a threadbare benchmark plan that would thwart the ACA’s effort to

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<sup>15</sup> See KAISER FAMILY FOUNDATION, EXPLAINING HEALTH REFORM: BENEFITS AND COST-SHARING FOR ADULT MEDICAID BENEFICIARIES (Aug. 2010).

<sup>16</sup> See EHB Bulletin, at 9.

<sup>17</sup> See EHB Bulletin, at 9.

<sup>18</sup> Robert Pear, *Health Care Law Will Let States Tailor Benefits*, N.Y. TIMES, Dec. 17, 2011, at A1.

<sup>19</sup> See Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act* 8 (Mar. 2012) (noting that the bulletin upends CBO’s prior estimates of what would count as essential health benefits), [www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf).

<sup>20</sup> See INSTITUTE OF MEDICINE, ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST 129 (2011).

<sup>21</sup> EHB Bulletin, at 4.

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guarantee the availability of comprehensive coverage. And tying local benefits to local market conditions probably results in less distortion (i.e. greater efficiency) than if benefits were required to be uniform.

The benchmark approach does create winners and losers. Because of the way premium subsidies and tax-sharing credits are calculated, recipients of subsidized coverage in states with generous benefits will receive modestly more federal support than those in less generous states. But that's no different from dozens of other policies; variation across states is simply a feature of our federal system. Even John Ball, the chair of the IOM panel that would have keyed essential health benefits to a target growth rate, offered only gentle criticism of the benchmark approach. "Given where the department is coming from, giving flexibility to the states is a good thing," he told *Politico*. "But I do think they missed an opportunity to take a crack at getting costs under control."<sup>22</sup>

Leading Republicans reacted much more harshly – but not to the substance of the policy. In a letter to HHS, a group of five influential Republican senators and congressmen objected instead to the process of announcing it:

By issuing a "bulletin" rather than a proposed rule, the administration has sidestepped the requirement to publish a cost-benefit analysis estimating the impact these mandates will have on health insurance premiums and the increased costs to the federal government. . . . [T]he administration is not required to respond to comments received regarding this "bulletin." . . . The bulletin also does not have the force of law and cannot, therefore, be considered an indication of what the proposed or final rule will decree. Thus, states still have many unanswered questions and no more certainty than they had before the "bulletin" was released. . . . It is unreasonable to expect states to be ready to implement such draconian changes by 2014, if the Administration is not even ready to issue a proposed rule on such an integral part of the functioning of the law.<sup>23</sup>

*d. From the bulletin to the notice of proposed rulemaking.*

This gloomy assessment notwithstanding, the bulletin prompted many states to launch their own administrative processes for selecting benchmark plans. And that was the point: "By releasing the bulletin now," the Secretary of HHS explained, "we're giving families, employers and states plenty of time to take this information into account as they plan for the big improvements the health care law will make to the

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<sup>22</sup> Jason Millman, *IOM Authors Fault HHS on Benefit Safeguards*, POLITICO PRO, Dec. 21, 2011.

<sup>23</sup> Letter from Michael B. Enzi, Orrin G. Hatch, Dave Camp, Fred Upton, & John Kline, U.S. Senators and Representatives, to Kathleen Sebelius, Secretary, HHS, Jan. 13, 2012.



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insurance market in 2014.”<sup>24</sup> With just over a year to go before the January 2013 deadline for demonstrating readiness to run an exchange, and myriad other tasks to complete, any state interested in running its own exchange could not really afford to wait.

To be sure, some states boycotted the process, and some officials cited the lack of adequate guidance from HHS on essential health benefits and other exchange-related issues as one of their ostensible reasons for refusing to participate.<sup>25</sup> In September 2012, Michael Consedine, the Insurance Commissioner for the state of Pennsylvania, stated in testimony before the Health Subcommittee of the House Ways and Means Committee that “[t]he lack of detailed information from HHS has put Pennsylvania, and many other states, in a very difficult position. We are traveling down a road, directionless, while knowing the road will end very soon—January 2014 is right around the bend.”<sup>26</sup> Robert Bentley, the Republican Governor of Alabama, was even more pointed in a letter sent a month later to the Secretary of HHS:

Your office released essential health benefits guidance on December 16, 2011, with the promise of more to come. It has yet to arrive. It has become clear to me that the states have been left to decide the fate of their insurance marketplaces with no additional guidance or regulations on essential health benefits. This places governors and other leaders in the untenable position of making a critical decision based on little more than vague guidance and guesswork. . . . I decline to make a decision on the essential health benefits benchmark plan. There is simply not enough valid information available now to make an informed choice for such an important decision.<sup>27</sup>

Ultimately, 22 states surmounted this uncertainty and, after undertaking their own notice-and-comment processes, submitted their benchmark plans to HHS by the

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<sup>24</sup> Conference Call Briefing with Secretary of Health and Human Services Kathleen Sebelius, White House Briefing, *FED. NEWS SERV.*, Dec. 16, 2011.

<sup>25</sup> Other reasons that were widely cited by states that did not proceed with implementation included uncertainty surrounding major legal challenges to the ACA (ultimately resolved by a Supreme Court ruling in June 2012) and uncertainty about the possibility of outright repeal of the health reform law, which has been more or less resolved by the outcome of the November 2012 elections.

<sup>26</sup> *Implementation of Health Ins. Exchanges & Related Provisions: Hearing Before the Subcomm. on Health of the H. Committee on Ways and Means*, Sept. 12, 2012 (statement of Michael Consedine, Comm’r, Penn. Office of the Comm’r, Dept. of Ins.).

<sup>27</sup> Letter from Robert Bentley, Governor of Alabama, to Kathleen Sebelius, Secretary, Department of Health & Human Services, Oct. 1, 2012, [http://governor.alabama.gov/pdfs/Letter\\_to\\_%20Sec\\_%20Sebelius\\_%20Oct\\_%2001\\_%2012.pdf](http://governor.alabama.gov/pdfs/Letter_to_%20Sec_%20Sebelius_%20Oct_%2001_%2012.pdf).

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October 1, 2012 deadline.<sup>28</sup> (Alabama and Pennsylvania were not among them.) A slender majority of the states (26) held a public comment period on the subject of the benchmark plan as part of the selection process.<sup>29</sup> On November 26, 2012—twenty days after the re-election of Barack Obama and not quite a year after the release of the bulletin—HHS published in the Federal Register a notice of proposed rulemaking (NPRM) on essential health benefits.<sup>30</sup> The NPRM formally proposed the benchmark approach that the bulletin had previewed. In its discussion of regulatory alternatives, the NPRM noted that “HHS considered one national definition of [essential health benefits] that would have applicable issuers offer a uniform list of benefits. However, this approach would not allow for state flexibility and issuer innovation in benefit design, would require a burdensome overhaul for issuers, and would disrupt the market.”<sup>31</sup> These two sentences represent the entirety of the NPRM’s discussion of the policy wisdom of the benchmark approach.

### 3. Legality

Because the ACA does not explicitly contemplate a benchmark approach to essential health benefits, the question immediately arises whether the approach is consistent with statute. In other words, has the Secretary exceeded the bounds of her discretionary authority?

HHS hasn’t yet offered a legal defense of the approach, but its argument will probably run something like this: Congress delegated to the Secretary of HHS broad authority to flesh out the meaning of “essential health benefits.” Under conventional principles of *Chevron* deference, the Secretary’s interpretation of the statutory phrase will be sustained (once a final rule has issued) so long as that interpretation offers a reasonable construction of the ACA.<sup>32</sup> Nothing in the statute precludes the Secretary either from linking those benefits to state health plans or from giving the states the flexibility to select benchmark plans. Given congressional silence on those points, the Secretary’s exercise of her authority is fully consistent with the ACA.

The argument is a powerful one. There are, however, two ways in which the benchmark approach is arguably difficult to square with the text of the ACA. The first is

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<sup>28</sup> Avalere Health. State Reform Insights. Updated October 1, 2012, at <https://www.politicopro.com/f/?f=11859&inb> on January 11, 2013.

<sup>29</sup> State Refor(u)m, *Summary of state progress on essential benefits as of October 3, 2012*, [www.statereforum.org](http://www.statereforum.org). Some states, including Alabama, began the process of selecting a benchmark but ultimately went with the default option rather than submit a choice to HHS.

<sup>30</sup> Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Notice of Proposed Rulemaking, 77 Fed. Reg. 70,644 (Nov. 26, 2012).

<sup>31</sup> 77 Fed. Reg. at 70665.

<sup>32</sup> See *Chevron v. NRDC*, 467 U.S. 837, 843 (1984).

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obvious. In a statute that is quite attentive to the division of regulatory labor between the federal government and the states, the ACA repeatedly confirms that “*the Secretary shall define the essential health benefits.*”<sup>33</sup> This is not casual language: in three separate places in the same statutory section, the Act contemplates that the Secretary would be the one “defining” and then “revising” what counts as essential health benefits.<sup>34</sup> The ACA even instructs the Secretary to “ensure that the scope of essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan, *as determined by the Secretary.*”<sup>35</sup> The phrase “as determined by the Secretary” would do no work unless it was the Secretary – not the states – doing the determining.<sup>36</sup>

Compelling as it may appear at first blush, however, this objection is not terribly persuasive. As the NPRM clarifies, the Secretary has not delegated to the states any final authority to define essential health benefits. Instead, the Secretary will choose a benchmark plan for any state that doesn’t pick a benchmark or selects an inappropriate benchmark.<sup>37</sup> Nothing in the ACA prevents the Secretary from deferring to those states that, in her judgment, select reasonable benchmark plans. That choice to defer is itself an exercise of her delegated powers.

The second potential objection to the benchmark approach is both less obvious and more substantial. Notwithstanding the Secretary’s wide discretion to define essential health benefits, there are limits to the deference that courts will give to agencies that interpret open-ended statutory language. As the D.C. Circuit has explained, the notion that an agency interpretation is permissible just because the statute in question “does not expressly negate the existence of a claimed administrative power (i.e. when the statute is not written in ‘thou shalt not’ terms), is both flatly unfaithful to the principles of administrative law . . . and refuted by precedent.”<sup>38</sup> The question at all times is whether Congress intended to delegate to the agency the authority to interpret the statute in the matter that it did.<sup>39</sup> Where the agency’s

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<sup>33</sup> ACA, §1302(b)(1) (emphasis added).

<sup>34</sup> ACA, §§1302(b)(2)(B), 1302(b)(3), 1302(b)(4).

<sup>35</sup> ACA, §1302(b)(2)(A) (emphasis added).

<sup>36</sup> The ACA also requires insurers to provide a succinct summary of benefits and a coverage explanation to their customers. That summary must include a description not only of the ten categories that are required to form part of the definition of EHB, but also of “other benefits, *as identified by the Secretary.*” ACA, Sec. 1201, §2715(b)(3)(B)(i). This again suggests that the Secretary will determine the “other benefits” that, together with the required categories, are considered essential.

<sup>37</sup> See 77 Fed. Reg. 70,667 (noting that “if a state elects not to substantially enforce the standards outlined in the final rule” for selecting a benchmark plan, “the Federal government will assume responsibility for these standards”).

<sup>38</sup> See *Railway Labor Executives’ Ass’n v. Nat’l Mediation Bd.*, 29 F.3d 655, 671 (D.C. Cir. 1994) (en banc).

<sup>39</sup> See Peter L. Strauss, “*Deference*” Is Too Confusing – Let’s Call Them “Chevron Space” and “Skidmore Weight”, 112 COLUM. L. REV. 1143, 1145 (2012) (“The whole idea of ‘agency’ is that the agent has a certain

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interpretation clashes with the statutory scheme or otherwise contradicts persuasive evidence of congressional intent, the courts will not presume that Congress meant to authorize the agency to so interpret the statute.<sup>40</sup>

As we've explained, the ACA was enacted on the assumption that HHS would establish a nationally uniform slate of essential health benefits. Under the benchmark approach, however, there will now be dozens of state-specific sets of essential health benefits. Many provisions of the ACA are inscrutable, extraneous, or impossible to implement in the face of that kind of variation. Consider again, for example, the requirement that essential health benefits must be "equivalent to the scope of benefits provided under a typical employer plan."<sup>41</sup> How could a variable roster of state-specific essential health benefits be "equivalent" to the scope of benefits provided under "a" (which is to say, one) employer plan?

Nowhere is the problem more apparent than in provisions governing state coverage mandates. Some states require insurers to cover specific benefits—for example, applied behavior analysis for autism or in vitro fertilization services—that Congress anticipated would exceed what the Secretary deemed essential.<sup>42</sup> Congress, however, didn't want to devote the tax credits and cost-sharing payments available on the exchanges to the coverage of state-mandated benefits. The ACA therefore limits exchange subsidies to defraying the costs of the benefits that the Secretary deems essential.<sup>43</sup> States must pick up the rest of the tab to assure that exchange plans with extra state-mandated benefits remain affordable.<sup>44</sup>

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authority, a zone of responsibility legislatively conferred upon it. ... Faced with the exercise of such authority, the natural role of courts, like that of referees in a sports match, is to see that the ball stays within the bounds of the playing field and that the game is played according to its rules."); Matthew C. Stephenson & Adrian Vermeule, *Chevron Has Only One Step*, 95 VA. L. REV. 597 (2009) (arguing that *Chevron* "calls for a single inquiry into the reasonableness of the agency's statutory interpretation").

<sup>40</sup> See *Brown v. Gardner*, 513 U.S. 115, 120 (1994) (holding that an agency interpretation was not owed deference in part because it was a "poor fit" with the statute as a whole); *California Independent System Operator Corp. v. FERC*, 372 F.3d 395, 401 (D.C. Cir. 2004) (same).

<sup>41</sup> ACA, §1302(b)(2)(A).

<sup>42</sup> See ACA, §1311(d)(3)(B)(i) (authorizing a state with coverage requirement that exceed essential health benefits to "require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b)").

<sup>43</sup> ACA, Sec. 1401, §36B(b)(3)(D)(ii) (tax credits); ACA, §1402(c)(4) (cost-sharing payments).

<sup>44</sup> See ACA, §1311(d)(3)(B)(ii) ("STATE MUST ASSUME COST. — A State shall make payments to or on behalf of an individual eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 to defray the cost to the individual of any additional benefits described in clause (i) which are not eligible for such credit or reduction under section 36B(b)(3)(D) of such Code and section 1402(c)(4).").

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All this is unnecessary, however, if state benchmarks establish the essential health benefits. A state benchmark plan will inevitably cover the treatments or services that the state has mandated. As such, state coverage mandates are, by definition, included in a state’s essential benefits. State coverage mandates can therefore never exceed essential health benefits, and states with extensive coverage mandates will never assume the additional costs that the ACA anticipates they will assume.<sup>45</sup>

The benchmark approach also raises questions about certain specialized insurance plans that the ACA anticipates will be sold on the exchanges. For the most significant example, the ACA instructs the Office of Personnel Management (OPM) to enter into contracts with health insurers to offer at least two multi-state plans on each state exchange. Per the ACA, those plans must “offe[r] a benefits package that is uniform in each State and consists of the essential [health] benefits.”<sup>46</sup> Where essential health benefits vary from state to state, however, a multi-state plan cannot both be uniform and cover only the essential health benefits.<sup>47</sup>

In proposing regulations for multi-state plans, OPM recognized the problem. Its solution was to read the “uniform in each State” language to require that “the benefits for each [multi-state plan] must be uniform within a State, but not necessarily uniform among States.”<sup>48</sup> Taking the text of the uniformity provision by itself, that interpretation is clumsy but potentially plausible. Subsequent provisions pertaining to multi-state plans, however, suggest that Congress was worried about inter-state, not intra-state, uniformity. Congress specified, for example, that nothing about the uniformity

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<sup>45</sup> See 77 Fed. Reg. 70,647 (“[W]e expect that there will be few, if any, payments made for state-required benefits since required benefits enacted prior to December 31, 2011 will be part of EHB, and therefore will not require the state to incur any costs.”). HHS apparently appreciates the problem, but its proposed workaround is awkward. After a two-year “transition period” in which it will waive the requirement that states defray any costs for coverage mandates, HHS will “evaluate the benchmark approach for the calendar year 2016 and will develop an approach that may exclude some State benefit mandates from inclusion in the State EHB package.” EHB Bulletin at 9-10. As we understand this statement (which is not elaborated on in the notice of proposed rulemaking), HHS anticipates that states might have to defray the costs for treatments and services that exceed some agency-determined baseline. In establishing that baseline, however, HHS will of necessity have to establish a shadow federal benefits package that would permit the allocation of state and federal financial responsibilities. That shadow package would not precisely match a federal determination of which benefits count as essential because states would still be free to select benchmark plans that covered fewer services than the shadow package. Nevertheless, the act of establishing the shadow package would require the agency to confront the very question that its benchmark approach purports to avoid: which benefits are so essential that the federal government ought to subsidize them?

<sup>46</sup> ACA, Sec. 10104(q), §1334(c)(1)(A).

<sup>47</sup> Congress’ use of the phrase “consist of” is typically defined to mean “be made up or composed of,” OXFORD ENGLISH DICTIONARY ONLINE (DEC. 2012), suggesting that Congress intended multi-state plans to cover *only* the essential health benefits.

<sup>48</sup> 77 Fed. Reg. 72,589 (2012).

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command prevents a state from requiring a multi-state plan to cover state-mandated benefits, so long as the state picks up the increased expense.<sup>49</sup> There would have been no need for Congress to bless that limited inroad on uniformity between the states if the ACA required only uniformity within each state.<sup>50</sup>

In short, the benchmark approach to essential health benefits is a poor fit with a number of provisions of the ACA. Although this raises the possibility of a credible legal challenge to the benchmark approach, we think such a challenge likely would—and should—fail. This is not a case where HHS has exploited statutory ambiguity in an underhanded effort to intrude into regulatory domains that Congress never intended it

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<sup>49</sup> ACA, Sec. 10104(q), §1334(c)(2) (providing that “[n]othing in paragraph (1)(A) shall preclude a State from requiring that benefits in addition to the essential health benefits required under such paragraph be provided to enrollees of a multi-State qualified health plan offered in such State.”).

<sup>50</sup> The benchmark approach also clashes with language establishing two other specialized insurance plans. First, the ACA authorizes the sale of certain insurance plans on a nationwide basis, although individual states can opt out and refuse to allow such plans to be sold in their states. ACA, §1333(b). Yet an insurer can offer a nationwide plan only if its benefits package is “uniform” across the country *and* covers the essential health benefits. ACA, §§1333(b)(3)(A) & (b)(6). This presents a tough question: must a uniform nationwide plan written in, say, New Hampshire and sold elsewhere cover only the “essential health benefits” in New Hampshire’s benchmark plan? Or must the nationwide plan cover any and all benefits covered in *any* state’s benchmark plan? Neither option seems plausible. If the New Hampshire benchmark could set the nationally uniform standard, insurers would have enormous incentives to relocate their businesses to states with threadbare benchmark plans—just the sort of race to the bottom that backers of the ACA sought to avoid in requiring uniform coverage of essential health benefits. See David M. Herszenhorn, *Let Health Insurance Cross State Lines, Some Say*, N.Y. TIMES, Feb. 14, 2010 (reporting that “President Obama and leading Democrats, however, warn that without new regulations [found in the ACA], private insurance companies would race to set up shop in states with lax regulation, minimal benefits requirements and the fewest consumer protections”). And if the nationwide plan had to cover every state-mandated benefit available anywhere in the country, Congress would have had no need to provide that insurers must adhere only to those coverage mandates applicable in the state where the nationwide plan “is written or issued.” ACA, §1333(b)(1)(B).

Second, the Community Health Insurance Option is to be a national, publicly operated insurance plan, run by HHS and available on the exchanges, that will cover “only” essential health benefits. ACA, §1323(b)(3)(A). Under HHS’s benchmark approach, the scope of coverage of this national plan would necessarily have to vary from state to state. The ACA, however, is explicit about permissible sources of state variation in the government-run insurance plan. Premiums can be geographically adjusted, states can apply their own consumer protection and solvency requirements, and the Secretary can collaborate with state officials to establish additional requirements and recommend policy. ACA, §§1323(b)(8), (d). Another provision does contemplate some variability in state-to-state coverage, but only where states (at their own expense) choose to mandate the coverage of benefits that exceed essential health benefits. ACA, §§1323(b)(3)(B), (D). Because each state’s essential health benefits will already incorporate those benefit mandates, however, the benchmark approach will countenance considerably more variability in coverage than the ACA appears to contemplate—without imposing any additional burdens on the states with extensive coverage mandates.

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to enter.<sup>51</sup> The agency has just chosen to coordinate with states in defining a statutory term that Congress gave it extensive latitude to define. Congress may not have contemplated that HHS would adopt a benchmark approach, but so what? Agencies routinely discharge their statutory obligations in ways that Congress doesn't anticipate, particularly in complex and fast-changing regulatory environments. Although the benchmark approach may render some of the ACA's provisions superfluous or awkward, an agency's choice is not usually deficient for that reason alone.<sup>52</sup> Any agency interpretation of a statutory provision almost inevitably makes other provisions of a complex statute less significant than they would have been under an alternative interpretation. The question remains whether the tension between statutory text and agency interpretation is so acute that Congress could not have intended to allow the agency to exercise its authority in the manner that it did.<sup>53</sup> Given the wide scope of the underlying delegation, it's difficult to find anything like that degree of tension here. Absent firmer indications that Congress intended to prohibit HHS from establishing essential health benefits with reference to state benchmarks, the agency's interpretation probably will, and ought to be, upheld.

#### 4. Procedure

Setting the legality of the controversial benchmark approach to one side, the fact remains that HHS used subregulatory guidance—a 13-page bulletin posted on its website—to announce it. The agency's unconventional policymaking process raises three concerns. First, in issuing the bulletin, HHS committed itself to the benchmark approach without abiding by the notice-and-comment procedures mandated by the APA.<sup>54</sup> In a call with reporters on the day it issued the bulletin, HHS confirmed that “[t]his is our intended regulatory approach” and rejected any suggestion that the agency might depart from it.<sup>55</sup> The formal notice-and-comment process currently underway was launched *after* most states had already selected their benchmark plans and promises to be even more of a charade than usual. Second, no executive order

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<sup>51</sup> See, e.g., *American Bar Ass'n v. FTC*, 430 F.3d 457, 470 (D.C. Cir. 2005) (invalidating an FTC interpretation regulating attorneys as “financial institutions” because it was a “poor fit [with] the statutory language”).

<sup>52</sup> Cf. *Babbitt v. Sweet Home Chapter, Communities for Great Ore.*, 515 U.S. 687, 722 (1995) (upholding EPA's interpretation of the Endangered Species Act, notwithstanding that its interpretation, as the dissenting justices argued, “makes superfluous (or inexplicable)” other provisions of the act).

<sup>53</sup> See *California Independent System Operator Corp. v. FERC*, 372 F.3d 395, 401 (D.C. Cir. 2004) (finding an agency interpretation to be “a sufficiently poor fit with the apparent meaning of the statute that the statute is not ambiguous on the very question before us”).

<sup>54</sup> 5 U.S.C. §553.

<sup>55</sup> Conference Call Briefing with Assistant Secretary Sherry Glied of HHS, White House Briefing, FED. NEWS SERV., Dec. 16, 2011 (stating “[n]o” in response to the question whether she anticipated, “based on the comment that comes in [sic], that there'll be either significant changes,” and confirming twice that “[t]his is our intended regulatory approach”).

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required OIRA review of the bulletin, diminishing the accountability benefits that presidential review might have afforded. And third, no court will review the bulletin before the provisions mandating that insurers cover essential health benefits go into effect, even though a rule adopted through notice-and-comment rulemaking could have been.

From this perspective, HHS’s procedural tack—a bulletin, followed by a long wait and then a hurried notice-and-comment session—is the worst nightmare of those who worry that agencies will use subregulatory guidance to avoid orthodox administrative procedures and, at low cost and with relative ease, dictate to regulated entities how they must order their affairs.<sup>56</sup> This has not gone unnoticed: HHS’s “atypical approach has been widely criticized.”<sup>57</sup> Confronted with a spare 13-page bulletin, states have been forced to select benchmark plans or cede to HHS the authority to select such plans on their behalf. Private insurers are already crafting new insurance products that comply with the state-selected benchmarks in anticipation of the January 1, 2014 date on which they must cover essential health benefits.

Looking a bit closer, however, what’s striking about the course of HHS’s decision-making is that the agency has voluntarily replicated most of the substance of the formal procedural requirements to which it was supposed to adhere.

*Notice and comment.* Before issuing its bulletin, HHS held a number of well-attended “listening sessions” where it sought views from states, insurers, providers, and consumer representatives. And starting in April 2010, HHS made weekly calls to state officials about implementation of the ACA, calls that informed its thinking about essential health benefits.<sup>58</sup> Around the same time, HHS also made it known to outside groups that it was toying with the idea of delegating to states wide authority to establish essential health benefits.<sup>59</sup> Four months before the bulletin was issued, the National Health Law Program (NHeLP) even submitted a lengthy letter to HHS on behalf of about six dozen public-interest groups objecting to any sort of benchmark approach. All this is in addition to the public discussion and comment process that IOM

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<sup>56</sup> See Robert A. Anthony, *Interpretive Rules, Policy Statements, Guidances, Manuals, and the Like – Should Federal Agencies Use Them to Bind the Public*, 41 DUKE L.J. 1311 (1992).

<sup>57</sup> Amanda Cassidy, *Health Policy Brief: Essential Health Benefits*, HEALTH AFFAIRS (Apr. 25, 2011), at [healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_68.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_68.pdf).

<sup>58</sup> See 77 Fed. Reg. at 70,667.

<sup>59</sup> Letter from National Health Law Program to Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services, Aug. 25, 2011 (“Some officials from HHS have suggested that the Department is considering giving states . . . significant discretion in defining the essential health benefits standard.”).



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carried out at HHS’s request<sup>60</sup> and to the notice-and-comment processes that 26 states used to select their benchmark plans.<sup>61</sup>

The agency didn’t have to do any of this. Without informing anyone of its thinking, HHS could simply have issued a notice of proposed rulemaking announcing its benchmark approach. After receiving comments and issuing a final rule, HHS would then have complied with all of the APA’s notice-and-comment requirements.

Paradoxically, however, formal compliance would have undermined HHS’s effort to seek and receive meaningful public input on its proposed approach. Because courts insist that agencies provide a fulsome explanation of the basis for their proposed rules, HHS would have had to elaborate its benchmark approach in a lengthy notice of considerable specificity.<sup>62</sup> Having done so, the agency might not have been receptive to comments suggesting that it abandon the benchmark approach in a final rule. The agency could have discarded the benchmark approach in favor of a federally uniform alternative only if it went through the laborious process of issuing a new notice of proposed rulemaking.<sup>63</sup> With statutory deadlines looming, however, the agency could not have afforded the delay that restarting the notice-and-comment process would have entailed.

Posting the bulletin was an ingenious way to solicit public comment without irrevocably committing the agency to the benchmark approach. The bulletin was a trial balloon—an effort to see if the approach would provoke the sort of public outcry or incisive criticism that called for a dramatic change in thinking. When reports surfaced just a week after the bulletin issued that “there was no backlash” to speak of, HHS learned something valuable about the broad acceptability of its chosen approach.<sup>64</sup>

In addition, the bulletin’s very first sentence explicitly invited comments from the public.<sup>65</sup> The agency received more than 11,000 of them in response.<sup>66</sup> Although

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<sup>60</sup> INSTITUTE OF MEDICINE, *ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST* (2011).

<sup>61</sup> State Refor(u)m, *Summary of state progress on essential benefits as of October 3, 2012*, [www.statereforum.org](http://www.statereforum.org).

<sup>62</sup> See E. Donald Elliott, *Re-Inventing Rulemaking*, 41 DUKE L.J. 1490, 1494 (1992) (“If the agency is to state the detailed basis for its actions in such a way that its actions will survive judicial review, public input through formal notice-and-comment rulemaking must come relatively close to the end of the agency’s process, when the proposed rule has ‘jelled’ into something fairly close to its final form.”).

<sup>63</sup> See *Int’l Union, United Mine Workers of Am. v. MSHA*, 407 F.3d 1250, 1259 (D.C. Cir. 2005) (final rule is a “logical outgrowth” of proposed rule “only if interested parties should have anticipated that the change was possible, and thus reasonably should have filed their comments on the subject during the notice-and-comment period.”).

<sup>64</sup> Jason Millman, *First crack at essential benefits guidance draws no backlash*, POLITICO, Dec. 18, 2011.

<sup>65</sup> EHB Bulletin, at 1 (stating that its “purpose . . . is to provide information and solicit comments on the regulatory approach” that it outlines.”).

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HHS has not made those comments public, the agency surely knows that they preview the concerns that commentators will voice during the full-dress notice-and-comment process – and that it will have to address those comments in issuing a final rule. If HHS believed that the comments presented cause for serious concern, the informality of the pre-notice process afforded the agency considerably more flexibility than notice-and-comment rulemaking to explore alternatives.

In short, at least from the perspective of meaningfully involving the public in agency decision-making, the bulletin-followed-by-rulemaking approach has been far superior to a routine process of APA notice-and-comment rulemaking. Significantly, it cleared a route for the agency to receive public comment at the all-important pre-notice phase of agency rulemaking. Commentators regularly lament that well-organized groups with concentrated interests have better access than diffuse public-interest groups to this pre-notice process where most important choices are made. The bulletin served as a partial equalizer in announcing to those groups with less access to the agency’s inner workings that the agency was open to hearing from them.

*OIRA review.* As it stands, no executive order currently requires agencies to clear subregulatory guidance documents like the bulletin through OIRA. Late in his administration, the second President Bush did issue an order subjecting guidance documents to OIRA review<sup>67</sup> out of concern that otherwise such documents “may not receive the benefit of careful consideration accorded under the procedures for regulatory development and review.”<sup>68</sup> Although President Obama rescinded that order shortly after taking office,<sup>69</sup> a memorandum from his budget director clarified that significant guidance documents remain subject to review.<sup>70</sup> In practice, however, review of guidance documents is unsystematic and spotty.<sup>71</sup> Perhaps, then, HHS issued its bulletin to avoid presidential meddling in its affairs even as it committed the executive branch to the benchmark approach.

Yet it turns out that HHS did share its bulletin with White House officials. OIRA’s website reports that it received the bulletin from HHS on December 14, 2011 and cleared it (with some revisions) two days later – the same day that HHS released it.<sup>72</sup> White House involvement likely ran deeper than this evidence indicates. Deciding

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<sup>66</sup> 77 Fed. Reg. at 70,646.

<sup>67</sup> Executive Order 13,422 (Jan. 18, 2007), at 72 Fed. Reg. 2763 (2007).

<sup>68</sup> 72 Fed. Reg. 3432 (Jan. 25, 2007).

<sup>69</sup> Executive Order 13,497 (Jan. 30, 2009) (rescinding Executive Order 13,422).

<sup>70</sup> Memorandum from Peter R. Orszag, Director, Office of Mgmt. & Budget 1 (Mar. 4, 2009), available at [www.whitehouse.gov/sites/default/files/omb/assets/memoranda\\_fy2009/m09-13.pdf](http://www.whitehouse.gov/sites/default/files/omb/assets/memoranda_fy2009/m09-13.pdf).

<sup>71</sup> See Jennifer Nou, *Agency Self-Insulation*, 126 HARV. L. REV. \_\_ (forthcoming 2013).

<sup>72</sup> See OIRA, *Historical Reports*, at [www.reginfo.gov/public/do/eoHistoricReport](http://www.reginfo.gov/public/do/eoHistoricReport).

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what counts as essential health benefits was perhaps the single most consequential policy choice that HHS will make in connection with the implementation of President Obama’s signal legislative achievement. As a matter of practical politics, HHS had no choice but to vet the bulletin at the very highest levels of the White House. Even in the absence of an executive order requiring centralized review, then, the bulletin received just the sort of review that is supposed to enhance the legitimacy and rationality of agency decision-making.

*Judicial review.* As it stands, HHS will likely issue a final rule on essential health benefits only months before the January 1, 2014 date on which the ACA requires private insurers (both on the exchange and off) to cover those benefits. In the meantime, a judicial challenge to the bulletin is probably a non-starter. The bulletin may not count as final agency action, and in any event it’s probably not ripe for review.<sup>73</sup> That’s so even though states, employers, and private insurers, anticipating that HHS will ultimately adopt the benchmark approach, must take steps to implement the bulletin in preparation for the 2014 deadline.

Contrast this with what would have happened if HHS had issued a proposed rule instead of the bulletin. The agency could have finalized the rule sometime in 2012 or early 2013, giving affected interests an opportunity to raise an expedited pre-enforcement challenge to the final rule before it sprang into force. If one purpose of pre-enforcement review is to avoid forcing regulated interests to make “an immediate and significant change in the . . . conduct of their affairs” that the law does not require them to make,<sup>74</sup> HHS’s unusual procedural tack has arguably thwarted that purpose.

There’s something to this – but not much. The benchmark approach embodied in the bulletin will not evade pre-enforcement review altogether. At most, HHS’s decision to outline its approach in a bulletin has allowed the agency to delay the date on which it issues a final rule. Whenever that final rule issues, *someone* will probably bring a pre-enforcement challenge. Perhaps the plaintiff will be the mother of an autistic son who can find no insurance plan in her state that covers needed services, but who believes that, had the agency gone through the process of establishing a uniform federal standard, HHS might have included such services in the package of essential health benefits.<sup>75</sup> Or perhaps it will be a California insurance company grouching that it must cover acupuncture.<sup>76</sup> The important point is that HHS knows that its final rule, when it

<sup>73</sup> See Nina Mendelson, *Regulatory Beneficiaries and Informal Agency Policymaking*, 92 CORNELL L. REV. 397, 411 (2007) (describing impediments to judicial review of agency guidance documents).

<sup>74</sup> *Abbott Laboratories v. Gardner*, 387 U.S. 138, 140 (1987).

<sup>75</sup> See *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 572 n.7 (1992) (“The person who has been accorded a procedural right to protect his concrete interests can assert that right without meeting all the normal standards for redressability and immediacy.”).

<sup>76</sup> See Phil Galewitz, *States Moving Ahead on Defining “Essential” Health Insurance Benefits Under Federal Law*, KAISER HEALTH NEWS, Sept. 30, 2012 (“California . . . will require coverage of acupuncture.”).

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issues, will almost certainly be challenged. There is thus every reason to think that the agency’s choice was disciplined by the near-certainty that the courts would one day scrutinize that choice. From the agency’s perspective, the *when* of pre-enforcement review is of less relevance than the *whether*.

Nor is it particularly worrisome that some states and insurers are taking immediate steps to comply with the approach that HHS has outlined. Even in the absence of final agency action, parties often structure their affairs in anticipation of governmental action. Earlier pre-enforcement review might have avoided some sunk costs—if the benchmark approach is invalidated, the efforts of states to select benchmark plans and of insurers to fashion new insurance products will be wasted. But steps made in anticipation of final agency action do not generally give rise to an entitlement to judicial review. What’s more, even if HHS had issued a notice of proposed rulemaking instead of a bulletin in December 2011, nothing would have required it to finalize the rule promptly. The agency might still have waited until the eleventh hour, devoting scarce resources to other pressing problems associated with implementation of the ACA. Against this backdrop, the notion that HHS used the bulletin to avoid judicial scrutiny is something of a stretch.

## 5. Conclusion

At first blush, HHS’s release of a terse bulletin to announce a major regulatory decision looks unusual, even improper. It seems to reinforce the fear that agencies routinely use subregulatory guidance documents to establish binding rules while evading the procedural obstacles that might otherwise deter them from acting.<sup>77</sup> And it appears to confirm the wisdom of the consensus view in the academy that guidance documents should be tolerated only grudgingly. Banning all guidance that effectively binds the public may be imprudent—better that regulated entities have some inkling of how agencies will carry out their duties than that they have none—but too much guidance risks undermining the procedural regularity of the administrative state.<sup>78</sup>

Yet this consensus view rests on an unstated and rather unappealing vision of administrative motivation. On this vision, agencies are staffed not by public officials

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<sup>77</sup> See, e.g., *Appalachian Power Co. v. EPA*, 208 F.3d 1015, 1020 (D.C. Cir. 2000) (“Law is made, without notice and comment, without public participation, and without publication in the Federal Register or the Code of Federal Regulations.”); House Committee on Government Reform, *Non-Binding Legal Effect of Agency Guidance Documents*, H. Rep. 106-1009, 106th Cong. 2d Sess. 9 (2000) (“[A]gencies have sometimes improperly used guidance documents as a backdoor way to bypass the statutory notice-and-comment requirements for agency rulemaking and establish new policy requirements.”).

<sup>78</sup> See Nina Mendelson, *supra* note 73, at 413 (explaining that “scholars have generally reacted to agency reliance on guidance documents with the guarded conclusion that this practice is better than nothing”); Conor N. Raso, *Strategic or Sincere? Analyzing Agency Use of Guidance Documents*, 119 *YALE L.J.* 782, 787 (2010) (noting the “common concern is that guidance documents allow agencies to make policy secretly and unilaterally, undermining the legitimacy of the administrative process”).

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anxious to assure that their choices are workable and publicly legitimate, but instead by a cadre of hardened bureaucrats bent on avoiding pesky procedures that slow them in their efforts to impose their will on the public. Guidance documents are tempting to those bureaucrats precisely because they allow them to avoid the sort of public input, executive oversight, and judicial review that, by fostering accountability to a broader public, could impede their efforts. (Or, to put it in terms more familiar to political scientists, to the extent that administrative procedures allow political principals to better control their agents,<sup>79</sup> agencies will use guidance documents to exploit the slack between them and those principals.)

Doubtless this accurately describes some agencies some of the time. But what then should we make of the fact that HHS has used its subregulatory guidance to replicate and reinforce—not avoid—the agency procedures that are supposed to assure agency rationality and fidelity to law? It turns out that HHS is hardly alone in adopting more administrative procedures than strictly necessary. In a recent book, Steven Croley documents a series of important rulemakings from the late 1990s and early 2000s, including EPA’s stringent regulation of ozone and particulate matter, FDA’s attempt to regulate tobacco products, and the Forest Service’s efforts to curtail road building in national forests. Although hardly a representative sampling, Croley’s examples “would all unquestionably make a short list of some of the most significant regulatory activity in more than a decade.”<sup>80</sup> And in each and every case, the agency “provided more notice, data, and opportunities for participation tha[n] the APA (or any other legal authority) demanded.”<sup>81</sup>

In other words, there’s nothing especially unusual about what HHS has done here. Far from ducking procedural obligations wherever possible, agencies sometimes embrace them. Why? At least for salient policy questions of substantial importance—a small but critical slice of agency action—agencies have a number of incentives having little or nothing to do with formal legal requirements to solicit public input and assure political oversight. Doing so provides the agencies with technical information, often available only to private parties, about how to craft policies that are capable of implementation. It arms them with scientific data that can help them better calibrate their rules. It teaches them about the political acceptability—and hence long-term sustainability—of the regulatory initiative. It identifies wellsprings of potential political

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<sup>79</sup> See Mathew D. McCubbins et al., *Administrative Procedures as Instruments of Political Control*, 3 J. L. ECON. & ORG. 243 (1987) (describing how “elected officials can design procedures . . . to mitigate [their] informational disadvantages [and] to enfranchise important constituencies in the agency decisionmaking processes”).

<sup>80</sup> STEVEN P. CROLEY, *REGULATION AND PUBLIC INTERESTS: THE POSSIBILITY OF GOOD REGULATORY GOVERNMENT* 160 (2008).

<sup>81</sup> *Id.* at 258. Nina Mendelson has likewise identified a number of agencies that make a habit of soliciting public input on guidance documents in the absence of legal compulsion to do so. See Mendelson, *supra* note 73, at 425.

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support for the rulemaking. It lends legitimacy to the regulatory initiative by assuring that all interested parties have had the opportunity to be heard both at the agency and in the courts. And it eases the concerns of those concerned that the agency is regulating by fiat. In sum, agency procedures can improve the workability and legitimacy of agency rules while protecting them from judicial or political attack.<sup>82</sup>

If agencies often have powerful incentives to voluntarily adopt administrative procedures, the reflexive distrust of agency guidance that runs like a leitmotif through the administrative law literature seems misplaced. This is not to deny that agencies use guidance to avoid the costs of burdensome procedural requirements. Of course they do. That's why issuing guidance is attractive to begin with. It doesn't follow, however, that agencies systematically use guidance to evade accountability. As the example of HHS's bulletin shows, sometimes guidance can enhance public responsiveness.

We don't mean to make too much of one case study. Agencies do sometimes use guidance to avoid scrutiny from Congress, the President, and the courts. But just how often? An impressive study from Conor Raso has found no empirical support for the assumption that agencies routinely use subregulatory guidance to avoid public accountability.<sup>83</sup> And, as a matter of first principles, that assumption seems no more plausible than the alternative assumption that agencies are usually sincere about what they use guidance for: to give regulated entities insight into the agency's private thinking, to shape how line officials carry out their duties, or even (as in the essential health benefits example) to facilitate a public debate about the wisdom of a regulatory approach.

Instead of assuming the venality of administrators, we might perhaps be better off acknowledging a banal point: that the administrative state is a complicated place, and that crude generalizations about bureaucratic behavior will often obscure more than they reveal. Guidance documents sometimes allow agencies to evade public accountability, but there's no particular reason to think that's inevitable or even all that common. As with other forms of agency action, guidance is neither good nor bad, but context makes it so. And when it comes to essential health benefits, context refutes the contention that HHS hurriedly issued its bulletin in a brazen effort to sidestep Congress and the President and shove an unlawful policy down the throats of the American public. When you look a little closer, quite the opposite seems to be true.

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<sup>82</sup> See CROLEY, *supra* n.80, at 259 (“Ultimately, the agencies’ final decisions following robust decisionmaking processes were then far less vulnerable to attack, whether by disgruntled interest groups, legislators, or litigants.”).

<sup>83</sup> See Raso, *supra* n.78.