ERISA AND STATE HEALTH CARE ACCESS INITIATIVES: OPPORTUNITIES AND OBSTACLES

Patricia A. Butler

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EXECUTIVE SUMMARY

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates private-sector pensions and other employee benefit programs, including employment-based health coverage. It is relevant to health policy because it preempts state laws that "relate to" private-sector, employer-sponsored plans. Consequently, ERISA can set limits on states' attempts to expand health care access through workplace coverage.

Given national interest in incremental health care reform and federal hopes that states will develop innovative approaches to expanding coverage, changes in or clarification of ERISA could facilitate these state efforts. This paper explores federal options in this area by first describing ERISA's background and purpose as well as changing federal and state responsibilities regarding the regulation of employer-sponsored health plans. It next discusses how recent court interpretations of ERISA preemption provide states more flexibility in financing health care programs, and how states' remaining uncertainty about ERISA preemption makes it difficult for them to move forward with confidence. Finally, the paper examines possible reforms at the federal level that could stimulate or support state access initiatives.

Over the years, court interpretations of ERISA's preemption provisions have prohibited states from requiring employers to offer workplace coverage or directly regulating private employer-sponsored health plans. Courts rulings have also preempted state laws that would indirectly affect employer-sponsored plans—for example, by levying health care provider taxes that would lead to higher plan costs. Recent court opinions, however, give states more authority. States can now tax health care providers to raise funds to support health care for low-income people. States also have greater flexibility to design "pay-or-play" programs that tax employers but provide a tax credit if they offer health coverage.

Yet providing guidance to policymakers about the impact of ERISA preemption is difficult. Only the courts can interpret the preemption clause, and relatively few state health care laws have been tested in court. Moreover, the U.S. Supreme Court—the final arbiter of interpretation of federal law—has decided only a handful of ERISA cases relevant to state health policy. As a result, many areas of potential action remain uncertain or limited. Absent congressional clarification of intent, states face a range of ambiguities as to which actions might relate to employer-sponsored health insurance and raise ERISA concerns.

Federal action to clarify ERISA or authorize specific types of experiments or actions could help support state access initiatives, including federal–state programs to insure children. Areas for possible federal action include:

- clarification that ERISA does not apply to state initiatives offering incentives to employers to offer coverage voluntarily;

- options to facilitate coordination among public programs and private employer-sponsored coverage; or

- uniform federal standards, for example, information reporting to states.

ERISA could be amended to allow states to design innovative insurance expansion approaches either by authorizing specific types of programs or by providing a process under which federal agencies could grant waivers to states for testing novel health care access programs.

ERISA AND STATE HEALTH CARE ACCESS INITIATIVES: OPPORTUNITIES AND OBSTACLES

INTRODUCTION

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates private-sector pensions and other employee benefit programs, including job-based health coverage. ERISA is relevant to health policy because it preempts state laws that "relate to" employee plans. The courts have interpreted this preemption provision as prohibiting states from requiring employers to offer workplace coverage or directly regulating private employer health plans.

As state and federal policymakers consider initiatives to expand access to health coverage, such as the federal State Child Health Insurance Program (CHIP) and many individual state programs, they are likely to confront ERISA preemption issues if they seek to build on the current foundation of workplace coverage. To frame discussion of ERISA implications for health coverage expansions, this paper first briefly describes ERISA's background and purpose as well as the changing responsibilities of the state and federal governments in regulating employer-sponsored health plans.[1] It next discusses how recent court interpretations of preemption provide states more flexibility in financing health care programs, and how states' remaining uncertainty about ERISA preemption makes it difficult for them to move forward with confidence. The paper concludes by examining possible reforms at the federal level that could stimulate access initiatives.

ERISA'S PREEMPTION PROVISIONS

Background and Purpose

ERISA, enacted by Congress in 1974 to remedy pension plan fraud and mismanagement, provides comprehensive federal standards to safeguard employee pension programs. The law also applies to other types of employee "welfare benefit programs," including health coverage, but it provides relatively few standards for non-pension plans. For example, it does not set standards for health plan solvency, participation, or vesting. ERISA, administered by the U.S. Department of Labor (DOL), covers pension and benefit programs operated by private employers (other than churches), which currently cover at least 123 million Americans. It does not apply to public plans, such as those operated by federal, state, or local governments.

Although it is customary for states to regulate in areas touched by federal law as long as state law does not directly conflict with federal law, ERISA contains a broad

preemption clause stipulating that it supercedes state laws that "relate to any employee benefit plan." An important exception to this preemption policy authorizes states to regulate health maintenance organizations and other licensed insurance companies. But ERISA also explicitly provides that states may not consider an employer-sponsored plan to be an insurer. The consequences of ERISA's preemption provisions are that:

- states cannot directly regulate employer-sponsored health plans;
- states can regulate *health insurers* that sell products to employer-sponsored plans; but
- states cannot regulate as insurers organizations that merely pay claims for employer-sponsored health plans (without bearing insurance risk).

The preemption provisions lead to the distinction between "self-insured" employer plans, which bear their own insurance risk and which states cannot regulate at all, and "insured" employer plans, over which states can exert influence by regulating the insurers selling policies to those plans. Both types of plans are, however, "ERISA plans"—a point that is sometimes misunderstood.[2] Although data on the number of employees covered by self-insured plans are imprecise and vary by state, an estimated 40 percent of people covered by private-sector, employer-sponsored health plans nationally are in self-insured programs.[3]

While Congress may not have contemplated the full implications of ERISA's preemption clause for some types of state health care initiatives, historical analysis leaves little doubt that Congress intended ERISA's preemption clause to be very broad. It prohibits states from regulating even in areas where federal law was silent in order to avoid the "threat" of conflicting and inconsistent state regulation—especially state laws attempting to tax or regulate the conduct of large, multistate businesses.[4]

ERISA Preemption Amendments

ERISA's preemption provisions have been amended several times in the last 25 years. A 1983 amendment permitted Hawaii to implement an employer health insurance mandate that had been adopted shortly before ERISA was enacted.[5] The Consolidated Budget Reconciliation Act of 1985 (COBRA) required ERISA plans to permit workers (and dependents) leaving the workplace to continue their group coverage for specified periods. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other 1996 and 1998 amendments imposed a floor of certain benefits and "insurance market" standards on self-insured health plans, while allowing states to impose additional,

enumerated types of standards on health insurers.[6] For example, HIPAA prohibits people leaving a job with health coverage from being denied coverage in a new job for health reasons. While imposing new requirements on self-insured employer-sponsored plans, HIPAA continues the split of authority between the federal and state governments—setting a federal floor for all ERISA plans and allowing states to supplement federal standards in regulating health insurers.

Courts initially had interpreted ERISA preemption quite broadly to prohibit many state or local initiatives from financing health care access expansions, for example, through taxes on health care providers. Recent court decisions have narrowed the scope of preemption and offer more flexibility to state and local governments.

EVOLUTION OF ERISA PREEMPTION POLICY: OPPORTUNITIES FOR STATES AND REMAINING LIMITS ON STATE EXPERIMENTATION

Recent Court Decisions That Enable State Health Care Initiatives

Only the courts can interpret the meaning of ERISA's preemption clause, and the Supreme Court is, of course, the final arbiter of federal law. For the first 20 years of ERISA's existence, the Court had interpreted ERISA's preemption provisions very broadly to invalidate many types of state laws, even those with an indirect or limited impact on employer-sponsored pension, health, or other benefit plans. Following early Supreme Court decisions on ERISA preemption, federal courts had held that ERISA preempts direct taxation of employer-sponsored plans as well as health care provider taxes or state laws that would impose costs or administrative burdens on these plans. State policymakers construed these court opinions to limit the ways they could finance health care access expansions. Two recent Supreme Court cases provide more flexibility for state taxes, however. In its 1995 *Travelers Insurance* decision, the Court upheld part of New York's hospital rate-setting system, which imposed a surcharge on hospital bills paid for by insurers other than Blue Cross.[7] The program was designed to defray some of the costs Blue Cross experienced by being the "insurer of last resort" in the state. Although the law imposed higher hospital costs on employer-sponsored plans that used insurers other than Blue Cross, the Court held that it was not preempted because it was a general tax law, under the state's public health regulatory authority, that applied to all health care purchasers, not just ERISA plans. *Travelers Insurance* had implications far beyond its specific authorization of state hospital rate-setting programs or provider taxes: it signaled a boundary to what many analysts believed was unlimited ERISA preemption of state law. The Court applied the same reasoning in its 1997 *De Buono* decision, which upheld New York's authority to tax health care providers, even clinics owned by union-sponsored plans, despite the costs they impose on ERISA plans.[8]

If a state law is challenged under ERISA preemption, the courts ask two questions. First, does the state law "relate to" an ERISA (i.e., private-sector, employer-sponsored) plan because it:

- directly refers to ERISA plans, for example, by imposing obligations on them or treating them differently (even preferentially)?

- regulates the same areas as ERISA (such as reporting, disclosure, or remedies)?

- regulates an ERISA plan's benefits, structure, or administration? and/or

- imposes substantial costs on ERISA plans?

Second, the courts ask whether the state law is "saved" from preemption because it is a law that regulates insurance.[9] To survive an ERISA challenge, a state law must either be found not to relate to employer-sponsored plans under the first test or to be a law regulating insurance.

Health Care Provider and Insurer Taxes. Most health care access initiatives require public funds. Taxing health insurers raises absolutely no ERISA obstacle. States have traditionally used health insurer taxes to fund high-risk pools for people unable to obtain insurance in the individual market. In many states, these programs serve as a way to meet federal requirements under HIPAA to provide a means for people leaving the group insurance market to obtain individual coverage. Although courts have held that states cannot tax self-insured, employer-sponsored plans directly to fund these risk pools, states can tax insurers—including insurers selling stop-loss policies to self-insured employer plans.

The decisions in *Travelers Insurance, De Buono,* and several lower federal court cases provide clear authority for states to tax health care providers. Currently, however, only Connecticut, Massachusetts, Minnesota, and New York use such taxes to finance health care for uninsured people.[10] Although state authority to impose some costs on private employer-sponsored health plans by taxing providers is no longer in doubt, state requirements that health plans *collect and remit* the tax, like those in Massachusetts and New York, may raise ERISA issues because they impose administrative obligations on employee plans.[11]

Provider taxes have a significant advantage over insurer taxes because they apply to all payers, including ERISA plans. On the other hand, insurer taxes increase health

insurance premiums. They may also encourage employers to self-insure their health plans, thereby avoiding both paying for the high-risk pools and meeting other state insurance standards.

Employer "Pay-or-Play" Initiatives. A "pay-or-play" model requiring employers to participate in financing health care was enacted in 1988 in Massachusetts, although it was subsequently repealed before implementation. Under the Massachusetts Health Security Act, employers would have paid a tax to fund a public health coverage program but could have credited against the tax the cost of any employee coverage they chose to offer. The law was carefully designed to avoid ERISA preemption; for example, it did not prescribe any features of workplace coverage to qualify for the tax credit. Particularly in light of *Travelers Insurance,* such an employer financing model would seem likely to survive an ERISA preemption challenge. Although no state has recently considered this type of pay-or-play proposal, similar approaches, including those discussed in Washington State (in a 1999 proposal to increase in the state's minimum wage) and Tennessee (as one way to save the state's TennCare program), have raised ERISA issues.[12]

Public Works Contracts. State or local governments might be able to expand access to health coverage for some employees of public works contractors by requiring these firms to offer coverage as a condition of public contracts. Because such conditions would relate to employer-sponsored coverage, they raise ERISA preemption issues. Some recent court cases involving wages, fringe benefits, and other labor protections offer support for state and local governments to include health coverage contract requirements in certain circumstances.[13] When a state or local government acts like other purchasers of services in the market, its contracting requirements may be viewed not as a law (that ERISA can preempt) but as "proprietary action." Public works contracting conditions are most likely to survive an ERISA preemption challenge if: 1) the government is motivated by proprietary interests (e.g., to advance the project's timely completion) rather than policy concerns (to expand access to health coverage); 2) the condition is relevant to the proprietary interest; 3) the condition applies on a project-by-project basis; 4) private organizations would impose similar conditions; and 5) the government is not acting as a monopoly purchaser (which can turn the purchasing conditions into regulation). Not all courts, however, have agreed that state or local actions survive ERISA preemption. Moreover, this approach, while worth exploring, is unlikely to expand health care coverage substantially.[14]

Portability and Continuity of Coverage. As confirmed by several ERISA amendments, states can use their authority to regulate insurers as a way to expand access to health

coverage or, at least, reduce the likelihood that insured people will lose coverage when they change jobs. Before Congress enacted HIPAA, most states had adopted insurance market reforms requiring insurers to issue and renew policies in the small group and, sometimes, in the individual market—regardless of enrollee health status. States also required them to credit pre-existing condition exclusion (pre-ex) periods if an enrollee changed insurers. These state laws have never been challenged under ERISA and would not be preempted as long as they do not prevent application of federal law or conflict with HIPAA, which prescribes areas states can supplement (for example, by setting shorter pre-ex periods).

States also could supplement federal COBRA requirements, which obligate group health plans with 20 or more workers to allow employees and their dependents to continue group coverage by paying the group premium after leaving a job. State laws could, for example, require insurers to permit continuation of group membership for employees of smaller businesses, provide longer continuation periods than COBRA, or permit conversion from a group policy to an individual policy without regard to health status. While these types of state authority are less likely to increase employee coverage than to reduce its decline, the HIPAA model illustrates one approach to limit ERISA preemption for certain, often narrowly described, types and features of state law.

Limits on State Initiatives: Restrictions and Areas of Ambiguity

Although recent ERISA cases make clear that ERISA does not preempt all types of state health care legislation, it still prohibits state laws directly aimed at private-sector employer-sponsored plans. Furthermore, the impact of ERISA preemption on many types of state health care access initiatives remains unclear because the courts have decided so few directly relevant cases.

Employer Mandates and Taxes. ERISA prohibits states from requiring that employers offer an employee health plan. The sole exception to this prohibition is Hawaii's 1974 employer mandate, which courts had invalidated shortly after ERISA was enacted but which was then authorized in a 1983 ERISA amendment (at least partly on the ground that the Hawaii law predated ERISA's enactment). ERISA also preempts other state requirements that would impose taxes or other obligations on employer-sponsored health plans, such as state laws requiring that health insurance cover medical claims resulting from automobile accidents. Consequently, ERISA interferes with state proposals to develop mandatory "24-hour coverage" programs that coordinate workers' compensation, workplace health programs, and disability coverage. The rationale behind court decisions prohibiting such mandatory requirements is that they dictate plan terms regarding benefits, structure, and administration.

On the same grounds, ERISA also is likely to limit states' ability to require that employer-sponsored plans report information on the numbers of people covered, the design of benefits, or self-insurance features. Although no court has considered such a state reporting requirement, it would arguably relate to employer-sponsored plans by imposing an administrative obligation already required by ERISA—that ERISA plans report certain data to the DOL. While states can collect information from insurers about people with workplace coverage, they are unable to obtain a complete picture of health care coverage without parallel data on people in self-insured ERISA plans.

Furthermore, the reasoning in cases holding that states cannot impose obligations on ERISA plans would prohibit states from requiring that employer-sponsored health plans participate in health insurance purchasing pools or coordinate with public health coverage programs. Many states pay part of the premium for workplace coverage for employed Medicaid beneficiaries and are interested in extending such subsidies to children in the State Child Health Insurance Program (CHIP) and to adults leaving welfare for work.[15] ERISA should not interfere with state programs that permit voluntary employer participation in public programs. But ERISA is likely to preempt state attempts to require that employers report information to states about health plan coverage and contributions, inform employees about buy-in opportunities, modify payroll tax deductions, or remit public funds to insurers.[16]

Employer Tax Incentives. Several states have adopted business income tax credits to encourage employers—particularly small firms—to offer workplace health coverage, although few remain in effect.[17] About half the states authorize tax incentives for employers to offer and for employees to establish medical savings accounts that coordinate with high-deductible insurance policies.

Although none of these state laws has been challenged in court, they can raise ERISA preemption concerns. These laws not only refer directly to employer-sponsored plans but also typically dictate the types of plans that qualify for the tax advantage.[18] Some state tax credits, for example, have been available only for plans covering certain benefits or where the employer pays a minimum share of the premium. Some state laws governing medical savings accounts condition favorable tax treatment on an employer's contribution levels, benefits for which accounts can be used, disclosure to plan participants, and reporting to state agencies. State laws offering tax benefits regardless of a workplace health plan's structure should easily survive ERISA preemption challenge. But it could be argued that prescribing conditions for the types of employer plans that qualify for tax benefits interferes with the administration of employer-sponsored plans by mandating benefits or

imposing obligations. Such conditions thus raise at least theoretical ERISA preemption issues.

In contrast to broad employer mandates, however, tax laws are probably less likely to face ERISA litigation. First, states could defend them as minimal intrusions on employer plan administration—employers who dislike the conditions could choose to design their plans accordingly and forgo the tax benefit.[19] Furthermore, because tax incentives offer benefits and are purely voluntary, as a practical matter they are less likely to be challenged in court.

Summary of ERISA Implications for State Health Care Access Legislation
Based on the terms of the fairly unambiguous Supreme Court decisions, in general:

- State laws **cannot**
  - ➢ mandate that employers offer or pay for insurance
  - ➢ directly tax private employer-sponsored health plans (whether insured or self-insured)
  - ➢ regulate private employer-sponsored health plan benefits or solvency.

- State laws **can**
  - ➢ tax and regulate health insurers (e.g., by mandating benefits to be included in health insurance products and other insurance policy terms)
  - ➢ tax and regulate health care providers.

- State health care access initiatives that raise possible ERISA preemption concerns, but whose validity remains uncertain because they have not yet been challenged directly, include:
  - ➢ those assuring that publicly funded health care access programs coordinate closely with employment-based coverage
  - ➢ those requiring that employer-sponsored plans pay health care provider assessments directly to state agencies
  - ➢ those providing employer tax credits or deductions that are conditioned on meeting specific standards for health benefits or plan reporting
  - ➢ employer pay-or-play laws (which should be defensible under the *Travelers Insurance* rationale).

OPTIONS FOR FEDERAL ACTION

Although some state health care access initiatives that raise ERISA issues may ultimately survive a court challenge, time-consuming and costly litigation can delay state action for years. Moreover, the threat of such litigation may stifle even *discussion* of innovative state programs. ERISA could be amended to permit various types of state initiatives that are clearly forbidden or initiatives whose legality remains uncertain under ERISA's preemption provisions. While it seems unrealistic to expect that ERISA's preemption clause would be repealed, more limited exceptions to preemption have been discussed in the past and might be worth reconsidering.

For example, ERISA could be amended to remove any doubt that it was not intended to prohibit purely voluntary programs that benefit employer-sponsored plans, such as tax credits. It could also be amended to facilitate coordination of public and private programs, such as CHIP. Or it could authorize state experiments to test new approaches for expanding health coverage, such as through a federal waiver process.

In the 25 years since ERISA was enacted, many amendment proposals have been considered to provide states with greater flexibility. In addition to the limited 1983 authorization for Hawaii's employer health insurance mandate, state-specific exceptions were proposed in 1993 for state health reform programs in Oregon and Washington and four state health care access programs, and in 1994 for several state health care reform proposals.[20,21,22,23] Legislation to authorize general categories of state health coverage initiatives was proposed in 1992.[24] Later bills would have exempted certain state laws from preemption as part of broad national health coverage proposals.[25]

Clarifying ERISA's Impact on Voluntary Employer Programs

It seems unlikely that ERISA's framers intended to preempt state health care access initiatives that offer incentives to employers to offer health coverage, such as state income tax credits, health coverage purchasing pool participation, or public works contracting. As discussed above, offering an unconditional tax credit or authorizing the creation of purchasing pools are unlikely to raise serious ERISA preemption problems. But a tax credit *conditioned* on meeting certain benefits or contribution standards, or an employer purchasing pool that restricts the numbers or types of products sold, raises at least theoretical ERISA issues. Similarly, the courts currently permit state and local government to require benefits or labor protections as a condition of public works contracts in only very limited circumstances. Insofar as public works contracting is voluntary, however, conditioning it on coverage requirements does not interfere with ERISA's objective to permit nationally uniform benefit plans. To remove any doubt about state authority to

develop such voluntary incentive programs conditioned on meeting enumerated standards, ERISA could be amended to make clear that these types of programs would not be preempted.

Facilitating Public/Private Health Coverage Coordination

Employer participation in public subsidy programs would facilitate current federal Medicaid and CHIP policy to encourage states to subsidize the purchase of cost-effective workplace coverage. But ERISA preempts states from requiring employers to cooperate in administering public subsidy programs or report data on their health coverage. ERISA (or the federal Medicaid and CHIP laws) could be amended to permit states to require that employers cooperate in CHIP or Medicaid workplace coverage subsidy programs. Under such a requirement, employers would report to state agencies basic information on health plan design and eligibility, inform employees about subsidy programs, and accept and remit public subsidies for lower-income employees.[26] This kind of cooperation could enhance the efficiency and outreach of public programs.

Federal Standards to Support State Efforts

Drawing on the HIPAA model, ERISA could be amended to create a federal floor of standards for employer-sponsored health coverage programs, which states could supplement in defined ways. For example, ERISA could be amended to authorize states to require that employer-sponsored plans regularly report to state agencies basic information about health plans, such as numbers of people covered, benefits design, and self-insurance features. To minimize reporting burdens, such data could be collected as part of other routinely submitted information, such as state income tax or unemployment insurance reporting. ERISA also could set federal standards for the solvency or content of employer-sponsored health plans, which states could supplement regarding insurers (as they do under current insurance regulation authority). Such an approach has the advantage of creating at least a minimum uniform standard that all employer-sponsored health plans must meet, while at the same time acknowledging states' traditional role in regulating insurance companies and their products.

Authorizing State Pilot Projects to Test Health Coverage Access Expansions

ERISA could be amended to allow states to test innovative approaches for expanding health coverage. This could be done either by authorizing explicit types of health care access or financing demonstrations or by permitting federal agencies to grant states waivers to test new programs. In either case, Congress could limit the number of state programs or the number of people covered under them, as it did in authorizing the federal medical savings account demonstration.

As an example of the first approach, all or a limited number of states could be authorized to:

- enact pay-or-play laws, which would tax employers to fund a public health coverage program but provide a tax credit if employers offer their own plans;
- tax employer plans (along with insurers) to fund state high-risk pools; or
- require (as opposed to merely permit) employer participation in purchasing pools.

Alternatively, the law could create a process for federal agencies, such as DOL and Department of Health and Human Services (DHHS), to grant preemption waivers. Waiver authority would permit states to design individual programs to demonstrate health care access approaches that could inform other states and the federal government. It could prescribe parameters, such as time limits or required evaluations, and renewals could be conditioned on meeting specified performance measures, such as enhanced access to health care or health coverage. Authority could be very general or circumscribed to permit only certain types of demonstrations (such as taxing self-insured employers to fund high-risk pools). Although permitting waivers for only limited types of initiatives might be easier to enact, more general authority would give states flexibility to test novel access approaches that emerged after the law was enacted.

Such a waiver process was proposed in 1992 by two different U.S. Senate bills, during a time of active state development of broad health care access initiatives. One bill would have created a national commission to grant waivers from certain Medicaid, Medicare, and ERISA provisions. Up to 10 states would have qualified for five-year grants to demonstrate universal health care financing programs.[27] Another Senate bill would have authorized the U.S. Secretary of Labor to grant ERISA preemption waivers, but only after the Secretary of Health and Human Services had determined that a state had the resources and capacity to achieve its health care access expansion goals.[28] A 1998 bill to authorize state access initiatives would have allowed the DHHS, in consultation with DOL, to waive ERISA preemption.[29]

A waiver process could provide complementary roles for DOL and DHHS. While it is reasonable that final authority to grant exceptions to ERISA preemption must rest with DOL (which administers ERISA), DHHS could have an important responsibility in analyzing the health care impacts of state access expansion proposals and measures needed to evaluate them. HIPAA offers a recent and evolving example of working relationships

between DOL and DHHS (as well as the Internal Revenue Service, which enforces certain aspects of ERISA). Questions have been raised about overlapping DOL and Health Care Financing Administration jurisdiction to handle consumer complaints under HIPAA.[30] But the agencies have been working to improve their coordination and should be able to draw on this experience to implement a waiver review, approval, and evaluation process.

In late 1994, the DOL Advisory Council on Employee Welfare and Pension Benefit Plans Working Group on Health Care Reform recommended that in the absence of national health care reform, whose prospects were waning, a state ERISA waiver process could include such elements as opportunities for states to develop regional multi-state proposals, specific federal standards for benefits and funding, and public hearings.[31]

Detailed analysis of a federal ERISA waiver process is beyond the scope of this report. Lessons might be drawn from several decades of experience with waivers under Section 1115 of the Social Security Act, including a recent spate of Medicaid program waivers that allow states to demonstrate different approaches to expand the populations eligible for Medicaid and serve them under different health care delivery mechanisms.[32] Such Medicaid waivers have raised policy concerns of little relevance to ERISA waivers, such as federal budget neutrality. However, they could inform ERISA waiver policy on such questions as how to measure impacts of reforms on the number of uninsured residents.

A waiver process that allows states flexibility in finding ways to meet certain federal policy goals, such as increasing health coverage, could be more sensitive to both current and future health policy needs than very prescribed types of programs. On the other hand, an open-ended waiver process would be more likely to generate political opposition.

Policy Advantages and Disadvantages of Amending ERISA

Amending ERISA would have the advantages of:

- providing states with flexibility to support experimentation that could inform both federal and state public policy development;

- strengthening states' ability to coordinate public programs and private-sector health coverage to make the most efficient use of public resources; and

- providing additional revenue sources.

On the other hand, amending ERISA to permit more state flexibility could:

- limit the flexibility of multistate employers and unions to develop nationally uniform benefits programs;

- reduce employer-sponsored plans' ability to innovate to control costs or improve quality; and

- discourage employers from offering coverage they feel is too costly.

CONCLUSION

This paper has demonstrated that ERISA's preemption clause provides both opportunities for and obstacles to state health care access initiatives. It also has underscored the ambiguity created by ERISA's preemption provisions. Only the courts can interpret ERISA's broad preemption clause, and very few state health policy initiatives have been litigated. Despite a few recent Supreme Court decisions narrowing the scope of ERISA preemption, the possibility hovers over state health policy deliberation. Although preemption may no longer be an impenetrable black cloud, it is nevertheless a gray fog of uncertainty that may discourage states from seriously considering creative initiatives to expand access to health care or protect consumers through health plan regulation.

Recent Supreme Court opinions remove all doubt that states can impose health care provider taxes, despite their likely cost impacts on employer-sponsored health plans. These decisions also strengthen state arguments in support of broader employer pay-or-play tax credit programs. But except for Hawaii's special exception, ERISA still preempts state attempts to tax or regulate employer-sponsored plans directly, for example, by mandating that employers offer workplace health coverage. And the authority for states to adopt many types of health care access initiatives, such as employer health coverage tax credits or public contracting requirements, remains unclear. Some of these ambiguities could be resolved by relatively uncontroversial ERISA amendments. Other state health coverage policy initiatives could be facilitated using the HIPAA model of basic federal requirements applying to all employer-sponsored health plans. States, meanwhile, can continue to regulate health insurers. Finally, ERISA could be amended to authorize federal agencies to grant waivers from ERISA preemption for state health care coverage expansions or financing mechanisms. Recent ERISA amendments, including HIPAA, provide models for federal action.

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#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70,* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 *Current Population Survey* and *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance,* this report examines reasons why nine of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#363 *A Vote of Confidence: Attitudes Toward Employer-Sponsored Health Insurance* (January 2000). Cathy Schoen, Erin Strumpf, and Karen Davis. This issue brief based on findings from *The*

Commonwealth Fund 1999 National Survey of Workers' Health Insurance reports that most Americans believe employers are the best source of health coverage and that they should continue to serve as the primary source in the future. Almost all of those surveyed also favored the government providing assistance to low-income workers and their families to help them pay for insurance.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance,* this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#262 *Working Families at Risk: Coverage, Access, Costs, and Worries—The Kaiser/Commonwealth 1997 National Survey of Health Insurance* (April 1998). This survey of more than 4,000 adults age 18 and older, conducted by Louis Harris and Associates, Inc., found that affordability was the most frequent reason given for not having health insurance, and that lack of insurance undermined access to health care and exposed families to financial burdens.

NOTES

[1] For more detailed discussion of ERISA preemption issues, including citations of court decisions, see P. A. Butler, *ERISA Preemption Manual for State Health Policy Makers,* Alpha Center and National Academy for State Health Policy, 2000; and National Association of Insurance Commissioners, *ERISA: Barrier to Health Care Consumers' Rights*. Washington, D.C.: NAIC, 1999.

[2] This misunderstanding becomes important when people mistakenly assert that states can, for example, regulate remedies (such as providing external review or tort damages) for people in insured plans, while acknowledging they cannot provide such remedies for people in self-insured plans. The courts have made clear that ERISA preempts such remedies as applied to all types of ERISA (i.e., private-sector employer-sponsored) plans.

[3] Researchers at the RAND Corporation recently estimated that the prevalence of private employer self-insurance declined from 40 percent of the people insured through the workplace in 1993 to 33 percent in 1997; see S. Marquis and S. Long, "Recent Trends in Self-Insured Employer Health Plans," *Health Affairs* 18 (March/April 1999):161–166. Other researchers, however, have estimated that the proportion of workplace-covered employees in self-insured plans increased from 46 percent in 1995 to 50 percent in 1998; see G. A. Jensen and M. A. Morrisey, "Employer-Sponsored Health Insurance and Mandated Benefit Laws," *Milbank Quarterly* 77 (December 1999):425–459, citing studies by Gabel and Jensen. A 1993 Robert Wood Johnson Foundation survey produced estimates of self-insurance in 10 states, but this survey has not been routinely updated nor is it available for all states; see G. Acs, S. H. Long, S. Marquis, and P. F. Short, "Self-Insured Employer Health Plans: Prevalence, Profile, Provisions and Premiums," *Health Affairs* 15 (Summer 1996):266–278.

[4] Because the preemption clause ultimately enacted in 1974 was broader than preemption proposals in either the House or Senate bills, its legislative history exists in only a few floor statements. As outlined in detail from later recollections of congressional leaders and staff members as well as stakeholders, however, this broad preemption was designed to thwart contemporary proposals to tax and regulate employer-sponsored health plans in several states. D. M. Fox and D. C. Schaffer, "Health Policy and ERISA: Interest Groups and Semipreemption," *Journal of Health Politics, Policy & Law* 14 (1989):239–260; M. S. Gordon, "Managed Care, ERISA Preemption, and Health Reform—the Current Outlook," *BNA Pension & Benefits Reporter* 22 (1995):852–856.

[5] This amendment limited Hawaii's law to its 1974 version. The state cannot change the mandated benefits package, require dependent coverage, or change the employer's share of premium contributions. Consequently, bills have been introduced to permit the state to amend its law without violating its ERISA preemption exemption, for example, S. 287 (103d Cong., 1st Session, 1993) and S. 266 (103d Cong., 2d Session, 1994).

[6] HIPAA requires ERISA plans and group insurers to guarantee issue and renewal for group coverage and credit satisfaction of pre-existing condition exclusion periods, and it limits the length of those pre-ex periods. Other laws enacted in 1996 and 1998 require a limited form of mental health parity, a minimum number of hours of postdelivery maternity and newborn hospitalization, and postmastectomy reconstructive surgery. These laws create several different types of state law preemption, resulting in new models of shared responsibility for employee health plan regulation between state and federal governments.

[7] *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.,* 514 U.S. 645 (1995).

[8] *De Buono v. NYSA-ILA Medical and Clinical Services Fund,* 520 U.S. 806 (1997).

[9] If a court holds that the state law relates to ERISA plans, it examines the second question by considering whether the state law: (1) regulates insurance by being directed at the insurance

industry, and (2) if so, is the regulated activity one that (a) spreads risk across a broad population; (b) integrally involves the relationship between the insurer and insured persons; and/or (c) is limited to entities in the insurance industry?

[10] Minnesota's tax supports a public coverage program for lower-income people ("MinnesotaCare"), while laws in Connecticut, Massachusetts, and New York fund uncompensated hospital care.

[11] These laws have never been challenged but could best be defended by arguing first that the administrative burden is slight (no different, for example, than remitting other taxes imposed by the state) and its cost minimal, and second, that this type of administrative obligation does not involve essential operations of an employee benefit plan, such as plan design, eligibility, and funding.

[12] The Washington State restaurant association proposed authorizing a lower minimum wage if the employer financed an acceptable level of health coverage. This proposal raised ERISA issues because it directly referred to employee health plans and attempted to dictate plan terms by conditioning the ability to pay a lower minimum wage on providing a certain set of benefits and paying a minimum share of the premium. A proposal under discussion in Tennessee in early 2000 would have taxed employers that did not insure their workers. It raised ERISA issues because it directly referred to ERISA plans and imposed the tax unless employer coverage met a specified state standard—a more prescriptive requirement than Massachusetts's 1988 pay-or-play proposal.

[13] This strategy is a more prescriptive variation on the longer-standing authority courts have given to states to require public works contractors to pay "prevailing" wages that include a combination of wages and benefits as long as the state law allows contractors to decide how to allocate the wage package between wages and fringe benefits.

[14] For a discussion of these cases, see P. A. Butler, *ERISA Preemption Manual.*

[15] L. Tollen, *Purchasing Private Health Insurance Through Government Health Care Programs: A Guide for States*. Washington, D.C.: Institute for Health Policy Solutions, 1999.

[16] For this reason, states like Massachusetts and Oregon pay employees directly rather than paying employers.

[17] S. Silow-Carroll, *Employer Tax Credits to Expand Health Coverage: Lessons Learned*. New York: The Commonwealth Fund, 2000. A proposal considered in a November 1999 special session of the Tennessee legislature would have credited against state business taxes the employer's cost of health coverage for employees enrolled in the state's TennCare public health care program. Had the law passed, it would have raised some ERISA concerns because of its reference to employer-sponsored health plans and its condition for the tax that employer coverage conforms to the state's small group coverage law. But as a tax credit, it might have been easier to defend than taxes under discussion in the 2000 legislative session (described in note 12).

[18] The Supreme Court, for example, has held that *exempting* ERISA plans from a state's garnishment law was preempted because the law referred to ERISA plans and treated them differently from other plans, even though the law did not impose burdens on the employee plans but rather benefited them (*Mackey v. Lanier Collection Agency,* 486 U.S. 834 (1988)). A Court of Appeals also held that ERISA preempts a state's "any willing provider" law that benefited ERISA plans by exempting them (*Prudential Insurance Co. v. National Park Medical Center,* 154 F.3d 812 (8th Cir. 1998)). Other courts, however, have taken a less literal approach to this preemption test. The court in *Thiokol, Morton, Int'l, Inc. v. Roberts,* 76 F. 3d 751 (6th Cir. 1996), *cert. denied,* 520 U.S. 1271 (1997), analyzed this issue in detail and held that a statutory reference to ERISA plans should cause preemption only when the law has a burdensome effect on ERISA plans. The court in *N.Y.S. HMO Conference v. Curiale,* 64 F. 3d 794 (2d Cir. 1995), held that the reference was

irrelevant because the law could be enforced without it. See also *Washington Physicians Service Assoc. v. Gregoire,* 147 F.3d 1039 (9th Cir. 1998), *cert. denied,* 119 S. Ct. 1033 (1999), where the Ninth Circuit ignored an exemption for ERISA plans in the state's law.

[19] This is a similar type of choice to that employer-sponsored plans faced in *Travelers Insurance:* they faced a strong incentive to choose Blue Cross plans, which did not pay the hospital tax. The Supreme Court, however, held this choice was not "dictated" by the state hospital tax program and consequently did not cause ERISA preemption.

[20] H.R. 3618 (103d Congress, 1st Session, 1993) would have exempted from ERISA Oregon laws relating to the state's high-risk insurance pool, employer-based coverage mandate, priority-setting Medicaid reform, cost-containment and technology assessment, and other provisions of state law necessary to achieve universal coverage under the Oregon Health Plan. The bill would not have permitted the state to impose taxes differently on insured and self-insured employer plans. Oregon's employer mandate expired before implementation.

[21] H.R. 2870 (103d Congress, 1st Session, 1993) would have exempted from preemption provisions of Washington State's health care reform law relating to enrolling employees in the Basic Health Plan; taxing health insurers and hospitals; mandating employers to cover employees; and requiring of large self-funded plans (that need not participate in the state's public purchasing pool) to provide uniform benefits, pay premium taxes, and comply with such state standards as using managed care, risk adjustment mechanisms, coverage portability, and restrictions on balance billing. Washington's employer mandate was repealed in 1995.

[22] As originally drafted, the 1993 federal budget bill (H.R. 2264, enacted as the Omnibus Budget and Reconciliation Act of 1993) would have permitted four states to continue several existing programs: 1983 amendments to Hawaii's Prepaid Health Plan Act; Maryland's all-payer hospital rate-setting law; Minnesota's provider tax, data collection, and uniform claims forms requirements; and New York's hospital rate-setting law, provider surcharges, and charity care/bad-debt pools. These proposals were dropped from the final law to conform to Senate rules prohibiting nonbudget items in budget bills.

[23] S. 2452 (103d Cong., 2d Session, 1994) would have authorized modifications to Hawaii's employer mandate and authorized reform proposals in Oregon, Washington, and Minnesota, as well as existing hospital rate-setting programs in Connecticut, Maryland, and New York. Despite the arguments from the House Budget Committee that ERISA has made it difficult "to evaluate the workability of key elements of the various reform proposals," (House Budget Committee, H. Rep. No. 103-111, 103d Cong., 1st Session, May 25, 1993) this bill was not enacted.

[24] S. 3223 (102d Cong., 2nd Session, 1992) would have exempted from preemption state provider tax laws and hospital rate-setting programs—types of laws that the Supreme Court subsequently held ERISA does not preempt.

[25] For example, H.R. 1200 (104th Congress, 1st Session, 1995) would have created a state-based universal coverage program that would have exempted state laws from ERISA preemption. S. 168 (104th Congress, 1st Session, 1995) would have imposed a national employer coverage mandate but allowed states to establish single-payer programs.

[26] While requiring employers to coordinate with public programs might seem uncontroversial, the author of a study (cited in note 15) of state attempts to elicit cooperation from employers found that employers object to the burden of administering premium subsidies. Furthermore, they feel that these subsidies are inequitable and worry that they might disappear. The study did find, though, that employers might be willing to inform states about the coverage they offer and employees about the availability of subsidies. Personal communication with Laura Tollen, Institute for Health Policy Solutions, February 4, 2000.

[27] S. 3180 (102d Cong., 2d Session, 1992) would have amended ERISA's preemption clause to permit states to: (1) tax all types of health plans; (2) tax providers or employers even if the ultimate impact would be absorbed by health plans; (3) require a uniform benefits package; (4) require use of common claims processing, data collection, utilization review, and quality assurance mechanisms; and (5) establish health care provider rates. A hearing was held on this bill, but Congress took no action on it. Hearing on S. 3180 before the U.S. Senate Committee on Finance, No. 102-1068, 102d Cong., 2d Session, September 7, 1992.

[28] S. 3223 (102d Cong., 2d Session, 1992) would have authorized the Secretary of Labor to permit states to: (1) tax providers; (2) set hospital rates; and (3) impose a nondiscriminatory tax on health plans to fund risk pools for uninsurable individuals or otherwise expand health care access.

[29] H.R. 3998 (105th Cong., 2d Session, 1998) provided for waivers "reasonable and necessary to carry out state comprehensive health insurance plans."

[30] Polzer, K. 1999. *Issue Brief No. 735. HIPAA as a Regulatory Model: Early Experiences and Future Prospects*. Washington, D.C.: National Health Policy Forum, George Washington University.

[31] These recommendations suggested, for example, that to minimize burdens on interstate employers and union (Taft-Hartley trust) plans, federal standards should prescribe minimum funding requirements, insolvency standards, claims forms, data collection, means to establish a standard benefits package, and disclosure standards. Advisory Council on Employee Welfare and Pension Benefit Plans, *Report of the Working Group on Health Care Reform* (11/10/94). Washington, D.C.: U.S. Department of Labor, 1994.

[32] General Accounting Office, *Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs* (GAO/HEHS 96-44). Washington, D.C.: U.S. General Accounting Office, 1995.