

## THE ACA, THE LARGE GROUP MARKET, AND CONTENT REGULATION: WHAT'S A STATE TO DO?

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### I. INTRODUCTION

The Patient Protection and Affordable Care Act<sup>1</sup> (“ACA”) significantly changes many aspects of health insurance regulation. One of the primary, and overarching, changes made by the ACA is to regulate health insurance at the federal, rather than state, level.<sup>2</sup> There is, however, at least one area of health insurance regulation that has been left almost entirely to the states: the regulation of the content of coverage in the large group market.<sup>3</sup>

The term “content regulation” refers to regulation that requires health insurance contracts to provide coverage for certain types of treatments, services, or providers.<sup>4</sup> State laws regulating the content of health insurance coverage are often referred to as “mandated benefits” or “state mandates.”<sup>5</sup> The ACA is not timid in its content regulation in market segments other than the large group market. Indeed, every individual and small group policy issued in 2014 and thereafter will be required to provide coverage for all “essential health benefits” (“EHB”), a federally-defined term.<sup>6</sup> Large group

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1. Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (to be codified in scattered sections of 29 U.S.C. & 42 U.S.C.). The two preceding laws will be hereinafter cited together as the “ACA.”

2. See, e.g., ACA § 1201 (to be codified at 42 U.S.C. § 300gg).

3. I use the term “large group market” to refer to employer groups with fifty or more employees who do not self-insure their health plans.

4. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727-28 (1985).

5. Gail A. Jensen & Jon R. Gabel, *State Mandated Benefits and the Small Firm’s Decision to Offer Insurance*, 4 J. REG. ECON. 379, 380 (1992).

6. ACA § 1201 (to be codified at 42 U.S.C. § 300gg-6) (adding PHSA § 2707); ACA § 1302 (to be codified at 42 U.S.C. § 18022). As this article was going to press, the Department of Health & Human Services issued a bulletin announcing that it intended to let each state select coverage terms from among a group of benchmark plans to serve as the definition of “essential health benefits” within that state. See CENTER FOR CONSUMER

policies face no similar requirements and can be freely regulated by the individual states.<sup>7</sup> In that sense, the ACA retains the status quo in the large group market with respect to content regulation. Given, however, the fundamental changes that are being made throughout the health insurance market, the ACA presents states with an important opportunity to give new consideration to the approach they take to content regulation in the large group market. Giving careful consideration to large group content regulation is important not only because of new market dynamics that will come into play as the ACA is fully implemented, but also because employers in the large group market have an effective way to avoid such regulation by choosing to self-insure their health plans. Self-insured plans cannot be regulated by the state,<sup>8</sup> and therefore states must take care to balance the benefits of content regulation against the increased potential to self-insure that such regulation might create. With these dynamics in mind, this article examines the benefits and costs of various state approaches to such content regulation, arguing that states should take this opportunity to fundamentally reform their approach to large group content regulation.

## II. THE LARGE GROUP MARKET

The “large group market” typically refers to the health insurance market segment that covers groups with more than fifty employees.<sup>9</sup> The ACA, however, defines the large group market as those groups with more than 100 employees, although states have the option in 2014 and 2015 to use the traditional fifty employee definition.<sup>10</sup> This part will provide a brief overview of the large group market under both current law and under the ACA, whose major insurance market reforms will not be effective until 2014.

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INFORMATION AND INSURANCE OVERSIGHT, U.S. DEP’T OF HEALTH & HUM. SERVS., 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). If the proposed framework is finalized, the result will be state-specific definitions of essential health benefits, a much different outcome than the federal definition that this article (and, arguably, the statute) presupposed.

7. See *id.*; see also Joe Tuschner & Sabrina Corlette, *Essential Health Benefits*, AM. CANCER SOC’Y 3, <http://www.acscan.org/pdf/healthcare/implementation/background/EssentialHealthBenefits.pdf> (last visited Oct. 5, 2011).

8. *Am. Med. Sec., Inc. v. Bartlett*, 111 F.3d 358, 361 (4th Cir. 1997).

9. See, e.g., Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws*, 32 U. MICH. J. L. REFORM 685, 689 (1999).

10. ACA § 1304(b)(1) (to be codified at 42 U.S.C. § 18024).

### A. Pre-ACA

Prior to the passage of the ACA, the large group market was regulated by both individual states and the federal government.<sup>11</sup> States regulated insurers offering large group coverage directly by dictating certain financial and consumer protection requirements. States also regulated the content of such coverage, requiring that certain treatments, services, and providers be covered by every health insurance policy issued within the state.<sup>12</sup> Large group insurance was regulated at the federal level, through the Employee Retirement Income Security Act of 1974, as amended<sup>13</sup> (“ERISA”), if the insurance was purchased by an employer for the benefit of its employees.<sup>14</sup> ERISA contains requirements relating to reporting and disclosure, fiduciary duties, claims procedures, and remedies.<sup>15</sup> ERISA also includes several provisions applicable only to group health plans.<sup>16</sup> For example, ERISA incorporates the provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) relating to non-discrimination in group health plans,<sup>17</sup> and the requirement to offer continuation coverage for group health plan participants that experience a qualifying event.<sup>18</sup> ERISA, however, contains very few requirements with respect to the content of coverage under a group health plan, specifying only that breast reconstruction following a mastectomy,<sup>19</sup> minimum hospital stays following childbirth,<sup>20</sup> and pre-existing conditions must be covered,<sup>21</sup> and that mental health benefits, if offered, must be offered on the same terms as other medical benefits.<sup>22</sup>

Notably, ERISA preempts any state laws that “relate to” an employee benefit plan.<sup>23</sup> As a result, many state laws that would otherwise affect an

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11. See Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1363-74 (providing an overview of pre-ACA group health insurance regulation).

12. *Id.* at 1363-64.

13. Employee Retirement Income Security Act (“ERISA”) of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of I.R.C. & 29 U.S.C.).

14. While it is possible that a non-employer would purchase health insurance coverage for a group, nearly all group health insurance contracts are purchased by employers and are subject to ERISA. Notable exceptions include church and governmental employers, who are exempt from ERISA. 29 U.S.C. § 1003(b) (2006).

15. 29 U.S.C. §§ 1021, 1101-1114, 1133, 1451.

16. *Id.* § 1161 & § 1181.

17. *Id.* § 1182.

18. *Id.* §§ 1161-1163.

19. *Id.* § 1185b.

20. 29 U.S.C. § 1185 (2006).

21. *Id.* § 1181.

22. *Id.* § 1185a.

23. *Id.* § 1144(a).

employer's health plan are preempted. ERISA, however, saves from preemption state laws that regulate insurance.<sup>24</sup> As a result, a state may regulate both the insurance company's business operations, and also the substance of the policies issued by the insurer, which the employer in turn purchases.<sup>25</sup> However, ERISA further provides that states may not regulate self-insured health plans as insurance companies.<sup>26</sup> As a result, an employer that chooses to self-insure its health benefits does not need to comply with state insurance laws, including state mandated benefit laws.<sup>27</sup> The result is that insured employer plans must comply with both state and federal regulation, while self-insured plans need to comply only with limited federal requirements.

A self-insured health plan is a plan in which the employer has retained the responsibility for paying claims.<sup>28</sup> In some circumstances, an employer simply pays all claims out of its general assets, while in other cases the employer purchases stop-loss insurance that reinsures the employer's risk of loss with respect to the plan above a certain "attachment point."<sup>29</sup> A plan does not lose its self-insured classification when it purchases stop-loss coverage, even if that coverage has a very low attachment point.<sup>30</sup> In nearly all circumstances, employers who self-insure hire a third-party administrator to provide a network of physicians, to perform various types of utilization review, and to process claims.<sup>31</sup> Rates of self-insurance vary by employer size, with large employers being much more likely to self-insure than small employers. For example, in 2008, 88% of workers in firms with 3-199 employees were covered by fully insured plans, while 89% of workers in firms with 5,000 or more employees were covered by self-insured plans.<sup>32</sup>

The high rate of self-insurance among employers is not, in and of itself, problematic. Rather, it is the possibility that differing content regulation between insured and self-insured plans drives the decisions of employers to

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24. *Id.* § 1144(b)(2)(A).

25. *Metro. Life Ins. Co.*, 471 U.S. at 728-29 n.2.

26. 29 U.S.C. § 1144(b)(2)(B).

27. See *Am. Med. Sec., Inc.*, 111 F.3d at 360.

28. See *id.* at 364; Christina H. Park, *Prevalence of Employer Self-Insured Health Benefits: National and State Variation*, 57 MED. CARE RES. & REV. 340, 341 (2000).

29. See Russell Korobkin, *The Battle Over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 110-11 (2005).

30. *Am. Med. Sec., Inc.*, 111 F.3d at 364.

31. Monahan, *supra* note 11, at 1372-73.

32. *Health Plan Differences: Fully-Insured vs. Self-Insured*, EMP. BENEFIT RES. INST. (Feb. 11, 2009), <http://www.ebri.org/pdf/FFE114.11Feb09.Final.pdf>.

self-insure that causes concern.<sup>33</sup> One primary cause for concern is that the differing content regulation will lead to inefficient self-insurance decisions.<sup>34</sup> Consider, for example, an employer that desires to design a plan free from the state mandates that would apply to an insured plan. That employer might decide to self-insure, even though it desires or may even need the financial protection associated with a fully insured product, and even though such a decision may result in higher administrative costs for the employer. Such decisions, caused by the regulatory disparity, create inefficiencies for the employer, and potentially expose the covered employees to undue risk. After all, in a self-insured plan if the employer is unable to pay claims, employees are limited to seeking payment in bankruptcy—where their status as unsecured creditors makes it unlikely they will be paid in full.<sup>35</sup> I will refer to this risk as “insolvency risk.”

A second concern fueled by the regulatory disparity between insured and self-insured plans is that employers will choose to self-insure in order to offer a less comprehensive plan than would be possible in the insured market.<sup>36</sup> If an employer’s self-insured plan fails to offer adequate coverage for employees’ medical expenses, employees may not be able to afford necessary medical treatment. I refer to this form of risk as “treatment-related financial risk.” Unfortunately, little is empirically known about the extent to which differing content regulation drives an employer’s decision to self-insure,<sup>37</sup> and data are similarly lacking regarding the extent of either insolvency risk<sup>38</sup> or treatment-related financial risk<sup>39</sup> that result from decisions to self-insure.

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33. For an overview of this issue, see Gail A. Jenson, Kevin D. Cotter & Michael A. Morrissey, *State Insurance Regulation and Employers’ Decisions to Self-Insure*, 62 J. RISK & INS. 185, 210 (1995).

34. *Id.* at 187.

35. See, e.g., Ianthe Jeanne Dugan, *For Workers, Medical Bills Add to Pain As Firms Fail*, WALL ST. J., Dec. 6-7, 2008, at A1 (describing the effect of a company’s bankruptcy on individuals covered by the firm’s self-insured health plan).

36. Jonathan Gruber, *State Mandated Benefits and Employer Provided Health Insurance* (Nat’l Bureau of Econ. Research, Working Paper No. 4239, 1992).

37. For an overview of the literature on the decision to self-insure, see CHRISTINE EIBNER ET AL., U.S. DEP’T OF LABOR & U.S. DEP’T OF HEALTH & HUMAN SERVS., *EMPLOYER SELF-INSURANCE DECISIONS AND THE IMPLICATIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AS MODIFIED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (ACA)*, 1, 17-18 (2011), available at [http://aspe.hhs.gov/health/reports/2011/LGHPstudy/EmployerSIDA\\_CA.pdf](http://aspe.hhs.gov/health/reports/2011/LGHPstudy/EmployerSIDA_CA.pdf).

38. See *id.* at 19-22.

39. See *id.* at 23-26 (discussing the coverage terms of insured versus self-insured plans and finding no significant difference in the actuarial value of the two plan types); see also Gruber, *supra* note 36.

## B. Post-ACA

When the ACA's major provisions become effective in 2014, health insurance will continue to be regulated by both the state and federal governments. However, several fundamental changes will be made. The federal government will take a more active role in health insurance regulation, requiring among other things that insurers offer coverage to all applicants at prices that can vary based only on a limited number of factors.<sup>40</sup> In addition, policies offered in the individual and small group markets must cover "essential health benefits."<sup>41</sup> This requirement to cover essential health benefits puts the federal government, for the first time, in the position of primary regulator of the content of coverage.<sup>42</sup> States will continue to be free to regulate the content of health insurance coverage offered to their residents, but they must subsidize the cost of any mandates that exceed the essential health benefits package.<sup>43</sup>

While large group policies must comply with the majority of the ACA's health insurance reforms,<sup>44</sup> the ACA engages in very little content regulation of such policies. Large group plans will be required to cover preventive services with no cost-sharing,<sup>45</sup> will be required to provide coverage for certain clinical trials,<sup>46</sup> will be prohibited from imposing annual and lifetime limits,<sup>47</sup> and will be limited in the overall cost-sharing they can impose,<sup>48</sup> but such plans are not otherwise subject to any content regulation pursuant to the ACA. In other words, the federal government will continue to leave nearly all content regulation of such policies to the states. The one notable exception is that states have the option, beginning in 2017, to bring large groups within the state's health benefit exchange.<sup>49</sup> These state-based exchanges, which will become operational in 2014, are designed to organize, simplify, and regulate the individual and small group markets within a state.<sup>50</sup> If states choose to allow large group policies to be offered within their exchanges beginning in 2017, the large group plans offered would be subject to the same regulation as the individual and small group

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40. ACA § 1201 (to be codified at 42 U.S.C. § 300gg) (adding PHSA § 2701).

41. *Id.* (to be codified at 42 U.S.C. § 300gg-6) (adding PHSA § 2707).

42. Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Healthcare Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 138 (2011).

43. ACA § 1311(d)(3)(B) (to be codified at 42 U.S.C. § 18031).

44. See ACA § 1201.

45. ACA § 1001 (to be codified at 42 U.S.C. § 300gg-13) (adding PHSA § 2713).

46. ACA § 10103 (to be codified at 42 U.S.C. § 300gg-8).

47. ACA § 10101 (to be codified at 42 U.S.C. § 300gg-11).

48. ACA § 1201 (to be codified at 42 U.S.C. § 300gg-6) (adding PHSA § 2707(b)).

49. ACA § 1312(f)(2)(B) (to be codified at 42 U.S.C. § 18032).

50. ACA § 1311(b)(1) (to be codified at 42 U.S.C. § 18031(b)(1)).

markets, including the requirement to cover all essential health benefits.<sup>51</sup> Absent a state's decision to bring large groups into the exchange, a state will retain its role as the primary regulator of the content of large group plans, changing little about the status quo.

### III. CONTENT REGULATION

Regulating the content of health insurance contracts is controversial.<sup>52</sup> On the one hand, where the market fails to provide coverage for certain types of losses, content regulation can be necessary in order to provide insurance against such losses.<sup>53</sup> And, we know, insurance coverage against a particular type of loss will often determine whether an individual has access to the related medical treatment.<sup>54</sup> However, some object to content regulation on normative grounds, arguing that the government should not interfere with freedom to contract.<sup>55</sup> Others argue that regulating the content of health insurance is economically inefficient and therefore welfare-reducing.<sup>56</sup> And many object to mandates not necessarily on normative grounds, but out of concern that the legislative process is unlikely, as a matter of institutional design, to lead to optimal outcomes.<sup>57</sup>

One primary argument in favor of mandates is that they can be used to address market failure, particularly failures that result from adverse selection.<sup>58</sup> Adverse selection, which refers to the phenomenon where individuals utilize private information in making insurance purchasing decisions, can occur at both the macro and micro levels with respect to health insurance.<sup>59</sup> At the macro-level, adverse selection occurs when individuals who are more likely to require health care purchase health

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51. See ACA § 1301 (to be codified at 42 U.S.C. § 18021).

52. See, e.g., INST. OF MED., NAT'L ACAD. OF SCI., PERSPECTIVES ON ESSENTIAL HEALTH BENEFITS: SUMMARY OF A WORKSHOP (2011) [hereinafter PERSPECTIVES], available at [http://www.iom.edu/~media/Files/Report%20Files/2011/Perspectives-on-Essential-Health-Benefits-Workshop-Report/essentialhealthbenefits\\_workshophighlights.pdf](http://www.iom.edu/~media/Files/Report%20Files/2011/Perspectives-on-Essential-Health-Benefits-Workshop-Report/essentialhealthbenefits_workshophighlights.pdf).

53. See Amy B. Monahan, *Value-Based Mandated Health Benefits*, 80 U. COLO. L. REV. 127, 133 (2009).

54. See, e.g., Kenneth E. Thorpe & David Howard, *Health Insurance and Spending Among Cancer Patients*, HEALTH AFF., w3-189, w3-189-90 (Apr. 9, 2003), <http://content.healthaffairs.org/content/early/2003/04/09/hlthaff.w3.189.full.pdf>.

55. See, e.g., Clark C. Havighurst, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM* 7 (1995).

56. See Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 21-36 (1999) (providing an overview of efficiency-based objections to mandated benefits).

57. See, e.g., *id.* at 80-81.

58. See Monahan, *supra* note 53, at 133-35.

59. See *id.*

insurance more often than those with below-average health risk.<sup>60</sup> When this happens, insurers raise their prices to reflect the worse-than-average risk of the insured population.<sup>61</sup> As prices rise, only those in comparatively worse health will find insurance to be worthwhile, and the rising price and worsening risk level can theoretically continue until the market collapses.<sup>62</sup> But adverse selection can also occur at the micro-level.<sup>63</sup> Assume there are two health insurance products offered on the market, one that covers mental health treatment and one that does not. Individuals who know or have reason to suspect that they may need mental health treatment are of course likely to purchase the policy that covers the treatment, while those that are at low-risk for requiring mental health treatment will opt for the policy that excludes such coverage. Where this happens, the insurer must price the policy that covers mental health benefits at a level that reflects the fact that the policy is being adversely selected by those with a high-risk of needing mental health treatment rather than at a rate that reflects community-average risk. If the adverse selection of the policy that includes mental health is strong, the marginal cost of the mental health coverage may in fact be equivalent to, or greater than, the actual expected cost of treatment. And where that occurs, insurance for mental health treatment essentially ceases to be available.<sup>64</sup> A mandate for all health insurance policies to cover mental health treatment solves this problem, and makes coverage for mental health treatment available to all purchasers at community-average rates.

The extent of adverse selection is, however, thought to be much less in the large group market as compared to either the small group or individual markets.<sup>65</sup> In large part, this is due to the fact that employer-provided coverage receives a tax benefit that individual coverage generally does not,<sup>66</sup> which lowers the effective cost of coverage, thereby encouraging

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60. See *id.*

61. See *id.*

62. See *id.*

63. See Monahan, *supra* note 53, at 133-35.

64. There is evidence that adverse selection does result in certain types of insurance coverage being unavailable. See, e.g., M. Kate Bundorf, et al., *Mandated Health Insurance Benefits and the Utilization and Outcomes of Infertility Treatments 2-5* (Nat'l Bureau of Econ. Research, Working Paper No. 12820, 2007), available at <http://www.nber.org/papers/w12820.pdf> (stating the insurance coverage for infertility treatment is generally not available on the individual market).

65. See TIMOTHY STOLTZFUS JOST, NAT'L ACAD. OF SOCIAL INS., *THE REGULATION OF PRIVATE HEALTH INSURANCE 3-4* (2009), available at [http://www.nasi.org/sites/default/files/research/The\\_Regulation\\_of\\_Private\\_Health\\_Insurance.pdf](http://www.nasi.org/sites/default/files/research/The_Regulation_of_Private_Health_Insurance.pdf).

66. See David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 31 (2001).

more low-risk individuals to elect for coverage under the group plan. The fact that employers on average contribute very generously to coverage further lowers the effective cost of coverage for employees, leading more low-risk employees to accept coverage than if they faced the full premium cost.<sup>67</sup> And finally, because the group that is insured is formed for reasons unrelated to the purchase of health insurance, the riskiness of the group is typically close to community-level risk.<sup>68</sup> To put these factors in perspective, assume that a comprehensive individual health insurance policy, that includes coverage for infertility treatment, costs \$7,000 per year and one that is less comprehensive and does not cover infertility treatment costs \$5,000 per year. Further assume that a comprehensive employer plan that also covers infertility treatment costs \$6,000 per year due to decreased administrative expenses. If the employer contributes \$3,000 to the cost of coverage, employees will face only \$3,000 in out-of-pocket premiums. And because these premiums can be paid on a pre-tax basis, coverage would be even more affordable than compared to coverage of an equivalent cost in the individual market. A low-risk individual eligible for the employer's plan would elect for employer coverage, even though her preference, absent any subsidies, might be for the less-comprehensive individual policy. Because the tax preference and employer subsidies entice low-risk individuals into the employer plan, adverse selection is of little concern in the large group market, even where the employer offers very comprehensive benefits.<sup>69</sup>

The nature of large employer groups and their corresponding tax benefits suggests that there is perhaps little need to regulate the content of large group policies. But the fact that low-risk individuals are likely to participate in large group plans does not actually tell us whether employers will make good decisions with respect to the scope of their plans' coverage in the absence of regulation. After all, there may be reasons unrelated to adverse selection that cause employers to make suboptimal coverage decisions.<sup>70</sup> Studies comparing the content of coverage in the insured market versus the self-insured market have found that coverage terms do not vary significantly between the two,<sup>71</sup> suggesting that employers might voluntarily cover those treatments and services that legislatures currently mandate. These studies, however, do not establish causation. It is difficult to discern whether self-insured employers voluntarily offer these benefits because they have come to independent decisions that it is in their and their employees' best interest to cover such services, or whether it is because such

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67. See *id.* at 32-33.

68. See *id.* at 32.

69. See *id.*

70. For a discussion of some of these causes, see Monahan, *supra* note 53, at 145-148.

71. See EIBNER ET AL., *supra* note 37, at 14.

employers must compete in the labor market with employers that offer fully insured plans that offer the range of mandated benefits. The bottom line is that even if one supports mandates generally, there is a tentative case to be made that the need to regulate content in the large group market is less than the need in other market segments.

#### IV. STATE REGULATORY CHOICES POST-ACA

Given that the ACA does very little to change content regulation in the large group market, one might wonder why there is a need to discuss a state's regulatory choices post-ACA implementation. After all, why not simply maintain the status quo? Part of the answer to that query is that the large group market does not exist in a vacuum, and as other health insurance markets are changed dramatically, they will undoubtedly have an effect on the large group market. States need to proactively consider and respond to these effects. Additionally, relatively few interested parties appear satisfied with the status quo. Given this dissatisfaction, and the significant changes taking place in other market segments, states have an important opportunity to revisit and reform their approaches to large group content regulation and thereby play an important role in health care reform. This part explores three such options: retaining the status quo, adopting the requirement to cover essential health benefits, or deregulating. It concludes by suggesting that states should consider either requiring large group plans to cover the essential health benefits or adopt a hybrid approach that combines deregulation with process reforms designed to move mandates outside of the political process.

##### A. *Retain Existing State Mandates*

The easiest thing for a state to do, precisely because it involves no affirmative action, is for a state to retain its existing mandated health benefits as they apply to the large group market. But aside from being easy, why might a state retain the status quo? The obvious answer is that a state would retain the status quo if it is confident that its existing state mandates effectively address market failures, reflect sound health policy, or at least result from a process that tends to produce good policy outcomes.

It is clear that mandates can serve hugely important health policy goals, and provide health insurance coverage for, and therefore access to, treatments that individuals could not otherwise access. However, there is also evidence that the state legislative process does not always lead to such optimal outcomes.<sup>72</sup> The legislative process simply may not be well-suited

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72. See Amy B. Monahan, *Fairness Versus Welfare in Health Insurance Content Regulation*, 2012 U. ILL. L. REV. (forthcoming).

to gather the types of evidence, and make the types of trade-offs that one would both want and expect in making such decisions. Because legislative decisions often are not informed by robust information or evidence,<sup>73</sup> my guess is that the vast majority of states are not currently in a position to adequately assess whether their mandates properly address market failures, further health policy goals, or rather make health insurance more expensive without meaningfully advancing such goals.

Even if the benefits of mandates are hard for states to ascertain without further study, it is nevertheless helpful to think through the potential harms that might result from mandates when deciding whether to maintain the status quo. There are at least two explicit harms that can be caused by state mandates. The first is that mandates incrementally increase the cost of coverage, potentially decreasing the number of individuals who will elect such coverage.<sup>74</sup> In other words, mandates can contribute to the problem of health insurance unaffordability. I have argued elsewhere that focusing solely on affordability is unwise, given the large practical importance that the scope of coverage has with respect to providing meaningful insurance to individuals,<sup>75</sup> but cost certainly is one piece of the larger puzzle that needs to be considered.

The second potential harm that might result from mandates is that they may lead firms to opt-out of the insurance market, and instead elect to self-insure their health plans.<sup>76</sup> A decision to self-insure is not in and of itself a bad outcome, but does carry with it two risks that potentially affect employees, and one that potentially reduces a state's revenue. The risks to employees have been previously mentioned.<sup>77</sup> The first is that mandates might lead some employers to self-insure despite the fact that they cannot adequately bear the corresponding financial risk. If an employer chooses to self-insure, but cannot cover the losses it is required to bear, the employer may be forced into bankruptcy, and participants may face unpaid medical plan claims.<sup>78</sup> The second risk to employees is that their employer, when unrestricted by state mandates, might offer a health plan that offers

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73. The California Health Benefits Review Program is probably the best example of a program that provides independent, extensive evidence regarding proposed mandates prior to a legislative vote. For an overview of that program, see Susan Phillip, *Overview and Commentary*, 41 HEALTH SERV. RES. 991 (2006). The extent to which that evidence influences mandate passage is unclear. See Monahan, *supra* note 72.

74. See, e.g., David M. Cutler, *Employee Costs and the Decline in Health Insurance Coverage*, 6 FORUM FOR HEALTH ECON. & POL'Y 27, 40-48 (2003).

75. Amy B. Monahan, *Health Insurance Risk Pooling and Social Solidarity: A Response to Professor David Hyman*, 14 CONN. INS. L.J. 325, 335 (2008).

76. See EIBNER ET AL., *supra* note 37, at 9-10.

77. See *supra* II.A.

78. See Dugan, *supra* note 35.

inadequate protection to employees with respect to certain types of health risks. There is also a direct downside to the state that results from increasing rates of employer self-insurance, in the form of decreased premium tax revenue. Nearly all states impose taxes on the premiums collected by insurance companies within the state.<sup>79</sup> Some of the revenue lost by employers choosing to self-insure is partially regained if the self-insured employer chooses to purchase stop-loss coverage to reinsure the risk related to the self-insured plan. However, stop-loss premiums, which only cover part of the risk associated with an employer's plan,<sup>80</sup> are lower than traditional health insurance premiums that cover all plan losses.<sup>81</sup> As a result, the revenue from stop-loss premiums is lower than that which could be collected on traditional premiums. Consequently, a state may be losing available revenue if its mandates are driving employers to self-insure their plans. Unfortunately, just as there is a lack of data regarding mandates themselves, there is also a lack of clear evidence regarding not only the extent to which mandates drive employer decisions to self-insure, but also the extent of the financial risks and state revenue loss that might result from such decisions.

Ideally, a state should balance the detriments of retaining existing mandates (lower premium tax revenue, potentially higher risk levels for employees, and potentially lower health insurance coverage rates) against the policy benefits that flow from the existing mandates. If mandates are the only way to achieve important health policy goals, the decision would likely be easy. But if mandates are of marginal policy value, it seems unwise to keep them in place. Of course, in many states, the truth may lie somewhere in between. Some mandates may very well make sense to keep, but others might not warrant their cost. The problem is, of course, distinguishing between the two and getting state legislatures to act on such information to the extent it is available. The current arrangement, where mandates are simply considered through the standard legislative process, appears to be poorly suited to the task at hand. Part V below explores some alternative institutional designs for content regulation that may lead to improved policy outcomes, or at least better-informed decisions.<sup>82</sup>

#### *B. Adopt Essential Health Benefits for the Large Group Market*

Another alternative for states to consider is to eliminate existing state mandates, and instead simply require all insurers offering policies within the state, regardless of market segment, to offer coverage for essential health

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79. See JOST, *supra* note 65, at 11.

80. See EIBNER ET AL., *supra* note 37, at 10.

81. See *id.* at 9-10.

82. See *infra* Part V.

benefits. As an initial matter, the attractiveness of this option to a given state will likely depend on two factors. The first concerns how, exactly, essential health benefits are defined. Recall that essential health benefits are not defined by statute, but will instead be defined by the Secretary of HHS based on criteria contained in the ACA.<sup>83</sup> If the definition established by HHS strikes most states and relevant stakeholders as providing the right balance of coverage and affordability, and is consistent with the state's health policy goals, adopting the EHB requirement for the large group market may be quite attractive.<sup>84</sup> Another primary consideration is whether the state plans to open its health insurance exchange to large groups in 2017.<sup>85</sup> However, many states are unlikely to make a decision about including large groups within the exchange until they are able to gauge the success of the exchange for the individual and small group markets.

Regardless of whether a state intends to open its exchange to large groups, there are advantages to having the same coverage requirements across market segments, notably that doing so would diminish the likelihood of adverse selection between the markets. Imagine, for example, that there is a requirement in the individual market to cover infertility treatment, but no corresponding requirement in the large group market in the state. Assuming that employers do not voluntarily choose to cover infertility treatment, those who have reason to believe that they will need infertility treatment are likely to forgo employer-provided coverage and instead purchase coverage on the individual market, at least during the year or years the individual intends to pursue treatment. When this happens, prices are likely to go up in the individual market, and down in the group market. If just a few individuals make these choices, the effect will not be significant. But if the essential health benefit requirements are much more generous than what is available in the large group market, adverse selection may be a significant concern and may threaten the viability of health care reform.<sup>86</sup>

Another advantage is realized through a standard content requirement between the large group, small group, and individual markets. If an individual loses coverage on the large group market, often the only (or at least the best) choice for the individual is to elect to continue coverage

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83. See ACA § 1302 (to be codified at 42 U.S.C. § 18022).

84. As of the time this article went to press, HHS had not yet promulgated proposed regulations defining the essential health benefits. However, the Institute of Medicine has published a report making recommendations to HHS regarding the criteria and principles that should guide the determination of essential health benefits. See INST. MED., NAT'L ACAD. SCI., ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST (2011), available at [http://books.nap.edu/openbook.php?record\\_id=13234](http://books.nap.edu/openbook.php?record_id=13234).

85. ACA § 1312(f)(2)(B) (to be codified at 42 U.S.C. § 18031).

86. See Monahan & Schwarcz, *supra* note 42, at 146-47.

under the employer's plan.<sup>87</sup> That, however, is likely to change beginning in 2014, when the ACA's insurance market reforms make individual insurance policies a much more attractive option than they are under current regulation.<sup>88</sup> If the content of coverage was equivalent on the large group, small group, and individual markets, the individual would have more choices in the event of a loss of group coverage, without worrying that certain treatments and services would not be covered with individual coverage. That does not mean that moving between the large group and individual market would be seamless. The individual might need to change carriers, and be faced with both a different plan design and network of providers, but it would eliminate one important difference with respect to the scope of coverage. Similarly, an individual who switched employment from a small firm to a large firm would enjoy a consistent scope of coverage if the essential health benefits definition applied in both markets and both firms chose a fully-insured plan.

Given these advantages, why might a state hesitate in adopting the essential health benefit requirements for the large group market? For one, if the scope of coverage required by EHBs is considered too broad, states might not want to adopt the requirements for fear that it will force even more employers into the self-insured market than under the status quo.<sup>89</sup> Relatedly, if the package of benefits is thought to be too expensive, states might not want to take actions that could result in fewer employees being able to afford coverage.

Another hesitation might be unwillingness on the part of the state to cede control of health insurance regulation to the federal government. Again, the strength of this objection will very likely depend on how the essential health benefits process and resulting definition is viewed by the states. It may also depend on how valuable state legislators view the ability to grant health insurance mandates. If mandates are valuable (and free)<sup>90</sup> political favors, legislators may be hesitant to part with them. Similarly, if states are not confident that the EHBs represent sound health policy, or if they are concerned that the framework that guides HHS in its decision-making regarding EHBs is not dynamic enough to respond quickly to

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87. See 29 U.S.C. § 1161 (2006) (describing an employee's right to continue coverage under certain circumstances).

88. See Monahan & Schwarcz, *supra* note 42, at 136-42 (providing an overview of the ACA's impact on the individual market).

89. The potential effect of the essential health benefit requirements on small firms' decisions to self-insure was enough of a concern that section 1254 of the ACA requires HHS to study the issue and report to congress. The report by EIBNER ET AL., *supra* note 37, was commissioned by HHS to fulfill that statutory requirement.

90. See David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 249 (2000).

changing market conditions, a state may be hesitant to use the EHB definition in the large group market.

Surprisingly, as this article was going to press, the Department of Health & Human Services announced that it intended to let each individual state choose its own definition of “essential health benefits” from a menu of pre-existing benchmark plans.<sup>91</sup> States would be permitted to use the coverage terms under one of the following plans as the basis for its essential health benefits definition: (1) one of the top three small group products currently offered in the state, by enrollment; (2) one of the largest three state employee health benefit plans, by enrollment; (3) one of the largest three national Federal Employees Health Benefit Plan options, by enrollment; or (4) the largest non-Medicaid Health Maintenance Organization operating in the state.<sup>92</sup> By allowing this type of choice, HHS will give states the ability to choose an essential health benefits definition that includes all existing state mandates without bearing any additional cost.<sup>93</sup> As a result, a state will have the ability to both maintain the status quo in the large group market and provide consistency of coverage terms between the individual, small, and large group markets by choosing an essential health benefits definition that incorporates all existing state mandates.

### C. *Deregulate*

Another option for states to consider with respect to content regulation in the large group market is simply to deregulate. That is, to repeal existing mandates and allow purchasers in the large group market to have unrestricted choice in designing their plans. The benefits, from a state’s perspective, are rather straightforward. First, because the decision to insure or self-insure would no longer depend on differing levels of content regulation, employers should, all other things equal, be more likely to insure their plans than they are under the status quo.<sup>94</sup> Prior to the ACA, there

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91. See Center for Consumer Information and Insurance Oversight, U.S. Dep’t of Health & Hum. Servs., 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).

92. *Id.* at 9.

93. If a state selects a benchmark plan that is subject to existing state mandates, such as a small group plan, those state mandates would be required under the essential health benefits definition and not require the state to bear any cost associated with those mandates. States could also choose a definition, such as the federal employee option, that is not subject to state mandates. If a state did so, and it retained its mandates in the individual and small group markets, it would have to pay any increased cost resulting from mandates that exceed the coverage of the federal employee plan selected.

94. Studies examining the effect of content regulation on the propensity to self-insure are mixed, so it is difficult to determine whether in fact rates of self-insurance would decline under deregulation. See EIBNER ET AL., *supra* note 37 and accompanying text.

were additional regulatory benefits to self-insuring that went beyond avoiding content regulation.<sup>95</sup> In particular, self-insured plans did not need to comply with state insurance laws regulating matters such as external review of claims denials.<sup>96</sup> The ACA, however, will require all employer plans, whether insured or self-insured, to comply with external claims review requirements, effectively eliminating the most valuable regulatory advantage to self-insurance outside of content regulation.<sup>97</sup> The elimination of this regulatory advantage for self-insured plans should tend to increase the propensity to insure as compared to the status quo. States could further encourage employers to insure their group plans by eliminating content regulation for such group plans. By doing so, states would help prevent employers from choosing to self-insure solely to avoid unwanted regulation, and this should help to reduce the number of instances where an employer elects to self-insure despite being unable to bear the financial risks associated with a self-insured plan. In addition, if rates of insurance go up in this market segment, state revenues received from premium taxes should rise as well. This potential benefit could be hard to ignore at a time when many states are struggling to make ends meet.<sup>98</sup>

Recall, too, that in the individual and small group markets, states will need to subsidize the cost of any mandates that exceed the essential health benefit requirements.<sup>99</sup> Given most states' strained fiscal position, it seems likely that states will simply eliminate any mandates in the individual and small group markets that exceed the essential health benefit requirements. If states regulate the content of health insurance primarily to address market failures in the individual and small group markets, and they will no longer be regulating for such purposes, deregulation of the large group market may make even more sense.

What might prevent a state from taking this action, which potentially offers better protection to consumers and more revenue for the state? There are two main counter pressures, one noble and one less so. First, giving up

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95. See *id.* at 10-11.

96. See Nan D. Hunter, *Managed Process, Due Care: Structures of Accountability in Health Care*, 6 *YALE J. HEALTH POL'Y L. & ETHICS* 93, 129 (2006).

97. EIBNER ET AL., *supra* note 37, at 41.

98. Elizabeth McNichol et al., *States Continue to Feel Recession's Impact*, CENTER ON BUDGET & POLICY PRIORITIES (June 17, 2011), <http://www.cbpp.org/files/9-8-08sfp.pdf>.

99. ACA § 1311(d)(3)(B) (to be codified at 42 U.S.C. § 18031). As noted above, the recent guidance from HHS concerning essential health benefits, if finalized in its current form, would allow a state to select an essential health benefits definition that incorporates all of its existing mandates, thereby negating the need for a state to pay any increased cost to retain its mandates. See Center for Consumer Information and Insurance Oversight, U.S. Dep't of Health & Hum. Servs., *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).

on mandates in the large group market potentially means giving up on a very important policy tool. Assume, for example, that a state decides to pursue deregulation in the large group market and all existing mandates are eliminated, including a mandate to cover diabetes self-management equipment and supplies. Employers, then, would have the ability to design a health plan that excludes coverage for diabetes self-management. They could make that choice whether they purchase an insurance policy to pay plan benefits, or if they chose to self-insure. While many employers may voluntarily choose to cover diabetes self-management, others might not. Under the ACA, diabetic individuals whose employers did not offer self-management coverage might be able to obtain appropriate coverage in the individual market, but that would mean losing several key advantages of employer-provided coverage and might not, therefore, be a viable option.<sup>100</sup> The result might be that many diabetic individuals lack coverage for self-management supplies and either face an increased financial burden as a result or, worse, fail to follow their physician's orders regarding self-management. Under a pure deregulatory approach, a state would not take action to remedy such a situation. And the result might be that some individuals who would otherwise be covered within the large group market would need to obtain coverage through the individual market. While the individual market might provide adequate coverage to such an individual, the individual would face higher costs for such coverage, and the state would have to be willing to accept that outcome if it wants to pursue a pure deregulatory approach.

The other counter pressure against pursuing deregulation is the loss of mandates as a political tool. As noted above, politicians may find mandates to be a very effective tool for providing political rents to constituents at very low cost. As a result, politicians may be hesitant to give mandates up. And even if an initial decision to deregulate is made, it is easy to imagine that under future legislatures the market might slowly creep back to regulation, when future politicians decide that a mandate is necessary. In the end, it is difficult to determine whether a state would be

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100. Contrast this example, dealing with a chronic disease, to that given in an earlier regarding the acute disease of infertility. See *supra* text accompanying notes 68–69. Whereas an infertile individual without access to employer-provided coverage could potentially obtain coverage on the individual market for a limited period of time (say, up to a maximum of five years), in order to obtain the desired treatment, and still benefit financially despite the loss of the employer-subsidy for coverage, an individual with a chronic disease would need to permanently switch to exchange-based coverage. This would mean giving up the employer's subsidy at least until alternative employment that provided group coverage for the chronic condition was obtained, potentially imposing a much greater financial burden on those with chronic conditions not covered by an employer's plan as compared to those with acute conditions that are not covered.

better off under a deregulatory approach. On the one hand, deregulation might allow a state to increase its revenue and better protect against employer insolvency risk without significantly affecting health outcomes. But it is also possible that a deregulatory approach to the large group market could leave many vulnerable individuals without affordable or adequate health insurance coverage.

#### V. AN IDEAL SOLUTION?

None of the three alternatives discussed above is perfect. Deregulation should provide the state with additional revenue and would solve the problem of employers choosing to self-insure in order to avoid mandates, but it might result in more employers offering health plans that do not adequately cover their employees' health needs, creating treatment-based financial risk for such employees. Retaining existing mandates is easy, but will continue the content regulation disparities between insured and self-insured plans, and will create new disparities between content regulation in the individual, small group, and large group markets. Further, these mandates might increase costs without meaningfully affecting health outcomes, although in most states this is difficult to determine because no systematic study of existing mandates has been undertaken. Adopting the essential health benefits definition is very attractive if states are pleased with both the process and resulting definition adopted by HHS, but it is too early to tell whether that will be the case. Given that each of the three options has flaws, how might a state proceed?

One possibility is to start from scratch with respect to mandates in the large group market. If a primary concern is that existing mandates result from an institutional design that is likely to result in suboptimal outcomes, it seems wise for states to reconsider that institutional design and move content regulation outside of the legislature. The first step that likely makes sense is to remove content regulation from legislative control, and instead delegate authority either to an existing administrative agency or to an independent commission. There is a large amount of literature on agency decision-making and institutional design that would be relevant to a decision between an agency or commission,<sup>101</sup> but for our purposes it is sufficient to note that either approach is likely to have institutional advantages over a legislature.

Simply changing the decisionmaker, however, will likely be insufficient to achieve fundamental reform of mandates. Rather, a part of the new

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101. See, e.g., TIMOTHY STOLTZFUS JOST, ROBERT WOOD JOHNSON FOUND., FRESH THINKING-LEGAL AND REGULATORY ISSUES PRESENTED BY HEALTH CARE REFORM 2-3, 14 (2009), available at <http://www.rwjf.org/files/research/legalandregulatoryissues.pdf>.

institutional design should also be decision-making criteria and guidelines that force the decisionmaker to make the trade-offs that are required with respect to health insurance decisions. Remember that one of the criticisms of the current legislative-based processes is that with them, mandates have little to no cost to politicians or the state government.<sup>102</sup> Assume, for example, that the parents of a child with a debilitating medical condition discover that their health insurance excludes coverage for their child's condition. Further assume that the parents approach their state representative, and suggest that insurance companies should be required to provide the coverage that their child needs. When faced with grief-stricken, financially-burdened parents, legislators may be very inclined to vote in favor of a mandate, particularly since the financial cost of such a mandate to the state is often non-existent.<sup>103</sup> It is a cost that is born by invisible others. Of course the mandate in my example might be necessary and well-worth the cost, but it is also possible that in fact the medical treatment desired by the parents for their child has been shown to be ineffective.<sup>104</sup> The difficulty here is that even if the treatment at issue is necessary and effective, it might be the case that covering it would result in some people being unable to afford insurance. The point is that the costs and consequences of mandates can be very real, but they often are not felt (or perhaps, even considered) by legislatures.<sup>105</sup> This disconnect between the decisionmaker and the true costs of regulation would not be changed simply by making an agency or a commission the relevant decisionmaker. In order to make a decisionmaker face a real choice (here, the desirability of certain coverage versus the cost of that coverage and its corresponding effect on health insurance affordability) it is critical that the decisionmaker be bound by concrete criteria. Goals could be varied, but for example the criteria might include a requirement that the premium impact of required covered services be kept constant, which would require that any new mandate that increases premiums be accompanied by a simultaneous decision to remove a mandate of similar cost. Or, a state could require that mandates may be passed only if there is evidence that the mandate would materially improve health outcomes in a cost-effective manner. It is up to the state to decide what its priorities are with respect to content regulation, but regardless of

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102. Hyman, *supra* note 90.

103. Mandates would result in a cost to the state only if the proposed mandate applied to the state's Medicaid plan or the plan for state employees.

104. For an example of a mandate that was passed in several states despite a lack of evidence supporting clinical effectiveness, see RICHARD A. RETTIG ET AL., FALSE HOPE: BONE MARROW TRANSPLANTATION FOR BREAST CANCER 3 (2007).

105. See Monahan, *supra* note 72 (finding relatively little use of evidence by legislatures in considering mandates).

what those priorities are, it is important that they be reduced to criteria that can clearly guide the relevant decisionmakers.

Once the decisionmaker and criteria had been established, there would be two potential methods by which to pursue content regulation. The first would be to have the commission or agency review all existing mandates and decide whether they would be retained. Another approach would be to repeal all existing mandates and then, in response to market conditions, consider "new" mandates as needed. After all, we do not actually know how the large group market will behave in a world without mandates. For example, if all mandates were eliminated, but it was then discovered that a significant number of diabetics were unable to obtain coverage for diabetes self-management expenses, the agency could consider a diabetes mandate in accordance with relevant criteria. But regardless of the starting point, any mandates would need to be reviewed on an ongoing basis to ensure continued satisfaction of the relevant criteria and any proposed mandates would need to go through a rigorous review process. It is probably clear at this point that the reform of institutional design would not by any means be simple, but if a state is unwilling to adopt the federally-defined essential health benefits, such institutional changes may be the best available alternative.

## VI. CONCLUSION

This article was written with the assumption that, pursuant to the terms of the ACA, HHS would play a leading role in health insurance content regulation and adopt a federal definition of essential health benefits for the individual and small group markets that could provide a good alternative for states to adopt in the large group market. It now appears, however, that HHS will be anything but a leader or innovator in content regulation, instead simply allowing states to continue with the status quo despite its many and varied critics. While the proposal from HHS may hamper innovation in the individual and small group markets, the good news is that states retain the ability to pursue reform in the large group market. If a state desires to move away from the status quo, it might consider radically changing the process by which it regulates the large group market. Rather than simply letting content regulation proceed through the standard legislative process, establishing a new institutional design that not only changes the decisionmaker, but also requires adherence to clear standards, would help address fundamental criticisms of state mandates and would lead to regulation that stands a much better chance of making a real difference in both coverage and treatment availability and access.