

January 2015

The ACA's 2017 State Innovation Waiver: Is ERISA a Roadblock to Meaningful Healthcare Reform?

Marea B. Tumber

Follow this and additional works at: <http://scholarship.law.umassd.edu/umlr>

 Part of the [Health Law Commons](#)

Recommended Citation

Tumber, Marea B. (2015) "The ACA's 2017 State Innovation Waiver: Is ERISA a Roadblock to Meaningful Healthcare Reform?," *University of Massachusetts Law Review*: Vol. 10: Iss. 2, Article 5.
Available at: <http://scholarship.law.umassd.edu/umlr/vol10/iss2/5>

This Note is brought to you for free and open access by Scholarship Repository @ University of Massachusetts School of Law. It has been accepted for inclusion in University of Massachusetts Law Review by an authorized administrator of Scholarship Repository @ University of Massachusetts School of Law.

The ACA's 2017 State Innovation Waiver: Is ERISA a Roadblock to Meaningful Healthcare Reform?

Marea B. Tumber

10 U. MASS. L. REV. 388

ABSTRACT

In 2017, the Affordable Care Act's (ACA) State Innovation Waiver (§ 1332) will enable states to waive many of the ACA's provisions and to develop their own creative solutions to reign in healthcare spending. The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to encourage employers to sponsor benefit plans and minimize potential conflicts with existing state laws. Because of ERISA, the regulation of employee benefit plans, including health plans, falls primarily under federal jurisdiction for about 131 million people. This Note explores the ways in which ERISA presents significant roadblocks to meaningful state level healthcare reform under § 1332. State laws cannot directly refer to ERISA, nor influence the benefits, administration, or structure of an ERISA plan. Also, if a state law limits employer choices too much, it will likely violate ERISA. This Note proposes that ERISA needs to be waived, amended or repealed so that states can implement meaningful healthcare reforms under § 1332.

AUTHOR NOTE

Candidate for Juris Doctor, December 2015, University of Massachusetts School of Law; MPH, Brown University; B.A., St. Lawrence University. I would like to thank my good friend and mentor Professor Amy Reichbach for her oversight of this project, and Professor Olivia Milonas for her guidance in legal scholarly research and writing. Rhode Island Lt. Governor Elizabeth H. Roberts, Jennifer L. Wood and Rebecca Kislak deserve a special thank you for the many interesting and engaging health policy discussions that helped to crystallize my approach to this topic. I would also like to thank the Board and staff of the UMass Law Review and Jim Tumber for their insightful editorial suggestions.

I. INTRODUCTION	390
II. BACKGROUND	391
A. Pre-ACA: The Uninsured and Rising Healthcare Costs	391
B. Overview of the ACA	392
1. Expanding Health Insurance Coverage.....	393
2. Controlling Costs and Improving Quality Under the ACA	397
III. OPTING OUT OF THE ACA: THE § 1332 WAIVER	401
A. Potential State Innovations Under § 1332.....	402
IV. LEGAL ISSUES: ERISA AND THE § 1332 WAIVER	407
A. ERISA Overview	407
1. ERISA’s Preemption and Savings Clauses	409
B. Judicial Interpretation of ERISA	411
1. “Reference to” an Employee Benefit plan.....	412
2. “Relates to” an Employee Benefit plan	413
V. POTENTIAL ISSUES FOR § 1332 WAIVERS UNDER ERISA	416
A. How the Courts May Interpret New State Laws’ Under § 1332 & ERISA.....	416
1. “Comprehensive” Benefit Plans, e.g. Minimum Benefits Packages	418
2. Coercion (“Pay Or Play”) Through a Payroll Tax	419
3. Changes In Plan Administration, e.g. “Single Pipe,” Rate-Setting	420
VI. SOLUTIONS	421
VII. CONCLUSION	424

I. INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) was signed into law in 2010.¹ The aims of the ACA are to reduce the number of uninsured individuals in the United States, to reign in rising healthcare costs, and to improve healthcare quality.² In 2017, the ACA's State Innovation Waiver (§ 1332) will enable states to waive many of the ACA's provisions and to create their own innovative solutions to control healthcare spending.³ However, the Employee Retirement Income Security Act of 1974 (ERISA)⁴ presents a number of significant legal hurdles to true innovation in healthcare. ERISA's original purpose was to encourage employers to sponsor benefit plans and minimize potential conflicts with existing state laws.⁵ Because of ERISA, the regulation of employee benefit plans, including health plans, falls primarily under federal jurisdiction for the forty-eight percent of the U.S. population insured through their employers.⁶ State laws cannot directly refer to ERISA, nor influence the benefits, administration, or structure of an ERISA plan.⁷ Also, if a state law limits employer choices too much, it will likely violate ERISA.⁸

The most aggressive innovation in combating high healthcare costs is the implementation of a single-payer health insurance system.⁹

¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010) as amended by the Healthcare and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (March 30, 2010) (hereinafter "ACA").

² *See id.*; *Reform Overview: Summary of the Health Reform Legislation*, HEALTH REFORM GPS, <http://healthreformgps.org/summary-of-the-legislation/> (last visited Dec. 20, 2014).

³ ACA § 1332, 42 U.S.C. § 18052 (2012).

⁴ Employee Retirement Income Security Act (ERISA) of 1974, Pub. L. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1453; Pub. L. 113-295, 128 Stat. 4010 (2012)) (hereinafter "ERISA").

⁵ *Id.*

⁶ *Health Insurance Coverage of the Total Population*, KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/total-population/> (last visited March 5, 2015) (stating that the breakdown of health insurance by source is as follows: employer (48%), Medicaid (16%), Medicare (15%), other public (2%), other private (6%)) (hereinafter "Health Insurance Coverage").

⁷ ERISA § 514(a), 29 U.S.C. § 1144(a) (2012); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995).

⁸ *Travelers*, 514 U.S. at 659.

⁹ *See infra* note 84.

However, in order to comply with ERISA, states would need to leave the employer-based health insurance market intact, which stymies true healthcare reform.¹⁰ Any innovation that is too coercive and leaves employers with little choice but to modify their plans, or requires that an ERISA plan be administered in a specific way or through a single processor, would likely violate ERISA.¹¹ Additionally, under § 1332, state statutes will be required to provide that employers offer coverage that is as “comprehensive” as is offered under the ACA.¹² These mandated benefits would also violate ERISA.¹³ This Note explores the ways in which ERISA is a significant legal roadblock to meaningful state-level healthcare reform under the ACA’s 2017 State Innovation Waiver. In order for states to truly innovate and reform their healthcare systems under § 1332, ERISA needs to be waived, amended, or repealed by Congress, or overridden by executive order.

This Note begins with an overview of the ACA in Part II, and describes the ACA’s 2017 State Innovation Waiver (§ 1332) in Part III. Part IV provides a background of ERISA and analyzes how the courts have interpreted the law. Part V analyzes how the courts may interpret new state laws and their interaction with ERISA under the § 1332 waiver. Finally, Part VI proposes several solutions to the preemption issues that will likely arise under states’ laws and ERISA.

II. BACKGROUND

A. Pre-ACA: The Uninsured and Rising Healthcare Costs

Before the ACA, approximately 16.3 percent of the United States’ population lacked health insurance; this translates to approximately 49.9 million people who were uninsured, with another 25 million who were underinsured.¹⁴ A lack of health insurance has adverse effects on an individual’s health due to a lack of preventive care and delays in

¹⁰ William C. Hsiao et al., *What Other States Can Learn From Vermont’s Bold Experiment: Embracing A Single-Payer Health Care Financing System*, 30 HEALTH AFFAIRS 1232, 1233-34 (2011).

¹¹ See *infra* Part V.

¹² ACA § 1332, 42 U.S.C. § 18052(b)(1)(A)-(D) (2012).

¹³ *Shaw v. Delta Air Lines*, 463 U.S. 85, 100 (1983).

¹⁴ *Health Insurance – Highlights-2010*, U.S. CENSUS BUREAU, <http://www.census.gov/hhes/www/Hlthins/data/incpovhlth/2010/highlights.html> (last visited Feb. 9, 2015).

accessing care when it is needed. These factors lead to higher-cost treatments, poorer prognoses, and cost-shifting in the form of higher premiums and overall health costs due to hospitals' uncompensated care.¹⁵

Health spending per capita in the United States is much higher than in other countries—at least fifty-one percent higher than in Norway, the next largest per capita spender.¹⁶ In the United States, which has both a high level of healthcare spending per capita and a relatively high rate of real growth in spending, the share of Gross Domestic Product (GDP) devoted to healthcare spending grew from nine percent of GDP in 1980 to sixteen percent of GDP in 2008.¹⁷ Healthcare costs are increasing at a faster rate than inflation.¹⁸ Actuaries project that healthcare spending will grow an average of 5.8 percent per year between 2012 and 2022.¹⁹ By 2022, annual healthcare spending will reach \$2.4 trillion, or 19.9 percent of U.S. GDP,²⁰ and it is projected that federal, state, and local governments will finance forty-nine percent of total healthcare spending.²¹

B. Overview of the ACA

President Obama signed the ACA into law in 2010, signaling the beginning of a nationwide effort to reform our healthcare system.²² The ACA was created to address three important goals: to reduce the

¹⁵ SARAH AXEEN & ELIZABETH CARPENTER, NEW AMERICA FOUNDATION, WHO RECEIVES UNCOMPENSATED CARE? 1 (2008); see JOHN HOLAHAN & BOWNE GARRETT, URBAN INSTITUTE, THE COST OF UNCOMPENSATED CARE WITH AND WITHOUT HEALTH REFORM (2010); see MELISSA MAJEROL, VANN NEWKIRK & RACHEL GARFIELD, KAISER FAMILY FOUND, THE UNINSURED: A PRIMER - KEY FACTS ABOUT HEALTH INSURANCE AND THE UNINSURED IN AMERICA (2015).

¹⁶ *Snapshots: Healthcare Spending in the United States & Selected OECD Countries*, KAISER FAMILY FOUND., <http://kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected-oecd-countries/> (last visited Dec. 31, 2014).

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ Gigi A. Cuckler et al., *National Health Expenditure Projections, 2012–22: Slow Growth Until Coverage Expands And Economy Improves*, 32 HEALTH AFFAIRS 1820, 1830 (2013).

²² ACA, 124 Stat. 119.

number of uninsured, to increase healthcare quality, and to reduce overall healthcare spending.²³

1. Expanding Health Insurance Coverage

The first aim of the ACA is to provide affordable health insurance to the uninsured.²⁴ This is a critical component in controlling the cost of healthcare because healthcare for the uninsured is extremely expensive. As described in Part II (A), a lack of health insurance increases the overall cost of healthcare.²⁵ In order to reduce the number of uninsured, the ACA uses the following strategies: the individual mandate, federal monies to subsidize the cost of insurance, and the removal of barriers to obtaining insurance.²⁶

Beginning in 2014, the ACA mandates that most individuals have “minimum essential coverage” health insurance²⁷ or pay a tax penalty.²⁸ Employers with at least fifty full-time employees are

²³ See *id.*; HEALTH REFORM GPS, *supra* note 2.

²⁴ The overall approach of the ACA is to expand access to coverage, and it requires most U.S. citizens and legal residents to have health insurance. The ACA creates state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 133-400% of the federal poverty level (the poverty level was \$19,530 for a family of three in 2013) and creates separate Exchanges through which small businesses can purchase coverage. The ACA requires employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. The ACA imposes new regulations on health plans in the Exchanges and in the individual and small group markets. The ACA also expands Medicaid to 133% of the federal poverty level. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM, SUMMARY OF THE AFFORDABLE CARE ACT 1 (2013).

²⁵ See *supra* note 14.

²⁶ U.S. Department of Health and Human Services (HHS), *Key Features of the Affordable Care Act By Year*, <http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html> (last visited March 5, 2015).

²⁷ 42 U.S.C. § 18091 (2012); 26 U.S.C. § 5000(A) (2012) (requiring all people to be covered by health insurance that provides at least “minimum essential coverage”).

²⁸ The ACA requires U.S. citizens and legal residents to have qualifying health coverage. “Those without coverage pay a tax penalty of the greater of \$695 per year up to a maximum of three times that amount (\$2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: a flat fee of \$95 in 2014, \$325 in 2015, and \$695 in 2016 or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable

required to either offer minimum health coverage to full-time employees and their dependent children, or pay a fine.²⁹ The ACA also provides federal money in the form of a premium tax credit for people with incomes between 100 and 400 percent of the federal poverty level (FPL),³⁰ as well as to employers with no more than twenty-five full-time employees, in order to encourage the purchase of insurance.³¹

income in 2016. After 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was \$9,350 for singles and \$18,700 for couples).” KAISER FAMILY FOUND., *supra* note 24, at 1.

²⁹ 29 U.S.C. §§ 218(a-b) (2012); 26 U.S.C. § 4980H (2012). As of January 1, 2014, the ACA “will assess employers with 50 or more full-time employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with 50 or more full-time employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee, excluding the first 30 employees from the assessment.” KAISER FAMILY FOUND., *supra* note 24, at 1.

³⁰ 26 U.S.C. § 36B (2012). As of January 1, 2014, the ACA provides “refundable and advanceable premium credits to eligible individuals and families with incomes between 100-400% of the Federal Poverty Limit (FPL) to purchase insurance through the Exchanges. The premium credits will be tied to the second lowest cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income levels: Up to 133% FPL: 2% of income; 133-150% FPL: 3-4% of income; 150-200% FPL: 4-6.3% of income; 200-250% FPL: 6.3-8.05% of income; 250-300% FPL: 8.05-9.5% of income; 300-400% FPL: 9.5% of income. The premium contributions for those receiving subsidies will increase annually to reflect the excess of the premium growth over the rate of income growth for 2014-2018. Beginning in 2019, the ACA will further adjust the premium contributions to reflect the excess of premium growth over CPI if aggregate premiums and cost sharing subsidies exceed 0.54% of [Gross Domestic Product] GDP.” KAISER FAMILY FOUND., *supra* note 24, at 2.

³¹ 26 U.S.C. § 45R (2012). The ACA provides “small employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees with a tax credit. Phase I: For tax years 2010 through 2013, the ACA provides a tax credit of up to 35% of the employer's contribution toward employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer

Additionally, in order to cover people who cannot afford health insurance, the ACA gives states an option to expand previous Medicaid eligibility and provides federal funding to all children, pregnant women, parents, and adults (who are under age 65 without dependent children) at an income level below 133 percent of the FPL.³² Approximately 20 million Americans have gained health

employees and average annual wages of less than \$25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward employee's health insurance premiums. Phase II: For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, the ACA provides a tax credit of up to 50% of the employer's contribution toward employee's health insurance premiums if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward employee's health insurance premium." KAISER FAMILY FOUND., *supra* note 24, at 3.

³² 42 U.S.C. § 1396a(a)(10)(VIII) (2012). Effective January 1, 2014, the ACA expands Medicaid "to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (as under current law undocumented immigrants are not eligible for Medicaid). All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits (EHBs) available through the Exchanges. The Supreme Court ruling on the constitutionality of the ACA upheld the Medicaid expansion, but limited the ability of HHS to enforce it, thereby making the decision to expand Medicaid optional for states. To finance the coverage for the newly eligible (those who were not previously eligible for at least benchmark equivalent coverage, those who were eligible for a capped program but were not enrolled, or those who were enrolled in state-funded programs), states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020 and later). States have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular FMAP until 2014. In addition, the ACA will increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for

insurance coverage since the major coverage provisions of the ACA went into effect in January 2014.³³ The percentage of uninsured Americans dropped from 18 percent in the third quarter 2013 to 13.4 percent in May 2014.³⁴

Another option available to states to increase access to health insurance is contained in § 1331 of the ACA.³⁵ Section 1331 allows states to create a Basic Health Program (BHP) for low-income residents who are not eligible for Medicaid and would otherwise be eligible to purchase coverage through the exchanges.³⁶ Under § 1331, benefits must include at least the ten “essential health benefits (EHBs),” specified in the ACA.³⁷ The BHP option gives states the ability to expand affordable coverage for these low-income residents and improve continuity of care for people whose income fluctuates above and below Medicaid and Children’s Health Insurance Program (CHIP) levels.³⁸ Minnesota was the first state to implement the BHP, with coverage beginning January 1, 2015.³⁹

2013 and 2014. States will receive 100% federal financing for the increased payment rates.” KAISER FAMILY FOUND., *supra* note 24, at 1-2.

³³ David Blumenthal & Sara Collins, *Healthcare Coverage Under the Affordable Care Act—A Progress Report*, 371 NEW ENG. J. MED. 275, 280 (2014).

³⁴ *Id.*

³⁵ ACA § 1331, 42 U.S.C. § 18051 (2012).

³⁶ 42 U.S.C. § 18051(a) (2012).

³⁷ 42 U.S.C. § 18051(a)(2)(b) (2012).

³⁸ 42 U.S.C. § 18051 (2012); The BHP enables states to provide coverage to individuals who are citizens or lawfully present non-citizens who do not qualify for Medicaid, CHIP, or other minimum essential coverage and have income between 133-200 % of the FPL. A state that operates a BHP will receive federal funding equal to 95% of the amount of the premium tax credits and the cost sharing reductions that would have otherwise been provided to or on behalf of eligible individuals if these individuals enrolled in qualified health plans on an exchange. Centers for Medicare & Medicaid Services (CMS), *Medicaid.gov, Keeping America Healthy, Basic Health Program*, <http://www.medicaid.gov/Basic-Health-Program/Basic-Health-Program.html> (last visited April 9, 2015).

³⁹ CMS, *supra* note 38.

2. Controlling Costs and Improving Quality Under the ACA

The ACA uses an insurance exchange mechanism as its primary means to control costs.⁴⁰ Coverage through the “Exchanges,” or “Marketplaces,” began in every state on January 1, 2014.⁴¹ The exchanges seek to stimulate competition between insurers by enabling consumers to make an informed decision while choosing between insurance plans listed in the exchange.⁴² The exchanges simplify the comparison of prices and benefits structure by categorizing benefit packages,⁴³ and brokers are employed to help people select appropriate plans.⁴⁴ Also, since the exchanges only allow plans covering the EHBs, minimum quality standards across plans are guaranteed.⁴⁵ Beginning in 2014, the ACA requires non-grandfathered health plans to cover the EHBs, which include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.⁴⁶ The EHBs should be equal in scope to a typical employer health plan.⁴⁷

⁴⁰ TIMOTHY S. JOST, *THE COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: KEY POLICY ISSUES* v-vi, 28-29 (2010).

⁴¹ 42 U.S.C. § 18031(b) (2012); Rachel Brand, *Facing the Future: Setting up Health Insurance Exchanges is One of the Big, Early Tasks for Lawmakers*, NAT’L CONFERENCE OF STATE LEGISLATURES, Oct./Nov. 2010, at 24.

⁴² Brand, *supra* note 41, at 25.

⁴³ 42 U.S.C. §§ 18022(d)-(e) (2012) (outlining that exchange plans should be categorized in one of the five following groups according to their actuarial value: bronze level with 60% actuarial value, silver level with 70%, gold level with 80%, platinum level with 90%, or a catastrophic plan covering only serious medical emergencies).

⁴⁴ *See* JOST, *supra* note 40, at 26.

⁴⁵ ALAN WEIL, ADI SHAFIR & SARABETH ZEMEL, NAT’L ACADEMY FOR STATE HEALTH POLICY, *HEALTH INSURANCE EXCHANGE BASICS* 2-3 (2011).

⁴⁶ 42 U.S.C. §§ 18022(b)(1)(A-J) (2012).

⁴⁷ 42 U.S.C. § 18022(b)(2)(A) (2012). (“The Secretary [of HHS] shall ensure that the scope of the EHBs under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of

States may elect to build a fully state-based marketplace, enter into a state-federal partnership marketplace, or default to a federally-facilitated marketplace.⁴⁸ The ACA directs the Secretary of Health and Human Services (HHS) to establish and operate a federally-facilitated marketplace in any state that is not able or willing to establish a state-based exchange.⁴⁹ In 2014, the federal government provided \$1 million in funding to each state that elected to set up a state-based exchange.⁵⁰ The exchanges are expected to help reduce healthcare costs by, among other things, preventing excessive adverse selection (the disproportionate purchase of health insurance by unhealthy individuals), reducing administrative expenses, promoting competition, and enabling comparative shopping.⁵¹ The ACA prohibits insurers from rejecting applicants or requiring high premiums based on factors other than whether such plan covers an individual or family, age, geographic area, or use of tobacco.⁵² The ACA also limits cost burdens on the insured by prohibiting insurers from sharing more than a certain amount of the cost with patients,⁵³ and sets up a national

employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.”); Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Additional Information on State Essential Health Benefits Benchmark Plans*, <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html> (last visited Dec. 27, 2014).

⁴⁸ Kaiser Family Found., *Establishing Health Insurance Marketplaces: An Overview of State Efforts*, <http://kff.org/health-reform/issue-brief/establishing-health-insurance-exchanges-an-overview-of/> (last visited Dec. 31, 2014).

⁴⁹ 42 U.S.C. § 18041(c) (2012).

⁵⁰ 42 U.S.C. § 18024(a)(1) (2012); see also HHS Announces State Insurance Exchange Development Grants, HEALTH REFORM GPS, <http://www.healthreformgps.org/resources/hhs-announces-state-insurance-exchange-development-grants/> (reporting that forty-eight states had received money to start building the exchanges for 2014) (last visited Dec. 27, 2014).

⁵¹ See JOST, *supra* note 40, at v-vi.

⁵² 42 U.S.C. § 300gg(a)(1)(A) (2012); KAISER FAMILY FOUND., HEALTH INSURANCE MARKET REFORMS: RATE RESTRICTIONS 3 (2012).

⁵³ 42 U.S.C. § 18022 (2012). Effective January 1, 2014, the ACA created an EHBs package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law Health Savings Account (HSA) limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan. The ACA requires all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small

high-risk pool for those with pre-existing medical conditions.⁵⁴ The exchanges can also control costs by reducing waste and fraud.⁵⁵

The United States spends nearly \$360 billion per year on administrative costs, accounting for fourteen percent of healthcare spending.⁵⁶ The ACA will help simplify administrative systems for all payers and providers by requiring uniform standards and operating rules for electronic transactions between health insurance plans and providers, which will curb administrative spending.⁵⁷ Currently, one of the primary reasons that administrative costs are excessive is that each provider negotiates payment rates with multiple insurers.⁵⁸

While the ACA mandates minimum quality and cost-control mechanisms, it also gives states significant flexibility. There are many ways that states can reduce healthcare spending under the provisions of the ACA. For example, states can increase alternatives to fee-for-

group markets outside the Exchanges, except grandfathered individual and employer-sponsored plans, to offer at least the EHBs package. KAISER FAMILY FOUND., *supra* note 24, at 6.

⁵⁴ 42 U.S.C. § 18001(a) (2012). The ACA establishes a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Premiums for the pool will be established as if for a standard population and not for a population with a higher health risk. Premiums may vary by age (by a 4 to 1 ratio), geographic area and family composition. Maximum cost-sharing will be limited to the current law HSA limit (\$5,950/individual and \$11,900/family in 2010). The ACA appropriates \$5 billion to finance the program. KAISER FAMILY FOUND., *supra* note 24, at 6.

⁵⁵ 42 U.S.C. § 18001(f)(2) (2012) (authorizing the Secretary of HHS to create procedures to protect against waste, fraud, and abuse in high-risk pool context). Similar provisions mandating care to be taken in guarding against waste and fraud appear throughout the ACA. The ACA will reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. The ACA will allow for the development of a database to capture and share data across federal and state programs, and increase penalties for submitting false claims, strengthen standards for community mental health centers, and increase funding for anti-fraud activities. KAISER FAMILY FOUND., *supra* note 24, at 9.

⁵⁶ Emanuel Ezekiel et al. *A Systemic Approach to Containing Healthcare Spending*, 348 NEW ENG. J. MED. 949, 951 (2012).

⁵⁷ 42 U.S.C. §§ 1320(d), (d-2) (2012).

⁵⁸ Ezekiel, *supra* note 56, at 949.

service payments,⁵⁹ and enroll more patients into Accountable Care Organizations (ACOs)⁶⁰ and Patient-Centered Medical Homes (PCMHs).⁶¹ If the exchanges engage in active purchasing, they can leverage their bargaining power to secure the best premium rates and promote reforms in payment and delivery systems.⁶² Also, increasing cost transparency would allow consumers to plan ahead and choose lower-cost providers, which may lead to lower prices due to increased competition.⁶³

While these creative solutions under the ACA will likely curb healthcare spending, the largest impact that the ACA may have on state innovation will be through § 1332, the Waiver for State Innovation.⁶⁴ Beginning in 2017, the § 1332 waiver will allow states to opt out of many of the ACA's provisions, and to implement an alternative system of their own.⁶⁵ Recognizing that states are

⁵⁹ A fee-for-service payment system encourages wasteful use of high-cost tests and procedures. Instead of paying a fee for each service, payers could pay a fixed amount to physicians and hospitals for a bundle of services (bundled payments) or for all the care that a patient needs (global payments). *Id.* at 950.

⁶⁰ An ACO is a network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending. Jenny Gold, *FAQ On ACOs: Accountable Care Organizations, Explained*, KAISER HEALTH NEWS (April 16, 2014), <http://kaiserhealthnews.org/news/aco-accountable-care-organization-faq/>.

⁶¹ A PCMH is a team-based healthcare delivery model led by a physician that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes, improving access to healthcare, increasing satisfaction with care, and improving health. It is a partnership between the patient, family, and primary provider in cooperation with specialists and support from the community. The patient/family is the focal point of this model, and the medical home is built around this center. Joint principles that define a PCMH have been established through the cohesive efforts of the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), American College of Physicians (ACP), and American Osteopathic Association (AOA). U.S. Department of Health and Human Services (HHS), Agency for Healthcare Research and Quality, PCMH Resource Center, *Defining the PCMH*, <http://pcmh.ahrq.gov/page/patient-centered-care> (last visited March 5, 2015).

⁶² Ezekiel, *supra* note 56, at 951.

⁶³ *Id.* at 951-52.

⁶⁴ 42 U.S.C. § 18052 (2012).

⁶⁵ *Id.*

historically more innovative than the federal government, the ACA was drafted to use the states as incubators of change.⁶⁶

III. OPTING OUT OF THE ACA: THE § 1332 WAIVER

A state seeking a § 1332 waiver must file an application with the Secretary of HHS. The state must propose an alternative system that meets the following criteria. The state plan must (1) provide coverage that is at least as comprehensive as the ACA,⁶⁷ (2) be at least as affordable as the ACA,⁶⁸ (3) provide coverage to at least a comparable number of its residents as the ACA,⁶⁹ and (4) be budget-neutral and not increase the Federal deficit.⁷⁰

A state seeking the § 1332 waiver must enact legislation that authorizes its waiver application, hold public hearings, and provide for a meaningful notice and comment period.⁷¹ The § 1332 waiver will

⁶⁶ See Press Release, The White House, Office Of The Press Sec’y, Fact Sheet: The Affordable Care Act: Supporting Innovation, Empowering States (Feb. 28, 2011), <http://www.whitehouse.gov/the-press-office/2011/02/28/fact-sheet-affordable-care-act-supporting-innovation-empowering-states>.

⁶⁷ 42 U.S.C. § 18052(b)(1)(A) (2012) (“provide coverage that is at least as comprehensive as the coverage defined in section 18022(b) of this title [the EHBs] and offered through Exchanges established under this title..”); JESSICA SCHUBEL & SARAH LUECK, CENTER OF BUDGET AND POLICY PRIORITIES, UNDERSTANDING THE AFFORDABLE CARE ACT’S STATE INNOVATION (“1332”) WAIVERS 3-4 (2015) (While coverage must be at least as comprehensive as the EHBs, a state may waive the specific EHB requirements. The authors conclude that additional federal guidance is needed to fully establish whether certain other ACA requirements and standards lie within or outside the scope of § 1332 waivers).

⁶⁸ 42 U.S.C. § 18052(b)(1)(B) (2012) (“provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide”); *see also* § 18022(c)(3) (explaining that “the term ‘cost-sharing’ includes deductibles, coinsurance, copayments, or similar charges; and any other expenditure required of an insured individual which is a qualified medical expense”).

⁶⁹ 42 U.S.C. § 18052(b)(1)(C) (2012) (“provide coverage to at least a comparable number of its residents as the provisions of this title would provide”).

⁷⁰ 42 U.S.C. § 18052(a)(1)(B)(ii) (2012) (“application shall...contain...a 10-year budget plan for such plan that is budget neutral for the Federal Government”); 42 U.S.C. § 18052(b)(1)(D) (2012) (the plan “will not increase the Federal deficit”).

⁷¹ 31 C.F.R. § 33.100 (a)(1) (2012).

also give states the same premium tax credits that they would have received if they had an exchange.⁷²

At a minimum, state waiver plans must meet the four criteria listed above. However, it is important to note that there are specific provisions in the ACA that are not subject to the § 1332 waiver and therefore cannot be waived.⁷³ Examples of these provisions that are not subject to the § 1332 waiver include the ACA's ban on coverage limits in most plans, the requirement to cover certain preventive procedures at no charge to enrollees, or the requirement to cover dependents up to age twenty-six.⁷⁴ Also, a state cannot use a § 1332 waiver to eliminate an array of ACA provisions that bar discrimination against people based on pre-existing conditions, disability status, race, age, or gender.⁷⁵

A. Potential State Innovations Under § 1332

The § 1332 waiver will give states tremendous flexibility. For example, states could use the waiver to create a public option.⁷⁶ The public option creates a state healthcare plan that competes with private insurers, enabling states to experiment with a Medicare-like option within the existing exchanges.⁷⁷ Individuals and small businesses would be able to buy these plans, just as they would purchase a healthcare plan from a private insurance company.⁷⁸ Some federal lawmakers pushed for this in 2008 and 2009, during the discussions surrounding the ACA.⁷⁹ However, this solution does not directly

⁷² 42 U.S.C. § 18052 (a)(3) (2012).

⁷³ SCHUBEL, *supra* note 67, at 3-4.

⁷⁴ *Id.*

⁷⁵ *Id.* at 4.

⁷⁶ A public option is intended to cover those who do not have health insurance, and it is designed to compete with private insurers. The public option that was discussed in 2008-2009 during the debates surrounding the ACA was proposed as an alternative health insurance plan offered by the government. *See* Dan Balz & Jon Cohen, Most support public option for health insurance, poll finds, WASH. POST, Oct. 20, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/10/19/AR2009101902451.html?sid=ST2009101902502>; JOHN SHEILS & RANDY HAUGHT, THE LEWIN GROUP, THE COST AND COVERAGE IMPACTS OF A PUBLIC PLAN: ALTERNATIVE DESIGN OPTIONS 1-2 (2009).

⁷⁷ SHEILS, *supra* note 76, at 1-2.

⁷⁸ *Id.*

⁷⁹ John E. McDonough, *Wyden's Waiver: State Innovation on Steroids*, 39 J. HEALTH POL. POL'Y & L. 1099, 1108 (2014).

address people with employer-based health insurance.⁸⁰ Since approximately forty-eight percent of the U.S. population is insured through their employer, the public option would exclude a large portion of the population from the healthcare reform innovation.⁸¹

In the U.S. in 2013, approximately six percent of the population had private health insurance that was not employer-based.⁸² It is possible that a state level reform under § 1332 could focus on this population, but the effect on overall costs would be minimal. If a state were to experiment with the public option and include both the non-employer-based insureds and Medicaid recipients, approximately twenty-two percent of the population could participate in the innovation.⁸³ However, in order to reduce healthcare costs significantly, meaningful state reform needs to address a much larger proportion of the population.

The most aggressive and comprehensive alternative to combat high healthcare costs is “single-payer” health insurance. A single-payer system generally refers to a healthcare system where a government agent or its designated entity (“single entity”) provides health insurance funded with tax dollars and covers all residents with the same benefit coverage.⁸⁴ This single entity collects healthcare fees and pays all healthcare costs, but is not involved in the delivery of healthcare services.⁸⁵ There is one insurance fund that provides benefits to consumers and pays providers under uniform mechanisms

⁸⁰ Initially, a public option would be available to individuals and the self-employed. It is not intended to include people with employer-based insurance. However, it is possible to implement a public option that is available to all. It is also possible that, over time, a public option could be so successful that it could crowd private insurers out of the market. *See* SHEILS, *supra* note 76, at 2; ROBERT E. MOFFIT, THE HERITAGE FOUNDATION, OBAMACARE AND THE HIDDEN PUBLIC OPTION: CROWDING OUT PRIVATE COVERAGE (2011).

⁸¹ Health Insurance Coverage, *supra* note 6.

⁸² *Id.*

⁸³ *Id.* (The 22% estimation is derived from combining the 6% of non-employer-based insureds with the 16% of Americans who receive Medicaid.)

⁸⁴ *See* Hsiao, *supra* note 10, at 1232.

⁸⁵ *What is Single Payer?*, PHYSICIANS FOR A NAT’L HEALTH PROGRAM (Feb. 9, 2015, 9:45 AM), <http://www.pnhp.org/facts/what-is-single-payer>; *see also* WILLIAM C. HSIAO, STEVEN KAPPEL & JONATHAN GRUBER, ACT 128 HEALTH SYSTEM REFORM DESIGN: ACHIEVING AFFORDABLE UNIVERSAL HEALTHCARE IN VERMONT 10 (Feb. 17, 2011).

and rates.⁸⁶ Single-payer systems contrast with our current multiple-payer system (governments, employers, and individuals), with variable payments and benefits packages.⁸⁷

There are other models of healthcare systems that incorporate many of these features. A single-payer system is defined as a health insurance system that provides insurance coverage to every resident with a standard benefit package.⁸⁸ Most commonly, a single-payer system unifies both the mechanisms (e.g. a “payment pipe”) by which services are paid for, and the actual payment amounts.⁸⁹ However, a “single pipe” is possible even when there are multiple payers and payment rates, and all providers send claims to a centralized processing center despite the existence of multiple insurance funds.⁹⁰ Various combinations of these features are used throughout the world.⁹¹

Single-payer insurance is distinct from “socialized medicine.” Socialized medicine, such as Britain’s National Health Service, or the U.S. Veterans Administration system, is a healthcare system in which the government owns and operates healthcare facilities and employs the healthcare professionals.⁹² In a single-payer system, the payment

⁸⁶ Hsiao, *supra* note 10, at 1232.

⁸⁷ *Id.*

⁸⁸ HSIAO, *supra* note 85, at 35.

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ For example, in both Germany and Japan, all providers send claims to a centralized processing center despite the existence of multiple insurance funds. In these countries there is also a uniform rate schedule, but it is also possible to have a single pipe for paying providers with multiple benefit packages and multiple rate schedules negotiated between different payers and provider groups. The authors modeled two types of single-payers systems. The first is a single pipe system, similar to that of Germany and Japan, in which different insurance plans channel all of their claim payments through one central organization. This can be seen in what they define as the Public Option, Option 2. The authors also modeled a more traditional system for Options 1 and 3, where there is just one insurance fund, and all payments, including those of Medicare, Medicaid and Worker’s Compensation medical claims, are paid using the same rates, payment methods and claim payment adjudication rules. *Id.*

⁹² Uwe E. Reinhardt, *Where ‘Socialized Medicine’ Has a U.S. Foothold*, ECONOMIX BLOGS N.Y. TIMES (Aug. 3, 2012, 6:00 AM), <http://economix.blogs.nytimes.com/2012/08/03/where-socialized-medicine-has-a-u-s-foothold/?ref=business>.

and delivery systems are separate, and providers are not government employees.⁹³ The term “single-payer” describes the funding mechanism and does not specify the type of delivery, or for whom doctors work.⁹⁴ Medicare is an example of a mostly single-payer system, as is France’s healthcare system; both of these systems have private insurers to choose from, but the government is the dominant purchaser.⁹⁵

Several states are considering applying for the § 1332 waiver and implementing a single-payer system; however, Vermont has made the most progress in establishing the first state-level single-payer system in the nation.⁹⁶ In 2010, Vermont’s Legislature commissioned a team of experts to produce a report on the viability of a single-payer system.⁹⁷ In that report, the authors estimated that after ten years, the single-payer system would reduce healthcare spending by 25.3 percent compared to what spending would be without reform.⁹⁸ The sources of savings include the following: administrative expenses (7.3%), reduced fraud and abuse (5%), payment reform and integration of delivery systems (10%), malpractice reform (2%), and governance and administration (1%).⁹⁹ In 2011, Vermont’s legislature passed Act 128 that established Green Mountain Care, which is a state-funded-and-managed insurance pool that would provide near-universal coverage to residents with the expectation that it would reduce healthcare spending.¹⁰⁰ Thus, Act 128 functionally established the first state-level single-payer healthcare system in the United States.¹⁰¹

⁹³ See *id.*; Ezra Klein, *Health Reform for Beginners: The Difference Between Socialized Medicine, Single-Payer Healthcare, and What We’ll Be Getting*, WASH. POST (June 9, 2009, 11:09 AM), http://voices.washingtonpost.com/ezraklein/2009/06/health_reform_for_beginners_th_1.html; HSIAO, *supra* note 85, at 35-36.

⁹⁴ See Klein, *supra* note 93; see HSIAO, *supra* note 85, at 35-36.

⁹⁵ See Klein, *supra* note 93.

⁹⁶ Kimberly Min, *Waiver For State Innovation: A Call For Increased Success Or A Projected Failure?*, 26 HEALTH LAWYER 32, 34-35 (2013).

⁹⁷ Hsiao, *supra* note 10, at 1232-33.

⁹⁸ *Id.* at 1236.

⁹⁹ *Id.*

¹⁰⁰ VT. STAT. ANN. tit. 18, § 9371 (2011).

¹⁰¹ *Id.*; PRIMARY CARE DEVELOPMENT CORPORATION, COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY STATE PROFILES: VERMONT VT-2 (2014). (“In 2011, the Vermont state government enacted a law functionally

However, on December 17, 2014, Governor Shumlin announced that he was abandoning Vermont's single-payer plan because the costs were too high.¹⁰² The Governor stated that the cost of the single-payer plan turned out to be "enormous", requiring an 11.5 percent payroll tax on all Vermont businesses and a public premium assessment of up to 9.5 percent of individual Vermonters' income.¹⁰³ However, these numbers are actually less than the 12.8 to 18.2 percent payroll taxes estimated by the authors in the 2011 report.¹⁰⁴ Businesses did make it clear to Shumlin that they did not want to pay for the single-payer plan while maintaining their own employee health plans.¹⁰⁵ Large companies, particularly the self-insured, threatened to leave the state rather than pay the payroll tax.¹⁰⁶ Although Vermont's current effort to establish a single-payer system failed, the lessons learned through their

establishing the first state-level single-payer health care system in the United States. Green Mountain Care creates a system in the state designed to provide universal health care coverage. The legislation will not be fully implemented until 2017, and up to that point, Vermont will continue with provisions of the Affordable Care Act."); see Jessica Marcy, *Vermont Edges Toward Single Payer Health Care*, KAISER HEALTH NEWS (October 2, 2011), <http://kaiserhealthnews.org/news/vermont-single-payer-health-care/> ("Starting now, Vermont begins building a single-payer health system that will move many state residents into a publicly financed insurance program and pay hospitals, doctors and other providers a set fee to care for patients. Proposed by the governor and passed by the Democratic-controlled legislature, the new program will replace the traditional insurance plans currently used in the state and the traditional fee-for-service reimbursements, giving the state a system different from its 49 counterparts and more like its neighbor to the north, Canada... It will be a unique endeavor; no other state has tried such a dramatic restructuring of its health care system, and national lawmakers backed away from such an option in the health care overhaul debate after vehement opposition from conservatives").

¹⁰² Sarah Wheaton, *Vermont bails on single-payer healthcare*, POLITICO (Dec. 17, 2014, 6:18 PM), <http://www.politico.com/story/2014/12/vermont-peter-shumlin-single-payer-health-care-113653.html#ixzz3N7bAZ71x>.

¹⁰³ Neal P. Goswami, *Shumlin scraps single payer plans*, RUTLAND HERALD (Dec. 18, 2014), available at <http://www.rutlandherald.com/article/20141218/NEWS03/712189953/1001/NEWS>; see STATE OF VERMONT AGENCY OF ADMINISTRATION, GREEN MOUNTAIN CARE: A COMPREHENSIVE MODEL FOR BUILDING VERMONT'S UNIVERSAL HEALTH CARE SYSTEM (2014).

¹⁰⁴ HSIAO, *supra* note 85, at xviii.

¹⁰⁵ Wheaton, *supra* note 102.

¹⁰⁶ Peter Hirschfeld, *Large Employers Grow Wary Of Single-Payer Plan*, VT. PUB. RADIO (Dec. 10, 2014), <http://digital.vpr.net/post/large-employers-grow-wary-single-payer-plan>.

efforts may provide useful information for other states considering a § 1332 waiver.

IV. LEGAL ISSUES: ERISA AND THE § 1332 WAIVER

Several federal laws could hinder state innovation under the § 1332 waiver. Medicare, which represents a major federal payer, and Medicaid, which is a federal-state partnership, are both potential roadblocks to major state innovations like a single-payer system.¹⁰⁷ However, the Centers for Medicare and Medicaid Services (CMS) promulgated regulations in 2012 that provide for a coordinated waiver process for all federal health laws in the jurisdiction of CMS, HHS and the Department of the Treasury (“Treasury”).¹⁰⁸ This includes waivers associated with Title XVIII (Medicare), Title XIX (Medicaid), and Title XXI (CHIP).¹⁰⁹ Section 1332 does not provide for laws outside of the jurisdiction of CMS, HHS, and the Treasury to be waived.¹¹⁰ One of the federal laws that falls outside of the coordinated waiver process is ERISA,¹¹¹ which is likely to be a significant barrier for states seeking the § 1332 waiver.

A. ERISA Overview

ERISA regulates most of the non-wage benefits that employers provide to employees, from retirement savings to welfare benefits, including health insurance.¹¹² ERISA is extremely relevant to healthcare law and policy because approximately half of the U.S.

¹⁰⁷ See Centers for Medicare & Medicaid Services (CMS), *Medicaid.gov, Federal Policy Guidance*, <http://medicaid.gov/federal-policy-guidance/federal-policy-guidance.html> (last visited April 12, 2015); see Centers for Medicare & Medicaid Services (CMS), *History*, <https://www.cms.gov/About-CMS/Agency-Information/History/index.html?redirect=/history/> (last visited April 12, 2015).

¹⁰⁸ 42 U.S.C. § 18052 (5) (2012); Waiver for State Innovation, 77 Fed. Reg. 11700, 11701 (Feb. 27, 2012) (codified at 31 C.F.R. § 33 & 45 C.F.R. § 155 (2012)).

¹⁰⁹ *Id.*

¹¹⁰ 42 U.S.C. § 18052 (c)(2) (2012); Waiver for State Innovation, 77 Fed. Reg. 11700, 11702 (Feb. 27, 2012) (codified at 31 C.F.R. § 33 & 45 C.F.R. § 155 (2012)) (The promulgated regulations provide for a coordinated waiver process only for all federal health laws in the jurisdiction of CMS, HHS and the Treasury. No Federal laws or requirements may be waived that are not within the Secretaries’ authority.).

¹¹¹ ERISA, 88 Stat. 829.

¹¹² See 29 U.S.C. §§ 1002, 1003 (2012).

population (forty-eight percent) had employer-provided health insurance coverage in 2014.¹¹³ Most importantly, ERISA preempts state laws purporting to regulate employee benefits.¹¹⁴ This section gives an overview of ERISA and relevant case law, and then discusses the effect the law has had on healthcare reform.

The federal government enacted ERISA in 1974 to help protect employees' pension plans against default.¹¹⁵ With ERISA, Congress aimed to safeguard "participants in employee benefit plans and their beneficiaries, by . . . establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and . . . access to the Federal courts."¹¹⁶ Pensions were the focus of the law at the time of ERISA's enactment, but ERISA also addresses welfare plans, which include employer-provided healthcare plans.¹¹⁷ The goals of ERISA were to protect employee benefit plan participants by federalizing the regulation of plan administration and reducing potentially conflicting

¹¹³ Health Insurance Coverage, *supra* note 6.

¹¹⁴ *Shaw*, 463 U.S. at 106; ERISA § 514(a), 29 U.S.C. § 1144(a) (2012).

¹¹⁵ 29 U.S.C. § 1001(a)-(c) (2012). ("The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is [*sic*] increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest. . .that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.").

¹¹⁶ 29 U.S.C. § 1001(b) (2012).

¹¹⁷ 29 U.S.C. § 1002(1) (2012).

state laws, and to simplify the process for large companies trying to administer benefit plans in multiple states.¹¹⁸

Because of ERISA, the regulation of employee benefit plans, including health plans, falls primarily under federal jurisdiction for about 131 million people.¹¹⁹ A health benefit plan is covered by ERISA only if it is “established or maintained by an employer or by an employee organization.”¹²⁰ ERISA’s definition of what constitutes an employee benefit plan is broad. Employee welfare benefit plans subject to ERISA’s provisions are defined as any plan or fund intended to provide “medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.”¹²¹

1. ERISA’s Preemption and Savings Clauses

Under the Supremacy Clause of the U.S. Constitution, a state law is “preempted” and unenforceable when it is inconsistent with a federal law.¹²² Section 514(a) states that ERISA supersedes any state laws “related to” an ERISA plan and may preempt a state law “if it has a connection with or reference to [an ERISA] plan.”¹²³ This phrase is commonly referred to as ERISA’s “preemption clause.” The preemption clause encourages employers to sponsor employee benefit plans and allows employer-sponsored benefit plans to operate independently of potentially differing state laws.¹²⁴ ERISA even preempts state laws that are consistent with the ERISA requirements

¹¹⁸ See 29 U.S.C. § 1144(a) (2012).

¹¹⁹ Hinda Ripps Chaikind, *ERISA Regulation of Health Plans: Fact Sheet*, CONG. RESEARCH SERV., 1 (March 6, 2003), available at <http://www.allhealth.org/briefingmaterials/erisaregulationofhealthplans-114.pdf>.

¹²⁰ 29 U.S.C. § 1002(1) (2012).

¹²¹ 29 U.S.C. § 1002(1)(A) (2012).

¹²² BLACK’S LAW DICTIONARY 1578 (9th ed. 2009); see U.S. CONST. Art. VI, cl. 2.

¹²³ ERISA § 514(a), 29 U.S.C. § 1144(a) (2012); see *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 129 (1992).

¹²⁴ *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). (“Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government.”).

because ERISA is meant to be the sole comprehensive regulation of employee benefits.¹²⁵

However, there are a significant number of plans that ERISA does not regulate. ERISA regulates only private employer benefit plans, not government plans, church plans, or those purchased by individuals.¹²⁶ Public health insurance programs, which are programs administered by or through public agencies, are also not within ERISA's scope because they are not provided or administered by an employer.¹²⁷

Section 514(b)(2) contains ERISA's "savings" and "deemer" clauses.¹²⁸ ERISA contains provisions that save for the states the general authority to regulate insurance ("savings clause"), but also dictates that states cannot claim that employer-sponsored plans are insurance plans solely for the purpose of regulating them ("deemer clause").¹²⁹ ERISA preemption is limited by an exception permitting states to enforce general insurance, banking, or securities regulation against employee benefit plans.¹³⁰ Pursuant to the McCarran-Ferguson Act of 1945, states retain the authority to regulate "the business of insurance."¹³¹ This authority appears to give states leeway to regulate the conduct of health insurance companies, but not to be involved with businesses' choices in purchasing products from those health insurance companies.¹³²

¹²⁵ N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995). (The Supreme Court limited this potentially expansive preemption of state law by noting that courts must presume that ERISA is not intended to supplant police powers unless explicitly stated.)

¹²⁶ 29 U.S.C. § 1003 (2012).

¹²⁷ 29 U.S.C. § 1003(b)(1) (2012), *citing* 29 U.S.C. § 1002(32) (2012).

¹²⁸ ERISA § 514(b)(2)(A) (2012), 29 U.S.C. §§ 1144(b)(2)(A)(B) (2012); *see* Edward Alburo Morrissey, *Deem and Deemer: ERISA Preemption Under the Deemer Clause As Applied to Employer Health Care Plans with Stop-Loss Insurance*, 23 J. LEGIS. 307, 308-10 (1997).

¹²⁹ ERISA § 514(b)(2)(A) (2012), 29 U.S.C. §§ 1144(b)(2)(A)(B) (2012); *see* Morrissey, *supra* note 128, at 308-10.

¹³⁰ 29 U.S.C. § 1144(b)(2)(A) (2012).

¹³¹ 15 U.S.C. § 1011 (2012).

¹³² PATRICIA A. BUTLER, ROBERT WOOD JOHNSON FOUND.'S STATE COVERAGE INITIATIVES AND THE NAT'L ACAD. FOR STATE HEALTH POLICY, INCLUDING EMPLOYER FINANCING IN STATE HEALTH REFORM INITIATIVES: IMPLICATIONS OF RECENT COURT DECISIONS 1,4 (2009).

States do not have the power to enforce laws regulating insurance against self-insured health benefit plans, a subset of ERISA plans where the employer bears the risk of higher costs.¹³³

ERISA is the only regulator for self-insured plans, whereas both ERISA and state insurance laws govern plans that are purchased by a third-party.¹³⁴ When ERISA was enacted, only about seven percent of covered workers were in self-insured plans; by 2011, approximately fifty-eight percent of workers under ERISA's jurisdiction were covered by self-insured plans, and therefore were beyond the reach of state insurance regulators.¹³⁵ This means that employer-provided health plans are potentially covered by ERISA and state insurance regulation, while self-insured plans are subject only to ERISA.

B. Judicial Interpretation of ERISA

Court decisions largely define the limitations of ERISA's preemption and savings clauses. The Supreme Court has held that it would not presume that Congress intended ERISA to preempt laws in areas of traditional state authority.¹³⁶ In so holding, the Court reasoned that in passing § 514(a), Congress intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law.¹³⁷ The goals of the legislation were to minimize the administrative and financial burdens of complying with conflicting directives among States or between States and the Federal Government, and to prevent the potential for conflict in substantive law requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.¹³⁸ The basic thrust of the preemption clause was to avoid a multiplicity of regulation in order to permit the nationally uniform

¹³³ J. R. Gabel, *Job-Based Health Insurance, 1977-1998: The Accidental System Under Scrutiny*, HEALTH AFFAIRS 62, 70 (1999).

¹³⁴ HSIAO, *supra* note 85, at 8.

¹³⁵ Gabel, *supra* note 133, at 70; Employee Benefit Research Institute, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size*, http://www.ebri.org/publications/notes/index.cfm?fa=notesDisp&content_id=5131 (last visited April 12, 2015).

¹³⁶ *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-55 (1995).

¹³⁷ *Id.* at 656 (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)).

¹³⁸ *See id.*

administration of employee benefit plans.¹³⁹ Currently, the Court uses a two-part test for ERISA preemption: a state law will be preempted if it (1) “refers” to an ERISA plan, or (2) “relates to” an ERISA plan by substantially affecting its benefits, administration or structure.¹⁴⁰

1. “Reference to” an Employee Benefit plan

State laws are preempted by ERISA if the law has a “reference to” an employee benefit plan.¹⁴¹ Where a state’s law acts immediately and exclusively upon ERISA plans, or where the existence of ERISA plans is essential to the law’s operation, that “reference” will result in preemption.¹⁴²

In *Mackey v. Lanier Collection Agency & Service, Inc.*, the Court held that a state law “references” an employee benefit plan if it singles out that plan for different treatment.¹⁴³ The Court stated that an “employee benefit plan or program subject to the provisions of [ERISA] . . . shall not be subject to the process of garnishment . . . unless such garnishment is based upon a judgment for alimony or for child support.”¹⁴⁴ The law at issue here applied only to ERISA plans and had an immediate effect on such plans, and as a result, it was held preempted on the grounds that it contained an impermissible reference to an ERISA plan.¹⁴⁵

The Court has also found a “reference to” an ERISA plan where the existence of ERISA plans are essential to a law’s operation.¹⁴⁶ There are two Supreme Court cases that have interpreted the “essential to the operation” standard. In *District of Columbia (D.C.) v. Greater Wash. Bd. of Trade*, the existence of ERISA plans was held to be “essential to the operation” because the D.C. law required that benefits for injured employees be set by reference to the terms of existing

¹³⁹ *Shaw v. Delta Airlines*, 463 U.S. 85, 98-100 (1983) (reviewing the legislative history of ERISA’s preemption provision).

¹⁴⁰ BUTLER, *supra* note 132, at 4.

¹⁴¹ *Shaw*, 463 U.S. at 96-97.

¹⁴² *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997).

¹⁴³ *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 829-30 (1988).

¹⁴⁴ *Id.* at 828 n.2 (quoting Ga. Code Ann. § 18-4-22.1 (1982)) (repealed 1990).

¹⁴⁵ *Id.* at 829-30.

¹⁴⁶ E.g., *Dillingham*, 519 U.S. at 325.

ERISA plans.¹⁴⁷ Here, the law under review provided that “any employer who provides health insurance coverage for an employee shall provide health insurance coverage equivalent to the existing health insurance coverage of the employee while the employee receives or is eligible to receive workers’ compensation benefits under this chapter.”¹⁴⁸ In *Ingersoll-Rand Co. v. McClendon*, the state law at issue provided employees with a wrongful discharge claim specifically when an employer’s desire to avoid making contributions to a pension plan is the principal reason for the employee’s termination.¹⁴⁹ Under this state law, the existence of an ERISA pension plan was necessary to establish a cause of action, and therefore essential to the law’s operation.¹⁵⁰

2. “Relates to” an Employee Benefit plan

The Court first articulated a broad understanding of the phrase “relates to” in § 514(a) and its preemptive effect in *Shaw v. Delta Air Lines, Inc.*¹⁵¹ The New York statutes in question aimed to establish certain rights regarding employees’ healthcare.¹⁵² New York’s “Human Rights Law”, which prohibited employers from structuring their employee benefit plans in a manner that discriminated on the basis of pregnancy, and New York’s Disability Benefits Law, which required employers to pay employees specific benefits, clearly “related to” benefit plans.¹⁵³ The Court held that ERISA § 514(a) invalidated the New York state statutes requiring employers to pay pregnancy-related disability benefits on the grounds that such a statute “. . . ‘relate[s] to’ an employee benefit plan . . . if it has a connection with or reference to such a plan.”¹⁵⁴

¹⁴⁷ 506 U.S. at 130-31.

¹⁴⁸ *Id.* at 128 (referring to D.C. Code Ann. § 36-307(a-1)(1) (Supp.1992).

¹⁴⁹ *Id.* at 140.

¹⁵⁰ *Id.*

¹⁵¹ *Shaw v. Delta Airlines*, 463 U.S. 85, 96-97 (1983).

¹⁵² The laws at issue were the state’s Human Rights Law, which forbade discrimination in employment, and the state’s Disability Benefits Law, which required payment by employers of sick-leave benefits for employees who could not work because of non-occupational disabilities. *Id.* at 88.

¹⁵³ *Id.* at 96-97.

¹⁵⁴ *Id.* at 96-97, 108.

In 1995, the Supreme Court narrowed the reach of ERISA's preemption clause by limiting the types of state laws it considers preemptive.¹⁵⁵ In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, the Supreme Court upheld a New York law imposing a hospital surcharge on all commercial insurers except Blue Cross.¹⁵⁶ The Court held that ERISA did not preempt New York's hospital rate-setting law, even though the legislation imposed some costs on ERISA health plans.¹⁵⁷ The Court reasoned that the law would not compel plan administrators to structure benefits in a particular way or limit their ability to design uniform interstate benefit plans.¹⁵⁸ The Court noted that "... cost uniformity was almost certainly not an object of preemption."¹⁵⁹ Here, the surcharge was not sufficiently connected to ERISA plans so as to "bind plan administrators to any particular choice," so it would not trigger ERISA's preemption clause.¹⁶⁰ Although this was not the case with the New York law under review, the Court also recognized that a state law might impose cost burdens so "exorbitant" that they removed any real choice and therefore could be preempted.¹⁶¹

The *Travelers* Court concluded that state laws that "mandate[] employee benefit structures or their administration" are preempted under § 514(a) as relating to ERISA-regulated benefit plans.¹⁶² A state law need not explicitly mandate employee benefit structures to be preempted by § 514(a). *Travelers* indicates that a state law is preempted by ERISA if that law "produce[s] such acute, albeit indirect, economic effects . . . as to force an ERISA plan to adopt a certain scheme of substantive coverage."¹⁶³ However, the twenty-four percent hospital surcharge in this case was not sufficiently high enough to create an ERISA preemption to the law.¹⁶⁴

¹⁵⁵ BUTLER, *supra* note 132, at 4.

¹⁵⁶ See *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 645, 668 (1995).

¹⁵⁷ *Id.* at 647.

¹⁵⁸ *Id.* at 659-60.

¹⁵⁹ *Id.* at 662.

¹⁶⁰ *Id.* at 659.

¹⁶¹ *Id.* at 664.

¹⁶² *Id.* at 658.

¹⁶³ *Id.* at 668.

¹⁶⁴ *Id.*

The Circuit Courts of Appeal are not uniform in their interpretations of ERISA. In *Retail Industry Leaders Association v. Fielder (RILA)*, the Court of Appeals for the Fourth Circuit struck down a Maryland law requiring Walmart's employer-sponsored healthcare plan to increase contributions and spend at least eight percent of its payroll on employee's health insurance costs, or pay the state that amount.¹⁶⁵ The court held that the state law violated ERISA because it left Walmart no real choice but to restructure its employer-sponsored healthcare plan, either by increasing contributions or by paying that money to the state.¹⁶⁶ Those choices are not "...meaningful alternatives by which an employer can increase its healthcare spending to comply with the [law] without affecting its ERISA plan."¹⁶⁷ The court held that because the statute would effectively have forced employers to restructure their employee health insurance plans, it conflicts with ERISA's goal of permitting uniform nationwide administration of these plans.¹⁶⁸

However, in *Golden Gate Restaurant Association v. City and County of San Francisco*, the Court of Appeals for the Ninth Circuit upheld a San Francisco ordinance requiring employers to make health expenditures on behalf of their employees, or make payments to the city.¹⁶⁹ In this case, the court relied on the Supreme Court's holding in *Travelers* to hold that the ordinance's influence on the employer's decision was "entirely permissible."¹⁷⁰ The court concluded that the ordinance offered San Francisco employers a realistic alternative to altering their ERISA plans.¹⁷¹ Therefore, the spending requirements "do not establish an ERISA plan, nor do they have an impermissible 'connection with' employers' ERISA plans or make an impermissible 'reference to' such plans."¹⁷² The court held that the city's ordinance does not act on ERISA plans because it involves only employer

¹⁶⁵ *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180, 200 (4th Cir. 2007) (hereafter "RILA").

¹⁶⁶ *Id.* at 197.

¹⁶⁷ *Id.* at 196.

¹⁶⁸ *Id.* at 183.

¹⁶⁹ *Golden Gate Restaurant Association v. City and County of San Francisco*, 546 F.3d 639, 660 (9th Cir. 2009).

¹⁷⁰ *Id.* at 656.

¹⁷¹ *Id.* at 660.

¹⁷² *Id.* at 661 (internal quotation marks added by the author).

spending and not benefits or plan administration.¹⁷³ These two Circuit Court of Appeals decisions leave some uncertainty about how the lower courts will interpret state laws under ERISA.¹⁷⁴

V. POTENTIAL ISSUES FOR § 1332 WAIVERS UNDER ERISA

Currently, ERISA is not at issue with the ACA's reforms because preemption does not apply to federal laws.¹⁷⁵ However, concerns about ERISA preemption have resurfaced as states begin to consider the § 1332 waiver application process. The Department of Labor (DOL) and the Treasury share ERISA jurisdiction; the latter oversees the tax administration part of the law, while DOL oversees the fiduciary aspects of the law.¹⁷⁶ In response to public comments requesting clarification of the interaction between ERISA and § 1332, the Secretaries of CMS, HHS, and DOL responded that while the Secretaries have "broad discretion to determine the scope of a waiver, no Federal laws or requirements may be waived that are not within the Secretaries' authority."¹⁷⁷ Thus, unlike Medicare and Medicaid, ERISA is not part of this coordinated waiver process. Without a waiver provision, state laws are likely to come into conflict with ERISA and the enforceability of their new laws will be subject to judicial interpretation.

A. How the Courts May Interpret New State Laws' Under § 1332 & ERISA

Since no court has considered state laws enacted under § 1332, it is not possible to predict precisely how a court would view such a challenge. The inconsistency in the Circuit Court rulings makes it difficult to assess how much latitude a state has under ERISA.¹⁷⁸ Any

¹⁷³ *Id.* at 660-61.

¹⁷⁴ RILA, 475 F.3d 180, 197 (4th Cir. 2007); *Golden Gate*, 546 F.3d at 660.

¹⁷⁵ ERISA § 514(a), 29 U.S.C. § 1144(a) (2012).

¹⁷⁶ PATRICK PURCELL & JENNIFER STAMAN, CONG. RESEARCH SERV., RL 34443, SUMMARY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA), http://assets.opencrs.com/rpts/RL34443_20080410.pdf CRS- 2 (April 10, 2008) (providing ERISA's historical and legislative background and a summary of employee benefit plans it covers).

¹⁷⁷ 42 U.S.C. § 18052 (2012); 77 Fed. Reg. 11700, 11711 (2012) (Feb. 27, 2012) (codified at 31 C.F.R. § 33 & 45 C.F.R. § 155 (2012)).

¹⁷⁸ See generally ERISA Preemption Primer, (Dec. 2011), available at http://www.nashp.org/sites/default/files/ERISA_Primer.pdf.

alternative state system risks ERISA preemption if it “refers to” or “relates to” an employer-based healthcare plan.¹⁷⁹ Given that each state would have its own healthcare reform strategies, ERISA would likely preempt any state law on grounds that it limits employers’ ability to design uniform interstate benefit plans.¹⁸⁰ National uniformity of benefit plans is a key purpose of ERISA, and disruption of that raises significant preemption concerns.¹⁸¹

As outlined in Part IV, in order to comply with the requirements of § 1332, states must propose an alternative system that meets the following criteria. The state plan must: 1) provide coverage that is at least as comprehensive as the ACA;¹⁸² 2) be at least as affordable as the ACA;¹⁸³ 3) provide coverage to at least a comparable number of its residents as the ACA;¹⁸⁴ and 4) be budget-neutral and not increase the Federal deficit.¹⁸⁵

In a hypothetical single-payer system, there are at least three potential preemption areas for § 1332 under ERISA: (1) mandated benefits via minimum coverage requirements; (2) coercion (“pay or play”) through payroll taxes; and (3) changes in benefit plan administration.

¹⁷⁹ ERISA § 514(a), 29 U.S.C. § 1144(a) (2012); *Shaw v. Delta Airlines*, 463 U.S. 85, 96-97 (1983).

¹⁸⁰ *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659-660 (1995).

¹⁸¹ *Shaw*, 463 U.S. at 99.

¹⁸² § 18052(b)(1)(A) (2012) (“provide coverage that is at least as comprehensive as the coverage defined in section 18022(b) of this title and offered through Exchanges established under this title”).

¹⁸³ § 18052(b)(1)(B) (2012) (“provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide”); *see also* § 18022(c)(3) (defining that “the term ‘cost-sharing’ includes deductibles, coinsurance, copayments, or similar charges; and any other expenditure required of an insured individual which is a qualified medical expense”).

¹⁸⁴ § 18052(b)(1)(C) (2012) (“provide coverage to at least a comparable number of its residents as the provisions of this title would provide”).

¹⁸⁵ 42 U.S.C. § 18052(a)(1)(B)(ii) (2012) (“application shall...contain...a 10-year budget plan for such plan that is budget neutral for the Federal Government”); 42 U.S.C. § 18052(b)(1)(D) (2012) (the plan “will not increase the Federal deficit”).

1. “Comprehensive” Benefit Plans, e.g. Minimum Benefits Packages

Under the § 1332 waiver, a state must provide coverage at least as comprehensive as is offered under the ACA.¹⁸⁶ As a result, states will need statutory mandates to ensure that insurers offer a minimum level of health benefits.¹⁸⁷ This type of provision will likely both “refer to” and “relate to” an ERISA plan. Under *Travelers*, state laws cannot specifically mention ERISA plans, and cannot influence benefits, administration, or structure under an ERISA plan.¹⁸⁸ The minimum coverage requirements will clearly influence benefits. As the concurring judges in *Egelhoff v. Egelhoff* summarized, “we look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans.”¹⁸⁹ Benefit-mandating statutes have consistently been held preempted under this test.¹⁹⁰

States could argue that they are permitted to regulate benefits through ERISA’s “savings clause.” *Travelers* does indicate that “general healthcare regulation” survives ERISA preemption.¹⁹¹ The *Travelers* Court cited two examples of general healthcare regulations that survive ERISA preemption: hospital “[q]uality control and workplace regulation.”¹⁹² However, since it is unlikely that a benefit mandate law could survive judicial scrutiny as either a quality control

¹⁸⁶ See note 67 and sources within.

¹⁸⁷ See 42 U.S.C. §18052(a)(1)(B)(i) (2012) (“A State may apply to the Secretary. . . [with a] comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver. . . .”); § 18052 (b)(1)(A) (2012) (HHS may grant a request for a waiver only if the Secretary “determines that the State plan will provide coverage that is at least as comprehensive as the coverage defined in section 18022 (b) of this title [EHBs] and offered through Exchanges established under this title.”).

¹⁸⁸ See *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995).

¹⁸⁹ *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (Scalia, J. and Ginsburg, J., concurring).

¹⁹⁰ *Shaw v. Delta Airlines*, 463 U.S. 85, 100 (1993) (holding that a state law was preempted given the “the plain language of § 514(a), the structure of the Act, and its legislative history”).

¹⁹¹ *Travelers*, 514 U.S. at 658.

¹⁹² *Id.* at 661.

measure or workplace regulation, the law will likely be preempted by ERISA.

2. Coercion (“Pay Or Play”) Through a Payroll Tax

In order to create a single-payer system, states would need to institute a payroll or income tax to pay for it. The Vermont plan incorporated a payroll tax as the preferred means to raise revenue to pay for a single-payer system.¹⁹³ A payroll tax can raise ERISA preemption problems because such taxes create incentives for employers who are sponsoring health coverage plans to terminate or modify their plans.¹⁹⁴

The amount of payroll tax that would be required to fund a single-payer system is not known, but the Hsiao report estimated it would be approximately 12.8 to 18.2 percent.¹⁹⁵ The Court in *Travelers* recognized that a state law might impose cost burdens so “exorbitant” that they removed any real choice and therefore could be preempted.¹⁹⁶ A 12.8 to 18.2 percent tax is significant and a court would likely find this “exorbitant”¹⁹⁷ under *Travelers*. Under *RILA*, the Court found that the eight percent payroll tax in that case left employers with a lack of “meaningful alternatives by which an employer can increase its healthcare spending to comply with the [law] without affecting its ERISA plan.”¹⁹⁸ A law that compels plan administrators to structure their benefits in a particular way, especially by forgoing their ERISA plans, would be preempted under *Travelers*.¹⁹⁹ This restructuring of

¹⁹³ The most equitable form of healthcare financing is household income tax. Under our progressive income tax system, wealthier individuals pay a larger share of their income in taxes than less wealthy individuals. Using the overall income tax base to finance healthcare keeps the progressive nature of the income tax system intact. However, employers currently benefit from a tax deduction for health premium payments, and this tax benefit would be lost under an household income tax-based system. Therefore, the authors recommend the implementation of a payroll contribution instead because in terms of equity, a payroll contribution is far superior to the current health insurance premiums. HSIAO, *supra* note 85, at 94.

¹⁹⁴ *Id.* at 10.

¹⁹⁵ *Id.* at viii.

¹⁹⁶ *Travelers*, 514 U.S. at 664.

¹⁹⁷ *See id.*

¹⁹⁸ *RILA*, 475 F.3d at 196.

¹⁹⁹ *Travelers*, 514 U.S. at 659-60.

employee plans also directly conflicts with ERISA's goal of permitting uniform nationwide administration of these plans."²⁰⁰

States could defend this approach with several credible arguments. For example, both taxation and healthcare financing are exercises of traditional state authority that a court should not presume Congress intended to preempt under § 514(b).²⁰¹ It could be argued that such a state law would not be directed at employer health plan administration, since employers would be free to provide coverage to employees even if they also were paying the tax. A payroll tax would involve no employer role other than remitting the funds.²⁰² Furthermore, the incidence of a payroll tax on employers actually falls on employees so its economic impacts are similar to those of an individual income tax.²⁰³ Despite these arguments, a payroll tax high enough to fund a single-payer system would likely be so "exorbitant"²⁰⁴ that a court would find the state law preempted by ERISA.

3. Changes In Plan Administration, e.g. "Single Pipe," Rate-Setting

State innovations under the § 1332 waiver will likely impact plan administration. For example, creating a single payment pipe is an essential feature of a single-payer plan since it reduces administrative waste.²⁰⁵ There are also healthcare reform models that propose a private-public system that leaves much of the health insurance system intact, but aim to save money through a uniform claims administration process.²⁰⁶ Requiring an ERISA plan to be administered in a specific way or through a single processor would likely violate ERISA.²⁰⁷ Under *Mackey*, a state law "references" an ERISA plan if it had an immediate effect on such plans by changing how the plan is administered.²⁰⁸ Any state law that prescribes a new payment

²⁰⁰ *Id.* at 656.

²⁰¹ *Id.* at 654-55.

²⁰² HSIAO, *supra* note 85, at 10.

²⁰³ *Id.*

²⁰⁴ *See Travelers*, 514 U.S. at 664.

²⁰⁵ *See supra* Part III(A).

²⁰⁶ HSIAO, *supra* note 85, at xii.

²⁰⁷ *Id.* at 11.

²⁰⁸ *Mackey v. Lanier Collection Agency and Service Inc.*, 486 U.S. 825, 830 (1988).

methodology would necessarily “refer”²⁰⁹ to an ERISA plan. Under the expansive *Shaw* reading of § 514(a) and its “relate to” clause, this type of statutory mandate is preempted by ERISA because the mandate both “refers to” and has a “connection with” employers’ ERISA-regulated plans for providing medical care.²¹⁰ A state could argue that this is a traditional state regulation under 514(b), but again, as in Part V(A)(1) above, under *Travelers*, it is unlikely that a benefit mandate law could survive judicial scrutiny as either a quality control measure or workplace regulation.²¹¹

Another change to plan administration would be through rate-setting. Having a uniform set of mechanisms and rates is typical of a single-payer system, and one of the greatest areas for cost savings.²¹² The rate-setting aspect of a single-payer system is likely to pass legal muster. Under *Travelers*, ERISA would not preempt a state rate-setting program that established rates for all providers, including hospitals, physicians and other providers, as long as it dictates what providers must charge rather than what payers must pay.²¹³ Both insured and self-insured ERISA plans would pay those rates under the reasoning in *Travelers*.²¹⁴

In sum, a state law that enacts a single-payer system under a § 1332 waiver will likely be preempted in at least three ways by ERISA. The law(s) would be preempted through (1) mandated benefits via minimum coverage requirements, (2) coercion (“pay or play”) through payroll taxes, and (3) changes in benefit plan administration.²¹⁵

VI. SOLUTIONS

As described in Part V, it is likely that ERISA will pose a legal roadblock to the enactment of successful state innovation waivers. ERISA preemption concerns may prevent states from experimenting

²⁰⁹ *Id.*

²¹⁰ *See Shaw v. Delta Airlines*, 463 U.S. 85, 97 (1983).

²¹¹ *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 660-61 (1995).

²¹² HSIAO, *supra* note 85, at 10.

²¹³ *See id.* at 12.

²¹⁴ *Id.*

²¹⁵ *See supra* Part V.

with health reforms since states may fear expensive litigation. There are several solutions to ERISA preemption that may improve the odds of success for a § 1332 waiver. Congress could amend or repeal ERISA,²¹⁶ or allow for ERISA to be part of the coordinated waiver process.²¹⁷ Another solution would be an executive order that would address the waiver provision that prevents the Secretary of HHS from waiving any law not in HHS's jurisdiction.²¹⁸

Since ERISA's original enactment, Congress has made changes to ERISA to remedy certain types of design limitations in employer-sponsored plans. In the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, Congress required group health plans to provide continuation coverage.²¹⁹ COBRA requires that group health plans offered by firms with twenty or more employees allow plan participants and beneficiaries to elect to continue their coverage under group health plans when they experience a qualifying event (e.g., worker's death, unemployment, divorce, attainment of Medicare eligibility) that otherwise would result in loss of coverage.²²⁰

Similarly, Congress modified ERISA with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which restricts the use of preexisting condition exclusions and limitations in the group market and creates certain coverage portability rights.²²¹ HIPAA also prohibits ERISA group health plans and health insurance issuers from discriminating against any individual in eligibility for coverage, enrollment, or premiums based on health-related factors, including: health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability on the part of

²¹⁶ See Christen Young, *Pay or Play Programs and ERISA Section 514: Proposals for Amending the Statutory Scheme*, 10 YALE J. HEALTH POL'Y L. & ETHICS 197 (2010) (describing in detail multiple proposals for amending ERISA).

²¹⁷ 42 U.S.C. § 18052 (5) (2012); Waiver for State Innovation, 77 Fed. Reg. 11700, 11701 (Feb. 27, 2012) (codified at 31 C.F.R. § 33 & 45 C.F.R. § 155 (2012)).

²¹⁸ 42 U.S.C. § 18052 (c)(2) (2012); 77 Fed. Reg. 11700, 11702 (Feb. 27, 2012) (codified at 31 C.F.R. § 33 & 45 C.F.R. § 155 (2012)).

²¹⁹ Public Law No. 99-272 was enacted on April 7, 1986. The COBRA continuation rules were generally applicable to group health plans for plan years beginning on or after July 1, 1986, but this effective date was delayed for certain collectively bargained plans.

²²⁰ ERISA §§ 601-08; 29 U.S.C. §§ 1161-68 (2012).

²²¹ ERISA §§ 701-07; 29 U.S.C. §§ 1181-83 (2012).

enrollees or their dependents.²²² Additionally, Congress has adopted a modest range of benefit mandates applicable to ERISA group health plans, including limited coverage of vaccines for children, a minimum length of stay for maternity coverage on newborn children, limited parity in mental health benefits, and certain medical and reconstructive benefits for participants who have undergone mastectomies.²²³

These mandates all occurred at the federal level, but Congress could amend § 514(a) to allow states to adopt legislation that would allow for innovations that include employer-provided health insurance plans. Legislation could specifically state that health reforms under § 1332 will not be preempted by ERISA. However, there would likely be significant opposition to ERISA amendment or waivers. If preemption supporters saw a real threat to the provision, they would undoubtedly lobby against it.²²⁴

As mentioned in Part IV, the § 1332 waiver prevents CMS, HHS, and the Treasury from waiving any law that is not in its jurisdiction.²²⁵ One possibility to circumvent this limitation in authority would be an executive order that allows for CMS, HHS, the Treasury, and DOL to work jointly to issue a waiver provision. The President could issue an order that would allow for a state to get a waiver under the ACA that would include a limited waiver from ERISA. Another solution is to

²²² ERISA § 702(b)(2), 29 U.S.C. § 1182(b)(2) (2012).

²²³ 29 U.S.C. §§ 1169(a) (2)-(4) (2012); 29 U.S.C. § 1185 (2012); ERISA § 712, 29 U.S.C. § 1185(a) (2012); ERISA § 713, 29 U.S.C. § 1185(b) (2012).

²²⁴ Soon after the ACA was enacted, the Department of Labor drafted a proposed regulation that would provide definitions of “employee welfare benefit plan” and “welfare plan,” but in such a way as possibly “to exempt from ERISA preemption State and local government health plans that included non-governmental employees.” The ERISA Industry Committee lobbied hard against this change, which did not take effect. *See, e.g.*, ERIC URGES WITHDRAWAL OF DRAFT PROPOSED REGULATION THAT WOULD CURTAIL ERISA PREEMPTION, ERISA INDUS. COMM. (Apr. 29, 2010), <http://www.eric.org/forms/documents/DocumentFormPublic/view?id=22C9B0000000F> (last visited Dec. 28, 2014); U.S. DEPARTMENT OF LABOR, DOL WITHDRAWS PROPOSED RULE ON DEFINITION OF WELFARE BENEFIT PLAN (July 30, 2010), <http://www.dol.gov/opa/media/press/ebsa/EBSA20101080.htm> (last visited Dec. 28, 2014); ERIC PLEASED WITH DOL WITHDRAWAL OF PROPOSED REGULATION THAT WOULD HAVE CURTAILED ERISA PREEMPTION, ERISA INDUS. COMM. (Aug. 2, 2010), <http://www.eric.org/forms/documents/DocumentFormPublic/view?id=22C9B0000000F> (last visited Dec. 28, 2014).

²²⁵ *See* 42 U.S.C. § 18052 (c)(2) (2012); 77 Fed. Reg. 11700, 11702 (Feb. 27, 2012) (codified at 31 C.F.R. § 33 & 45 C.F.R. § 155 (2012)).

permit states to apply for a specific ERISA waiver. Congress could pave the way for states to file an application with DOL as a part of the § 1332 coordinated waiver process.

VII. CONCLUSION

It is difficult to envision significant state experimentation with health reform that is not vulnerable to ERISA preemption. ERISA preemption concerns will not prevent states from experimenting with insurance regulation or with healthcare reforms outside of the employment context. However, as long as states cannot include members of the population with employer-based health insurance, they cannot optimize innovations under the ACA.

Pursuant to § 514(a) and the controlling case law, a single-payer system and many other creative state level innovations under § 1332 appear threatened by ERISA preemption. Particular areas of concern include the ACA's requirements that states must provide minimum benefits packages, the coercive nature of a potential payroll tax and the necessary changes in plan administration.²²⁶ These requirements are likely to "refer to" or "relate to" an ERISA plan, and therefore will be preempted.²²⁷ States may argue that they are operating in an area of traditional regulatory authority, but judicial precedent is not in their favor.²²⁸ Even if a state could successfully make this argument, those covered by employer-sponsored self-insured plans would most certainly remain out of reach to state innovations. Without changes to ERISA, or to the waiver process, § 1332 State Innovation Waivers will be limited to health reforms that exclude the majority of the population. Unless Congress or the President act, the ACA will fail in its goal to fully engage the states as "laboratories of experiment"²²⁹ in the area of healthcare.

²²⁶ See *supra* Part V.

²²⁷ BUTLER, *supra* note 132, at 4.

²²⁸ N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 659-60 (1995).

²²⁹ New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).