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## Individual And Group Coverage Under The ACA: More Patches To The Federal-State Crazy Quilt

January 17th, 2013

by **Alice Noble** and **Mary Ann Chirba**[Tweet](#)[Recommend](#) 3

Throughout the 2012 Presidential campaign, Republican contenders criticized the Affordable Care Act (ACA) as a “federal take-over of health care” for its promotion of national uniformity in health coverage and access. Yet long before passage, the architects of the ACA quickly rejected a federal single payor system, or even a federal public plan to complement the private sector plans due to forceful opposition to national reform. Instead, they traveled the only politically viable road to reform: maintaining the fragmented and complex system of health care coverage, where federal and state governments as well as the private sector play pivotal roles. The ACA’s expansion of coverage is accomplished by continuing and even increasing state oversight, reinforcing the private market, and involving both employers and individuals. As enacted, therefore, the ACA’s fragmented approach to health reform is clearly not a federal take-over.

As implementation unfolds, however, the ACA’s impact on the roles of federal, state, and private actors is uncertain. Given the statute’s ambitions and complexity, uncertainty may be inevitable. Nevertheless, recent developments demonstrate that implementation may bring surprising results which, at least in some instances, are both unintended and problematic. We address two that pose particular challenges to achieving the ACA’s goals of expanding and harmonizing coverage among and between states: 1) the establishment of state exchanges, and 2) the determination of essential health benefits. We will leave the related topic of legal challenges to the so-called “employer mandate” for future discussion.

### 1. State Exchanges

The ACA seeks to preserve and even enhances the states’ traditional role in regulating health insurance through newly created state health insurance exchanges to assist individuals and small employers to obtain coverage. It was widely assumed that states would prefer to operate their exchanges for their own residents instead of having the federal government do it. Consequently, the ACA contemplates states running most of the exchanges, with the federal government stepping in only when a state is unable or unwilling to do so.

States had until mid-December 2012 to declare their preference and, contrary to initial assumptions about states wanting to maintain control, only 18 plus the District of Columbia decided to establish their own exchanges. To date, HHS has conditionally approved 17 states plus the District of Columbia to operate a state-based exchange. Of that group, only 3 would qualify as politically “Red” states

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(Idaho, Kentucky and Utah). HHS has yet to rule on Mississippi's application to run its own exchange.

The remaining 32 states that passed on running their own exchanges must decide by February 15, 2013 whether to partner with the federal government or delegate all exchange responsibilities to HHS. Residents of these (predominantly Red) states will therefore be consigned to federal or federal-state hybrid exchanges. Two early applicants, Arkansas and Delaware, received conditional approval to run a state and federal partnership exchange. The hybrid approach envisions federal transitional assistance during the early years of the exchange, after which the exchange will be run exclusively by the state. In contrast, solely federal exchanges are not transitional and are expected to operate indefinitely, until a state applies to run its own exchange.

The ACA's reliance on state-based exchanges was designed to maintain state influence over their insurance markets, as they have done under the McCarron-Ferguson Act and the Employee Retirement Income Security Act (ERISA). Wide scale rejection of state authority is thus surprising and ironic. What is immediately apparent is that with regard to state-based expectations, by yielding control of exchanges to the federal government, states punted. The result is an unexpected power shift away from the states and to the federal government.

## 2. Essential Health Benefits

The state and federal balance is playing out quite differently in the story of essential health benefits. Here, too, a power shift has occurred, but this time, it is the federal government that has punted. The ACA was designed to improve uniformity of the content of health care coverage among the states and different markets. It does so by requiring the federal government to determine mandated "essential health benefits" (EHBs). By ceding this authority to the states, HHS has made the law as implemented look more like a federal retreat than a take-over.

Traditionally, many states have required health insurance policies to cover certain benefits over and above standard offerings, although the additionally mandated benefits will vary from state to state. For example, fertility treatments, substance abuse treatments, and acupuncture have been mandated in certain states and not others. One study finds that prescription drug coverage may be broad enough to cover virtually all drugs approved by the FDA in some states, while other states only require coverage of less than half of such drugs.

The ACA provides that small group and individual insurance policies, offered both inside and outside of the exchanges, must cover a core set of "essential health benefits" (EHBs). States that continue to mandate benefits in addition to EHBs must pay an additional amount toward the subsidy provided to individuals on the exchanges (which could discourage states from requiring anything more than EHBs). As written, the ACA puts the federal government squarely in charge of defining EHBs. Vesting primary control over the content of health insurance policies in federal regulators would, in theory, replace the patchwork of varying state-by-state benefits with a more uniform federal requirement.

CMS's proposed rule, however, abandons this quest for uniformity by directing each state to designate its own EHB "benchmark" plan from a range of HHS-identified plans offered within that state. Twenty-two states failed to designate an EHB benchmark by the December 26 deadline and those states will be required to use the largest selling plan in the small-group market as their benchmark EHB plan. All plans that cover EHBs must offer benefits that are substantially equal to the benefits offered by the benchmark plan.

The rule provides that state benefits mandates enacted as of December 31, 2011 will be considered part of the EHB package for plans within the same market, at least during a transition period from 2014 through 2015. This would relieve states from having to pay additional subsidies for their mandated benefits. Nevertheless, permitting states to determine EHBs and preserving additional pre-2012 state benefit mandates causes [considerable interstate variability](#) in covered benefits for the individual and small group policies subject to the EHB requirement.

In the private market, only individuals covered by insurance policies in the individual and small employer markets will benefit directly from this new requirement – at least initially. (Medicaid essential health benefit rules, which are not discussed here, have been proposed.) Private self-insured small group plans, and large group plans (both fully insured and self-insured) are generally not included in the exchanges and therefore are not required to cover EHBs. Accordingly, for the immediate future, the proposed EHB rule will extend to a relatively small segment of the American public. Even with this

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limited impact, it boldly upends early predictions of a more uniform “national benefits package” with a diminished role for the states.

And this impact is likely to grow if more plans are brought within EHB requirements as originally envisioned by the ACA. Presently, large fully insured employer plans are exempt from EHB requirements but must comply with state benefits mandates and the modest coverage requirements of ERISA. (See **Note 1** below.) This could change in 2017, when states are permitted to open exchanges to large fully insured health plans. At that point, presumably such plans would be required to offer the EHBs as well as any additional ERISA mandated benefits, but future guidance from HHS is needed on this point. The ACA also exempts certain individual, small group and large group insured “grandfathered plans” from EHB rules. This, too, could change over time with the expansion of exchanges. To what extent grandfathered plans will lose their grandfathered status over time is not yet known.

Some large and small employers, however, choose to self-insure, paying the costs of employee health benefits as they are incurred (often relying on reinsurance once a certain payout level is reached). Due to the complexities of ERISA preemption, self-insured plans are “saved” from state benefit mandates although they are subject to the handful of benefits required under ERISA. The federal [Agency for Healthcare Research and Quality estimates](#) that in 2011, 68.5 percent of all health plan participants employed by large companies (i.e., those with more than 50 employees), and approximately 11 percent employed by small companies were enrolled in self-insured plans. Overall, self-insured plans covered 58.5 percent of private sector health plan enrollees. Thus, even after 2017, the reach of the EHB requirement into the large group market will be limited.

The absence of consistent coverage of benefits under the ACA is on full display with the law’s fractured regulation of employer sponsored small group plans. By leaving ERISA largely intact, the ACA excludes self-funded employment-based ERISA plans from state exchanges and EHB requirements. Preserving broad ERISA preemption of state law also continues to exempt such plans from state mandated benefits entirely. The ACA also excludes grandfathered plans from the EHB requirements. Thus, with the ACA, there are now five categories of employer-sponsored small group plans: 1) self-funded small group ERISA plans; 2) insured small group ERISA plans offered on the exchanges; 3) insured small group ERISA plans offered outside the exchanges; 4) grandfathered insured small group ERISA plans; and 5) grandfathered self-insured small group ERISA plans. (See **Note 2** below) Plan types in the individual and group markets and their coverage implications may be organized as follows (click on the chart to enlarge it):

VARIABLES AFFECTING BENEFITS COVERAGE FOR EMPLOYER-SPONSORED ERISA PLANS AND INDIVIDUAL PLANS INSIDE AND OUTSIDE STATE EXCHANGES AS OF 2014					
	SUBJECT TO ERISA MANDATED BENEFITS	OFFERED ON EXCHANGE AS OF 2014	SUBJECT TO EHB REQUIREMENT (may include state-specific benefits mandated as of 12/31/2011)	SUBJECT TO NON-EHB STATE MANDATED BENEFITS AS OF 2014	OFFERED ON EXCHANGE + EHBs REQUIRED AS OF 2017
<b>LARGE GROUP MARKET</b>					
Insured	Yes	No	No	Yes	Maybe (up to States)*
Grandfathered Insured	Yes	No	No	Yes	No
Self-Insured	Yes	No	No	No	No
Grandfathered Self-Insured	Yes	No	No	No	No
<b>SMALL GROUP MARKET</b>					
Insured <i>inside</i> Exchange	Yes	Yes	Yes	Yes ( + state \$\$ to offset related subsidies)	Yes
Insured <i>outside</i> Exchange	Yes	No	Yes	Yes	Yes
Grandfathered Insured	Yes	No	No	Yes	No
Self-Insured	Yes	No	No	No	No
Grandfathered Self-Insured	Yes	No	No	No	No
<b>INDIVIDUAL MARKET</b>					
Inside Exchange	No	Yes	Yes	Yes ( + state \$\$ to offset related subsidies)	Yes
Outside Exchange	No	No	Yes	Yes	Yes
Grandfathered	No	No	No	Yes	No

\* States may opt to permit (but cannot require) large employers to offer plans on the exchange. Presumably the EHB requirement would apply, as it does to all Qualified Health Plans offered on the exchanges. Whether the EHB requirement would also apply to non-grandfathered large group insured plans outside the exchanges is uncertain. Further guidance will be needed to resolve these and other issues related to the 2017 expansion of exchanges.

### 3. Conclusion

The federal government’s role in health care regulation has grown over time, especially since the inception of Medicare and Medicaid in the 1960s. That federal involvement has been fragmented is nothing new. The Employee Retirement Income Security Act (ERISA) of 1973 and the insurance reforms of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, for example, took a patchwork approach to allocating oversight responsibilities among federal and state regulators, while respecting the role of private players in health care insurance and delivery systems.

The ACA continues this trend, but its approach is decidedly tempered in order to accommodate both states and the private sector. The result is a dizzying array of plan types (self-insured, fully insured, small market, individual market, large market, grandfathered) subject to an equally dizzying array of ACA, ERISA, and individual state requirements. Such fragmentation may confound those who criticized the ACA as a federal-takeover of health care. ACA supporters who anticipated that federal reform would simplify the complex blend of federal and state regulation may be equally bewildered by the ongoing confusion. Consequently, instead of bringing order to a system that had become synonymous with fragmentation, the ACA follows tradition by adding to the crazy quilt of U.S. health care.

These and other developments underscore the fluid nature of health reform. The ACA is being defined as it is implemented, with unexpected twists and turns along the way. How this story will unfold, and what effect the ACA will ultimately have, cannot be known until it reaches the final chapter of full implementation and its impact in the years to come.

**Note 1.** The ERISA benefit mandates are limited and include coverage parity between medical/surgical benefits and mental health benefits; minimum hospital stays following childbirth; and certain benefits related to reconstructive surgery following a mastectomy.

**Note 2.** Excluded from this discussion are small group plans that are not employer-sponsored ERISA plans (e.g., government plans, certain church plans, certain plans sponsored by associations).

It is obvious, however, that such variation exacerbates the fragmentation described above.

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