



ARTICLES

Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured

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INTRODUCTION

The old joke about governmental responses to serious social ills goes something like this: What do the people in charge do when they must appear to be taking action while they wish to avoid actually doing anything? They establish a committee to investigate the problem. And if it's a really big problem, one that is in urgent need of a solution, they establish two committees. In real life, of course, the problems of the uninsured are no joke. Which is undoubtedly why there are at this moment three federal committees investigating the problem of providing access to health care for the uninsured,¹ why many state level commissions

¹ The three committees are the Pepper Commission (officially, the U.S. Bipartisan Commission on Comprehensive Health Care, currently chaired by Senator Jay Rockefeller (D-WV)), the Advisory Council on Social Security (chaired by Deborah Steelman), and the Domestic Policy Council (led by Dr. Louis Sullivan, Secretary of Health and Human Services). The Pepper Commission has already released its report and recommendations, which were immediately labeled DOA by influential members of Congress. See Greenberg, *Pepper Rebuffed*, 335 THE LANCET 649, 649-50 (1990). The other committees were scheduled to release their reports and recommendations in the Fall of 1990. See generally *infra* notes 312-14.

As one commentator has noted, 1990 is 'the year of the commissions.'

are engaged in the same enterprise,² and why scholars and policy analysts too numerous to count have lent their weighty expertise to the task.³ The problems facing our health care system are stark and widely known. It is as though many of us have correctly, articulately, and forcefully observed that the emperor has no clothes. Some have called for the tailor, others have submitted their own designs, but the embarrassing problem remains.

In short form, the system's numerous problems can be reduced to two: cost and access. Americans spend more on health care per capita than any other country in the world. Further, health care spending by private and public entities has been increasing at an alarming rate. Yet, health care expenditures in the United States obscure serious access and distribution problems that prevent many from benefiting from health care. For some, access to health care is made possible through public or private insurance programs. But almost one-fifth of the population remains without health insurance coverage. As many or more have inadequate insurance coverage that does not protect against the cost of catastrophic illness.

From a policy perspective, the problem is how to provide health care for the uninsured or underinsured in a complex and competitive economic environment characterized by an unwillingness to commit either state or federal funds to new social programs. National health insurance — meaning a radical restructuring of the health care system that would incorporate public funding — is politically unlikely.⁴ Policy initiatives will have to be shaped carefully to conform to interest group politics and fiscal constraints at the state and national level.

Frieden, 1990: *New Directions for Congress*, BUS. & HEALTH, Mar. 1990, at 54, 54 (quoting Chip Kahn, a professional staff member for the minority on the House Ways and Means health subcommittee). William Roper, President Bush's director of the White House Office of Policy Development, has dismissed the need for additional national commissions, noting that political will was in shorter supply than ideas. Roper, *Financing Health Care: A View From The White House*, HEALTH AFFS., Winter 1989, at 97, 101.

² See *infra* text accompanying notes 287-91.

³ As a short and random list of recent offerings, meaning to slight no one by inclusion or exclusion, see, e.g., Enthoven & Kronick, *A Consumer-Choice Health Plan for the 1990s* (pts. 1 & 2), 320 NEW ENG. J. MED. 29, 94 (1989); Himmelstein & Woolhandler, *A National Health Program for the United States*, 320 NEW ENG. J. MED. 102 (1989); Reinhardt, *Work Toward a Fail-Safe Health Insurance System*, 2 GENERATIONAL J., Apr. 1989, at 43.

⁴ See *infra* text accompanying notes 292-93.

From a legal perspective, the problem is also related to federalism. Federal preemption under the Employee Retirement Income Security Act⁵ (ERISA) presents a difficult hurdle for those attempting to craft state level solutions to the problems of the uninsured. Even when state initiatives to improve access manage to lift themselves over the ERISA bar, the results may be problematic. Lightening a state level solution can eviscerate its effective impact. Molding a state access plan to avoid ERISA preemption can result in conflicted policies that promise to self destruct before effective results are achieved. All of this is made all the more frustrating because no comprehensive federal action has occupied the field that federal preemption has so assiduously cleared.

This Article's contribution to the ongoing debate is an analysis of ERISA preemption and its effect on state level solutions to the problems of the uninsured. The scope of the health care system's cost and access problems will be discussed in Section I. In Section II, the appropriate role of federal and state governments will be examined from the standpoint of both law and policy. Of particular interest will be the perverse obstacles to health care access created by ERISA, which preempts many state attempts to regulate employee health plans. Alternative state level solutions for the uninsured will be discussed in Section III. The innovative (and arguably doomed) approaches taken by Massachusetts⁶ and Washington⁷ will be compared. Finally, in Section IV, the Article concludes that specific federal statutory action is required, either through amendment of ERISA or adoption of a comprehensive federal access plan.⁸

The health care system in the United States is plagued with serious distributional inequalities that prevent some from securing access to health care, and thus from securing access to health. Despite widespread public dissatisfaction with the current system,⁹ politicians have rejected a radical restructuring of the

⁵ 29 U.S.C. §§ 1001-1461 (1988).

⁶ MASS. GEN. LAWS ANN. ch. 118F (West Supp. 1990).

⁷ WASH. REV. CODE ANN. §§ 70.47.010 -.901 (West Supp. 1989).

⁸ See, e.g., Senator Kennedy's Basic Health Benefits for All Americans Act of 1989, S. 768, 101st Cong., 1st Sess., 135 CONG. REC. S 3763-75 (daily ed. Apr. 12, 1989).

⁹ In a recent survey, two-thirds of Americans sampled preferred the Canadian health care system, expressing more dissatisfaction with their current system than respondents in nine of the ten nations sampled.

health care finance and delivery system, leaving incremental improvements as the only method for reducing inequities in access. However, even incremental policy approaches are stymied at the state level by ERISA preemption, which may preclude effective financing mechanisms, and by states' fears that redistributive policies will lead to business migration. I therefore conclude that a comprehensive federal solution presents the greatest potential for positive change. In the alternative, I argue for the creation of an ERISA waiver for state-level programs designed to improve access for the uninsured.

I. RISING COSTS AND RESTRICTED ACCESS

With advances in medical knowledge and technique, good health has been inexorably linked to access to health care.¹⁰ The linkage is not precise: health is difficult to define and access to medical care does not guarantee its attainment.¹¹ Greater health care expenditures may not guarantee greater health. Despite these caveats, access to health care is strongly related to good health.

Improving access to health care requires an understanding of the distribution of health care expenditures and the prevalent methods of financing health care. The distribution of health care expenditures reveals inequities in the current distribution of care. Identifying the current payers of these health care costs can point

Blendon, Leitman, Morrison & Donelan, *Satisfaction with Health Systems in Ten Nations*, HEALTH AFFS., Summer 1990, at 185, 186-88. While support for radical change is widespread, it is also thin and confused. Surveyed Americans are not willing to bear more than modest tax increases to achieve a new system. Blendon & Donelan, *Special Report: The Public and the Emerging Debate Over National Health Insurance*, 323 NEW ENG. J. MED. 208, 210 (1990). Nor were they sure what the new system should look like, 46% preferring a universal public plan and 33% supporting a mixed private-and-public plan. *Id.*

¹⁰ Before these advances, "health care was of little value in the treatment of most illnesses." PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, 1 SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES 13 (1983) [hereafter PRESIDENT'S COMMISSION, SECURING ACCESS].

¹¹ See, e.g., *Ethical Essentials of a National Health Program*, 11 J. PUB. HEALTH POL'Y 5, 5-6 (1990) (noting that equity in access is not equivalent of equity in health); Freedman & Baylis, *Purpose and Function in Government-Funded Health Coverage*, 12 J. HEALTH POL. POL'Y & L. 97 (1987) (discussing possible definitions of "health").

the way to policies to improve access. Health care payments, for example, are almost always made by some form of insurance, whether public or private. Those without health insurance are often denied access to health care.

A. Expenditures

Health care expenditures in the United States have dramatically increased over the last twenty years, both in absolute and relative terms. In 1988, health care spending in the United States reached \$539.9 billion, representing an average expenditure of \$2,124 for each person.¹² Health expenditures doubled as a percentage of GNP from 1960 to 1988.¹³ The impact of these enormous expenditures has been dulled, however, by financing mechanisms that are diverse and diffused among government payers, private health insurance companies, employers, and individuals.

Private sources paid over half of the total health expenditures in 1988.¹⁴ Health insurance payments are strongly linked to employment, with eighty-one percent of those with insurance "obtain[ing] coverage through an employer-sponsored health plan."¹⁵ Public funding accounted for a little over forty percent of the spending, with the federal government taking two-thirds and state or local government picking up the remaining one-third.¹⁶

¹² Levit, Freeland, & Waldo, *National Health Care Spending Trends: 1988*, HEALTH AFFS., Summer 1990, at 171, 171-73. In 1985 spending was \$1800/person, compared with \$1300/person in Canada, \$800/person in Japan, and \$600/person in Britain. Rovner, *The Coming Dilemma: Access, Quality, Cost* 46 CONG. Q. 2505, 2505 (1988).

¹³ Levit, Freeland & Waldo, *supra* note 12, at 173 (Exhibit 2). The percentage of GNP devoted to health care expenditures increased from 5.3% in 1960 to 7.3% in 1970, 9.1% in 1980 and 11.1% in 1988. *Id.* The escalating rate of expenditures is related to increases in both the prices and the quantity of care provided. Fuchs, *The Health Sector's Share of the Gross National Product*, 247 SCIENCE 534 (1990). Uwe Reinhardt, a leading health care economist, has wryly noted that, if current trends continue, in 81.5 years the entire GNP will be devoted to health care. Reinhardt, *Could Health Care Swallow Us All?*, BUS. & HEALTH, Feb. 1990, at 47, 48.

¹⁴ Levit, Freeland & Waldo, *supra* note 12, at 175 (Exhibit 4) (\$312.4 million or 57.86%). Over 92% of these private payments were made by consumers: \$113.2 million for out-of-pocket expenses and \$174.9 million for private health insurance. *Id.*

¹⁵ *Id.* at 177.

¹⁶ *Id.* at 175 (Exhibit 4). Most federal payments were made through

This significant devotion of resources to health care in an era of fiscal constraint has sparked concern for cost containment. These figures, however, also obscure the extent to which access to health care is unevenly distributed and the degree to which significant health needs among the population remain unmet. Despite the sums spent on health care, health care has not been deemed an entitlement for the entire population,¹⁷ and the web of financing mechanisms has left a significant proportion of Americans either uninsured or underinsured.

B. Access

Despite the growth of private health insurance coverage since World War II and the enactment of Medicare and Medicaid in 1965,¹⁸ thirteen to fifteen percent of Americans remain entirely without health insurance.¹⁹ In addition, another large segment of the population is underinsured with insurance coverage that is inadequate or incomplete.²⁰ There are two useful ways of analyz-

Medicare and Medicaid, entitlement programs that fund certain types of health care for the elderly and the very poor, respectively. The federal government's health care expenditures were divided between Medicare (\$91.8 million or 58.17% of the federal total), Medicaid (\$31.1 million or 19.71%) and other federal programs (at \$35 million or 22.18%). *Id.* at 175 (Exhibit 4); *see also* Rovner, *supra* note 12, at 2505. In fiscal 1987, Medicare and Medicaid expenditures totaled 11.6% of total federal spending, outstripping all other spending programs besides social security and defense. *Id.*

¹⁷ *Cf.* *Memorial Hosp. v. Maricopa County*, 415 U.S. 250 (1974) (noting that there is no constitutional right to receive nonemergency medical care); Dowell, *State and Local Government Legal Responsibilities to Provide Medical Care for the Poor*, 3 J.L. & HEALTH 1 (1988-89).

¹⁸ CONG. RESEARCH SERVICE FOR HOUSE COMM. ON EDUC. & LABOR, HOUSE COMM. ON ENERGY & COMM., AND SENATE SPECIAL COMM. ON AGING, 100TH CONG., 2D SESS., HEALTH INSURANCE AND THE UNINSURED: BACKGROUND DATA AND ANALYSIS 2 (Comm. Print 1988) [hereafter HEALTH INSURANCE BACKGROUND DATA].

¹⁹ P. SHORT, A. MONHEIT & K. BEAUREGARD, NATIONAL MEDICAL EXPENDITURE SURVEY: A PROFILE OF UNINSURED AMERICANS (Research Findings 1) 2 (Department of Health & Human Services Pub. No. (PHS) 89-3443, 1989) (15.5% of population) [hereinafter NATIONAL MEDICAL EXPENDITURE SURVEY]; Moyer, *A Revised Look at the Number of Uninsured Americans*, HEALTH AFFS., Summer 1989, at 102, 104 (31.1 million, or 12.9% of population in 1987).

²⁰ The definition of "inadequate" is, of course, subject to some debate. Compare Farley, *Who Are the Underinsured?*, 63 MILBANK MEMORIAL FUND Q. 476, 481-87 (1985) (using measures of out-of-pocket expenses) with

ing the uninsured or underinsured population: examining the characteristics of the insured and examining the characteristics of the uninsured. Both analyses suggest possible flaws in the current system of health care financing and can, in turn, suggest likely corrective policies.

About eighty-seven percent of Americans have some form of health insurance.²¹ The most striking characteristic of the insured population is the large percentage who obtain their coverage through employment. About sixty percent of the population is covered by employment-based insurance.²² In contrast, Medicaid covers less than ten percent of the population.²³

The uninsured and underinsured populations present an interesting contrast. There were about 31.1 million uninsured in 1987, almost thirteen percent of the population.²⁴ Almost as

Bovbjerg & Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857, 857, 859 & 859 n.11 (1986) (defining underinsured as those with incomplete coverage, particularly for catastrophic care).

²¹ Moyer, *supra* note 19, at 104. *But see* NATIONAL MEDICAL EXPENDITURE SURVEY, *supra* note 19, at 6 (74.5% insured). About 85.4% of the population has insurance coverage once the elderly, who are almost uniformly covered by Medicare, are excluded. Moyer, *supra* note 19, at 104. Different methods of analysis may lead to slightly different results, but the general pattern of coverage remains roughly the same. *See, e.g.*, NATIONAL MEDICAL EXPENDITURE SURVEY, *supra* note 19, at 4 (only 82.6% of non-elderly had insurance coverage in 1987).

The most recent comprehensive surveys of health insurance status measure the extent of coverage as it existed in 1987. Two different sources are available: The National Medical Expenditure Survey (NMES) and the March 1988 Current Population Survey (CPS). Moyer, *supra* note 19, at 104-05 (Exhibit 1). The data on health insurance status analyzed here represent 1987 figures unless otherwise indicated. For a comprehensive, though slightly dated, review of insurance data, see HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA (1989).

²² Moyer, *supra* note 19, at 104 (Exhibit 1). *But see* NATIONAL MEDICAL EXPENDITURE SURVEY, *supra* note 19, at 6 (estimating 64.3%). Over 70% of all those people who have health insurance acquire it through employer-sponsored plans. Moyer, *supra* note 19, at 104 (Exhibit 1). Only 14% of the population has non-employment based private insurance. *Id.*

²³ Moyer, *supra* note 19, at 104 (Exhibit 1) (8.7%).

²⁴ *Id.* The uninsured population grew by about 30% from 1979 to 1986. Eno & Haugh, *The Uninsured: Shaping a Solution*, 89 BEST'S REV., Oct. 1988, at 38 (available on LEXIS, NEXIS library, BRLIFE File). This increase may be related to state adoption of more stringent Medicaid eligibility requirements and the recession of the early 1980's. Bovbjerg & Kopit, *supra* note 20, at

many or more may be underinsured.²⁵ Income and employment are, not surprisingly, related to insurance status. Thus, almost one-third of the uninsured are in poverty and almost one-fourth have no ties to the employment market.²⁶

Yet, surprisingly, a significant proportion of the uninsured are employed, and some have relatively high incomes.²⁷ It seems, for example, that employees of small companies, service employees, and non-unionized employees are all more likely to be uninsured.²⁸ Workers without health coverage reflect employers' fail-

868-69 (noting recession and changing employment patterns). The number of uninsured may continue to increase because of structural changes in the economy, because of tax reform efforts which reduce the incentive to receive compensation in the form of health benefits, and because of the increasing cost of health insurance caused by state benefit mandates. *Id.*

²⁵ See, e.g., Bovbjerg & Kopit, *supra* note 20, at 857 (35 million people uninsured in 1984, about 40 million more with incomplete coverage); Farley, *supra* note 20, at 477 (estimating 8-26% of the insured non-elderly may be underinsured). The data for determining the extent of underinsurance is somewhat more dated than that available for analyzing the uninsured population. With this caveat, the underinsurance data can be used to illustrate the scope of the problem.

²⁶ Moyer, *supra* note 19, at 106 (Exhibit 2). Another 10% of the uninsured have incomes between 100-124% of the poverty level. *Id.*

Medicaid, the public health insurance program designed to protect the poor, actually covers less than half of those with incomes below the federal poverty level. See, e.g., J. HOLAHAN & J. COHEN, MEDICAID: THE TRADE-OFF BETWEEN COST CONTAINMENT AND ACCESS TO CARE 33-34 (1986); Davis & Rowland, *Uninsured and Underserved: Inequities in Health Care in the United States*, 61 MILBANK MEMORIAL FUND Q. 149, 155-57 (1983).

²⁷ In fact, 75% of the uninsured were employed at some point during the year, with almost 25% working full-time all year. Moyer, *supra* note 19, at 106 (Exhibit 2). This means that the number of uninsured full-time employees equalled the number of the uninsured without any employment.

²⁸ As employer size decreases, or as the percentage of workers employed at or near the minimum wage increases, employees are less likely to receive health care benefits. See *id.* at 107 (Exhibit 3); Rossiter & Taylor, *Union Effects on the Provision of Health Insurance*, 21 INDUS. REL. 167, 173 (1982). Almost one-half the employed uninsured work in companies with 24 or fewer employees. Moyer, *supra* note 19, at 107 (Exhibit 3). There is also some evidence that service workers are less likely to receive coverage. Rossiter & Taylor, *supra*, at 174. Union workers may be more likely to obtain employer-provided health insurance benefits. Davis & Rowland, *supra* note 26, at 154-55. *Contra* Rossiter & Taylor, *supra*, at 173 (presence of union not statistically related to probability that employer offers health benefits). Insurance coverage may also be difficult to obtain in some industries. With the advent of AIDS, for example, there is evidence that insurers are denying coverage to some types of businesses stereotypically

ure to provide such benefits, but they also represent employees' failure or inability to purchase individual coverage.²⁹ About one to two million of the uninsured, for example, form a special subgroup — the medically uninsurable³⁰ — who cannot obtain coverage. Increasing access to insurance for this group requires the development of unique policy initiatives.³¹ Other middle class workers without employment-based insurance have also failed to obtain individual coverage. Transaction costs and the high expense of individual insurance coverage may present barriers to coverage for these persons. Some may also have implicitly chosen to forgo health insurance, allocating income to other necessary goods.

There are therefore subgroups within the uninsured population who may be uninsured for quite different reasons. Low-income uninsured persons may be too poor to afford health insurance coverage and yet remain ineligible for publicly funded programs.³² Another segment of the population is uninsurable because of pre-existing illness. Finally, non-poor working individuals may not have health insurance if their employers do not offer it as a benefit. Policies to extend health insurance coverage must take these failures in the ties between employment and

associated with the employment of gay males. Freudenheim, *Health Insurers, to Reduce Losses, Blacklist Dozens of Occupations*, N.Y. Times, Feb. 5, 1990, at A-1, col. 1.

²⁹ Bovbjerg & Kopit, *supra* note 20, at 862.

³⁰ Laudicina, *State Health Risk Pools: Insuring the 'Uninsurable'*, HEALTH AFFS., Fall 1988, at 97, 97. Genetic screening advances may expand the ranks of the medically uninsurable by permitting identification of greater numbers of individuals at risk for development of various diseases or conditions. See, e.g., M. ROTHSTEIN, MEDICAL SCREENING AND THE EMPLOYEE HEALTH CRISIS 78-79 (1989); Thomas, *DNA Dx Invites National Insurance*, MED. WORLD NEWS, Sept. 1990, at 29.

³¹ See *infra* note 138 (discussing risk sharing pools); see also Wilensky, *Filling the Gaps in Health Insurance: Impact on Competition*, HEALTH AFFS., Summer 1988, at 133, 142-43.

³² While a large percentage of the uninsured have some contact with the employment market, a significant percentage of the uninsured would not be reached by any workplace solution. The static view of the uninsured can be compared with a dynamic analysis of changes in insured status over time for given groups. See Davis & Rowland, *supra* note 26, at 152; Montiert & Schur, *The Dynamics of Health Insurance Loss: A Tale of Two Cohorts*, 25 INQUIRY 315, 315 (1988). Dynamic analysis indicates that those who persistently remain without coverage tend to have lower incomes and less employment. *Id.* at 325.

health insurance into account.³³

Measures of the uninsured alone understate the true extent of the distribution problem in health care. They do not take into account those with inadequate health insurance, the underinsured, who represent yet another category of people with insufficient access to health care.³⁴ Although definitions of the underinsured can vary,³⁵ it would appear that an additional five to eight percent of Americans are underinsured.³⁶ As with the uninsured, the underinsured are distributed across the population, with more than half being full-time employees or their

³³ Comprehensive policy initiatives designed to improve access to health care may attempt to address one or more of these problems. However, solutions to the problems of the uninsured may differ based on an uninsured's wealth, employment status, and health. Should the program be limited to the poor, whether working or unemployed? Should it focus on the problems of employed individuals without insurance? Or, should government's role be limited to providing access to insurance markets for medically uninsurable people? These are difficult questions; unless carefully designed, government programs can lead to "free rider" problems. The presence of a governmental program, for example, may discourage individuals and businesses from obtaining coverage privately. *See also* Bovbjerg & Kopit, *supra* note 20, at 895-96, 896 n.227.

³⁴ The level of benefits provided also raises the specter of a two-tiered medical system in which the wealthy have access to a wider range of health services than the poor. Policy makers and the public are usually uneasy about establishing a "two-tier" medical system, but it may already exist as an unavoidable political reality: "insisting on single-tier medicine for all in practice means eliminating any assistance for many of the least fortunate, because currently society demonstrably will not provide unlimited funds." Bovbjerg & Kopit, *supra* note 20, at 914, 917.

States often require that insurance policies sold within a state include certain state mandated benefits. There are, at present, over 680 such mandates, requiring that insurance policies include coverage of mental health services, drugs, chiropractic, or other types of services. *Lack of Health Insurance Due to Regulations*, PR Newswire, Nov. 2, 1988 (LEXIS, NEXIS Library, PRNEWS file) (reporting on study by the National Center for Policy Analysis). Critics contend that these mandates — products of "special interests" — increase the cost of health insurance beyond the price that many consumers are willing or able to pay. *Id.* These mandates do not apply to self-insured employee benefit plans. *See infra* text accompanying notes 106-17.

³⁵ One commentator classifies an individual as underinsured when there is a significant probability that her personal health care expenditures will exceed 10% of her gross income. Farley, *supra* note 20, at 493.

³⁶ *Id.* at 493-95 (based on 1977 data). This figure rises to 18.3% if an alternate definition of underinsured is used which emphasizes lack of protection from catastrophic costs. *Id.*

dependents.³⁷

In the current system of health care delivery, failure to obtain adequate insurance can have serious effects, both physical and financial.³⁸ Studies have repeatedly indicated that lack of insurance coverage decreases or delays access to medical care from either physicians or hospitals.³⁹ In a recent survey, 300,000 families reported that a family member had been refused medical care for financial reasons.⁴⁰

Where care is provided, care givers face the problem of nonpayment. The amount of uncompensated care — traditionally defined as the total of charity care and bad debts — is another measure of the extent of the problems created by the lack of

³⁷ *Id.* at 500.

³⁸ As Davis and Rowland have noted:

Lack of insurance coverage has three major consequences: it contributes to unnecessary pain, suffering, disabilities and even death among the uninsured; it places a financial burden on those uninsured who struggle to pay burdensome medical bills; and it places a financial strain on hospitals, physicians, and other health care providers who attempt to provide care to the uninsured.

Davis & Rowland, *supra* note 26, at 170.

³⁹ See, e.g., *id.*; Braveman, Oliva, Miller, Reiter & Egerter, *Adverse Outcomes and Lack of Health Insurance Among Newborns in an Eight-County Area of California, 1982 to 1986*, 321 *NEW ENG. J. MED.* 508 (1989) (finding that lack of insurance was associated with adverse health outcomes); Freeman, Aiken, Blendon & Corey, *Uninsured Working-Age Adults: Characteristics and Consequences*, 24 *HEALTH SERVICES RES.* 811, 817-21 (1990) (uninsured have fewer doctor visits and lower rate of hospitalization than insured).

Insured individuals average 3.7 doctor visits per year, compared with an average of 2.4 for the uninsured. Davis & Rowland, *supra* note 26, at 161-62; see also *HEALTH INSURANCE BACKGROUND DATA*, *supra* note 18, at 137-42. The uninsured typically obtain less preventive care in the form of common screening tests. Woolhandler & Himmelstein, *Reverse Targeting of Preventive Care due to Lack of Health Insurance*, 259 *J. A.M.A.* 2872 (1988). These differences persist when hospital care is examined: there “[t]he insured receive 90% more hospital care than do the uninsured.” Davis & Rowland, *supra* note 26, at 162-63. The differential cannot be explained by differences in the health status between the two groups; in fact, the uninsured are generally sicker than the insured. *Id.* at 165. See also *HEALTH INSURANCE BACKGROUND DATA*, *supra* note 18, at 143-47.

⁴⁰ Dallek, *States Study Health Care for the Uninsured Poor*, 18 *CLEARINGHOUSE REV.* 740, 741 (1984). In a study conducted by the Robert Wood Johnson Foundation, 1 million people reported that they had been denied care because of inability to pay, while almost 14 million reported that they had not sought care because of inability to pay. *HEALTH INSURANCE BACKGROUND DATA*, *supra* note 18, at 135-36.

insurance.⁴¹ This measure is imperfect. It is underinclusive because it does not reflect the amount of care forgone by the uninsured.⁴² It may also overstate the cost of care because it is based on charges rather than costs and because it includes bad debts, some of which may be sums owed by financially able patients.⁴³ With these caveats, however, the level of uncompensated care remains one rough measure of the cost of providing care for the uninsured and underinsured. In 1982 uncompensated care cost medical providers \$10 billion and created additional impetus for political change.⁴⁴

⁴¹ EMPLOYEE BENEFIT RESEARCH INSTITUTE, *Employer-Provided Health Benefits: Legislative Initiatives*, 62 EBRI ISSUE BRIEF 2 (1987) [hereafter EBRI]; Lewin, Eckels & Miller, *Setting the Record Straight: The Provision of Uncompensated Care by Not-for-Profit Hospitals*, 318 NEW ENG. J. MED. 1212, 1215 (1988); Mulstein, *The Uninsured and the Financing of Uncompensated Care: Scope, Costs, and Policy Options*, 21 INQUIRY 214 (1984).

⁴² EBRI, *supra* note 41, at 2. The measure is underinclusive in two other respects. First, uncompensated care may not always be reported. Second, uncompensated care levels may not reflect the difference between cost and reimbursement, a significant factor given Medicaid's very low reimbursement levels.

⁴³ Lewin, Eckels & Miller, *supra* note 41, at 1215. Research suggests that poor patients, who are more likely to be without insurance, actually use more hospital resources (and are thus more expensive) than patients from higher socioeconomic levels. See Epstein, Stern & Weissman, *Do the Poor Cost More? A Multihospital Study of Patients' Socioeconomic Status and the Use of Hospital Resources*, 322 NEW ENG. J. MED. 1122 (1990).

⁴⁴ Bovbjerg & Kopit, *supra* note 20, at 868 (estimate based on assumption that two-thirds or three-fourths of uncompensated care occurred in hospitals). From a policy standpoint, it is also important that this care is not evenly distributed. Different types of hospitals, or hospitals in different geographic areas, may exhibit very different levels of uncompensated care. *Id.* at 866. Hospitals have traditionally paid for "free" care by cross-subsidizing: charging paying patients and insurers more for their care. Hospitals with large amounts of uncompensated care may charge higher prices that render them uncompetitive compared to those with low rates of charity care. See, e.g., *id.* at 869. Perhaps in reaction to these economic pressures, some hospitals have reduced the amount of uncompensated care provided. Dallek, *supra* note 40, at 741. At the same time, those health care providers facing large charity caseloads have exerted pressure at the state and federal level for solutions to the problems of the uninsured and underinsured. See EBRI, *supra* note 41, at 3; Bovbjerg & Kopit, *supra* note 20, at 865.

The costs of uncompensated care can be compared with the estimated costs of programs designed to improve access to care. The total cost of access initiatives varies with the level of coverage and type of benefits provided. Researchers suggest that most plans to relieve the problems of

Health expenditures in the United States are large and steadily expanding. Yet a significant percentage of the population has no health insurance coverage or, at best, inadequate coverage. The lack of adequate health insurance entails hidden costs. The uninsured or underinsured are often denied access to the health care system. Further, when they do obtain medical care, public funds or cost shifting to those who do maintain health insurance may ultimately pay for it.

The uninsured and underinsured are found nationwide. Yet the costs of uncompensated care or care forgone are most often borne at the state or local level. This is the classic dilemma of policymaking in a federal system. Here federalism issues are somewhat complicated by the Employee Retirement Income Security Act (ERISA), which preempts many state efforts to improve health care access despite the failure of the federal government to adopt any comprehensive plan of its own. The level of government that attempts to resolve problems of the uninsured may therefore be as important as the content of the policy developed.

II. FEDERALISM: ERISA AND STATE IMPOTENCE

A. Access as Federal or State Policy

Policies to provide increased access for the uninsured or underinsured could be designed at either the state or federal level. In the end, the level chosen may be a political problem that is decided by influence or default. There are, however, important reasons to examine carefully the advantages and disadvantages of both approaches. Federalism is an enduring issue given new life in the Reagan years, and it is likely to remain vital in the Bush administration.⁴⁵ While seen by some as a code word for federal

the uninsured range in price from "\$5-50 billion, with \$15-20 billion a reasonable estimate for moderate initiatives." Bovbjerg & Kopit, *supra* note 20, at 903.

⁴⁵ Federalism is "the mode of political organization that unites separate polities within an overarching political system by distributing power among general and constituent governments in a manner designed to protect the existence and autonomy of both." D. J. ELAZAR, *AMERICAN FEDERALISM: A VIEW FROM THE STATES* 2 (3d ed. 1984). It is commonplace to describe our constitutional system as a compromise between liberal and republican philosophies. Republican political philosophy emphasizes self-governance for the common good by small, relatively homogeneous groups. See Michelman, *Traces of Self-Government*, 100 HARV. L. REV. 1, 18-19 (1986);

abdication,⁴⁶ a federalist analysis can reveal important policy reasons to support either federal or state solutions to problems.

State and federal governments differ in their capacity to formulate and implement policies. The proper level of governmental action may depend on the nature of the problem to be solved. The uninsured are a national problem, but there are a disproportionate number found in some geographic regions, employment groups, and social classes. The uninsured population is heterogeneous, with most having some ties to employment but with a significant percentage at or near the poverty level. Improving access to health care for the uninsured will require some sort of redistribution, whether explicit or implicit.

Those seeking new social programs to solve national problems often look to the federal government. The federal government has enormous resources for policy development and implementation. Both the Congress and the Executive Branch have readily available technical expertise and vast administrative resources. Further, federal solutions have the advantages of centralization and economies of scale. National policies tend to be more redistributive than state policies because federal taxes are more progressive in character than state taxes. A federal policy can set and enforce national minimum standards for social programs.

There are drawbacks to a federal strategy, however. National policies often cannot be tailored to local variations, problems, and concerns. The federal government may not be politically responsive to its citizenry and may be dominated by specialized interest groups.⁴⁷ Further, political development of national poli-

Sullivan, *Rainbow Republicanism*, 97 YALE L.J. 1713, 1713 (1988). Liberal philosophy, in contrast, builds upon Lockean notions of social contract and emphasizes private rights and limited government. See M. TUSHNET, RED, WHITE, AND BLUE: A CRITICAL ANALYSIS OF CONSTITUTIONAL LAW 4-7, 9-10 (1988). Although the liberal construction of government has been strengthened over time, a significant reservoir of republican idealism still remains. See, e.g., Kennedy, *Form and Substance in Private Law Adjudication*, 89 HARV. L. REV. 1685 (1976); Michelman, *supra*, at 18.

⁴⁶ See, e.g., Maranville, *Welfare & Federalism*, 36 LOY. L. REV. 1, 41 (1990) (discussing rhetoric and politics of federalism in the context of the AFDC program); Scheiber, *Federalism and the Legal Process: Historical and Contemporary Analysis of the American System*, 14 LAW & SOC'Y REV. 663, 690 (1980).

⁴⁷ For a discussion of politics and health policy in the context of ERISA, see Fox & Schaffer, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 AM. J. TAX POL'Y 47 (1988) [hereafter Fox & Schaffer, *Semi-Preemption in ERISA*]; Fox & Schaffer, *Health Policy and ERISA: Interest Groups*

cies can be paralyzed by the sheer scope and complexity of some social ills.

State solutions to policy dilemmas have some advantages. As smaller political bodies, states hold the promise of greater responsiveness to the needs of their citizens. State level solutions may also encourage diverse and experimental approaches. If necessary, the lessons from these approaches can eventually be built upon by the federal government.⁴⁸ And, traditionally, it has been the states who have, in fact, borne the burden of providing medical care for the indigent.⁴⁹

Historically, despite these asserted advantages to state level policy initiatives, state governments have been viewed by some as less competent and capable than the federal government. In the past, many states lacked the administrative and policy expertise to develop complex social programs.⁵⁰ With the revitalization of federalism, some contend that states have dramatically improved their capacity to design, administer, and fund important social programs.⁵¹ Yet even if states' administrative and policy expertise has improved, barriers to effective state funding remain. States are notoriously reluctant to initiate redistributive policies, even to attain the benefits of a healthy citizenry.⁵² State tax struc-

and *Semipreemption*, 14 J. HEALTH POL. POL'Y. & L. 239 (1989) [hereafter Fox & Schaffer, *Health Policy*].

⁴⁸ "It is one of the happy incidents of the federal system that a single courageous State may . . . serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

⁴⁹ See, e.g., Dowell, *supra* note 17.

⁵⁰ Thompson, *New Federalism and Health Care Policy: States and the Old Questions*, 11 J. HEALTH POL. POL'Y & L. 647, 648-49 (1986). They also cannot take advantage of economies of scale. Cf. Maranville, *supra* note 46, at 31 (discussing economies of scale in welfare program).

⁵¹ See, e.g., U.S. ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS, *THE QUESTION OF STATE CAPACITY* 364 (1985).

⁵² Thompson, *supra* note 50, at 648-49. Thompson contends that state ability to tax and spend has actually decreased, although he concedes that administrative abilities have improved. *Id.* He notes that the state variation in tax capacity — the amount of tax money available to state governments at a set rate of taxation — has actually increased. *Id.* at 664-65. This indicates that state ability to fund social programs is likely to vary as well. Variations in state capabilities may be an important factor in determining whether to impose a national plan. Cf. Maranville *supra* note 46, at 42, 46-47 (discussing impact of variable state capacity to fund welfare benefits).

tures are usually not suited to redistribution, as they are generally less progressive than the federal system.

A number of interest groups broker both federal and state political solutions. Providers advocate increased coverage to decrease uncompensated care and to raise demand for their services. Program beneficiaries and their supporters naturally advocate increased access. Opposing these interests are those who, generally speaking, may be forced to pay for them. Many businesses, particularly small ones, have opposed requiring employers to provide health insurance benefits. Individuals who favor improved access in the abstract may be unwilling to pay additional taxes to fund publicly supported programs.⁵³

Business and taxpayer opposition raises a fundamental distinction between redistributive policies at the state and federal levels. States have twin fears. If a state adopts greater redistributive policies than other states, the needy may migrate to the state to take advantage of better benefits while businesses and other "payers" may leave the state for other states with lower taxes.⁵⁴ Individual states thus have little incentive to enact more redistributive policies. On the national level these constraints may be mediated, although increased labor costs could theoretically lessen the international competitiveness of U.S. businesses.⁵⁵

⁵³ See, e.g., Bergthold, *Purchasing Power: Business and Health Policy Change in Massachusetts*, 13 J. HEALTH POL. POL'Y & L. 425 (1988); Thompson, *supra* note 50, at 655-57. Somewhat less obviously, some unions may have favored increases in the minimum wage and required health benefits because these programs decrease the price differential between union and non-union labor. Health care benefits have been a hotly contested issue in recent labor strikes. See, e.g., Gorman, *Can't Afford to Get Sick*, TIME, Aug. 21, 1989, at 43.

⁵⁴ These disincentives are applications of migration theory and economic development theories. Thompson, *supra* note 50, at 648-49, 656-57; Maranville, *supra* note 46, at 33-34 (discussing impact of state competition on welfare benefits). Employment levels may decline even if businesses remain in the state because state-made products may be more expensive than out-of-state products. In reality, of course, businesses may choose to remain in states with higher taxes because of inertia, access to a suitable workforce, the availability of governmental services, or other factors. See Tannenwald, *Rating Massachusetts' Tax Competitiveness*, NEW ENG. ECON. REV. 33, 33 (1987).

⁵⁵ Odynocki, *The Unhealthy State of Employee Health Care*, BUS. & SOC'Y REV., Summer 1987, at 16, 16 (employers seek to cut benefits in face of foreign competition). Employee benefits in the United States already make up 34.6% of the hourly wage, compared with 21% in South Korea, 16.8% in

States have enacted some business-funded health care initiatives, despite fears of patient influx and business efflux. But they appear to have done so at the behest of provider interest groups rather than client groups.⁵⁶ For example, states have generally been willing to mandate the inclusion of certain benefits in health insurance policies. These mandates are advocated by health care providers. Although they arguably improve the level of care, they also increase the price, thus actually reducing access to health insurance for low-income citizens.⁵⁷

States have not been as willing to expand access to health care by adding direct public funding. The Medicaid program presents a classic example of great state variation in the extent of funding and, therefore, coverage.⁵⁸ The low level of Medicaid coverage in some states already contributes to the ranks of the uninsured. While some states have enacted dramatic access initiatives, many states are more properly viewed as part of the problem rather than the solution.⁵⁹ These states are unlikely to enact new access initiatives and, in the absence of national requirements, citizens of these states will have less access to health care.⁶⁰

The Medicaid program also illustrates another policy approach:

Japan, and 5% in Taiwan. Canner, *Mandating Health Benefits Is Bad Health and Bad Economic Policy*, 4 COMPENSATION & BENEFITS MGMT. 181, 182 (1988).

⁵⁶ See Thompson, *supra* note 50, at 661 (relatively high benefit levels associated with increased presence of certain medical providers).

⁵⁷ Bovbjerg & Kopit, *supra* note 20, at 891.

⁵⁸ See J. HOLAHAN & J. COHEN, *supra* note 26, at 16-23. To determine state commitment to redistributive health policies, Thompson studied state tax efforts devoted to health care and state Medicaid outlays. He found that state tax effort and expenditures grew more diverse from the 1970s to the 1980s, indicating that states were becoming increasingly dissimilar in their commitment to redistributive health policies. See Thompson, *supra* note 51, at 661. Ironically, "[w]ealthier states tend to spend more money per capita on Medicaid." *Id.* at 661; see also J. HOLAHAN & J. COHEN, *supra*, at 24-28.

⁵⁹ J. HOLAHAN & J. COHEN, *supra* note 26, at 38-40 (discussing variations in Medicaid coverage among states). States with unreasonably low income levels for Aid to Families with Dependant Children (AFDC), and consequently for Medicaid, help create a significant segment of the poor uninsured. "The evidence provides little support for the view that most states have taken or will take bold new strides toward assuring adequate access to health care for the poor or medically needy." Thompson, *supra* note 50, at 662.

⁶⁰ Even national requirements might not be a panacea — they could reflect fiscal conservatism more than social beneficence. Cf. Maranville, *supra* note 46, at 42 (discussing restrictive federal control of AFDC program).

combining federal and state solutions in an attempt to build upon the strengths of each. The federal government sets general "categorical" program eligibility standards and agrees to contribute to a share of expenditures made under the program to eligible recipients. States administer the program, determine which optional levels of coverage to provide, set income ceilings in some categories, and fund a portion of the program's costs. The program thus exploits national expertise and broad-based funding while permitting local administration and decision-making. Despite these theoretical advantages, however, in reality the federal-state partnership in Medicaid has resulted in inadequate coverage for the poor because many states have established unreasonably stringent eligibility requirements.⁶¹ Efforts to set minimum federal standards for coverage have run into state resistance: states contend that they cannot bear additional Medicaid costs.⁶²

⁶¹ Improvements in joint state-federal programs like Medicaid will require both federal and state action. A major flaw in the program is caused by state variations in coverage. There is no national standard of income eligibility for AFDC, and some state income requirements are exceedingly stringent. J. HOLAHAN & J. COHEN, *supra* note 26, at 5-7, 33. States that may want to expand the program have been hampered by its statutory linkage to cash awards under AFDC and by the loss of federal support where Medicaid assistance is extended to non-optional groups. *See, e.g.,* Eno & Haugh, *supra* note 24. Congress has acted to remedy some of these problems by encouraging coverage for low income pregnant women and children. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(IV) (1990).

Some, including President Bush, advocate federal legislation permitting low-income workers to "buy-in" to the Medicaid program. *See, e.g.,* EBRI, *supra* note 41, at 11, 13. These workers would pay a subsidized premium to receive Medicaid benefits. *Id.*; *see also* Eno & Haugh, *supra* note 24 (discussing Health Insurance Association of America proposal to expand Medicaid). The Medicaid program presents fascinating and important policy questions that are beyond the scope of this Article.

⁶² Many states already experience serious Medicaid funding shortfalls, often "blame[d] . . . on new federal mandates that order states to expand coverage to various groups, particularly pregnant women and children." Kimball, *Medicaid Shortfall Hits 29 States*, HEALTH WEEK, June 11, 1990, at 4, 66. The increasing costs of care and unrealistic budget projections have also played important roles. *Id.* at 66-67. States can also expect increased litigation from health care providers contending that state Medicaid reimbursement does not provide "reasonable and adequate" reimbursement. *Wilder v. Virginia Hosp. Ass'n*, 110 S.Ct. 2510 (1990) (Boren Amendment creates substantive federal right to reasonable and adequate payment under Medicaid, enforceable by health care providers

At a policy level, a federalist analysis of the problems of the uninsured favors a national solution. Health care seems essential enough to require establishment of some uniform minimum level of access. The problem is national in scope and will require the sort of redistribution that states fear because of taxpayer migration. The major drawback to a national solution is political. Glittering new access initiatives are regularly set afloat in legislative waters, only to sink as they strike out from shore.

B. ERISA: Frustrated Federalism

1. ERISA Preemption

A legal analysis of the federalist balance struck by Congress in regulating employee benefit plans provides a useful counterpoint to the policy analysis of these issues. One recent commentator has suggested that ERISA's preemption of state laws relating to benefit plans has provided a model of effective federalism.⁶³ In the context of state level efforts to improve access to health care, however, ERISA's preemption doctrine can be more accurately termed a disaster.⁶⁴ Preemption of state laws to insure uniformity

under § 1983); *see also* Pear, *Ruling Likely to Increase Strains on Medicaid*, N.Y. Times, June 15, 1990, at A11, col. 4.

⁶³ Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV. 427 (1987) [hereafter Gregory, *ERISA Preemption*]. Gregory argues that ERISA's preemption provision represents an example of positive federalism:

ERISA preemption of state employee benefit law, while extensive, has been neither absolute nor indiscriminate. Through both case law construction and subsequent enlightened legislative amendments during the past decade, the scope of ERISA preemption has been periodically recalibrated. These responsible judicial and legislative refinements have preserved ERISA's strong federal primacy in employee pension and welfare benefit law, while simultaneously allowing for dynamic and flexible state initiatives consonant with ERISA's policy of protecting and furthering employee pension and welfare benefit plans. The cumulative result yields a study in Hamiltonian federalism.

Id. at 429. Gregory's praise of ERISA preemption can probably best be understood as a contrast to his criticism of preemption under the National Labor Relations Act (NLRA). *See id.* at 434-35; Gregory, *The Labor Preemption Doctrine: Hamiltonian Renaissance or Last Hurrah?*, 27 WM. & MARY L. REV. 505 (1986).

⁶⁴ In general, commentators studying the health care aspects of ERISA preemption have been critical of broad federal preemption in the absence of

of regulation at the federal level seems justifiable. But preemption of state level solutions in the absence of federal substantive regulation seems to be but a perverse obstacle to improving access to health care for millions of the uninsured.

ERISA was enacted to set minimum standards of information disclosure and to establish fiduciary responsibilities in the establishment, operation, and administration of employee benefit plans.⁶⁵ ERISA governs two types of employee health benefit plans: pension and welfare. ERISA's application to employee

federal substantive regulation. *See, e.g.,* Bovjberg & Kopit, *supra* note 20, at 906-09; Brummond, *Federal Preemption of State Insurance Regulation under ERISA*, 62 IOWA L. REV. 57 (1976); Note, *ERISA Preemption and Indirect Regulation of Employee Welfare Plans Through State Insurance Laws*, 78 COLUM. L. REV. 1536 (1978); Comment, *Federal Preemption of State Mandated Health Insurance Programs Under ERISA—The Hawaii Prepaid Health Care Act in Perspective*, 8 ST. LOUIS U. PUB. L. REV. 339 (1989) [hereafter Comment, *Federal Preemption*]; Note, *ERISA: Supreme Court Clarifies Preemptive Effect of Section 514(a) on State Welfare Legislation: Shaw v. Delta Air Lines, Inc.*, 18 SUFFOLK U.L. REV. 723, 751-55 (1984) [hereafter Note, *Supreme Court Clarifies*]; Note, *ERISA Preemption of State Health Care Laws and Worker Well-Being*, 1981 U. ILL. L. REV. 825 (1981) [hereafter Note, *Worker Well-Being*]; Note, *ERISA's Deemer Clause and the Question of Self-Insureds: What's a State to Do?*, 67 WASH. U.L.Q. 291 (1989) (discussing *Reilly v. Blue Cross & Blue Shield United of Wis.*, 846 F.2d 416 (7th Cir. 1988)) [hereafter Note, *What's a State to Do?*]. Some scholars, however, have either favored the preemptive scope reflected in the statute and judicial decisions or have argued for even greater federal preemption. *See, e.g.,* Gregory, *ERISA Preemption*, *supra* note 63, at 474-75; Hutchinson & Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 U. CHI. L. REV. 23 (1978) (contending that ERISA's preemption clause should be interpreted broadly to achieve national uniformity); Comment, *Defining the Contours of ERISA Preemption of State Insurance Regulation: Making Employee Benefit Plan Regulation an Exclusively Federal Concern*, 42 VAND. L. REV. 607 (1989).

⁶⁵ Congressional findings and declarations of policy can be found at § 2(a) of ERISA, 29 U.S.C. § 1001 (1988). Congress was also concerned with the substantive vesting requirements and financial stability of employee benefit plans. 29 U.S.C. § 1001(a); *see also* Fox & Schaffer, *Semi-Preemption in ERISA*, *supra* note 47. This benevolent view of Congressional intent has recently been questioned by one law and economics analyst. *See* Ippolito, *A Study of the Regulatory Effect of the Employee Retirement Income Security Act*, 31 J.L. & ECON. 85 (1988). Ippolito contends that Congress could not have been concerned with the problems posed by fraudulent pensions because there was little fraud in the pension market at the time of enactment and because the statute as written was ineffective for that purpose. *Id.* at 119-20. Instead, Ippolito contends that "the regulation was enacted to benefit a small, concentrated group: union workers in dying firms." *Id.* at 120. It seems uncontested, however, that Congress was primarily concerned with

welfare plans includes plans concerned with providing various types of health insurance.⁶⁶ Although ERISA establishes reporting, disclosure, administrative, and fiduciary requirements for employee welfare benefit plans, it does not regulate the substantive content of such plans.⁶⁷ The statute neither requires that

pension plans, and that ERISA's effect on health insurance benefits was incidental, if profound.

⁶⁶ The statute provides:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits.

29 U.S.C. § 1002(1) (1988). Courts typically hold that health insurance benefits provided to employees constitute an employee welfare benefit plan. *See, e.g.*, *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988) (existence of plan is question of fact; purchase of insurance may be evidence of plan), *cert. denied*, 109 S.Ct. 3216 (1989); *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277, 280-81 (11th Cir. 1987) (holding group health insurance policies in question constituted employee benefit plan); *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc) (purchase of group insurance is substantial evidence of plan); *Rasmussen v. Metropolitan Life Ins. Co.*, 675 F.Supp. 1497, 1500-01. (W.D. La. 1987) (health benefits constitute plan). *But see* *Brady v. Empire Blue Cross/Blue Shield*, 732 F. Supp. 678 (W.D. La. 1990) (no ERISA plan where employer merely contracted with insurer to purchase health insurance coverage for employee); *Sayble v. Blue Cross*, 256 Cal. Rptr. 820 (Cal. App. 2d Dist. 1989) (ordered not published pursuant to Rule 976, Cal. Rules of Ct.) (employer's payment of employees' health insurance premiums not sufficient to establish employee welfare benefit plan). Employee welfare benefit plans can also be established or maintained by employee organizations or by both the employer and an employee organization. 29 U.S.C. § 1002(1) (1988); *see also* 29 C.F.R. § 2510.3-1 (1990). Section 1003 establishes which plans will be covered by ERISA and excepts, for example, governmental and church plans. 29 U.S.C. § 1003 (1988).

⁶⁷ Title I of ERISA has five regulatory subparts, only three of which are applicable to employee welfare plans. The first subpart establishes reporting and disclosure requirements that permit employees to effectively exercise their rights and that permit oversight by the Secretary of Labor. 29 U.S.C §§ 1021-1031 (1988); *see also* *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977) (describing structure of ERISA), *cert. denied*, 435 U.S. 980 (1978). The fourth subpart creates the fiduciary responsibilities associated with the establishment and maintenance of employee benefit plans. 29 U.S.C. §§ 1101-1114. The fifth subpart establishes administrative responsibilities and sets out criminal and civil enforcement procedures. 29 U.S.C. §§ 1131-1145; *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101

employers provide such plans nor prescribes minimum types and levels of benefits for those plans in existence.⁶⁸

Given the lack of substantive regulation, the most significant aspect of ERISA is its preemption provision which provides that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”⁶⁹ This preemption clause must be read in conjunction with its associated “savings” and “deemer” clauses. The savings clause qualifies federal preemption by permitting state statutes, even when they “relate to” employee benefit plans, if those statutes constitute traditional state regulation of insurance, banking, or securities.⁷⁰

(1989). The second and third parts of Title I refer to pension plans, and are inapplicable here. *See* 29 U.S.C. §§ 1051-1061 (participation and vesting requirements for pension funds); 29 U.S.C. §§ 1081-1086 (pension plan funding).

⁶⁸ *See, e.g.,* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 732 (1985) (ERISA “does not regulate the substantive content of welfare-benefit plans”).

⁶⁹ 29 U.S.C. § 1144(a) (1988). The exact language of section 1144(a) provides:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

Id. “State” and “state law” are further defined within section 1144:

(c) For the purposes of this section:

- (1) The term “State law” includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a state law rather than a law of the United States.
- (2) The term “State” includes a state, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

Id. § 1144(c).

⁷⁰ 29 U.S.C. § 1144(b)(2)(A) (1988). Specifically, this provision provides that:

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

The deemer clause, in turn, limits the application of the savings clause by providing that:

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts.⁷¹

The complex and somewhat opaque interaction⁷² of these three provisions has spawned extensive litigation, as employers and states struggle to define the limits of state power to regulate health insurance.⁷³

Id.

⁷¹ 29 U.S.C. § 1144(b)(2)(B) (1988). The full text of subparagraph (B), the deemer clause, provides:

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Id.

Section 1144 also exempts from preemption certain other state laws, including “generally applicable criminal law[s],” banking and securities regulation, certain qualified domestic orders, and third party liability laws under the Medicaid system. *See id.* §§ 1144 (b)(3),(4),(7),(8).

⁷² As the Supreme Court has noted:

The two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting, for while the general pre-emption clause broadly pre-empts state law, the savings clause appears broadly to preserve the States’ lawmaking power over much of the same regulation. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time.

Metropolitan Life, 471 U.S. at 739-40.

⁷³ For an interesting discussion of the political background to ERISA’s passage and application to health insurance benefits, see Fox & Schaffer, *Semi-Preemption in ERISA*, *supra* note 47. Fox and Schaffer essentially contend that Congress was primarily concerned with pension fund benefits and did not give much thought to ERISA’s application to health benefits. After preemption was established, however, various interest groups exerted sufficient power to preserve its effect in the health benefit area. *Id.*

2. The "Relate to" Requirement

The preemptive effect of federal statutes is ordinarily determined by ascertaining Congressional intent.⁷⁴ Here, Congress has explicitly preempted state statutes that "relate to" employee benefit plans.⁷⁵ ERISA's "relate to" provision is not, however, well defined. Litigants attempting to pursue state law remedies or to wear the cloak of ERISA preemption have offered widely disparate interpretations. Courts have confronted and rejected, for example, the possibility that Congress intended that ERISA preempt state laws only when they cover the same kinds of regulation as those incorporated in ERISA.⁷⁶ They have also rejected the contention that ERISA preempts only those state laws that intentionally or directly affect employee benefit plans.⁷⁷ Instead, courts have read the provision in light of Congressional intent to remove "the threat of conflicting or inconsistent State and local regulation of employee benefit plans."⁷⁸ Thus, "[a] law 'relates

⁷⁴ *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95 (1983); *see also* Sherrick, *ERISA Preemption: An Introduction*, 64 MICH. BAR J. 1074 (1985).

⁷⁵ 29 U.S.C. § 1144(a).

⁷⁶ *See, e.g.*, *Ingersoll-Rand Co. v. McClendon*, 59 U.S.L.W. 4033, 4035 (1990) (preemption not restricted to state laws affecting plan terms, conditions or administration); *Shaw*, 463 U.S. at 98 (holding ERISA cannot "be interpreted to pre-empt only state laws dealing with the subject matters covered by ERISA — reporting, disclosure, fiduciary responsibility, and the like"); *Standard Oil Co. v. Agsalud*, 633 F.2d 760, 765 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981). Justice Stevens, in a recent dissenting opinion, has revived the argument, suggesting that the preemption provision "should apply only to those state laws that purport to regulate the subjects regulated by ERISA or that are inconsistent with ERISA's central purposes." *FMC Corp. v. Holliday*, 59 U.S.L.W. 4009, 4013 (1990) (Stevens, J., dissenting).

⁷⁷ State laws may be preempted even if they were not "specifically designed to affect employee benefit plans." *Shaw*, 463 U.S. at 98. Similarly, state laws having only an indirect economic impact on an employee benefit plan may be said to "relate to" the plan. *See, e.g.*, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (benefit mandate law relates to employee benefit plans because employers who purchase insurance coverage will have greater costs); *Northern Group Servs., Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 87-88 (6th Cir. 1987) (state coordination-of-benefits statute relates to employee benefit plan), *cert. denied sub nom. Northern Group Servs., Inc. v. State Farm Mut. Auto. Ins. Co.*, 486 U.S. 1017 (1988); *General Motors Corp. v. Caldwell*, 647 F. Supp. 585, 587-88 (N.D. Ga. 1986) (state act prohibiting discount prescription arrangement associated with employee welfare plans relates to those plans).

⁷⁸ *Shaw*, 463 U.S. at 99 (quoting Senator Williams, 120 CONG. REC.

to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."⁷⁹ Accordingly, even indirect state action bearing on such plans can be preempted.⁸⁰

29,933 (1974)); *see also* *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) (per curiam) (preemption provisions are "deliberately expansive").

⁷⁹ *Mackey v. Lanier Collections Agency & Serv.*, 486 U.S. 825 (1988); *see also* *FMC Corp. v. Holliday*, 111 S. Ct. 403, 407-08 (1990); *Shaw*, 463 U.S. at 96-97; *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 8 (1987) (" 'relate to' should be construed expansively"). The "reference" and "connection" tests are discussed in *FMC Corporation*, 111 S. Ct. at 408. There the Court found that a Pennsylvania antisubrogation law related to an employee benefit plan, in part because it had the effect of "requir[ing] plan providers to calculate benefit levels in Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation." *Id.*; *see also* *Ingersoll-Rand Co. v. McClendon*, 111 S. Ct. 478, 483-84 (1990) (preempting state common law claim that employee was discharged to prevent attainment of benefits under ERISA plan).

The "relate to" clause has been widely discussed in the law reviews. *See, e.g.*, Brummond, *supra* note 64, at 64-67; Hutchinson & Ifshin, *supra* note 64, at 52-65; Kilberg & Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 TEX. L. REV. 1313 (1984); Comment, *ERISA Preemption of State Law: The Meaning of "Relate To" in Section 514*, 58 WASH U.L.Q. 143 (1980).

⁸⁰ 29 U.S.C. § 1144(c)(2) (1988) (direct or indirect state regulation); *see also* *Ingersoll-Rand Co. v. McClendon*, 59 U.S.L.W. 4033 (1990); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). Even state common law causes of action can be subject to ERISA preemption where they are applied to affect employee benefit plans. *See* *Ingersoll-Rand Co. v. McClendon*, 111 S. Ct. at 483; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987).

The Supreme Court has noted that there remain some state laws whose connection to benefits plans would be "too tenuous, remote, or peripheral . . . to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21. The Second and Ninth Circuit Courts of Appeals have been particularly active in attempting to sketch the outer limits of the "relate to" provision. *See, e.g.*, *Howard v. Gleason Corp.*, 901 F.2d 1154, 1157 (2d Cir. 1990) (notice statute relates to ERISA plans); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146-47 (2d Cir.) (relation requirement not met by indirect effect on ERISA plan administrative procedures), *cert. denied*, 110 S.Ct. 57 (1989); *Martori Bros. Distribs. v. James-Masengale*, 781 F.2d 1349 (9th Cir.) (state labor provision not preempted), *amended by*, 791 F.2d 799, *cert. denied*, 479 U.S. 1018 (1986); *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2d Cir. 1984) (economic impact of provision not determinative if it "does not affect the structure, the administration, or the type of benefits provided by an ERISA plan"), *cert. denied*, 472 U.S. 1008 (1985). These Circuits appear to have adopted a two part analysis; they examine the state law's relationship to

The first ERISA preemption challenge to a state health care access initiative arose in Hawaii. Hawaii's comprehensive Prepaid Health Care Act, enacted the same year as ERISA, required that employers provide a health care plan for their employees and mandated that employers pay one-half the premium cost. When challenged, however, the court decided that "[i]n any normal meaning, the Hawaii Act relates to employee benefit plans," and held ERISA preempted the Act.⁸¹ Similar comprehensive health access plans in California and Minnesota were subsequently preempted when courts held that those plans also related to

ERISA plans and then determine whether the law "purports to regulate" those plans. *Rebaldo*, 749 F.2d at 137; *Local Union 598, Plumbers & Pipefitters Indus. Journeymen & Apprentice Training Fund v. J.A. Jones Const. Co.*, 846 F.2d 1213, 1218 (9th Cir.) (citing Kilberg & Inman's "relate to" analysis), *aff'd mem.*, 488 U.S. 881 (1988); *United Food & Commercial Workers Employers Ariz. Health & Welfare Trust v. Pacyga*, 801 F.2d 1157, 1160 (9th Cir. 1986); *see also* Kilberg & Inman, *supra* note 78, at 1327-36 (suggesting that courts emphasize purpose-effect and regulation-interpretation distinctions as alternative approach to "relate to" requirement). The Sixth Circuit has rejected the "purports to" analysis. *See Authier v. Ginsburg*, 757 F.2d 796, 799 n.4 (6th Cir.), *cert. denied*, 474 U.S. 888 (1985); *see also* *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters.*, 793 F.2d 1456, 1467 n.9, 1467-68 (5th Cir. 1986) (expressing no opinion on validity of "purport to" analysis, rejecting consideration of state law's traditional or nontraditional character), *cert. denied*, 479 U.S. 1034 (1987).

⁸¹ *Standard Oil Co. v. Agsalud*, 442 F. Supp. 695, 707 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981). The key issue in *Standard Oil* was not whether the Hawaii plan "related to" employee benefit plans, but whether the law was exempt from preemption because it was a disability plan. 442 F. Supp. at 697; *see also* 29 U.S.C. § 1003(b)(3) (1988) (exempting from coverage plans "maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability laws"). The Ninth Circuit agreed with the District Court's finding that the Hawaii plan was not a disability insurance law. *Standard Oil*, 633 F.2d at 764.

Rejecting any distinction between state-mandated contributions and benefits, courts have also preempted state laws that required contributions to an employee benefit plan. *See, e.g.,* *Local Union 598, Plumbers & Pipefitters Indus. Journeymen & Apprentices Training Fund v. J.A. Jones Const. Co.*, 846 F.2d 1213, 1219 (9th Cir.) (dichotomy unsupported by law), *aff'd mem.*, 488 U.S. 881 (1988); *Stone & Webster Eng'g Corp. v. Ilsley*, 690 F.2d 323, 329 (2d Cir. 1982) (ERISA preempts Connecticut law which "add[ed] an additional statutory requirement — the cost of which is to be borne by the employer — to a private employee benefit plan"), *aff'd mem. sub nom.* *Arcudi v. Stone & Webster Eng'g Corp.*, 463 U.S. 1220 (1983).

employee welfare benefit plans.⁸² Thus, ERISA's preemption provision clearly preempts state attempts to directly require employers to provide health care plans for their employees.

ERISA's preemptive provision may apply to even more modest and indirect state attempts to improve access to care. For example, some states have attempted to require insurers, including employee benefit plans, to underwrite and administer state programs that establish high-risk pools which provide health insurance to the medically uninsurable.⁸³ However, these programs, although far more modest than employer mandates, impose substantive and reporting requirements on employee welfare benefit plans, and thus have been found to "relate to" those benefit plans.⁸⁴

Most states have established benefit mandates — requirements that insurance policies issued in a state include coverage of cer-

⁸² *Hewlett-Packard Co. v. Barnes*, 425 F.Supp. 1294 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978) (finding California's Knox-Keene health plan related to employee benefit plans); *St. Paul Elec. Workers Welfare Fund v. Markman*, 490 F. Supp. 931 (D. Minn. 1980) (finding that Minnesota's Comprehensive Health Insurance Act related to employee benefit plans).

There is some case law support for the proposition that not all state laws related to health plans will be preempted. In *Rebaldo v. Cuomo*, the Second Circuit Court of Appeals found that a New York law requiring hospitals to establish particular rates for self-insured employee welfare plans did not "relate to" employee benefit plans. 749 F.2d at 138. "Where, as here, a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated." *Id.* at 139.

⁸³ *See, e.g.*, MINN. STAT. ANN. §§ 62E.01-.55 (West 1986 & Supp. 1990). The Minnesota Comprehensive Health Insurance Act of 1976 established a comprehensive health association, composed of "all insurers, self insurers, fraternal and health maintenance organizations licensed or authorized to do business in the state," which was to underwrite and administer a program to provide health insurance to high-risk or uninsurable residents. *Id.* § 62E.10. For purposes of the statute, "self insurer" was defined as "an employer or an employee welfare benefit fund or plan which directly or indirectly provides a plan of health coverage itself or through an insurer, trust or agent." *Id.* § 62E.02(21).

⁸⁴ *St. Paul Elec. Workers Welfare Fund*, 490 F. Supp. at 933 (preempting Minnesota program because "[t]here is no doubt that the provisions here in question 'relate to' employee benefit plans"). Accordingly, ERISA preempts such programs to the extent that they purport to regulate self-insured employee benefit plans. *Id.* at 934; *see also infra* Part II.B.3. (discussing effect of savings and deemer clause on such programs).

tain illnesses or provide for the reimbursement of particular classes of providers.⁸⁵ These benefit mandates, however, are also subject to possible preemption because they “relate to” employee benefit plans. For example, Massachusetts enacted a law requiring that all health insurance policies cover certain mental health benefits for state residents.⁸⁶ The Supreme Court, in *Metropolitan Life Insurance Co. v. Massachusetts*,⁸⁷ found that the statute related to ERISA-protected plans: “Though [the statute] is not denominated a benefit-plan law, it bears indirectly but substantially on all insured benefit plans, for it requires them to purchase the mental-health benefits specified in the statute when they purchase a certain kind of common insurance policy.”⁸⁸

These expansive interpretations of the “relate to” provision must be contrasted, however, with the Supreme Court’s recent decision in *Fort Halifax Packing Co. v. Coyne*.⁸⁹ In *Fort Halifax*, the Court confronted ERISA’s application to a Maine statute which “requir[ed] employers to provide a one-time severance payment to employees in the event of a plant closing.”⁹⁰ The plaintiff argued that Maine’s severance pay statute both established and

⁸⁵ Benefit mandates and employer mandates are not identical. A state imposes benefit mandates when it requires that health insurance plans sold within the state include coverage of certain conditions (*e.g.*, alcohol or drug addiction) or provide reimbursement for particular providers (*e.g.*, podiatrists or chiropractors). A state imposes employer mandates when it requires that employers provide some kind of health insurance to their employees.

⁸⁶ MASS. GEN. LAWS ANN. ch. 175, § 47B (West Supp. 1990).

⁸⁷ 471 U.S. 724 (1985).

⁸⁸ *Id.* at 739. The statute, as applied to policies purchased by employee benefit plans, was saved from preemption, however, by the Court’s application of the savings clause. *See infra* notes 106-17 and accompanying text.

⁸⁹ 482 U.S. 1 (1987).

⁹⁰ *Id.* at 3. The statute provided that:

Any employer who relocates or terminates a covered establishment shall be liable to his employees for severance pay at the rate of one week’s pay for each year of employment by the employee in that establishment. The severance pay to eligible employees . . . shall be paid within one regular pay period after the employee’s last full day of work, notwithstanding any other provisions of law.

Id. at 4 n.1 (quoting ME. REV. STAT. ANN. tit. 26, § 625-B (Supp. 1986-87)). Employers are not liable for severance pay under this statute if, among other things, “[t]he employee is covered by an express contract providing for severance pay.” *Id.*

regulated an employee benefit plan relating to severance benefits, and thus was subject to preemption.⁹¹ The Court, however, rejected this contention, relying upon “the plain language of ERISA’s pre-emption provision, the underlying purpose of that provision, and the overall objectives of ERISA itself” to find that the statute was not subject to ERISA preemption because it did not relate to an employee benefit “plan.”⁹²

This holding rests upon the critical distinction between employee *benefits* and employee *plans*. The Court offered a three-part rationale for this distinction. First, the plain language of the preemption clause limits its application to state laws “relating to ‘employee benefit *plans*.’ ”⁹³ Second, Congress intended to preempt state and local laws which could conflict and therefore complicate the administration of employee benefit plans.⁹⁴ Preemption only made sense when employer provision of the benefits required an “ongoing administrative program,” and thus plans, rather than benefits, were the focus of the Act.⁹⁵ Third, ERISA was intended to ensure the “administrative integrity of benefit plans — which presumes that some type of administrative activity is taking place.”⁹⁶ In *Fort Halifax* the Court found that Maine’s severance payment provision did not establish or require

⁹¹ *Id.* at 7.

⁹² *Id.* In addition, the Court found that the logical result of the appellants’ argument would be the foreclosure of “virtually all state legislation regarding employee benefits.” *Id.*

⁹³ *Id.* at 7-8 (emphasis in original).

⁹⁴ The *Fort Halifax* Court noted that:

[E]mployers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Fort Halifax, 482 U.S. at 11. Thus, the Court noted, “[w]e have not hesitated to enforce ERISA’s pre-emption provision where state law created the prospect that an employer’s administrative scheme would be subject to conflicting requirements.” *Id.* at 10.

⁹⁵ *Id.* at 11.

⁹⁶ *Id.* at 15.

maintenance of an employee benefit *plan*.⁹⁷ Thus, since the statute established no plan, ERISA preemption provision could not apply.⁹⁸

⁹⁷ *Id.* at 12. The required payment of a benefit was distinguishable from the establishment of a plan:

The requirement of a one-time lump-sum payment triggered by a single event requires no administrative scheme whatsoever to meet the employer's obligation. The employer assumes no responsibility to pay benefits on a regular basis, and thus faces no periodic demands on its assets that create a need for financial coordination and control. Rather, the employer's obligation is predicated on the occurrence of a single contingency that may never materialize. . . . To do little more than write a check hardly constitutes the operation of a benefit plan. . . . The theoretical possibility of a one-time obligation in the future simply creates no need for an ongoing administrative program for processing claims and paying benefits.

Id. (footnote omitted). The Court contrasted the Maine provision with Hawaii's comprehensive health care plan. The Hawaii statute related to employee welfare plans because it required either 1) payment of certain benefits by an existing plan; or 2) "establishment of a separate plan where none existed before." *Id.* at 12-13. The Maine statute did not mandate a benefit plan, it merely required a possible one-time future payment. *Id.* at 14.

⁹⁸ *Id.* at 19 (reasoning that Maine's severance pay provision was an "attempt[] to address uniquely local social and economic problems" that raises no danger of conflict with federal law). The dissent, however, forcefully argued that the majority's opinion created a loophole in ERISA preemption by constructing and then relying upon a definition of "plan" that focused on the existence or absence of an "administrative scheme." *Id.* at 23 (White, J., dissenting). Justice White contended that the majority's definition of plan did not have support in ERISA's statutory provisions, *id.* at 24 (observing Section 1002(1) does not require that "a 'plan' meet any specific formalities or that there be some policy manual or employee handbook to effectuate it"), and conflicted with precedent. *Id.* at 25-26 (citing *Gilbert v. Burlington Indus.*, 765 F.2d 320 (2d Cir. 1985), *aff'd mem. sub nom. Roberts v. Burlington Indus.*, 477 U.S. 901 (1986)). White argued that states could use the new definition to create benefit mandates that could avoid the preemptive effect of ERISA. *Id.* at 23. The majority rejected these contentions, finding that a state could not avoid preemption merely by correctly managing the formal characteristics of the mandated benefit. *Id.* at 18 n.12. The majority reasoned that the administrative scheme requirement was stringent enough to prevent evasion:

Thus, if a State required a benefit whose regularity of payment necessarily required an ongoing benefit program, it could not evade pre-emption by the simple expedient of somehow formally characterizing the obligation as a one-time lump-sum payment triggered by the occurrence of a certain contingency.

Even after *Fort Halifax*, however, ERISA's "relate to" provision will ordinarily be read quite broadly to encompass state laws or regulations which, directly or indirectly, affect employee benefit welfare plans. There may be some opportunity for states to extract payments from employers to employees if the state program does not establish regular, predictable payments or require an employer to establish an administrative scheme.⁹⁹ Nevertheless, state efforts to mandate benefits or to mandate coverage will, for the most part, "relate to" employee benefit plans and face preemption. The question then becomes whether the state regulation is nonetheless exempted from preemption by the "savings" clause; that is, whether the state is merely regulating insurance.

3. "Saving" Without "Deeming"

Preemption is the presumption against which all state laws relating to employee benefit plans must labor.¹⁰⁰ However, the

Id.

Recently, the Court revisited the definition of an "employee welfare benefit plan," finding that an employer's payment for unused vacation time at discharge was not such a plan. *Massachusetts v. Morash*, 109 S.Ct. 1668 (1989). In reaching this conclusion the Court noted that "ordinary vacation payments are typically fixed, due at known times, and do not depend on contingencies outside the employee's control." *Id.* at 1673. Under such circumstances, the vacation payments made out of general assets would not constitute a benefit plan. *Id.* at 1675-76. Creation of a separate fund for the payments would, however, be sufficient to establish a benefit plan. *Id.*; see also *Howard v. Gleason Corp.*, 901 F.2d 1154 (2d Cir. 1990) (rejecting contention that statute requiring notice of conversion right was one-time benefit under *Fort Halifax*); *Akau v. Tel-A-Com Hawaii, Inc.*, No. 89-00912 (D. Haw. Apr. 17, 1990) (unpublished decision available on WESTLAW, 1990 WL 49818) (preempting a state severance scheme which imposed slightly greater administrative burdens than that in *Fort Halifax*); *Minnesota Chamber of Commerce & Indus. v. Hatch*, 672 F. Supp. 393 (D. Minn. 1987) (rejecting argument that state law requiring that employee benefit plans post surety bond simply creates employee benefit without relating to benefit plans).

⁹⁹ The limits of the administrative scheme definition of "plan" may have been sketched in the Court's recent decision in *Mackey v. Lanier Collections Agency & Serv.*, 486 U.S. 825 (1988). In *Mackey*, the Court found that a Georgia garnishment statute was not preempted by ERISA, despite the fact that "[c]ompliance with the state . . . procedures subjects the plan to significant administrative burdens and costs." *Id.* at 842 (Kennedy, J., dissenting).

¹⁰⁰ See, e.g., Note, *Pilot Life Insurance Co. v. Dedeaux: The Supreme Court's Federalization of Employee Benefit Law*, 23 TORT & INS. L.J. 507, 514 (1988).

savings clause allows states to enact laws which relate to employee benefit plans if those laws merely constitute traditional state regulation of insurance.¹⁰¹ The savings clause is limited, in turn, by the deemer clause which prevents states from avoiding preemption by simply treating employee benefit plans as insurers.¹⁰² Courts have considered the effect of the savings and deemer clauses on three different types of state health care access regulation: 1) employer mandates; 2) special taxing statutes applied to health insurance plans; and 3) benefit mandates.¹⁰³ The interaction of the savings and deemer clauses has led to the complete preemption of the first type of statute,¹⁰⁴ and partial preemption

The textual analysis of the savings and deemer clauses focuses on state health insurance regulation. Although not relevant here, other kinds of state laws also have been preempted. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (per curiam) (ERISA provides sole enforcement action to obtain benefits); *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 494 (9th Cir. 1988) (per curiam) (preempting statute establishing private cause of action for mishandling of insurance claims), *cert. denied*, 109 S.Ct. 3216 (1989) (following *Pilot Life*).

¹⁰¹ 29 U.S.C. § 1144(b)(2)(A) (1988). For the full text of the savings clause, see *supra* note 70.

¹⁰² 29 U.S.C. § 1144(b)(2)(B) (1988). For the full text of the deemer clause, see *supra* note 71.

¹⁰³ Courts have also been concerned with the potential preemption of other kinds of state regulation not considered here. *See, e.g., Howard v. Gleason Corp.*, 901 F.2d 1154 (2d Cir. 1990) (potential preemption of state insurance regulation mandating notification of conversion rights).

¹⁰⁴ *See, e.g., St. Paul Elec. Workers Welfare Fund v. Markman*, 490 F. Supp. 931 (D. Minn. 1980) (preempting Minnesota's Comprehensive Health Insurance Act); *Hewlett-Packard Co. v. Barnes*, 425 F.Supp. 1294 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978) (preempting California's Knox-Keene health plan); *Standard Oil Co. v. Agsalud*, 442 F. Supp. 695, 707 (N.D. Cal. 1977) (preempting Hawaii Prepaid Health Plan under ERISA), *aff'd*, 633 F.2d 760 (9th Cir. 1980) (per curiam), *aff'd mem.*, 454 U.S. 801 (1981); *see also* Note, *Worker Well-Being*, *supra* note 64, at 825-26.

After the preemption of the Hawaii Act, Congress amended ERISA to permit Hawaii to operate its Prepaid Health Plan, within certain limitations. 29 U.S.C. § 1144(b)(5) (1988). Hawaii's exemption was long fought and hard won. The price was an explicit Congressional limitation of the exception to Hawaii's plan, which was not to have any precedential value. The Senate version of the Hawaii exception would have permitted study of other state plans. S. REP. No. 646, 97th Cong., 2d Sess. 18, *reprinted in* 1982 U.S. CODE CONG. & ADMIN. NEWS 4580, 4595-96. The House did not favor such study, and the Conference Report followed the House. *See* H.R. REP. No. 832, 97th Cong., 2d Sess., *reprinted in* 1982 U.S. CODE CONG. & ADMIN. NEWS 4580, 4603-04; H.R. CONF. REP. No. 984, 97th Cong. 2d Sess. 18,

of the second and third kinds of state regulation.¹⁰⁵

The Supreme Court first confronted the savings and deeming clauses in a benefit mandate case, *Metropolitan Life Insurance Co. v. Massachusetts*.¹⁰⁶ The Massachusetts statute at issue required health insurance companies to include mental health benefits in all group health insurance contracts, including those sold to employee benefit plans.¹⁰⁷ After deciding that the statute clearly related to employee welfare plans governed by ERISA,¹⁰⁸ the Court had to determine whether the statute was a permissible regulation of insurance rescued from preemption by the savings clause.

In deciding *Metropolitan Life*, the Court established a two-part analysis for determining whether a challenged statute is preserved by the savings clause: 1) a common sense application of the terms of the savings clause; and 2) an analysis of whether the state provision regulates the "business of insurance" as defined

reprinted in U.S. CODE CONG. & ADMIN. NEWS 4598, 4603-04. Two scholars have recently reported on the political battle behind Hawaii's amendment. See Fox & Schaffer, *Health Policy*, *supra* note 47, at 246-51.

¹⁰⁵ See, e.g., *FMC Corp. v. Holliday*, 111 S. Ct. 403 (1990) (holding Pennsylvania antisubrogation law constitutes state regulation of insurers); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (holding state law mandating provision of mental health benefits in insurance contracts is regulation of insurance); *Blue Cross & Blue Shield v. Bell*, 798 F.2d 1331 (10th Cir. 1986) (holding Kansas law mandating benefits and providers was regulation of insurance); *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977) (holding New Hampshire law mandating inclusion of mental health benefits in insurance contracts is regulation of insurance), *cert. denied*, 435 U.S. 980 (1978); *St. Paul Elec. Workers Welfare Fund*, 490 F. Supp. 931 (preempting Minnesota's Comprehensive Health Insurance Act which required employee benefits plans to join risk pool that would underwrite a state insurance plan for the uninsured). *But see* *Insurance Bd. of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987) (holding Pennsylvania mandated benefit law could not be applied to Blue Cross plans that merely provided administrative services for self-insured employee benefit plan).

¹⁰⁶ 471 U.S. 724 (1985). Mandated benefit statutes "require an insurer to provide a certain kind of benefit to cover a specified illness or procedure whenever someone purchases a certain kind of insurance." *Id.* at 728. Such statutes, like many other state insurance regulations, "regulate the substantive content of health-insurance policies to further state health policy." *Id.* at 729.

¹⁰⁷ *Id.* at 729-30 (quoting MASS. GEN. LAWS ANN. ch. 175, § 47B (West Supp. 1985)).

¹⁰⁸ *Metropolitan Life*, 471 U.S. at 739.

under the McCarran-Ferguson Act.¹⁰⁹ Three different criteria are in turn relevant to determining whether a state statute regulates the business of insurance: “‘first, whether the practice has the effect of transferring or spreading a policyholder’s risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.’”¹¹⁰

Initially, the Court found that the state statute regulated insurance under the common sense meaning of the savings clause because it regulated the terms of certain insurance contracts.¹¹¹ The Court then analyzed the McCarran-Ferguson factors to find

¹⁰⁹ *Metropolitan Life*, 471 U.S. at 740-747; see also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46-48 (1987) (explaining and applying *Metropolitan Life* analysis). The savings and deemer clauses have been discussed in several law review articles and comments. See, e.g., Bishop & Denney, *Hello ERISA, Good-Bye Bad Faith: Federal Preemption of DTPA, Insurance Code, and Common Law Bad Faith Claims*, 41 BAYLOR L. REV. 267 (1989); Note, *supra* note 100, at 512-13.

The McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011-1014 (1988)), provides that “[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.” 15 U.S.C. § 1012(a). The Act limits federal preemption of state insurance law to a narrow range of cases. Federal Acts which specifically regulate insurance are to be given effect. In addition, the Sherman Act, the Clayton Act, and the Federal Trade Commission Act are to “be appli[ed] to the business of insurance to the extent that such business is not regulated by state law.” 15 U.S.C. § 1012(b). For a recent discussion of the problems of defining the “business of insurance,” see Howard, *Uncle Sam Versus the Insurance Commissioners: A Multi-Level Approach to Defining the “Business of Insurance” Under the McCarran-Ferguson Act*, 25 WILLAMETTE L. REV. 1 (1989).

¹¹⁰ *Metropolitan Life*, 471 U.S. at 743 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)) (emphasis in original); see also *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

¹¹¹ *Metropolitan Life*, 471 U.S. at 740. In addition, the Court noted that the deeming clause referred to state regulation of “insurance contracts,” thus making “explicit Congress’ intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the savings clause.” *Id.* at 741.

The Court rejected the assertion that the Massachusetts regulation was not a “traditional” insurance regulation because it merely used insurance laws to accomplish state health policy objectives. *Id.* The Court stated “it is both historically and conceptually inaccurate to assert that mandated-benefit laws are not traditional insurance laws.” *Id.* at 742.

In contrast, the Court in *Pilot Life* found that Mississippi’s common law of bad faith did not fall within “a common-sense understanding of the phrase ‘regulates insurance.’” 481 U.S. at 50. To regulate, “a law must not just

that the Massachusetts statute was saved from preemption by the "savings clause." First, the statute clearly regulated the spreading of risk for mental health benefits.¹¹² Second, the statute "directly regulate[d] an integral part of the relationship between the insurer and the policyholder by limiting the type of insurance that an insurer may sell to the policyholder."¹¹³ Third, the statute regulated only insurers.¹¹⁴ Massachusetts' mandated-benefit law was thus saved from complete preemption by the operation of the "savings" clause of ERISA.¹¹⁵

Under this analysis, however, state benefit mandates are still partially preempted. The savings clause allows states to require inclusion of some benefits in health insurance plans, but the deemer clause forbids the application of such rules to an

have an impact on the insurance industry, but be specifically directed toward that industry." *Id.*

¹¹² *Metropolitan Life*, 471 U.S. at 743. The state had found that such coverage was difficult or expensive to obtain in the absence of mandated benefits because of the problem of adverse selection. *Id.* at 731.

¹¹³ *Id.* at 743. In *Pilot Life*, the Court conceded that Mississippi's common law of bad faith concerned "the policy relationship between the insurer and the insured." 481 U.S. at 50. The connection, however, was "attenuated"; for "the common law of bad faith does not define the terms of the relationship between the insurer and the insured." *Id.* at 50-51.

¹¹⁴ *Metropolitan Life*, 471 U.S. at 743. The common law provisions in *Pilot Life*, in contrast, did not apply solely to insurance contracts. *Pilot Life*, 481 U.S. at 50-51.

¹¹⁵ *Metropolitan Life*, 471 U.S. at 744.

In *Pilot Life*, the Court reaffirmed the use of the *Metropolitan Life* factors in determining the application of the savings clause, but expanded the analysis to include "the role of the saving clause in ERISA as a whole." *Pilot Life*, 481 U.S. at 46-49, 51. The Court looked to the provisions of ERISA as a whole, and to their object and policy. *Id.* at 51. Applying this new factor, the Court determined that state common law remedies for bad faith should not be saved by the savings clause because Congress intended to create exclusive federal remedies. *Id.* at 51-57. The Court noted that this result was not in conflict with *Metropolitan Life* because that case "did not involve a state law that conflicted with a substantive provision of ERISA." *Id.* at 56-57.

Other kinds of state laws have also been saved from preemption. *See, e.g.*, *Northern Group Servs., Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 89-90 (6th Cir. 1987) (state law mandating particular coordination of benefits), *cert. denied sub nom. Northern Group Servs., Inc. v. State Farm Mut. Auto Ins. Co.*, 486 U.S. 1017 (1988); *Blue Cross & Blue Shield v. Bell*, 798 F.2d 1331 (10th Cir. 1986) (mandated provider law); *Soniat v. Travelers Ins. Co.*, 538 So. 2d 210 (La. 1989) (statute requiring insurance coverage for claims arising before cancellation of policy); *Blue Cross Hosp. Serv., Inc. v. Frappier*, 698 S.W.2d 326 (Mo. 1985) (en banc) (mandated provider law).

employer's self-insured benefit plan.¹¹⁶ As the Court noted, its analysis of the Massachusetts statute distinguishes state regulation of self-insured plans from state regulation of health insurance purchased by employee benefit plans, forbidding the former but permitting the latter.¹¹⁷

¹¹⁶ Originally, the Massachusetts statute had applied to both regular insurance contracts and the health insurance benefits provided by self-insured employee benefit plans. The application of the statute to self-insured employee benefit plans had been concededly barred by the deemer clause and found severable by the Supreme Judicial Court of Massachusetts. See *Attorney Gen. v. Travelers Ins. Co.*, 385 Mass. 598, 601-02, 433 N.E.2d 1223, 1225 (1982). The Court thus treated the statute as though it did not apply to self-insured plans. *Metropolitan Life*, 471 U.S. at 735 n.14.

¹¹⁷ The Court saw this as a result compelled by ERISA and within the domain of further Congressional action:

We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter.

Metropolitan Life, 471 U.S. at 747 (footnote omitted). The Supreme Court recently reaffirmed the differential treatment of insured and self-insured plans:

We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulat[e] insurance" within the meaning of the savings clause. By forbidding States to deem employee benefit plans "to be an insurance company or other insurer . . . or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state law "purporting to regulate insurance" after application of the deemer clause . . . [and] is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

FMC Corp. v. Holliday, 111 S. Ct. 403, 409 (1990). In reaching this conclusion, the Court rejected the narrow interpretations of the deemer clause proffered by the respondent Holliday and the amici curiae National Conference of State Legislatures, et al. Under these alternative constructions, state regulation of self-funded plans would have been permitted so long as the regulation was not a "pretext[] for impinging on core ERISA concerns" or so long as it did not require the self-funded plans to meet the licensing and capitalization standards of organizations truly in the business of insurance.

In contrast, state level employer mandates, such as those imposed by Hawaii's Comprehensive Pre-Paid Health Care Act, have been completely preempted because the savings clause has been held inapplicable. These statutes relate to employee benefit plans because they require the provision of a particular kind of benefit plan.¹¹⁸ But they are not saved from preemption because they do not constitute traditional state regulation of insurance. In addition, state employer mandates imposed under the guise of regulating insurance would violate the deemer clause if applied to self-insured employee benefit plans.

Finally, courts have partially invalidated state plans designed to spread the cost of insuring the uninsured through risk pools or taxing schemes.¹¹⁹ Some states have attempted to provide access to care for the uninsured by taxing insurers or requiring that they join together to underwrite insurance for the uninsured within the state. Insurance taxes or risk pools are not extraordinary and would appear to be well within state regulatory and taxing power.¹²⁰ But these state access initiatives will be preempted under the deemer clause to the extent that they attempt to spread

Id. at 410. These attempted restrictions on the scope of the deemer clause were rejected as inconsistent with Congress' desire to exclusively federalize the regulation of benefit plans and with the need to establish clear workable rules governing the permissible scope of state regulation. *Id.* The Supreme Court's decision in *FMC Corp.* will reaffirm differential treatment of insured and self-funded plans, see, e.g., *Baxter ex rel. Baxter v. Lynn*, 886 F.2d 182, 186 (8th Cir. 1989), while calling into question those decisions upholding indirect state regulation even of self-insured plans, see, e.g., *Northern Group Servs., Inc.*, 833 F.2d at 91-95.

¹¹⁸ See, e.g., *Standard Oil Co. v. Aghalud*, 633 F.2d 760, 764 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981).

¹¹⁹ See, e.g., *St. Paul Elec. Workers Welfare Fund v. Markman*, 490 F. Supp. 931, 932 (D. Minn. 1980); *General Split Corp. v. Mitchell*, 523 F. Supp. 427 (E.D. Wisc. 1981) (preempting Wisconsin statute that required self-insurers to participate in risk pool with other insurers).

¹²⁰ In arguing against preemption of its health care plan, Hawaii had characterized the employer's required premium payment as a tax and contended that preemption would violate its tenth amendment right to tax. The Court of Appeals agreed with the district court in rejecting the tenth amendment's application, noting that "the taxing power is the power to require money to be 'paid to the State as a State,' and that power is not invoked here." *Aghalud*, 633 F.2d at 765. Congress attempted to clarify ERISA's affect on state taxing power when it amended the statute to exempt Hawaii's health care plan. The relevant text of the amendment provides:

(5)(A) Except as provided in subparagraph (B), subsection (a) of [the preemption provision] shall not apply to the Hawaii

the costs of improving access to self-insured employee benefit plans.

In *St. Paul Electrical Workers Welfare Fund v. Markman*,¹²¹ for example, beneficiaries and trustees of an employee welfare trust contended that the Minnesota Comprehensive Health Insurance Act was preempted by ERISA.¹²² The statute required both insurers and self-insurers, including employer or employee welfare benefit plans, to join an association that would underwrite and administer a state insurance plan for the uninsured.¹²³ Self-insurers were required to provide continuation of coverage for terminated employees.¹²⁴ Employers who provided health insurance plans were required to make a qualified plan available, or face the loss of tax benefits.¹²⁵ The Minnesota Act imposed substantive and reporting requirements on employee benefits plans and thus clearly "related to" those plans. The Act was also part of the state's insurance law, and the court implicitly concluded that the statute would be preserved from preemption by the "savings" clause unless the "deemer" clause applied.¹²⁶ The court concluded that the deemer clause did apply because the state stat-

Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of [the preemption provision]—

(i) any State tax law relating to employee benefit plans.

29 U.S.C. § 1144(b)(5) (1988). A fair reading of this amendment indicates that Congress thought that state tax laws relating to employee benefit plans were preempted and that it sought to make clear that Hawaii's waiver for its Prepaid Health Care Act did not alter that result.

¹²¹ 490 F. Supp. 931 (1980).

¹²² *Id.* at 932. Insurance companies in the state had contested the validity of the Minnesota statute shortly after its passage. *Id.* at 931. However, a court rejected the companies' constitutional and ERISA preemption claims. *See Insurers' Action Council, Inc. v. Heaton*, 423 F. Supp. 921, 926 (D. Minn. 1976). This determination was not on the merits, however, as the court was concerned only with the plaintiffs' motion for a preliminary injunction. *Id.* at 923.

¹²³ MINN. STAT. ANN. § 62E.10 (West 1986 & Supp. 1990). An employer or employee welfare benefit plan was subject to the statutory requirements if it "directly or indirectly provide[d] a plan of health coverage to its employees and administers the plan of health coverage itself or through an insurer, trust or agent." *Markman*, 490 F. Supp. at 932.

¹²⁴ *Markman*, 490 F. Supp. at 933.

¹²⁵ *Id.*

¹²⁶ *Id.* at 933-34.

ute treated employee benefit plans as insurers, in direct contravention of the deemer clause.¹²⁷ ERISA thus preempted the Minnesota Act to the extent that the Act attempted to regulate employee benefit plans.¹²⁸

Thus, while ERISA itself does not require that employers establish employee health insurance plans, it does effectively preclude state statutes that would mandate such plans.¹²⁹ And even indirect state attempts to mandate benefits or to spread the costs of insurance for the uninsured face partial preemption to the extent that they apply to self-insured employee benefit plans. The distinction, resulting from this partial preemption, between self-insured plans and those insured by third parties plays an additional practical role in frustrating state efforts to create uniform health access policies.

4. ERISA's Constriction of State Alternatives

Under ERISA, indirect state regulation of employee benefit plans, in the form of benefit mandates and cost-spreading risk pools, is possible. However, the deemer clause effectively insulates self-insured employee benefit plans from such regulation. Because of the nature of the insurance market, this distinction plays an important practical role in frustrating state health care access initiatives.

A state's insurance market can be divided into segments based on the kind of health insurance provided. Some insurance is provided publicly or is obtained by private individuals. Most insur-

¹²⁷ "Neither an employee benefit plan . . . , nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for the purposes of any law of any State purporting to regulate insurance companies." *Id.* (quoting 29 U.S.C. § 1144(b)(2)(B)); see also *General Split Corp. v. Mitchell*, 523 F. Supp. 427 (E.D. Wisc. 1981) (preempting Wisconsin statute which required self-insurers to participate in risk pool with other types of insurers); Note, *What's a State to Do?*, *supra* note 64 (discussing 7th Circuit decision preempting state law claims against self-insured employee benefit plan). *But see* *Northern Group Servs., Inc. v. Auto Ins. Co.*, 833 F.2d 85 (6th Cir. 1987) (upholding indirect state regulation of self-insured plans), *cert. denied sub nom.* *Northern Group Servs., Inc. v. State Farm Mut. Auto. Ins. Co.*, 486 U.S. 1017 (1988).

¹²⁸ *Markman*, 490 F. Supp. at 934.

¹²⁹ See, e.g., Note, *Worker Well-Being*, *supra* note 64, at 845-46 (concluding that ERISA hurts workers by preempting attempts to mandate benefits to aid workers).

ance, however, is provided through employment. Employers can contract directly with an insurance company to spread the risk of health care expenses.¹³⁰ Employers can also self-insure.¹³¹ Self-insured employers assume the risk for paying health benefit claims themselves, although they may turn to an insurance company to provide administrative services or stop-loss coverage.¹³²

¹³⁰ Employers can spread the risk of health care expenses by contracting with commercial insurers or with Blue Cross/Blue Shield insurers.

Commercial insurers generally charge premiums that are "experience rated" *i.e.*, the premiums will actually equal the total benefits paid out by the commercial insurer during a prior period, plus administrative and other costs. Wallen & Williams, *Employer-Based Health Insurance*, 7 J. HEALTH POL. POL'Y & L. 366, 369 (1982).

In contrast, premiums to Blue Cross and Blue Shield traditionally were "community-rated" rather than experience-rated. HEALTH INSURANCE BACKGROUND DATA, *supra* note 18, at 21. This meant that the actual company usage of health benefits was not directly reflected in the premium charged. *Id.* at 10-11. In recent years, however, Blue Cross and Blue Shield have joined commercial insurers in using experience-ratings. *Id.* at 21.

Insurance plans that do not use experience-rating systems can suffer from "skimming" practices by other insurance companies. Insurance companies using experience-ratings can offer lower rates to healthier groups. As these healthier groups leave community-rated programs, the costs of those plans increase, leading to the exodus of still more relatively health insureds who can get cheaper rates elsewhere. See Stein, *The Revolt Against the Blues*, Boston Globe, Apr. 8, 1990, at A1, col. 4.

¹³¹ Two other variations are possible. In the first, the employer self-insures and bears the risk of health care expenditures, but contracts with an insurance company to administer its health insurance plan. In the second, the employer self-insures but contracts with an insurance company to provide stop-loss coverage. Here the employer does contract away part of the risk, and thus is no longer truly self-insured. Jenson & Gabel, *The Erosion of Purchased Health Insurance*, 25 INQUIRY 328, 328-29 (1988).

¹³² *Id.* Employers can contract with insurance carriers or third party administrators (TPAs) for administration and claims processing. *Id.* at 329. Employers who obtain stop-loss coverage may not always be able to avoid state regulation because some courts have held that these plans are no longer self-insured. See, *e.g.*, Michigan United Food & Commercial Workers Unions v. Baerwaldt, 767 F.2d 308, 312-313 (6th Cir. 1985) (state benefit mandate applied to plans through their stop-loss insurers), *cert. denied*, 474 U.S. 1059 (1986); State Farm Mut. Auto. Ins. Co. v. American Community Mut. Ins. Co., 659 F. Supp. 635 (E.D. Mich. 1987) (state law establishing priority of medical coverage between insurers applied to benefit plan with stop-loss coverage), *aff'd by unreported decision*, 863 F.2d 49 (6th Cir. 1988) (text available on WESTLAW). But see Brown v. Granatelli, 897 F.2d 1351 (5th Cir. 1990) (state insurance provision requiring that individual and group policies cover newborns did not apply to stop-loss policy); Moore v. Provident Life & Accident Ins. Co., 786 F.2d 922 (9th Cir. 1986) (savings

Self-insurance is usually a realistic option only for medium or large firms.¹³³

Despite these requirements, the number of self-insured employers has grown tremendously since ERISA's passage in 1974.¹³⁴ This growth has been fueled by several federal incentives.¹³⁵ Under *Metropolitan Life*, ERISA preempts state attempts to apply minimum benefit laws to self-insured plans.¹³⁶ Self-insured plans may thus offer less comprehensive, and less expen-

clause inapplicable when stop-loss insurance coverage never effectuated); *Rasmussen v. Metropolitan Life Ins. Co.*, 675 F.Supp. 1497, 1502 (W.D. La. 1987) (court in dicta rejects indirect state regulation of plan through stop-loss insurer where loss trigger never reached). For a discussion of the split of authority concerning stop-loss coverage, see Engel, *ERISA: To Preempt or Not to Preempt, That is a Question!*, 22 TORT & INS. L.J. 431, 443-46 (1987) (discussing partially insured plans). Self-insured plans that contract with insurance companies for administrative services generally remain free from state regulation. See, e.g., *Insurance Bd. of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987); *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), cert. denied, 476 U.S. 1170 (1986); *Self-Insurance Inst. of America v. Gallagher*, No. TCA 86-7308 WS, (N.D. Fla. June 2, 1989) (available on WESTLAW, 1989 WL 143288) (discussing cases), aff'd, 909 F.2d 1491 (11th Cir. 1990) (July 9, 1990) (Table No. 89-3547); *Worthington v. Metropolitan Life Ins. Co.*, 688 F. Supp. 298 (S.D. Tex. 1987).

¹³³ Larger firms are better able to self-insure for several reasons. First, a relatively large number of employees is necessary to spread the risk of a large payout. Second, economies of scale in plan development and implementation are only reached with relatively large numbers of employees. Finally, companies that self-insure must be prepared to face possibly complicated benefits administration and larger fluctuations in cash flow. Jenson & Gabel, *supra* note 131, at 330.

¹³⁴ The percentage of medium- and large-sized employers who self-insure grew from 22% in 1981 to 42% in 1985. *Id.* at 331 (mid-sized employers are those with from 100 to 999 employees; large employers have at least 1000 employees). In 1985 "42 percent of all workers in medium and large establishments participated in a self-insured health plan." EBRI, *supra* note 41, at 11. The definition of "medium" varies by industry, but generally requires at least 250 employees. *Id.* at 11 n.2. In 1984, 80% of the Fortune 500 companies were self-insured. Odynocki, *supra* note 55, at 19; see also Firfer, *Direct Employer-Provider Contracting and ERISA Preemption: A Regulatory Loophole?*, FICC Q. 195, 200-03 (1990) (discussing employers' increasing use of self-insurance).

¹³⁵ See, e.g., Jenson & Gabel, *supra* note 131, at 329-30 (summarizing advantages of self-insurance); Wallen & Williams, *supra* note 130, at 370 (same); EBRI, *supra* note 41, at 11-13 (same).

¹³⁶ See *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985). These minimum benefit laws violate the deemer clause by treating

sive, health benefit plans.¹³⁷ ERISA also relieves self-insured plans of the financial burden of contributing to state risk pools along with other insurers, and from the regulatory burden of other state insurance requirements.¹³⁸ Finally, self-insured companies are not subject to state insurance premium taxes.¹³⁹ Thus, those employers who can self-insure often choose to do so. As a result, ERISA's preemption provision combines with the large number of unregulatable self-insured health plans to frustrate state attempts to improve health care access.

Indirect state regulation cannot be effective in this mixed mar-

self-insured employee benefit plans as though they were insurers. See 29 U.S.C. § 1144(b)(2)(B) (1988).

¹³⁷ *Metropolitan Life*, 471 U.S. at 735-36 n.14; see, e.g., *Liberty Mut. Ins. Group v. Iron Workers Health Fund*, 879 F.2d 1384 (6th Cir. 1989) (state insurance statute requiring coordination of benefits not applicable to self-insured plans); *Children's Hospital v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985) (self-insured plan exempt from state statute requiring equal treatment of physical and mental illness benefits). State mandate laws can increase premiums by 11%. Jenson & Gabel, *supra* note 131, at 330.

Despite their cost advantage, self-insured plans may actually be more expensive than commercial and Blue Cross/Blue Shield coverage. *Id.* at 339; see also Browne, Browne, McLaughlin & Wagner, *Effect of Mandated Drug, Alcohol, and Mental Health Benefits on Group Health Insurance Premiums*, J. AM. Soc'y CLU & CHFC, Jan. 1987, at 74, 77 (98% of firms responding to survey indicate their switch to self-insured status was not solely based on state mandated benefits). It remains true, however, that self-insured plans may provide different types of health benefits. EBRI, *supra* note 41, at 11.

¹³⁸ See, e.g., *General Split Corp. v. Mitchell*, 523 F.Supp. 427 (E.D. Wis. 1981). In *General Split*, the district court confronted the application of ERISA to a Wisconsin statute that established a health insurance risk sharing pool for the medically uninsurable. *Id.* at 429. State risk pools provide coverage to the medically uninsurable at higher premium rates. Losses from the risk pools are ordinarily financed by assessments on health insurance companies within the state. Self-insured health benefit plans cannot be assessed to finance the risk pools. Self-insurers are also exempt from state financial reserve requirements that ordinarily apply to insurance companies. Jenson & Gabel, *supra* note 131, at 330.

¹³⁹ Jenson & Gabel, *supra* note 131, at 330. The premium tax can range from 2-4%. Wallen & Williams, *supra* note 130, at 369.

Self-insured plans also present business advantages for medium and large firms. The firms do not have to pay for health care costs up-front, and can thus earn interest on funds that will later be paid out in claims. *Id.* The firms also gain access to claims data, which may make it easier to manage health costs. Jenson & Gabel, *supra* note 131, at 330. This access to information can have an adverse impact on employees, as employers try to rid their workforce of medically expensive workers. See e.g., Wallen & Williams, *supra* note 130, at 370; Odynocki, *supra* note 55, at 19.

ket. Benefit mandates are realistically limited: the greater the state mandates, the greater the incentive for employers to self-insure. Attempts to raise funds for access initiatives from the health insurance market are also frustrated. ERISA preempts state attempts to directly tax employee benefit plans.¹⁴⁰ The statute has prevented attempts to broaden the funding of state high-risk pools — self-insured employers have remained free of liability for loss assessment.¹⁴¹ Similarly, proposals to provide risk pools for small employers at the state level have been hampered by the inability of states to spread the potential losses from such programs across the entire insurance market, including self-insured employers.¹⁴² In fact, ERISA's preemptive provisions actually worsen the situation for small employers, who generally cannot self-insure, by raising their insurance costs.¹⁴³

Alternative policy solutions must be found if states are to play a major role in improving access to health insurance despite ERISA's provisions. There are three basic possibilities: 1) state taxation of employers that is not "related to" employee benefit plans; 2) establishment of state-funded plans; and 3) federal action in the form of either a comprehensive federal access plan or a limited federal repeal of ERISA's preemption provisions. The next section of this Article will examine the two possible state level solutions. Possible federal action, in turn, will be discussed in the final section.

¹⁴⁰ See, e.g., *General Split Corp.*, 523 F. Supp. at 431 (ERISA preempts state laws taxing welfare plans and requiring them to contribute to state risk-sharing plan).

¹⁴¹ Eno & Haugh, *supra* note 24. "Efforts to mandate participation by self-insurers to spread costs across a wider base have failed. Legal challenges by self-insurers in three states (Connecticut, Minnesota, and Wisconsin) have affirmed . . . that ERISA exempts them from state insurance regulation and, therefore, from participation in risk pools." Laudicina, *supra* note 30, at 100.

¹⁴² Eno & Haugh, *supra* note 24.

¹⁴³ Jenson & Gabel, *supra* note 131, at 341. Jenson and Gabel conclude that:

The larger the number of self-insured plans, the smaller the number of employers who must bear the costs of subsidizing the pool, thereby further increasing the advantage of self-insurance. Unless state governments can find a method for financing risk pools that does not discriminate against fully insured plans, the incentives for employers to self-insure will only increase.

Id.

III. THE FRUSTRATION OF STATE INITIATIVES

A. Incremental Innovations

In the 1960s the problems of the poor and elderly uninsured led Congress to enact Medicare and Medicaid. Interest in creating even more comprehensive or universal access to health care flourished at the state and federal level into the early 1970s. As federal initiatives started, sputtered, and stalled, states began to enact their own access programs.¹⁴⁴ These state level programs have generally failed, however, either because of direct ERISA preemption, or because of the economic inefficiency created by attempts to conform to ERISA's requirements.

Hawaii, California, and Minnesota implemented the most comprehensive programs, each of which was at least initially preempted by ERISA. Hawaii's Prepaid Health Care Act, enacted in 1974, mandates health insurance coverage for "workers who at present do not possess any or possess only inadequate prepayment coverage."¹⁴⁵ Under the plan, every private employer who pays at least a minimum specified wage to a regular employee¹⁴⁶ is required to "provide coverage of such employee by a prepaid group health care plan qualifying" under the statute.¹⁴⁷ The

¹⁴⁴ See, e.g., Note, *Worker Well-Being*, *supra* note 64, at 828-29. Some states have explicitly stated that their state health plans will be repealed if national health insurance becomes a reality. See, e.g., HAW. REV. STAT. § 393-51 (1985) (Hawaii's Prepaid Health Plan Act will terminate if federal government legislates mandatory prepaid health care or voluntary prepaid health care with equivalent or better benefits); R.I. GEN. LAWS § 42-62-25 (1988) (enabling "director of the department of medical services . . . to promulgate regulations to ensure that . . . Rhode Island will not duplicate benefits available through any national health insurance program").

¹⁴⁵ HAW. REV. STAT. § 393-2 (1985). For a discussion of the Hawaii Act's background and provisions, see Comment, *Federal Preemption*, *supra* note 64, at 348-53.

¹⁴⁶ Regular employees are those who work at least 20 hours per week for one employer. HAW. REV. STAT. § 393-3(8) (1988). Seasonal employees, some employees paid by commission, and some domestic workers are excluded from mandatory coverage. *Id.* §§ 393-3(8), -5, -11 (1985 & Supp. 1989). To be covered, an employee must earn "monthly wages in an amount of at least 86.67 times the minimum hourly wage." *Id.* § 393-11. *But see id.* § 393-3(3) (public employers not covered by Act). Employers are not obliged to provide coverage for persons who are covered by another private or public plan. *Id.* § 393-17.

¹⁴⁷ *Id.* § 393-11. The health care plan may "qualify" under the statute by meeting one of two tests, providing that it also meets minimum statutory standards. The plan must either provide coverage for those services

Hawaii plan provides that employers and employees each pay half of the health insurance premium for qualified coverage.¹⁴⁸

The Standard Oil Company, an employer, successfully challenged Hawaii's plan in federal court.¹⁴⁹ The United States Court of Appeals for the Ninth Circuit affirmed, holding the Prepaid Health Act was preempted by ERISA because it related to an employee welfare benefit plan and did not meet any exemption from preemption.¹⁵⁰ ERISA preemption had thus foreclosed a state effort to promote access for the uninsured.

Hawaii's representatives in Congress vowed to overturn the judicial result and, after a long political battle, Congress enacted a limited waiver from ERISA preemption for the Hawaii plan.¹⁵¹

provided by the benefit plan which has "the largest number of subscribers in the State," or it must demonstrate it provides "sound" levels of coverage. *Id.* § 393-7(a)-(b). In any event, to qualify the plan must include at least certain statutorily required benefits types, such as maternity and substance abuse benefits. *Id.* § 393-7(c).

¹⁴⁸ But employees cannot be forced to contribute more than 1.5% of their wages, unless a collective bargaining agreement specifies otherwise. *Id.* § 393-13. The statute prohibits agreements by employees to pay more than one half the premium amount, unless the employee has agreed to pay for coverage of her dependents. *Id.* § 393-21(e)-(f); *see also id.* § 393-15 (continuation during disability). Employers are prohibited from coercing employees into waiving coverage. *Id.* § 393-21(d).

Some small employers are entitled to state subsidization of premiums "if the employer's share of the cost of providing such coverage . . . exceeds 1.5 per cent of the total wages payable to such employees and if the amount of such excess is greater than five per cent of the employer's income before taxes directly attributable to the business in which such employees are employed." *Id.* § 393-45(a). Few employers receive state subsidies. Friedman, *Helping the Uninsured Employed*, MED. WORLD NEWS, May 12, 1986, at 41, 41.

¹⁴⁹ *Standard Oil Co. v. Agsalud*, 442 F. Supp. 695 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981). *See also* Comment, *Federal Preemption*, *supra* note 64, at 353-58 (discussing litigation of case in district and appellate courts).

¹⁵⁰ *Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981).

¹⁵¹ The amendment, enacted in 1983, was limited to cover the terms of the Hawaii program as it had existed in 1974. 29 U.S.C. § 1144(b)(5) (1988). Thus more extensive (and expensive) benefit mandates that had been imposed after that date would still be preempted. Only administrative amendments enacted after 1974 would escape preemption. *See Council of Hawaii Hotels v. Agsalud*, 594 F. Supp. 449 (D. Haw. 1984); S. REP. NO. 646, 97th Cong., 2d Sess. 18, *reprinted in* 1982 U.S. CODE CONG. & ADMIN. NEWS 4580, 4595-96. For a discussion of the political climate in which the

Operating under this waiver, nearly all employed Hawaiians have gained health insurance coverage.¹⁵² The political price for Hawaii's exemption was high: the waiver for Hawaii's plan clearly states that it is "not to be considered a precedent for extending non-preemption to any other State law."¹⁵³ Despite the apparent success of Hawaii's initiative, ERISA still poses an almost insurmountable bar to comprehensive and efficient state level programs.

Both California and Minnesota enacted comprehensive health access plans which did not receive Congressional waivers. California's Knox-Keene plan directly "regulated standards and general conduct" for health benefit plans.¹⁵⁴ The Minnesota Comprehensive Insurance Act required that all employee health benefit plans provide minimum health benefits.¹⁵⁵ Both these state regulatory schemes were eventually invalidated by application of ERISA's preemption provision.¹⁵⁶

Given ERISA, states generally have been forced to forbear comprehensive access initiatives. Many states have attempted to avoid ERISA preemption by enacting small scale incremental solutions, designed to ameliorate the problems faced by smaller

waiver was contested, see Fox & Schaffer, *Semi-Preemption in ERISA*, *supra* note 47; Comment, *Federal Preemption*, *supra* note 64, at 358-362 (discussing Congressional debate).

¹⁵² Friedman, *supra* note 148, at 41 (98%); Comment, *Federal Preemption*, *supra* note 64, at 362-67. Hawaii recently moved to provide access for those not covered by employer mandates. The new State Health Insurance Program (SHIP) is financed from general revenues. See HAWAII REV. STAT. §§ 431N-1 to -8 (1989); see also Friedman, *Hawaii Adopts Universal Coverage*, MED. WORLD NEWS, Mar. 12, 1990, at 12. Yet some Hawaiians remain dissatisfied with the limited exemption from preemption Congress gave them. Hawaii Senator Daniel Akaka has introduced a bill designed to remove the remaining ERISA preemption bar, which prevents further expansion of the program. See *Hawaii Seeks ERISA Exemption*, Nation's Health, Aug. 1990, at 4, col. 1.

¹⁵³ H.R. CONF. REP. No. 984, 97th Cong., 2d Sess. 18, reprinted in 1982 U.S. CODE CONG. & ADMIN. NEWS 4598, 4603.

¹⁵⁴ Note, *Worker Well-Being*, *supra* note 64, at 829 n.27.

¹⁵⁵ *Id.*

¹⁵⁶ See *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978); *St. Paul Elec. Workers Welfare Fund v. Markman*, 490 F. Supp. 931 (D. Minn. 1980). *But see* *Insurers' Action Council, Inc. v. Heaton*, 423 F. Supp. 921 (D. Minn. 1976) (rejecting preliminary injunctive relief against Minnesota plan, expressing doubt as to merits of preemption claim).

segments of the uninsured population.¹⁵⁷ Yet even these more limited initiatives must either conform to ERISA's demands, at the price of lost efficiency and effectiveness, or face preemption.

In the mid-1970s, for example, Rhode Island instituted a catastrophic health insurance plan (CHIP).¹⁵⁸ Under CHIP, the state pays for some medical treatments for people who have already incurred health care expenditures greater than the statutorily specified amounts.¹⁵⁹ In a key provision, the amount of health expenditures necessary to trigger eligibility varies depending on whether the person seeking eligibility was a member of a "qualified health program."¹⁶⁰ Members of such programs can incur less personal expense before becoming eligible for state-funded catastrophic relief.

Insurers must apply to the state for a determination whether their plans meet the substantive coverage requirements of qualified plans.¹⁶¹ Further, under the statute all types of "insurers"

¹⁵⁷ In addition, some states have addressed the problem of underinsurance by mandating that insurance policies provide certain types of benefits. Heitler, *Mandated Benefits: Their Social, Economic, & Legal Implications*, 11 L. MED. & HEALTH CARE 248, 249 (1983). Minimum mental health and substance abuse treatment mandates are increasingly common. Browne, Browne, McLaughlin & Wagner, *supra* note 137, at 74. Critics contend that mandated benefits are enacted to meet provider, rather than consumer, demand, and that they make health insurance more expensive than consumers would want. Heitler, *supra*, at 249-50; Kusters, *Mandating Benefits—On the Agenda*, REGULATION, 1988 No. 3, at 21, 26. Mandated benefit laws, which do not apply to self-insured plans under *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 735-36 (1985), may "accelerate a trend by employers toward self insurance." Browne, Browne, McLaughlin & Wagner, *supra* note 137, at 74.

¹⁵⁸ R.I. GEN. LAWS §§ 42-62-1 to -28 (1988 & Supp. 1989).

¹⁵⁹ *Id.* § 42-62-6.

¹⁶⁰ *Id.* § 42-62-7; *see also id.* § 42-62-10 (defining "qualified health program"). Members of qualified programs with incomes less than \$39,999 are eligible if they incur obligations of the greater of \$1,000 or 10% of adjusted income. Members with incomes greater than this amount are eligible after they incur health care obligations that exceed 12 1/2% of adjusted income. *Id.* § 42-62-7(d)(1)(A). In contrast, persons with unqualified health insurance benefits must have incurred expenses equal to those of members of qualified plans "*plus* the difference, not to exceed . . . \$2,000, between costs covered by his or her plan or plans of coverage and a qualified program." *Id.* § 42-62-7(d)(1)(C) (emphasis added). People without any health insurance coverage are eligible only if they incur obligations of the greater of \$10,000 or 50% of their adjusted income. *Id.* § 42-62-7(d)(3).

¹⁶¹ *Id.* § 42-62-10.

may participate in the program, including "all persons, firms, or corporations providing health benefits coverage for employees on a self-insurance basis without the intervention of other entities."¹⁶² The state, therefore, indirectly encourages the provision of certain types of coverage by offering to fund part of the catastrophic coverage for individuals participating in qualified plans. Although not yet judicially tested, CHIP would appear vulnerable to an ERISA challenge based on its treatment of self-insured employers as "insurers."¹⁶³

State risk pools are another method of addressing the problems of the uninsured, although they can potentially reach only a small subset of the population.¹⁶⁴ At least nineteen states have enacted these pools, which usually provide subsidized health insurance coverage for those whose medical history make them "uninsur-

¹⁶² *Id.* § 42-62-4(c).

¹⁶³ See Note, *Worker Well-Being*, *supra* note 64, at 862-63. In *Standard Oil Co. v. Aghalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981), Hawaii had argued that the existence of CHIP meant that its Prepaid Health Plan should not be preempted. The Ninth Circuit disagreed, noting that the Rhode Island statute did not focus on the employer-employee relationship and that it involved only a fund administered by the state. *Id.* at 765.

It could nonetheless be argued that the CHIP plan should be subject to preemption because it relates to employee benefit plans and because it applies to self-insured plans in violation of the deemer clause. The fact that the state law results in favorable treatment for self-insured plans should be irrelevant for purposes of the preemption analysis. As the Supreme Court noted in *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825 (1988), any state law that makes "reference to" ERISA plans "relates to" those plans and is subject to preemption. *Id.* at 829. The fact that ERISA plans were being singled out for more favorable treatment was not sufficient to save the law from preemption. *Id.* On the other hand, it could be argued that CHIP should nonetheless survive preemption because, though it refers to ERISA plans, it does not subject them to "different treatment." *Id.* at 830, 838 n.12. This argument seems weak, for the benefits law partially preempted in *Metropolitan Life* clearly "related to" ERISA plans even though it did not single them out for different treatment. See 471 U.S. at 739. Consistent application of the broad preemption standard would appear to result in CHIP's preemption. Such a challenge seems unlikely, however, since application of the plan qualification provisions benefits employee welfare plans while burdening only the state coffers, which must supply funds to pay for catastrophic coverage.

¹⁶⁴ See, e.g., Bovbjerg & Koller, *State Health Insurance Pools: Current Performance, Future Prospects*, 23 *INQUIRY* 111 (1986) (discussing state risk pools and prospects for expansion); Bovbjerg & Kopit, *supra* note 20, at 910.

able" by private insurance plans.¹⁶⁵ The success of pools, measured by their level of enrollment and their financial stability, has been mixed.¹⁶⁶ Enrollment in state risk pools remains far short of potential, possibly because the insurance policies remain quite expensive even after state subsidization.¹⁶⁷ In addition, most of the high-risk pools continue to experience financial shortfalls, which are typically met by levying a tax on insurance companies within the state. Yet ERISA impedes this method of financing because it immunizes self-insured plans from state mandated contributions to make up a risk pool's shortfall.¹⁶⁸

ERISA's preemption provision is like a locked valve, shutting off access initiatives at the state level or shunting them into inefficient pathways. As the pressures on the health system have continued to increase, the design and implementation of new state level initiatives has grown in importance. As of 1984, more than fifteen states were studying improving access to health care for the uninsured.¹⁶⁹ By January 1989, about forty states had considered legislation, enacted small scale pilot projects, or established

¹⁶⁵ McEachern, *Problem of Uninsured Spurs More States to Consider Risk Pools, Employer Mandates*, *Managed HealthCare*, Mar. 12, 1990, at 1, col. 1 & 7, col. 4 (California, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Maine, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Oregon, South Carolina, Tennessee, Texas, Washington, Wisconsin); *see also* Laudicina, *supra* note 30, at 98. Fifteen states are considering introduction of risk pools. McEachern, *supra*, at 1.

¹⁶⁶ McEachern, *supra* note 165, at 7 (the number of enrollees in operating programs range from 0 in Illinois and 49 in Maine to 14,386 in Minnesota); Laudicina, *supra* note 30, at 97-99; *see also* EBRI, *supra* note 41, at A1-A7 app. Table 2 (comparing 10 state health insurance pools).

¹⁶⁷ Laudicina, *supra* note 30, at 98; EBRI, *supra* note 41, at 9-10.

¹⁶⁸ *See* Laudicina, *supra* note 30, at 100; *supra* notes 119-29 and accompanying text. ERISA prohibits application of state contribution requirements to self-insured plans. It also sets an outside limit on such requirements as a matter of economics. Burdening insurance companies with high contributions will raise the cost of insurance, making self-insurance even more attractive. As companies choose to self-insure, the cost of financing the risk pool must be spread over an even smaller insurance market. Plans considered in the 99th Congress would have permitted "states to tax self-insured health plans . . . to help underwrite state insurance risk pools." EBRI, *supra* note 41, at 8.

¹⁶⁹ Dallek, *supra* note 40, at 740, 741. Alabama, Arkansas, Georgia, Kentucky, New Mexico, North Carolina, Oregon, South Carolina, Tennessee, Texas, Utah and Virginia were studying the problem. *Id.* Colorado, Ohio, Florida and Washington had already completed studies. *Id.*

commissions to study the development of such projects.¹⁷⁰ The Massachusetts Universal Health Care Plan ("UHCP") and the Washington Basic Health Plan ("BHP") have been the most prominent paradigms in the new wave of state initiatives. Each is a complicated multifaceted attempt to deal with the problems of the uninsured, and each focuses on a different central funding mechanism. The Massachusetts program incorporates special employer taxes, while the Washington plan relies solely on public funding. An analysis of these programs will show that ERISA continues to impede implementation of economically and politically viable state level initiatives to improve access for the uninsured.

B. Massachusetts and Employer Mandates

1. The Promise of Universal Coverage

A combination of economic and political factors laid the groundwork for Massachusetts' attempt to create a comprehensive state-level solution for the problems of the uninsured.¹⁷¹ The Massachusetts economy was generally perceived to be strong at the time of the bill's passage, with low unemployment, excess state revenues, and a low rate of uninsurance.¹⁷² An uneasy alli-

¹⁷⁰ See, e.g., Eno & Haugh, *supra* note 24; Knox, *Wisconsin's Turn: A Year Later, 2d State Debates Health Coverage*, Boston Globe, Apr. 11, 1989, at 9, col. 1.

¹⁷¹ The health insurance initiative evolved in a politically liberal state. State residents had overwhelmingly approved the concept of mandated health insurance in a 1986 referendum. Holthaus, *Massachusetts Bill Will Be Hard to Follow*, HOSPITALS, Nov. 5, 1987, at 64, 64; see also Sager, *Making Universal Health Insurance Work in Massachusetts*, 17 L. MED. & HEALTH CARE 269, 272 (1989). Governor Dukakis' national political ambitions fueled his support for an innovative and comprehensive solution to a problem with national implications. See, e.g., Peirce, *States Are Trying Universal Health Insurance*, 19 NAT'L J. 2812, 2812 (1987); Gold, *Health Insurance in Massachusetts To Cover All; Victory for Dukakis*, N.Y. Times, Apr. 14, 1988, at A1, col. 5.

¹⁷² Holthaus, *supra* note 171, at 64. The strength of the state's economy helped to overcome fears that businesses would migrate to other states if the cost of labor was increased. *Id.* Massachusetts already had an extensive Medicaid program, for example, leaving a smaller percentage of poor or near-poor in need of state assistance. Lipson, *Massachusetts Legislation: A Model for Other States or a Costly Mistake?*, BUS. & HEALTH, Aug. 1988, at 48, 48; see also Peirce, *supra* note 171, at 2812 (13.1 percent of nonelderly uninsured compared to national average of 17.4 percent). Approximately 600,000 Massachusetts residents were uninsured at the time of the bill's

ance between hospitals, businesses and health care advocates resulted in passage of a universal access plan.¹⁷³ Analysis of the UHCP's somewhat complicated coverage, benefit, financing and cost containment provisions reveals a fragmented policy set to implode before full implementation. The Plan's public financing provisions will likely lead to a legislative backlash, while its employer taxation system is open to an ERISA preemption challenge.

Based on the foundation of health care access as a right,¹⁷⁴ the UHCP represents an ambitious attempt to provide universal

passage. Polzer, *Massachusetts' Universal Health Plan: Who Will Pay the Bill?*, BUS. & HEALTH, Apr. 1990, at 48, 50 (73% were employed or dependents of employed; 17% were part-time workers or unemployed; 5% were disabled or retired; 5% were students).

¹⁷³ See Gold, *supra* note 171, at A1, col. 1. The initial plan, proposed by Dukakis but opposed by both businesses and health care providers, included not only employer mandates, but also an attempt to revamp the state's hospital industry through creation of a central state agency with wide-ranging powers and duties. Peirce, *supra* note 171, at 2812; see also Bergthold, *supra* note 53, at 441; Sager, *supra* note 171, at 274. The health care plan that eventually emerged from the political process was a compromise wrought by the Chair of the State Senate Ways and Means Committee, Patricia McGovern. *Id.*; see also Mercure & Pell, *Politics and Health Care Mingle in Massachusetts*, BUS. & HEALTH, May 1988, at 10, 12. McGovern tied the hospital financing bill to an altered universal health insurance coverage plan. Gold, *supra* note 171, at A1, col. 1. The final bill combined a financial bail-out for Massachusetts hospitals with an ambitious attempt to incrementally provide basic health coverage for all state citizens. Hospitals, businesses, and health care access advocates thus entered into an uneasy political alliance which was powerful enough to gain narrow passage of the measure. See Sager, *supra* note 171, at 273-276 (analyzing political background of UHCP); Sager, Hiam & Socolar, *Promise and Performance: First Monitoring Report on "An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing,"* (Unpublished Report prepared at Boston University School of Public Health, Apr. 9, 1989) (summarizing and evaluating UHCP legislation); see also Bergthold, *supra* note 53, at 446, 449 (discussing importance of political alliances). Businesses may have been motivated to join this alliance by state legislation enacted in 1985 that made it clear to the private sector that employers who provided health insurance coverage for their employees were already paying for a substantial portion of the "uncompensated" care within the state. See Lipson, *supra* note 172, at 48; Mercure & Pell, *supra*, at 10, 12.

¹⁷⁴ Massachusetts has declared that "the access of residents of the commonwealth to basic health care services is a natural, essential, and unalienable right which is protected by . . . the Constitution." MASS. GEN. LAWS ANN. ch. 118F, § 1 (West Supp. 1990).

access financed by a combination of new employer taxes and general state revenues. The primary state agency responsible for developing and overseeing the expansion of health insurance coverage is the Department of Medical Security ("DMS" or "Department").¹⁷⁵ Although the Massachusetts plan aims for universal coverage, it is to be implemented in stages.¹⁷⁶ Coverage is to be expanded through a complicated combination of new state-funded programs,¹⁷⁷ Medicaid buy-ins,¹⁷⁸ state brokering of insurance for small businesses,¹⁷⁹ health insurance mandates for college students,¹⁸⁰ tax incentives to small businesses,¹⁸¹ and state programs to fund insurance for both unemployed and employed persons.¹⁸²

Some of UHCP's access initiatives already have been imple-

¹⁷⁵ The purpose of the DMS is "to provide, on a basis calculated to reduce or contain the costs of the program, a program of insurance coverage for health care services for persons in the commonwealth who are not otherwise eligible for or covered by" private or public health insurance. *Id.* ch. 118F, § 3. Although the Department is to establish health insurance programs to increase access to health care for the presently uninsured, it may not operate as a insurance company. Instead, it is to serve as a insurance broker. *Id.* ch. 118F, § 8. The DMS is to "make health insurance plans available . . . through the purchase of health insurance plans . . . from private health insurance companies, a hospital service corporation, a medical service corporation, or health maintenance organizations, and through the brokering of health insurance for employers and consumers of health care services." *Id.*; see also *id.* ch. 118F, § 6 (establishing general powers and duties of DMS).

¹⁷⁶ "The department shall provide that all residents of the commonwealth will have access to basic health insurance or managed care at a reasonable cost by [March 1, 1992], subject to the availability of unappropriated funds." *Id.* ch. 118F, § 19. A recent study indicates, however, that "42 percent of the currently uninsured would still be uncovered [after UHCP's full implementation] because of the exemption for workers in small firms with fewer than six employees, seasonal workers and others." Knox, *Lacking Insurance, People Visit Doctor Less*, Boston Globe, Oct. 4, 1990, at 37, col. 4.

¹⁷⁷ See, e.g., MASS. GEN. LAWS ANN. ch. 111, § 24D (new program for pregnant women and infants).

¹⁷⁸ *Id.* ch. 118F, § 6A, B (Medicaid buy-in provisions for disabled).

¹⁷⁹ *Id.* ch. 118F, § 11 (DMS will assist small businesses).

¹⁸⁰ *Id.* ch. 15A, § 7B (college student mandate).

¹⁸¹ *Id.* ch. 62, § 6(f), ch. 63 § 31E (credits against personal and corporate income tax for small businesses).

¹⁸² *Id.* ch. 151A, § 14G(a)-(b) (medical security payment and unemployment health insurance contribution imposed to help fund coverage for the employed and unemployed).

mented. These provisions generally extend Medicaid coverage to otherwise ineligible groups or create new state-funded programs for the near-poor who remain Medicaid ineligible.¹⁸³ One set of initiatives, for example, covers pregnant women and infants.¹⁸⁴ Medicaid coverage has also been expanded for other groups, like the newly employed, and disabled adults or children.¹⁸⁵ As of 1990, state officials asserted that 17,000 people will have received coverage under these provisions.¹⁸⁶

Yet, despite the progress already achieved, some of the most important and contested coverage provisions face implementa-

¹⁸³ On a different track, mandates have been imposed on university students. By September of 1989, all full- and part-time college students were required to be enrolled in a qualifying health insurance program. MASS. GEN. LAWS ANN. ch. 15A, § 7B (West Supp. 1990). Students who elect not to participate in plans offered by their college must offer proof of other qualifying coverage. *Id.* Colleges or universities who fail to implement the UHCP's provisions are subject to the same penalties imposed on employers. *Id.*; *see id.* ch. 151A, § 14G(i). Under this mandate an estimated "50,000 to 60,000 previously uninsured students now have basic coverage at a yearly costs of \$270." Polzer, *supra* note 172, at 52; Department of Medical Security, Universal Health Care Update 2 (Nov. 1989) (unpublished report available from the Commonwealth of Mass., Exec. Office of Human Services, Dept. of Medical Security).

¹⁸⁴ Medicaid coverage of pregnant women and infants is to be extended to those without other coverage whose incomes is less than 185% of the federal poverty level. MASS. GEN. LAWS ANN. ch. 118E, § 1A (West Supp. 1990). Other pregnant women and infants may be eligible for new state sponsored limited health coverage. The Act requires the state Department of Public Health to establish a program of medical care and assistance for pregnant women and infants who do not qualify for Medicaid or have other adequate insurance coverage but whose income is between 185% and 200% of the federal poverty level. *Id.* ch. 111, § 24D. The program is to provide general pre- and post-partum obstetric and gynecological care along with limited newborn care, but does not cover inpatient hospitalization.

¹⁸⁵ Those who become ineligible for welfare because of employment can retain Medicaid benefits for up to two years. *Id.* ch. 118E, § 1B (so long as their income remains below 185% of the federal poverty level and their employer does not provide health insurance). This Medicaid extension program will sunset in 1992, the year in which the other employment related health insurance programs will take effect. *Id.* The UHCP also establishes buy-in programs for Medicaid which permit disabled adults and children to obtain Medicaid coverage according to sliding scale payments. *Id.* ch. 118E, § 6A, B.

¹⁸⁶ Polzer, *supra* note 172, at 52 (9,000 newly employed former welfare recipients, 6,500 pregnant women and infants, and 1,500 of the disabled); Department of Medical Security, *supra* note 183, at 3 (describing the Common Health program).

tion in the next two years. The state has just begun to implement programs to provide insurance for the unemployed¹⁸⁷ and for those employed by small businesses.¹⁸⁸ A comprehensive health care program for General Relief recipients is to be in place by 1991.¹⁸⁹ Finally, by January 1992, the indirect employer mandate provisions of the bill will be applied, and the DMS must begin a program to provide health insurance to those remaining employed persons not covered by workplace plans.

In sum, the coverage provisions of the Massachusetts plan reflect the different discrete populations contained within the ranks of the uninsured: the poor, near poor, disabled, unemployed, and employed.¹⁹⁰ Members of different groups receive different levels of health insurance benefits. Certain pregnant women and infants, individuals with low levels of employment, and disabled adults and children will receive Medicaid benefits.¹⁹¹

¹⁸⁷ In January 1990, the state began collecting a special unemployment tax from employers. The receipts were to be used to subsidize health insurance for low-income unemployed persons beginning in the Summer of 1990. MASS. GEN. LAWS ANN. ch. 118F, § 19(6) (West Supp. 1990); Bushnell, *Meet the Man Who's Bringing Mandated Health-Care to Massachusetts*, Boston Globe, June 5, 1989, at 13, col. 2 (businesses required to "contribute .12 percent of the first \$14,000 of each employees wages, up to a maximum of \$16.80"). State officials predicted that \$34 million would be used "to provide about 30,000 people and their families with health coverage." Polzer, *supra* note 172, at 52; *see also* Department of Medical Security, *supra* note 183, at 2.

¹⁸⁸ Department of Medical Security, *supra* note 183, at 1 (describing phase-in initiatives). The DMS was to devise "phase-in initiatives to broker health insurance transactions between small businesses and health insurance" providers. MASS. GEN. LAWS ANN. ch. 118F, §§ 10, 11 (West Supp. 1990). The small business demonstration projects were designed for small businesses without insurance coverage for their employees. Polzer, *supra* note 172, at 53. The department is stabilizing the cost of health insurance by providing stop loss insurance. *Id.* The Department also will establish a health insurance pool for small businesses employing six or fewer full-time employees. MASS. GEN. LAWS ANN. ch. 118F, § 11 (West Supp. 1990).

¹⁸⁹ MASS. GEN. LAWS ANN. ch. 117, § 1A (West Supp. 1990); *id.* ch. 118F, § 19(7).

¹⁹⁰ Although the coverage for the program is theoretically universal, it is not completely mandatory. While college and university students are required to maintain health insurance coverage, for example, employees are not. In the final analysis, the extent of actual coverage of some groups under UHCP will be affected by the financial incentives or disincentives created under the program.

¹⁹¹ MASS. GEN. LAWS ANN. ch. 118F, § 1A (pregnant women and infants);

Those state residents who are covered by wholly state-funded programs other than Medicaid generally receive less comprehensive benefits.¹⁹² Finally, the UHCP does not attempt to prescribe the types of benefits offered by employers.¹⁹³

The UHCP's financing is complicated and contains elements likely to bring both a political backlash and an ERISA challenge. The UHCP's complex access provisions are financed through both public and private funds. Medicaid extensions authorized by Congress will be funded by both the state and federal governments.¹⁹⁴ The state will finance a comprehensive health program including hospitalization costs for persons on General Relief.¹⁹⁵ Estimates of the level of new state funding for the first five years of UHCP, including the new hospital financing attached to the

id. § 1B (some low wage employed adults); *id.* § 6A-B (disabled adults and children).

Although Medicaid pays for most "medically necessary" care, recipients often are practically restricted in their choice of providers. Massachusetts' Medicaid program provides a relatively generous range of benefits. *Id.* ch. 118E, § 6 (West 1989); *see also* 42 U.S.C. § 1396a (1988) (detailing federally required Medicaid benefits); FEIN, MEDICAL CARE, MEDICAL COSTS 113 (1986). The federal government pays a percentage of Medicaid costs for mandatory and optional benefits. Abortion is one exception to this rule. *See Harris v. McRae*, 448 U.S. 297 (1980) (upholding Hyde amendment which denied federal reimbursement for medically necessary abortions). Many providers refuse to accept Medicaid patients because the Medicaid reimbursement rate for services is very low and payments are slow or unreliable.

¹⁹² The Massachusetts program for pregnant women and infants, for example, provides only limited obstetrical, gynecological, and pediatric care. MASS. GEN. LAWS ANN. ch. 111, § 24D (West Supp. 1990). Inpatient hospitalization for the mother is specifically excluded from coverage. *Id.*

¹⁹³ *Id.* ch. 151A, § 14G(c). The Act does not provide incentive to offer a complete set of benefits because the maximum amount of special tax to which an employer could be subject, \$1680, is lower than the usual cost of an employee's health insurance. *See infra* text accompanying notes 197-99. The Plan does, however, provide extensive benefits for individuals purchasing their insurance coverage through the DMS, which is required to provide all benefits mandated under state law. The Department is to provide each enrollee with a choice of at least two health benefits plans, each of which must provide a "reasonable range" of health services and must "include any mandated benefits otherwise required by law." MASS. GEN. LAWS ANN. ch. 118F, § 9.

¹⁹⁴ Such as the extension of Medicaid coverage to near-poor pregnant women and infants. *See* MASS. GEN. LAWS ANN. ch. 118E, § 1A (West Supp. 1990); *supra* note 184.

¹⁹⁵ MASS. GEN. LAWS ANN. ch. 118F, § 19(7) (West Supp. 1990).

access provisions, range from \$600 million to \$1 billion.¹⁹⁶ The success or failure of the plan rests in part on the state's fiscal health and the willingness of state residents to fund health care access initiatives from state revenues. As a new program, UHCP may be particularly vulnerable to legislators seeking deficit reductions.

Despite the high level of state funding, a significant portion of the money to be used to pay for improved access is to be raised by taxing employers.¹⁹⁷ Employers must pay a new tax, called the

¹⁹⁶ Lipson, *supra* note 172, at 48. According to official estimates, the program was to "cost the state an estimated \$50 million in FY 1988, \$95 million in FY 1989, \$125 million in FY 1990, \$195 million in FY 1991 and \$195 million in FY 1992." McGovern, Chair, Senate Ways and Means Committee, *Answers to the Most Popular Questions About Universal Health Care in Massachusetts* 6 (1988). *But see* Polzer, *supra* note 172, at 48 (estimating \$250-300 million will be needed in 1992). These estimates "include funding for \$50 million in annual state contributions to hospitals to make up for potential federal Medicare cuts." Polzer, *supra* note 172, at 55. As some commentators have noted, the hospital bail-out provisions of the UHCP actually cost far more than the increased access provisions. *Id.* (predicting 5.5 times more money for hospitals than for improving access); Sager, *supra* note 171, at 270-71 (noting that hospital revenues are expected to increase by \$1.14 billion while access provisions are expected to cost \$585 million).

UHCP also includes other state financed mechanisms designed to encourage otherwise exempt employers to provide employee health insurance. Small businesses are exempt from the medical security payments, but are given other tax incentives to encourage insurance coverage. MASS. GEN. LAWS ANN. ch. 151A, § 14G(b), (f) (West Supp. 1990). Small businesses which have not offered health insurance benefits to their workers in the past will be permitted to apply a partial credit against taxes levied in the first two years in which they begin to offer health benefits to their employees. *Id.* ch. 62, § 6(f) (credit against personal income tax); *id.* ch. 63, § 31E (credit against corporate excise tax); *see also* Polzer, *supra* note 172, at 54 (noting importance of small business provisions). Small businesses whose medical security contribution exceeds 5% of their gross revenue are eligible for the UHCP's health insurance hardship program that reduces their contribution to 5% of gross revenues. MASS. GEN. LAWS ANN. ch. 118F, § 13; *see also id.* ch. 151A, § 14G(b). In effect, the state initially subsidizes the cost of coverage for small employers by providing a tax credit.

¹⁹⁷ Initially, Massachusetts hoped to obtain a Congressional waiver from ERISA preemption which would permit the state to simply require employers to provide benefits. Holthaus, *supra* note 171, at 64. The alternative, later adopted, was to finance coverage through taxes levied on employers. *Id.* Employers who fail to comply with the new tax provisions are liable for the greater of \$35 or \$5 per employee per day of noncompliance. MASS. GEN. LAWS ANN. ch. 151A, § 14G(i). In addition,

medical security payment, which, based on an employee's wages, can reach \$1680 per employee.¹⁹⁸ The amount of the medical security payment can be reduced to zero by deducting an employer's per employee health care cost.¹⁹⁹ The medical security payments will be used to subsidize coverage for uninsured employed individuals.

This tax and credit mechanism may encourage some employers to provide health insurance coverage for their employees to avoid paying the special employment tax.²⁰⁰ Individuals who are not

they may be held liable for "any amounts owed to the medical security trust fund as a result of" their non-compliance. *Id.*

¹⁹⁸ These employers will also be required to pay a medical security contribution of 12% of the first \$14,000 of certain employees' wages. MASS. GEN. LAWS ANN. ch. 151A, §§ 14G(b), 14G(e)(2). Medical security contributions need not be made on the wages of some temporary or seasonal employees. *Id.* § 14G(b). Nor is an employer required to make medical security payments on the wages of many part-time employees. *Id.* Finally, the employer is not required to make medical security payments on the wages of employees covered by other public or private insurance. *Id.* The initial medical security contribution will equal about \$1680 per worker. After 1992, the \$14,000 wage base will be indexed by the health insurance inflation rate. *Id.* ch. 151A, § 14G(e)(2). The base rate can also be increased based on the costs of coverage for the unemployed or employed under the Medical Security Department's programs. *Id.* ch. 151A, § 14G(h).

New businesses, which are exempt from coverage if they have been in operation for less than 12 months, are offered a slightly different type of incentive. *Id.* ch. 151A, § 14G(f). The UHCP permits a gradual phase-in of the program's requirements for businesses after the 12 month grace period. *Id.* §§ 14G(f)(2)-(3). New businesses are thus protected from the full immediate impact of the program's tax provisions.

Employers are also required to pay a special tax designed to pay for coverage of the unemployed. Every employer with more than five employees will be required to pay an unemployment health insurance contribution of .12% of the first \$14,000 of wages for all employees. *Id.* ch. 151A, § 14G(a). State officials estimated that 40% of the unemployed were without insurance. *See* Polzer, *supra* note 172, at 52.

¹⁹⁹ Employers will be permitted to deduct from their medical security payments their "average expenses per employee for providing health insurance coverage," provided the payments are allowable as a business expense under Internal Revenue Service Regulations. MASS. GEN. LAWS ANN. ch. 151A, § 14G(c). The deduction cannot result in a credit for the employer. *Id.*

²⁰⁰ There are three possible situations. Employers are not given an incentive to find health insurance coverage that costs less than the medical security payment, because they will just incur a tax liability equal to the difference. This scenario is unlikely in any event, however, because the medical security payment level is set relatively low and it would be difficult

covered by their employers or other insurance sources will be able to obtain coverage from programs brokered by the DMS. These individual enrollees will, however, be required to contribute to premiums, copayments, deductibles or co-insurance at a rate based on their income and family size.²⁰¹ Imposing these costs on enrollees may deter some from seeking coverage under the state brokered insurance plans.²⁰²

The UHCP requires large financial contributions from the state and from employers. The size of the bill for improved access raises the issue of cost containment. Health care expenditures and costs in Massachusetts are already the highest per capita in the country.²⁰³ Increasing access to health care is likely to increase health expenditures in an absolute sense. Yet, theoretically at least, unnecessary health expenditures might be reduced through cost containment measures.²⁰⁴

to provide health insurance coverage for less. See Polzer, *supra* note 172, at 48, 50. Employers who can find health insurance coverage for their employees at a cost equal to the medical security payment may decide to provide insurance coverage instead of paying the special tax because of the greater employee goodwill earned by providing the benefit directly. On the other hand, employers who are worried about escalating health insurance premiums may prefer to pay the more stable medical security payment. Finally, employers whose insurance coverage costs more than the amount of the medical security payment may have some incentive to stop providing coverage directly and to begin paying the medical security tax. This could result in rapidly escalating costs for the state insurance program as employers with generally higher health care costs dump their expensive workforces into the state run program. Polzer, *supra* note 172, at 50.

²⁰¹ Enrollees will be required to contribute based on a sliding scale. MASS. GEN. LAWS ANN. ch. 118F, § 9. Individuals whose income "substantially exceeds" the federal poverty level must pay 100% of premiums. *Id.*

²⁰² The actual extent of individual enrollment in these programs may well depend on the ability or willingness of enrollees to bear premium, copayment and deduction costs. The goal of universal access may be hampered by the inability of the near-poor to afford cost-sharing. Universal coverage may also be thwarted if that proportion of the uninsured who do have incomes that substantially exceed the federal poverty level continue to elect not to pay for coverage. The Plan does not provide incentives for these individuals to obtain coverage. For example, the state does not offer a less expensive health insurance plan stripped of state mandates.

²⁰³ Sager, *supra* note 171, at 269; see also Kong, *Report: Health Costs May Rise Steeply*, Boston Globe, Oct. 31, 1990, at 1, col. 3.

²⁰⁴ Inefficient providers might be eliminated from the system. Health insurance policies can be designed to encourage the provision of necessary and cost efficient care through the use of managed care arrangements and

The Act, however, does little to promote efficient medical care.²⁰⁵ The DMS is encouraged to purchase managed care plans for its enrollees.²⁰⁶ The legislation also provides that enrollees may bear the cost of premiums and may be responsible for copayments and deductibles. These features of the Act may discourage the overutilization of health services, but must be evaluated to ensure that they do not hinder access to care for the near poor.

2. Death by Postponement or Preemption

Economic criticisms of the Massachusetts plan's operation focus on the methods of financing which may create problems for businesses, employees, and politicians. The employer tax system, it is asserted, will harm small businesses,²⁰⁷ workers,²⁰⁸ and state

copayment arrangements. Governor Dukakis' initial universal health care proposal would have created a state agency with broad power over both access and cost. After political compromises, the Department of Medical Security emerged stripped of much of its power to control health care costs. Instead of acting as a public insurer, which could have directly bargained for cost reductions from providers, the DMS's role was reduced to that of purchasing insurance from others. The DMS's potential power was also decreased by the requirement that it purchase no more than 30% of its coverage from one source. *See MASS. GEN. LAWS ANN.* ch. 118F, § 9 (West Supp. 1990).

²⁰⁵ The UHCP legislation does contain hospital financing provisions. But these portions of the statute for the most part provide increased revenues for hospitals and add to health care inflation. Polzer, *supra* note 172, at 50, 55. The Act does not directly reduce the overcapacity that can lead to the inefficient delivery of care. An Acute Hospital Conversion Board is established to "administer the provisions of [the statute] concerning the closing of acute hospitals or their conversion to other health, rehabilitative or public purposes." *MASS. GEN. LAWS ANN.* ch. 6A, § 101(a). Its mandate is reactive, however, it merely responds to hospitals who notify it of financial instability. *Id.* § 101(b). Once notified of the hospital's intent to close or its financial instability, the Board is empowered to appoint a community need determination committee to study the potential ill effects of the hospital's closure. *Id.* The Board then has the power to facilitate closures or conversions through increased funding and exemptions from certain regulatory mandates. *Id.* ch. 6A, § 101(d).

²⁰⁶ *MASS. GEN. LAWS ANN.* ch. 118F, § 9.

²⁰⁷ Economically, critics contend that the state's program will disproportionately burden small employers. *See, e.g.,* Polzer, *supra* note 172, at 55-56; Reinhardt, *supra* note 3, at 43; *Statements from the Field*, BUS. & HEALTH, May 1988, at 14, 14-16, 18. To some extent small business concerns are reflected in the final legislation, which exempts very small and new employers from the medical security payment. *MASS. GEN. LAWS ANN.* ch. 151A, § 14G(b), (f); *see also id.* ch. 118F, § 7 (establishing small business

competitiveness.²⁰⁹ Critics of the public financing portion of the bill contend that the state cannot afford the costs of access, particularly in the absence of strict cost containment.²¹⁰ Finally, the UHCP is vulnerable to a legal challenge because ERISA might

advisory board for Department of Medical Security); *id.* ch. 62, § 6(f) (tax credits for small businesses); *id.* ch. 118F, § 11 (risk pools for small businesses).

²⁰⁸ The UHCP could potentially create problems for employees. First, as the cost of labor increases employment may be reduced. The plan does little to ameliorate this problem. Second, employer-funded health care plans can create incentives for employer discrimination in hiring and retention. The UHCP attempts to prevent discrimination against applicants or employees based on health insurance status. Recognizing the adverse employer incentives that the medical security tax creates, the Massachusetts plan provides that an employer may not "require an applicant for employment to disclose his health insurance status or that of his spouse, dependents, or other family members." MASS. GEN. LAWS ANN. ch. 151A, § 14G(b). The Act also prohibits employer discrimination against a job applicant based on his or her health insurance status. *Id.* While UHCP forbids discrimination based on health insurance "status," it may not forbid discrimination based on the health insurance "cost."

²⁰⁹ Passage of the Massachusetts plan inevitably led to charges that the bill would cause the migration of businesses from the state and an influx of needy seeking health coverage. *See, e.g.,* Polzer, *supra* note 172, at 50 (citing health policy analyst who contends Massachusetts is at competitive disadvantage); Gold, *supra* note 171, at B7 col. 2; *Statements from the Field*, *supra* note 207, at 14-16, 18. The program's supporters counter that corporate flight is unlikely for at least three reasons. First, Massachusetts generally has lowered its relative rate of taxation. Second, the new access systems may actually reduce costs for some businesses who had been providing health insurance benefits and thereby paying for previously uncompensated care through higher insurance premiums. Third, as a practical matter, addition of a single social welfare program is unlikely to force business relocation. *See* Tannenwald, *supra* note 54, at 33; *see also* Sager, *supra* note 171, at 272 (tax collections only slightly above national average).

Nor is the Act likely to increase the number of medically needy within the state. The Legislature was clearly mindful of the possibility; the UHCP discourages immigration by excluding from coverage persons who "move to Massachusetts for the sole purpose of securing health insurance under this Chapter." MASS. GEN. LAWS ANN. ch. 118F, § 2. The statute does not specify any practical method for implementing this exclusion, which is, in any event, constitutionally suspect as an infringement of the right of interstate travel. *Memorial Hosp. v. Maricopa County*, 415 U.S. 250 (1974) (invalidating a durational residency requirement that applied to publicly funded nonemergency hospitalization or medical care).

²¹⁰ *See infra* notes 212-14 and accompanying text.

preempt its medical security provision.²¹¹

The UHCP has been plagued by budget battles almost since its inception. Republicans and fiscally conservative Democrats have been waging a war of attrition and delay. The UHCP's failure to adopt stringent cost control measures is widely regarded as a fatal, if politically predictable, flaw.²¹² The Massachusetts budget crisis continues to cast an ominous shadow over the program's prospects. Even if the program survives current budget debates, however, an even more rigorous test will come in 1992, when implementation of the mandatory health insurance provisions is scheduled to begin.²¹³ Businesses will then be confronted with additional costs imposed by the medical security payments. Political and legal challenges are expected.²¹⁴

²¹¹ See *infra* notes 215-46 and accompanying text.

²¹² Zoler, *Massachusetts Plan Limping Toward Rewrite*, MED. WORLD NEWS, Mar. 12, 1990, at 13, 13; see also Polzer, *supra* note 172, at 57; Sager, *supra* note 171, at 276-77 (analyzing funding access provisions and observing that "access provisions have been financed at only about half of promised levels"); Fehrstrom, *State 'to begin pilot universal health plan'*, Boston Herald, Feb. 25, 1989, at 3, col. 5-6; Knox, *supra* note 170, at 13, col. 1 & 28, col. 3; Lipson, *Massachusetts Will Awake to Threat of Universal Health Statute*, Boston Globe, Dec. 22, 1988, at 58 (arguing for repeal of Massachusetts Act, partially on budgetary grounds). A recent report indicates that the state has fewer uninsured residents than initially estimated, potentially reducing the actual costs of the program. See Knox, *No Health Insurance Means Fewer Doctor Visits, Study Says*, Boston Globe, Oct. 4, 1990, at 33, col. 3.

The first casualty from the UHCP was the promised infusion of hospital payments. In the Spring of 1989, the state legislature rejected attempts to fulfill hospital funding commitments made during the universal health insurance compromise process. Phillips, *State Hospitals Denied \$50 million in House Reversal of Earlier Vote*, Boston Globe, Apr. 25, 1989, at 26, col. 1. After a public advertising campaign waged by the hospitals, the state eventually allocated money for the Medicare shortfall fund. Polzer, *supra* note 172, at 55. But a new budget fight was promised for the following year. *Id.*

The legislature will be required to revisit the hospital financing issue before September 1991. A special legislative commission is now considering a range of radical and reformist proposals for legislative action. The commission's report is due in December 1990. Kong, *Report: Health Costs May More Than Double*, Boston Globe, Oct. 31, 1990, at 6, col. 2.

²¹³ See, e.g., Knox, *Now—Universal Health*, Boston Globe, Feb 21, 1989, at 46, col. 1.

²¹⁴ See, Sager, *supra* note 171, at 276 ("business groups have threatened a legal test of" the medical security payment scheme). The legislature recently passed two bills designed to delay implementation of the UHCP. One would have delayed implementation of the employer tax provisions,

ERISA's preemption provision provides a potential legal challenge to the employer tax aspect of the Massachusetts program. Under ERISA, the UHCP's central medical security financing provision may be preempted if it "relates to" employee benefit plans,²¹⁵ unless it merely "regulates insurance."²¹⁶ Unlike earlier state plans, UHCP does not directly attempt to regulate the health insurance benefits provided by employers. Instead, it indirectly influences the adoption of such plans by taxing employers to help finance a state insurance fund, additionally providing a deduction for health insurance payments made by employers.²¹⁷ Although the courts have not yet ruled on ERISA's effect on such a plan, it could be argued that the program would be invalidated under a broad reading of ERISA's preemptive intent.²¹⁸

the other would have delayed a portion of the state-funded insurance program. Both bills were vetoed by Governor Dukakis. *Massachusetts Health Insurance*, Nation's Health, Sept. 1990, at 5, col. 1. Governor-elect Weld, a Republican, has expressed doubts about the employer tax provisions. See Knox, *No Health Insurance Means Fewer Doctor Visits, Study Says*, Boston Globe, Oct. 4, 1990, at 33, col. 2; and Knox, *Weld May Retain, Revise Universal Health Care*, Boston Globe, Dec. 11, 1990, at 1, col. 1.

²¹⁵ 29 U.S.C. § 1144(a) (1988).

²¹⁶ 29 U.S.C. § 1144(b)(2)(A) (1988); see *infra* note 246. Further, under the deemer clause, employee benefit plans cannot be "deemed" insurers under state insurance regulations. 29 U.S.C. § 1144(b)(2)(B) (1988).

²¹⁷ Bovbjerg and Kopit first suggested a similar financing method in 1986:

It might be possible for states to achieve similar "insurance" goals through their power to tax employers. Clearly, ERISA would not prohibit states from taxing all employers to fund care or coverage for the uninsured, for example, through a general payroll tax. . . . A payroll tax would, of course, tax employers already providing coverage in order to help those not now providing coverage, and could thus considerably hurt incentives to insure, especially in industries where many companies already provide no insurance. To maintain insurance incentives, employers could be allowed to deduct from the amount of payroll tax due any amounts contributed to health benefit plans (insured or self-insured) for their employees.

Bovbjerg & Kopit, *supra* note 20, at 907-08.

²¹⁸ ERISA's preemptive effect has been discussed in scholarly commentary. In a cogent analysis, Bovbjerg and Kopit have suggested that a combined payroll tax, health care expenditure deduction is unlikely to be preempted. *Id.* at 908-09. The present analysis reaches a different conclusion, although it incorporates many of these arguments, updated to reflect recent ERISA caselaw and expanded to specifically consider ERISA's policy concerns.

A preemption analysis of the question must consider several factors: 1) whether the medical security tax payment meets the “relates to” requirement; 2) whether the payment relates to an employee benefit “plan”; and 3) whether preemption would serve Congressional policy.²¹⁹ The first two of these arguments are the most complicated and contested, involving multiple subfactors: before ERISA’s preemption provision can be invoked it must be shown that the state taxing provisions “relate to” employee benefit “plans.”

ERISA’s “relate to” preemptive power has been construed broadly to cover both direct and indirect state actions that affect employee benefit plans.²²⁰ Courts struggling with the “relate to” requirement have focused on Congressional intent in enacting the preemption provision, the state legislature’s intent in enacting the challenged regulation, and the state law’s impact on employee benefit plans.²²¹ An analysis of these factors here suggests that the relate to requirement may have been met.

First, it seems clear that Congress intended to preempt direct state taxation of employee benefit plans.²²² The preemption provision contains no exclusion for state tax laws. In the conference process preceding ERISA’s enactment, Congress expressly refused to exempt state taxation of pension plans.²²³ Finally, in granting Hawaii’s preemption waiver, Congress later specifically stated that it should not “be construed to exempt from [the preemption provision] . . . any State tax law relating to employee benefit plans.”²²⁴ Courts have thus uniformly held that state

²¹⁹ See *id.* at 908.

²²⁰ See, e.g., *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 19 (1987); *supra* text accompanying notes 74-99.

²²¹ Some courts also have considered the degree of state control usually exercised in the regulatory area. See, e.g., *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 555 (6th Cir. 1987). *But see Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters.*, 793 F.2d 1456, 1467-68 (5th Cir. 1986) (rejecting consideration of this factor), *cert. denied*, 479 U.S. 1089 (1987).

²²² See *Bovbjerg & Kopit*, *supra* note 20, at 908.

²²³ *National Carriers’ Conference Comm. v. Heffernan*, 454 F. Supp. 914, 917 (D. Conn. 1978).

²²⁴ 29 U.S.C. § 1144(b)(5)(B)(i) (1988). The legislative history of Hawaii’s exemption from ERISA also supports the inference that Congress considers state tax laws preempted. H.R. REP. NO. 984, 97th Cong., 2d Sess. 18, *reprinted in* 1982 U.S. CODE CONG. & ADMIN. NEWS 4603 (“Under the provision . . . *preemption is continued* with respect to . . . any State tax law relating to employee benefit plans”) (emphasis added).

taxes related to employee benefit plans could be preempted.²²⁵

Second, Massachusetts clearly *intends* that the law affect employer provision of health benefits to employees. The combined tax-deduction scheme is merely an attempt to indirectly impose that which ERISA directly forbids: employer health insurance mandates. Employers will be taxed to provide for such plans and will receive a full tax credit if they provide plans of equal cost. The question becomes whether the mechanism chosen to affect this prohibited purpose successfully avoids triggering federal preemption.

The third factor to be considered then is the most important: the state law's impact on employee benefit plans. State tax laws can have either direct or indirect regulatory effect on benefit plans; they can either tax the plans directly or indirectly. In *National Carriers' Conference Committee v. Heffernan*, for example, the district court held that ERISA preempted a state statute that "specifically" taxed employee benefit plans because such a tax met the "related to" requirement.²²⁶ Courts have typically preempted state taxes that are based on the amount of benefits provided by a welfare plan.²²⁷ Such taxes clearly relate to benefit plans because they can discourage the provision of plan benefits.

²²⁵ See, e.g., *General Motors Corp. v. California State Bd. of Equalization*, 815 F.2d 1305, 1310 (9th Cir. 1987) (holding, however, that savings clause preserves McCarran-Ferguson Act's reservation of states' powers to "tax and regulate insurance"), *cert. denied*, 485 U.S. 941 (1988); *National Carriers'*, 454 F. Supp. at 916. See also, *Northwest Airlines, Inc. v. Roemer*, 603 F. Supp. 7 (D. Minn. 1984) (ERISA preempts state authority to levy upon an employee pension plan to satisfy state income tax liability of plan participant).

²²⁶ *National Carriers'*, 454 F. Supp. 914, 915 (D. Conn. 1978). The Connecticut statute at issue required a group maintaining an employee benefit plan to pay an annual tax "on 'the amounts paid as benefits to or on behalf of the residents of' Connecticut during the preceding calendar year." *Id.*

²²⁷ See, e.g., *Birdsong v. Olson*, 708 F. Supp. 792, 798-99 (W.D. Tex. 1989) (preempting a state tax on the administrative fee received by insurance companies for administration of ERISA plans); *General Split Corp. v. Mitchell*, 523 F. Supp. 427, 431 (E.D. Wisc. 1981) (preempting a state risk sharing plan in which state-mandated contributions to the plan were "based on the total benefits paid"); see also Irish & Cohen, *ERISA Preemption: Judicial Flexibility and Statutory Rigidity*, 19 J.L. REFORM 109, 140-42 (1985); Brummond, *supra* note 64, at 110; Comment, *supra* note 79, at 165-66. But see *General Motors Corp. v. California Bd. of Equalization*, 815 F.2d 1305, 1309-10 (9th Cir. 1987) (finding a California premium tax assessed against insurance companies — and calculated, in part, with

Indirect taxation, though it might achieve the same result, has not elicited consistent judicial treatment.²²⁸ Instead, preemption has depended on the basis of the taxation and the identity of the entity taxed. Here, Massachusetts has designed a mechanism that is equivalent in effect to simply taxing employers if they fail to provide employee health plans — a tax that would be preempted by ERISA. Yet the form is different; the tax appears to be related to an employer's payroll rather than to the amount of benefits provided and it is levied on the employer rather than on the plan itself. In form, then, the Massachusetts plan is distinguishable from the plan challenged in *National Carriers*'. In that case, courts confronted state taxes levied on the amount of benefits paid by a plan.²²⁹ Here, in contrast, there is "a general taxing provision that catches employee benefit plans within its wide sweep."²³⁰ The Massachusetts scheme seems closer to that upheld by the Sixth Circuit in *Firestone Tire and Rubber Co. v. Neusser*.²³¹ In *Firestone* the plaintiffs challenged a two percent city income tax that was calculated based on a worker's total income, including income that the employee contributed to some ERISA plans. The plaintiffs argued that the tax should be preempted because workers' contributions to the plans would be influenced by the city tax.²³² The court rejected this contention, distinguishing *National Carriers*', because the city's plan "merely tax[e] income without regard to the employee's decisions concerning plan contributions."²³³

Yet *Firestone* is not precisely on point either. There the court was able to characterize the tax scheme as "neutral" because it "tax[e] income without regard to the ultimate disposition of that income."²³⁴ Here, in contrast, the amount of tax actually paid *will*

reference to benefits paid by ERISA-covered plans — related to those plans, but was saved from preemption by the savings clause).

²²⁸ See also Bovbjerg & Kopit, *supra* note 20, at 908-09.

²²⁹ See *supra* notes 223-26.

²³⁰ *National Carriers*', 454 F. Supp. at 915.

²³¹ 810 F.2d 550 (6th Cir. 1987).

²³² *Id.* at 554.

²³³ *Id.*

²³⁴ *Id.* The plaintiffs argued that if the Akron tax was applied, then workers would lose some of the tax advantages of contributing to an ERISA plan, and they would be less likely to make those contributions. *Id.* The court, however, focused on the basis of the tax paid, noting that the city was taxing income without regard to the existence of any ERISA plan. *Id.* at 556.

depend on the amount of the employer's contribution to employee health benefits. The Massachusetts statute thus more directly affects the level of contribution.²³⁵

Further, turning to the nature of the entity taxed, some courts have rejected formal distinctions between direct regulation of plans versus employers.²³⁶ Under the UHCP the medical security payment does not directly tax employee benefit plans, but it does effectively tax employers who maintain such plans differently from those who do not. The identity of the taxed organization may be irrelevant if the tax scheme affects protected employee benefit plans. In this case, taxing the employer rather than the employee benefit plan seems but a chimerical difference, insufficient to protect the statute against a preemption attack.²³⁷

In summary, courts may hold that the stick and carrot taxing scheme meets the "relates to" requirement. Congress clearly did not exempt state tax laws from preemption, the Massachusetts plan is intended to affect employer provision of benefits and the

²³⁵ Although the actual incentive given may vary with the cost of health insurance. See *supra* note 200.

²³⁶ See, e.g., *St. Paul Elec. Workers Welfare Fund v. Markman*, 490 F. Supp. 931, 934 (D. Minn. 1980).

²³⁷ *Bovbjerg and Kopit* reach a contrary result in their analysis. See *Bovbjerg & Kopit, supra* note 20, at 908. Here, Massachusetts has merely imposed a payroll tax on employers and permitted a credit for health insurance benefits. MASS. GEN. LAWS ANN. ch. 151A, § 14G(c) (West Supp. 1990). This credit is the same as that provided under the Internal Revenue Code as a "deductible business expense." *Id.* *Bovbjerg and Kopit* develop a fairly persuasive contradictory approach:

First, the tax is analogous to a state corporate income tax that allows deductions for an employer's expenses incurred in maintaining employee benefit plans. Clearly, such state income taxes with such deductions have not yet been found to "relate to" employee benefit plans for the purposes of ERISA preemption. A payroll tax with similar offsets should be afforded similar status.

Bovbjerg & Kopit, supra note 20, at 908. One problem with their argument is that the medical security payment is not really "analogous to a corporate income tax." It is based on employee wages, not corporate income and can be reduced to zero by the average medical expense per employee. This expense is nearly always incurred through provision of an employee welfare benefit plan. Further, it is a dedicated tax that is to be used to subsidize the cost of insurance for employed individuals. MASS. GEN. LAWS ANN. ch. 118F, § 16 (medical security trust fund); *cf. Standard Oil Co. v. Aghalud*, 633 F.2d 760, 765 (9th Cir. 1980) (discussing state taxing power and employer mandates).

scheme adopted has an indirect impact on benefit plans. Two inquiries remain: Does the tax relate to a "plan" and would preemption serve Congressional purpose?

Under the Court's analysis in *Fort Halifax*, the UHCP medical security tax is subject to preemption if it relates to employee benefit plans.²³⁸ This holding may seriously restrict the application of ERISA preemption where an employer does nothing more than make a payment.²³⁹ It could be argued that, like the severance pay statute at issue in *Fort Halifax*, UHCP's medical security payment does not require employers to maintain "an ongoing administrative program," or plan.²⁴⁰ The Massachusetts statute does not require employers to establish employee benefit plans or to process claims or to pay benefits. Instead, it requires only that they "write a check."²⁴¹ Yet, from a different perspective, the statute arguably does try to force employers to adopt some program of administering health benefits, through the provision of insurance or otherwise.²⁴² Failure to adopt such programs will, it is true, result only in the writing of a check. But this analysis merely confuses the statutory penalty for its goal.

Finally, Congress' policy concerns support the conclusion that the Massachusetts plan should be subject to ERISA preemption.

²³⁸ *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987); *see supra* text accompanying notes 89-99.

²³⁹ Yet, as noted above, employer contributions to health insurance premiums are usually sufficient to establish an employee welfare benefit plan. *See supra* note 66. There has been one decision to the contrary. A California appeals court recently considered whether employers who merely pay health insurance premiums for their employees can be said to have established employee benefit plans. Applying *Fort Halifax*, the court found that payment of Blue Cross premiums did not establish a "plan" because the employer was not involved in any administration of benefits. *Sayble v. Blue Cross*, 208 Cal. App. 3d 1108, 256 Cal. Rptr. 820 (1989).

²⁴⁰ *Fort Halifax*, 482 U.S. at 11.

²⁴¹ *Id.* at 12. The payment to the medical security fund is more certain than the "contingent" severance pay at issue in *Fort Halifax*. As the Court notes in *Fort Halifax*, ERISA's provisions were enacted to "ensure the administrative integrity of benefit plans — which presumes that some type of administrative activity is taking place." *Id.* at 15.

²⁴² *See supra* note 66. The health benefits provided give rise to a credit only when they are deductible under the Internal Revenue Code. MASS. GEN. LAWS ANN. ch 151A, § 14G(c) (West Supp. 1990); *cf. In re Komet*, 104 B.R. 799, 801 n.3 (Bankr. W.D. Tex. 1989) (statutory reference to Internal Revenue Code, rather than ERISA, does not mean that ERISA plans not implicated).

However misguided, Congress favored preemption to remove “the threat of conflicting and inconsistent State and local regulation of employee benefit plans.”²⁴³ Massachusetts’ medical security payment program may burden multistate employers who will have to adjust their employee benefit plans in Massachusetts to take the new medical security payment into account. Administrative complexity would be magnified if other states adopted different programs providing tax credits of different amounts or types.²⁴⁴ Challengers to the UHCP will contend that it is preempted because it relates to employee benefits plans and conflicts with Congressional policy. It is at least arguable that these concerns will find a receptive judicial audience.²⁴⁵

²⁴³ *Shaw v. Delta Air Lines*, 463 U.S. 85, 99 (1983) (quoting Senator Williams, 120 CONG. REC. 29,933 (1974)); see also *Fort Halifax*, 482 U.S. at 10; and *FMC Corp. v. Holliday*, 111 S. Ct. 403, 408-09 (1990).

²⁴⁴ The actual additional significance of this additional burden is debatable. As matters stand, employers in Massachusetts who do not self-insure already face additional costs because they are subject to state insurance mandates. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 (1987). Further, UHCP requires only that employers pay a tax. The tax incentives may encourage — but do not require — employer administration of a special Massachusetts employee health program. Finally, unlike the Connecticut taxing plan examined in *National Carriers’ Conference Comm. v. Heffernan*, 454 F. Supp. 914 (1978), the Massachusetts plan does not attempt to impermissibly influence an employer’s choice between commercial insurance and self-insurance. The differential treatment of insurers and self-insurers was an important factor in the *National Carriers’* court’s preemption decision:

In the present action the challenged statute imposes a 2.75% annual tax on benefits paid by employee benefit plans. This contrasts with Connecticut’s tax on the premiums received by insurance companies, which is only 2%. . . . This tax structure may operate as an incentive to use traditional insurance, rather than ERISA-covered plans. Although the impact of the tax discrepancy may be only nominal at present, its economic impact is not the measure of its significance. Rather, the discrepancy is illustrative of the potential use of taxation as a means of regulation. Because of that potential, preempting state taxation of ERISA-covered plans is necessary to effectuate Congressional objectives.

National Carriers’, 454 F. Supp. at 918. The state has created an incentive for employer-provided health insurance, but it treats all methods of financing equally.

²⁴⁵ But see *Bovbjerg & Kopit*, *supra* note 20, at 908-09 (arguing that, despite broad ERISA preemption, states may still be able to enact financing mechanisms like the Massachusetts tax). Potential challengers may have to

Therefore, if ERISA's preemption provision applies, the Massachusetts employer taxation provision would be preempted unless it constitutes the regulation of insurance under the savings clause. The medical security plan would not, however, be "saved" by this provision because the Massachusetts' statute does not even purport to regulate insurance.²⁴⁶ Accordingly, if challenged, this provision of the UCHP may be vulnerable to ERISA preemption.

In summary, the Massachusetts access plan is a comprehensive initiative designed to provide universal coverage. This access will not be uniform — some groups will have more extensive benefits than others. A more serious problem is posed by the lack of stringent cost containment devices. The program's potential for explosive financial demands is likely to be politically unworkable. Finally, ERISA poses a serious threat to the program's emphasis on employer taxation.

C. *Washington and Public Financing*

1. *Basic Coverage*

The Washington legislature has also been attentive to the problems of the uninsured. In this state a round of government

initially pursue their claims in state court because of the Tax Injunction Act. *See General Motors Corp. v. California State Bd. of Equalization*, 815 F.2d 1305, 1308 (9th Cir. 1987) (noting that Act prohibits district court actions to hinder state tax collection when adequate state court avenue for claims exists, even when district court presented with ERISA preemption claims), *cert. denied*, 485 U.S. 941 (1988); 28 U.S.C. § 1341 (1988).

²⁴⁶ The state tax scheme does not transfer or spread a policyholder's risk, it is not an integral part of the relationship between the insurer and the insured, and its application is not limited to entities within the insurance industry. *See supra* text accompanying notes 106-17.

The Ninth Circuit Court of Appeals decision in *General Motors* is thus distinguishable. In *General Motors*, then Judge (now Justice) Kennedy upheld a state premium tax that was computed, in part, based on the benefits provided by the insurance plans. The plans involved stop-loss coverage, with the employer paying benefits up to a certain amount, and paying a premium to an insurance company to administer the plan and to take the excess risk. *General Motors*, 815 F.2d at 1307. Judge Kennedy held that the premium taxing program was "saved" as permissible state regulation of insurance. Kennedy reasoned that the state's premium tax could be applied to the whole amount, what he termed "the net premium and the loading," because the tax was formally borne by the insurer rather than the employer. *Id.* at 1310. This result has been criticized. *See, e.g., Firfer, supra* note 134, at 224-26. In any event, it is clear that the Massachusetts tax is not "regulation of insurance" because it is borne by the employer, not the insurer.

commissions eventually yielded a legislative plan of action.²⁴⁷ In 1986, the state formally established the Washington Health Care Project Commission “to study and address the needs of the state’s uninsured.”²⁴⁸ The Commission’s final report included proposals for providing basic health services to state residents at low premium levels that could be subsidized by the state.²⁴⁹ The legislature acted on the proposals, modifying them and enacting the Basic Health Plan (BHP or the Plan) in 1987, a state-funded plan to improve health care access for low-income residents.²⁵⁰

Washington’s approach to the problems of access differs from Massachusetts’ in two fundamental respects.²⁵¹ First, Washing-

²⁴⁷ The Washington legislature has commissioned various studies of the problems of the uninsured. In the early 1980’s, an Ad Hoc Advisory Committee on Uncompensated Health Care studied the problems of the uninsured in the state and issued a report to the state legislature. Dallek, *supra* note 40, at 742. The Committee found that, as of 1981, about 21% of the state population was uninsured for all or part of the year, and that 30% of the population living below 125% of the poverty line was uninsured all or part of the year. *Id.* These percentages are comparable to those calculated on a national level in 1984. *See supra* text accompanying notes 24-26.

²⁴⁸ AMERICAN HOSPITAL ASSOCIATION, PROMOTING HEALTH INSURANCE IN THE WORKPLACE: STATE AND LOCAL INITIATIVES TO INCREASE PRIVATE COVERAGE 146 (1988) [hereafter AHA REPORT].

²⁴⁹ The first proposal concentrated on “provid[ing] ambulatory and acute inpatient care;” the second, more expensive, version expanded benefits to include dental services and reduced some copayments. AHA REPORT, *supra* note 248, at 146.

²⁵⁰ WASH. REV. CODE ANN. §§ 70.47.010 - .901 (Supp. 1990) (“Health Care Access Act of 1987”). Jim McDermott, then a state legislator, now a Congressman, authored the plan. *Pacific Health Joins Washington Basic Health Plan*, Business Wire, July 6, 1989 (available on LEXIS, NEXIS library, BWIRE file).

Subsequently, the state also implemented a high-risk insurance pool to provide separate coverage for the medically uninsurable. *See* WASH. REV. CODE ANN. §§ 48.41.010 - .910 (Supp. 1990). The risk pool was intended to “provide access to health insurance coverage to all residents of Washington who are denied adequate health insurance for any reason.” *Id.* § 48.41.020. This program was designed to improve the viability of the BHP by separately providing the more expensive coverage for the medically uninsurable. AHA REPORT, *supra* note 248, at 147 (new pool will “help avoid adverse risk selection in the Basic Health Plan projects”). An estimated 31,000 state residents were eligible for coverage at the time of its enactment. McDaniel, UPI, June 30, 1988 (available on LEXIS, NEXIS library, UPSTAT file). This high-risk pool plan can be considered an integral part of Washington’s initiative.

²⁵¹ Like the Massachusetts program, the Washington plan is

ton has avoided potential ERISA preemption by rejecting employer mandates or special employer taxes in favor of state-funded insurance subsidies. Second, Washington's plan is less comprehensive, focusing on a small segment of the uninsured population and rejecting the notion of access to health care as a right.²⁵² Here ERISA and the nature of our federal system combine to produce another type of flawed state level initiative. To clear the ERISA bar, Washington was forced to ignore the close connection between employment and insurance. The only alternative was the politically impractical solution of public funding. Funding access initiatives from general state revenues is extremely difficult because of fears of budget deficits and lost state competitiveness. An analysis of the BHP's coverage, benefit, financing, and cost containment provisions reveals that the program is an incremental solution undercut by parsimonious public funding.

The BHP is not designed to provide universal coverage. The Plan does not link insurance to employment status or operate through expansion of the Medicaid program.²⁵³ Instead, it is targeted to cover a specified number of low-income residents,²⁵⁴

administered by a new independent state agency. *See* WASH. REV. CODE ANN. § 70.47.040 (Supp. 1990) (establishing independent state agency).

²⁵² In 1986, the Washington State Hospital Association disinterestedly had proposed making access a constitutional right for all state residents. *Constitutional Amendment for Health Care Proposed*, UPI, May 29, 1986 (available on LEXIS, NEXIS library, UPSTAT file) (discussing proposed amendment and hospital funding battles).

²⁵³ The Plan does not provide incentives for employer-provided health insurance. In fact, Washington fears that its state-funded program may discourage employee insurance programs. Employers of low-income workers might decide not to provide health insurance coverage because a state-funded alternative is available. *See infra* text accompanying notes 262-63.

²⁵⁴ Although the BHP could theoretically cover a large number of state residents, the legislation "strictly limit[s] . . . the total number of individuals who may be allowed to participate." WASH. REV. CODE ANN. § 70.47.010(4) (Supp. 1990). As of July 1, 1988, the Administrator was authorized to enroll up to 30,000 residents in the subsidy program. *Id.* § 70.47.080. The legislature, however, provided funding for only 25,000 participants through June 30, 1991. Washington Basic Health Plan: Annual Report to the Legislature 4 (Jan. 1990) (unpublished report on file at the U.C. Davis Law Review). In 1989, there were approximately 410,000 potentially eligible uninsured people, out of an estimated 720,000 total uninsured. *Pacific Health Joins Washington Basic Health Plan*, *supra* note 250.

The BHP is designed for state residents whose family income is less than

who are to be served without discrimination based on health status.²⁵⁵ The Plan is similar to the Massachusetts program in that, if fully funded, it could theoretically provide health insurance coverage for all low-income state residents.²⁵⁶ Two problems make this result unlikely. First, the program is numerically limited to only a fraction of the potential enrollees.²⁵⁷ Second, the BHP

200% of the federal poverty level but who are not eligible for Medicaid. WASH. REV. CODE ANN. § 70.47.010(2). Eligible applicants earn between \$6,000 and \$12,000. O'Connor, *Washington's Working Poor Slow to Embrace State Health Plan*, *Managed Health Care*, Apr. 9, 1990, at 1, col. 4; see also Fact Sheet: Washington Basic Health Plan (July 6, 1990) (unpublished document on file at U.C. Davis Law Review) (family of four with income less than \$25,400 eligible). Participating residents whose income rises to over 200% of the poverty level can continue enrollment for a six month period by paying unsubsidized premiums. WASH. REV. CODE ANN. § 70.47.060(9). Some Medicaid recipients may enroll in the Basic Health Plan, and in such cases the department of social and health services makes payments to the administrator. *Id.* § 70.47.110.

Eligibility for the program depends on potential enrollees' willingness to participate in a managed care plan. *Id.* § 70.47.020(4). Pilot plan operations may also be limited to particular geographic areas of the state. *Id.* § 70.47.060(6).

²⁵⁵ Participating managed health care systems are not to "discriminate against any potential or current enrollee based upon health status," among other factors. WASH. REV. CODE ANN. § 70.47.100 (Supp. 1990) (other factors include sex, race, ethnicity, or religion). Since participation in the Plan is voluntary, there are potential problems with adverse selection. Adverse selection occurs when generally sicker residents join the program, driving the costs of coverage up; these higher costs in turn discourage generally healthier persons from seeking coverage. The state legislature established a high-risk pool for the medically uninsurable to lessen the adverse selection problems in the BHP. *See id.* § 48.41.010. Persons generally become eligible for the pool after being rejected for health insurance coverage for medical reasons. Persons seeking coverage must provide "evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a preexisting conditions limitation on health insurance, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk." *Id.* § 48.41.100(1). Persons are ineligible for the program if they are eligible for public assistance, or have already received \$500,000 in benefits from the pool. *Id.* § 48.41.100(2)(c). The pool is obligated to renew health insurance coverage until the enrollee becomes eligible for Medicare. *Id.* § 48.41.160. A drawback to the program, however, is the six month waiting period for enrollees with pre-existing conditions. McDaniel, *supra* note 250.

²⁵⁶ The program would not address the problems of uninsured families who have income greater than 200% of the poverty level.

²⁵⁷ *See infra* note 271 and accompanying text.

relies on choice rather than mandates. Residents eligible for the state subsidized Plan may choose not to participate for a variety of reasons.²⁵⁸ Total coverage under the Washington program is thus likely to reach only a small percentage of the uninsured or underinsured in the state.

Basic Health Plan benefits are generally to be provided within a managed care system.²⁵⁹ Within certain statutory limits, the administrator of the BHP has the power to design the range of physician services, inpatient, and outpatient hospital benefits to be provided under the managed care program.²⁶⁰ The minimum benefit level set by the statute is relatively high: it includes preventive and primary care, and pre- and post-natal care.²⁶¹

Unlike Massachusetts, Washington plans to pay for universal access solely from enrollee payments and state funds.²⁶² The

²⁵⁸ Similarly, persons eligible for the high-risk pool may choose not to participate because of the high cost of health benefits.

²⁵⁹ Enrollees are to be given a choice between at least two such systems. WASH. REV. CODE ANN. § 70.47.060(7) (Supp. 1990). Additionally, the Plan administrator is to design and implement a separate fee-for-service alternative that includes nominal premiums, modified fee-for-service provider payments, limited coinsurance rates, and a case management system. *Id.* § 70.47.060(4).

²⁶⁰ *Id.* § 70.47.060(1).

²⁶¹ The benefits provided are to “emphasize proven preventive and primary health care, [and]. . . include all services necessary for prenatal, postnatal, and well-child care.” *Id.* § 70.47.060(1). The administrator is to “consider” the state mandated benefit law. *Id.*; see also *id.* § 48.42.080 (discussing social and financial impact of mandates); *id.* § 601.422 (same). The BHP “does not cover such services as eyeglasses, dental care, mental health treatment, custodial care, and prescription drugs.” Fact Sheet, *supra* note 254.

The high-risk pool plan provides similar types of benefits. The pool, however, operates on a fee-for-service rather than a managed care system. *Id.* § 48.41.110(1). Rather than prepaid capitated payments, the pool will pay “only usual, customary, and reasonable charges for medically necessary eligible health care services.” *Id.* The level of benefits established under the risk pool policy is specific, and includes hospital and professional services, drugs, diagnostic tests, and certain other medically necessary services. *Id.* § 48.41.110.

²⁶² *Second State Tackles Issue of Health Insurance*, Chicago Tribune, Jan. 4, 1989, at C8 [hereafter *Second State*].

Washington’s high-risk pool is designed to decrease the cost of the Basic Health Plan by siphoning those requiring higher-cost coverage away from the BHP. In contrast to the BHP, the pool is financed by a combination of premiums and private subsidies. See WASH. REV. CODE ANN. §§ 48.41.090, .120 (Supp. 1990) State residents who choose to enroll in the pool will have

Plan Administrator is empowered to establish periodic premiums for enrollees based on gross family income. The state will subsidize the remainder of the premium cost. Eligible residents can receive state subsidies of up to ninety percent of the cost of their health insurance.²⁶³ The state plan thus provides no incentives for employers to offer health insurance to their employees; it may even encourage employers of low-income workers to discontinue benefits.

The BHP incorporates three different cost containment strategies.²⁶⁴ First, it emphasizes the provision of care on a "prepaid, capitated basis" that may encourage efficient, cost-effective provision of care.²⁶⁵ Second, it creates a central agency which has the

to pay relatively high premiums. *Id.* § 48.41.200 (maximum rate 150% of small group risk rate). All commercial health insurers and HMOs are members of the state health insurance pool and contribute subsidies. *Id.* § 48.41.040; *id.* § 48.41.090(2)(b). Note that ERISA's preemption provision prevents the state from forcing self-insured employers to contribute to the high-risk fund. *See supra* text accompanying notes 118-29. This creates an imbalance in the funding system, and gives employers an incentive to self-insure to avoid the costs associated with the risk pool. The Washington high-risk pool provides that self-insured employers are to become members of the pool if and when permitted by federal law. WASH. REV. CODE ANN. §§ 48.41.030(13), .040(1).

²⁶³ *Second State, supra* note 262, at C8. The subsidies will reduce the typical monthly premium for an eligible family of four from about \$250/month to \$7.50-\$38/month. *Id.*

²⁶⁴ The health insurance risk pool also limits costs in several other ways. The policy provided under the pool is to include "preadmission certification and concurrent inpatient review" to increase the cost effectiveness of the program. WASH. REV. CODE ANN. § 48.41.110(2) (Supp. 1990). Enrollees are required to pay either a \$500 or a \$1,000 deductible per year and are liable for a mandatory coinsurance payment of 20% on expenditures greater than the deductible. *Id.* § 48.41.010. An enrollee's total yearly expenditures are limited, however, to \$1500/individual and \$3000/family for the \$500 deductible plan and \$2500/individual and \$5000/family for the \$1,000 deductible plan. *Id.* § 48.41.120(3). The statute also denies further coverage to enrollees who have received \$500,000 in benefits. *Id.* § 48.41.100. In some cases, pre-existing conditions may be excluded from coverage for a six month period. *Id.* § 48.41.140.

²⁶⁵ WASH. REV. CODE ANN. § 70.47.020(3) (Supp. 1990). Prepaid, capitative financing systems differ from the traditional fee-for-service payment method. In a prepaid, capitative system, a health care provider organization agrees to provide care for enrollees in return for a prepaid fee for each enrollee. *See C. VADAKIN & Z. LIPTON, THE HEALTH INSURANCE ANSWER BOOK 97-98 (1986)*. Since the same fee is paid for each individual, no matter how many services are provided, the participating organization

power to negotiate with managed care systems in a competitive process that may produce lower costs.²⁶⁶ Third, it limits program costs in an absolute way by limiting the enrollment and expenditures under the program.²⁶⁷ The task of balancing cost limitation with increasing health care access is a difficult one; here at least the legislative enactment recognizes the conflict. Yet the empha-

has an incentive to provide only necessary health services, thus reducing costs. The BHP emphasizes the provision of health care within a prepaid, managed health care system. WASH. REV. CODE ANN. § 70.47.010 (Supp. 1990). The Plan also requires the establishment of an alternate modified fee-for-service system. Even this alternative is cost conscious, however, including both nominal premiums and coinsurance costs. *Id.* § 70.47.060(4). Further, the managed care option sets the outside limit on the cost of the fee-for-service plan: the total cost per fee-for-service enrollee cannot exceed that of a managed care enrollee. *Id.* § 70.47.060(4). The per capita payment method used in managed care systems may provide incentives for providers to forgo unnecessary medical procedures. Further, the Plan administrator is to design a system of small copayments that will "discourage inappropriate" utilization by enrollees without creating "a barrier to appropriate utilization of health services." *Id.* § 70.47.060(3). Early reports indicate that the utilization rate for Plan enrollees is equivalent to that of other managed care participants. O'Connor, *supra* note 254, at 1, col. 5.

²⁶⁶ The administrator of the BHP has the express duty and power to bargain for cost efficient providers. The administrator is to estimate the reasonable cost for the health care services and to negotiate with managed care systems for the provision of services. At the outset, the administrator is to determine "the reasonable cost of providing the schedule of basic health care services." WASH. REV. CODE ANN. § 70.47.100 (Supp. 1990). Then the Administrator issues requests for proposals, negotiates with responding managed health care systems, and selects one or more systems within a particular geographic area. *Id.* This process of cost estimation and negotiation may create a competitive pressure that reduces costs.

Washington reaffirmed its concern with cost containment in the Health Care Reform Act of 1988. 1988 Wash. Laws 107. The Act established a new agency, the Washington State Health Care Authority. The Authority is responsible for "study[ing] all state-purchased health care, alternative health care delivery systems, and strategies for the procurement of health care services and mak[ing] recommendations aimed at minimizing the financial burden which health care poses on the state . . . while at the same time allowing the state to provide the most comprehensive care possible." *Id.* § 2. The new agency was to review the operation of the basic health plan. *Id.* § 6.

²⁶⁷ The BHP limits costs by requiring the Plan administrator to close enrollment of persons who qualify for subsidies when a danger of overexpenditure arises. WASH. REV. CODE ANN. § 70.47.060(5) (Supp. 1990). This technique of "cost containment" actually vitiates the goal of increasing access.

sis on cost containment has clearly resulted in an inadequate program that can only hope to serve but a fraction of the state's uninsured.

2. Death by Delay

The Washington plan represents another attempt to improve health care access at the state level. The BHP avoids ERISA preemption problems by forgoing employer mandates or employer taxes.²⁶⁸ But, in the place of these private sector devices, the state has substituted a poorly funded choice-based system that is unlikely to make a significant difference for most of the state's uninsured population.²⁶⁹ Because the program relies on public financing, it is unlikely to be funded to the extent of need.

Perhaps as a necessary corollary to its source of funding, Washington contemplates only a small scale implementation of its program.²⁷⁰ The expense of Washington's basic health plan led the legislature to limit enrollment to 30,000 people, only four per-

²⁶⁸ In the process, it also avoids creating incentives for employers to rid their workplaces of employees with high medical costs.

The availability of public funding for health insurance might provide a negative incentive for employer-provided health insurance. Washington hopes to prevent employers from leaving the provision of health insurance to the state. The BHP states:

[i]t is not the intent of this chapter to provide health care services for those persons who are presently covered through private employer-based health plans, nor to replace employer-based health plans. Further, it is the intent of the legislature to expand, wherever possible, the availability of private health care coverage and to discourage the decline of employer-based coverage.

Id. § 70.47.010(3). The administrator is to monitor the Plan's effect on employer-based coverage and is to "take appropriate measures" to "discourage reduction of such coverage in the state." *Id.* § 70.47.060(14). The statute does not provide a solution for this potential problem, other than to severely restrict the number of people covered.

²⁶⁹ In addition, the state's high-risk pool faces the same infirmities as those established in other states. *See supra* text accompanying notes 166-70. The premium costs for potential enrollees are relatively high, representing a barrier to many potential enrollees. The pool's cost may mean that it will not have an appreciable effect in reducing adverse selection problems in the BHP.

²⁷⁰ The enabling statute merely encouraged the Administrator to establish at least five managed care systems in different geographic areas by July of 1988. WASH. REV. CODE ANN. § 70.47.080 (Supp. 1990). The Plan's administrator has not aggressively marketed the program, partially to avoid

cent of the total number who might eventually be eligible.²⁷¹ At this capped rate of enrollment, the program would have probably cost \$66 million for its first two years.²⁷² But actual implementation has been significantly slower: As of April 1990, the Plan had enrolled only 8,200 members.²⁷³ It seems unlikely that coverage will be expanded dramatically. Nor is the Washington plan out of the political frying pan; the program's costs are likely to receive close scrutiny when the program faces renewal in two years.²⁷⁴

IV. FEDERALISM: REFORM OR REVOLUTION?

A. ERISA Revisited

The Massachusetts and Washington plans represent two different archetypes of state level solutions for the problems of the uninsured. The best aspects of our federalist system of government are represented in these legislative enactments. Two states, recognizing that their citizens suffered because of a serious social ill, constructed individual solutions tailored to their particular political, social, and economic climates. But the likely failure of both approaches is also representative of the drawbacks of local

"long waiting lists of people who would be dissatisfied and have unrealistic expectations of access." O'Connor, *supra* note 253, at 18, col. 3-4.

²⁷¹ *Second State*, *supra* note 262, at C8; see also Peirce, *States Are Trying Universal Health Insurance*, 19 NAT'L J. 2812 (1987). Other factors will also limit enrollment. The Plan administrator, for example, has been unable to find a managed care provider for the rural, eastern part of the state. O'Connor, *supra* note 254, at 18, col. 4.

²⁷² *Second State*, *supra* note 262, at C8. In contrast, the state's high-risk pool, funded by contributions from insurance companies, was expected to lose \$12-\$18 million a year. McDaniel, *supra* note 250.

²⁷³ "Five HMOs and one PPO have contracted with the state and enrolled 8,200 members in five counties, well short of the BHP's target of 25,000 by next year. Only two of the counties have waiting lists." O'Connor, *supra* note 254, at 1, col. 3.

²⁷⁴ Despite the cramped successes of the Washington plan, and the fear of a fiscal black hole, some elements in the Washington legislature continue to advocate universal access. One legislative proposal, considered but rejected in the 1990 legislative session, would have implemented a single state insurance plan to cover all residents, eliminating in the process all private insurers. Strand & Mickelsen, *State Proposals on Uninsured Hold Changes for Managed Care*, Healthweek, June 11, 1990, at M-14, col. 2. In the end, the legislature took a different tack, establishing yet another commission to explore the problems of the health care system. *Id.* The commission is to present its recommendations to the Governor by December 1991. *Id.*

solutions constrained by ERISA's broad preemptive power and fears of business migration. The two plans can be compared over four different variables: the source of financing; the extent of coverage; the type of benefits provided; and the use of cost containment methods.

The most controversial and important variable is the method of financing.²⁷⁵ It is this factor that drives the other elements of program design. And it is the impossible fiscal constraints imposed by political realities and ERISA preemption that ultimately doom state level solutions. ERISA either prohibits or impedes state attempts to shift the cost of care to the private sector. States cannot simply mandate that employers provide health benefits, for example. Nor can the state indirectly finance access initiatives by taxing self-insured benefit plans. Finally, the availability of self-insurance imposes a practical limit on the amount of financing that can be extracted from the private insurance market.²⁷⁶

The Washington and Massachusetts plans demonstrate the frailties of two different methods of navigating the shoals of ERISA preemption.²⁷⁷ The Massachusetts plan attempts to use the carrot and stick of a payroll tax with a health care credit to encourage employers to provide coverage and to provide a means of financing coverage for those whose employers fail to do so. The plan's chief virtue is also its folly — it is an off-budget solution to financing care for the uninsured which raises the specter of ERISA preemption. The Washington plan takes a different route to potential failure, relying primarily on public financing through general state revenues.²⁷⁸ ERISA does not prohibit state initiatives in which the state itself serves as an insurer through

²⁷⁵ See, e.g., Lipson, *supra* note 172, at 48-49.

²⁷⁶ See *supra* notes 134-39 and accompanying text. Increasing the cost of private insurance coverage only increases the incentives for employers to avoid these costs through self-insurance.

²⁷⁷ Both the Massachusetts and Washington plans partially rely on the premium contributions of voluntary enrollees, who may choose not to participate if they find the premium or copayment requirements are unacceptably high.

²⁷⁸ The Massachusetts plan also requires state funding insofar as it broadens Medicaid eligibility and expands state medical programs. These are relatively minor aspects of the UHCP. See *supra* text accompanying notes 195-96. The Washington plan, in turn, encompasses an effort to force the private sector to bear the cost of insuring the medically uninsurable. See *supra* note 262.

public funding.²⁷⁹ While this method avoids political and legal difficulties associated with employer mandates, it creates other problems. The most prominent drawbacks to publicly financed health access initiatives are that they fail to take advantage of the strong links between employment and insurance coverage²⁸⁰ and

²⁷⁹ Government funding poses serious political problems, particularly in an age of budget deficits and tax phobias. The additional expenditures required by access initiatives might be extracted through broad based taxing programs or from narrowly targeted "revenue enhancement," either explicit or implicit. Governments could employ an explicit tax on labor, either on employers or directly on employees. See Kusters, *supra* note 157, at 22. Uwe Reinhart, for example, has proposed that financing be funded through a surcharge on individual income taxes. Passell, *Economic Scene: Paying for Wider Health Insurance*, N.Y. Times, May 18, 1988, at D2, col. 3. States could also try to pay for coverage of the uninsured by enacting a general payroll tax. Even a payroll tax related to the number of employees would not violate ERISA. Bovbjerg & Kopit, *supra* note 20, at 907-08. However, such a payroll tax would disproportionately burden employers who provide health benefits and would therefore decrease incentives to provide insurance. *Id.* Alternatively, tax credits for some of the uninsured, perhaps those with lower incomes, could indirectly fund health insurance. Tax exemptions for employers who provide insurance might also indirectly fund insurance. See Kusters, *supra* note 157, at 22. Some states are considering offering tax credits to small employers to encourage them to provide health insurance. Montiert & Schur, *supra* note 32, at 326 (Oregon, Michigan, Maine, and Denver County, Colorado).

These broad-based tax proposals can be contrasted with efforts to impose specialized taxes on health care providers or insurance companies. For example, the providers themselves could be taxed and given an offset for any charity care provided. Bovbjerg & Kopit, *supra* note 20, at 909. Similarly, a few states tax hospital providers to fund charity care pools. EBRI, *supra* note 41, at 10; Jones, *The Florida Health Care Access Act: A Blended Regulatory/Competitive Approach to the Indigent Health Care Problem*, 14 J. HEALTH POL. POL'Y & L. 261 (1989). Six states finance charity care through a special add-on rate to hospital charges. EBRI, *supra* note 41, at 10 (Connecticut, Maine, Maryland, Massachusetts, New Jersey, New York).

²⁸⁰ As Professors Fox and Schaffer note in their comprehensive study of ERISA politics:

From the legal point of view, Hawaii always had available to it a simple and complete solution. Hawaii could have adopted a plan by which the state itself insured its citizens. . . . ERISA does not preempt state governments from acting as insurers. Neither Hawaii nor any other state whose health laws ERISA has preempted has turned to this solution. In other words, ERISA preemption of state law has been important because ours is a system in which health insurance is linked to employment.

Fox & Schaffer, *Semi-Preemption in ERISA*, *supra* note 47, at 55 (footnotes omitted).

that they are invariably underfunded. The Washington plan, for example, can only improve access for a limited number of enrollees.²⁸¹

The two plans' coverage, benefit, and cost containment provisions can also be compared. The Massachusetts plan provides the best example of comprehensive coverage. Through a complicated system of employer incentives, private payments, and state subsidies, the state can theoretically attain universal coverage. This goal may not be met, however, in part because ERISA prohibits the use of employer-mandates, leaving the state to rely on less efficient employer-incentives. The actual level of coverage reached under the program will depend on the effectiveness of employer incentives and the ability of the state to attract low cost health insurance alternatives for the uninsured. The Washington plan's coverage provisions, in contrast, are more modest, consonant with the emphasis on public funding. The plan provides coverage only for low-income uninsured residents and the medically uninsurable. The number of low-income participants is strictly limited to a small fraction of the population.

Both legal and policy concerns also affect the range of benefits offered under these programs. Clearly, ERISA prevents a state from mandating that self-insured employers provide a particular set of benefits. But more subtle constraints are imposed by states' fear of business efflux and beneficiary influx. High levels of benefits financed by employer taxes might drive businesses to relocate to other states while tempting potential beneficiaries to immigrate.

Both programs offer a typical range of benefits to enrollees that includes inpatient and some limited outpatient services. The Massachusetts plan establishes variable levels of benefits that depend on the nature of financing. Some state residents will receive standard Medicaid coverage or limited state funded coverage. Individuals who purchase insurance coverage from the Department of Medical Security, however, must purchase policies that include the wide range of services and providers mandated under state law.²⁸² The Washington plan emphasizes benefits offered within a managed health care system. The level of serv-

²⁸¹ See *supra* text accompanying notes 270-73.

²⁸² Further, employers are not required to provide a particular level of benefits unless they provide coverage through insurance companies subject to the state mandates.

ices to be provided appears relatively high, but the plan administrator need not provide all state mandated benefits.

Cost containment provisions are the final important program variable. Cost containment in an absolute sense is unlikely where increased access to health care is the goal. Nonetheless, access initiatives can be more or less attentive to the need to efficiently deliver necessary care while eliminating wasteful or unnecessary services. Cost constraints are both necessary and politically unpopular. They are necessary to prevent the cost escalations that can scuttle a program. They are unpopular with both providers and beneficiaries to the extent that they deny coverage for certain conditions or require copayments. Moreover, a rigorous cost containment strategy presents its own dangers, as emphasis on cost containment can result in policies which actually hinder access.

The Washington BHP, perhaps because of its emphasis on public funding, focuses on the need for cost containment. It emphasizes the delivery of care within managed care systems that may provide incentives to reduce costs. It also requires the use of nominal copayments and premiums to prevent overutilization. These measures may encourage the efficient delivery of care. The BHP, however, conflicts with access objectives by absolutely limiting program enrollment and the high-risk pool hinders access by imposing relatively high costs on program enrollees.²⁸³

The Massachusetts UHCP, perhaps because it relies on employer financing, does not exhibit the same attention to cost containment. The original Massachusetts legislation would have created a state agency that could have effectively reduced unnecessary health care costs. The actual UHCP has more limited cost containment provisions. The DMS is encouraged to purchase managed care plans for enrollees, and enrollees may be assessed premium costs, copayments and deductibles.²⁸⁴

Thus coverage, benefits, financing, and cost containment provisions do overlap. The choice of financing method, for example, has clear implications for the extent of coverage. If the goal is increasing insurance coverage, employer mandates have two advantages: 1) they shift the costs to the private sector, thus protecting governmental budget deficits from further expansion; and 2) they require coverage, thus lessening some of the adverse

²⁸³ See *supra* text accompanying notes 254-67.

²⁸⁴ See *supra* text accompanying notes 201-07.

selection problems that accompany voluntary plans.²⁸⁵

Voluntary programs at the state level — the kind permitted by ERISA — cannot be as efficiently financed and can only hope to extend coverage through a combination of incentives and state subsidies. The use of public funds to extend coverage to low-income persons is relatively noncontroversial. Expanding coverage to those with higher incomes may depend on the effectiveness and political feasibility of employer incentives and the development of low-cost health insurance options.²⁸⁶ If states require very comprehensive benefits packages, for example, relatively healthy state residents may choose to forgo the expense of coverage. Similarly, voluntary programs face adverse selection problems: higher risk persons may join plans disproportionately, driving up plan costs and thereby discouraging relatively healthy persons from joining.

Despite their flaws, state level initiatives to improve access are proliferating in the absence of federal action. Massachusetts' universal health program has served as a model for proposals in Wisconsin²⁸⁷ and New York.²⁸⁸ Washington's reliance on public

²⁸⁵ Mandates also have their drawbacks. They arguably paternalistically deny freedom of choice, for example, coercing individuals to obtain a socially valued good.

²⁸⁶ Many policies to improve access seem to be based on the assumption that significant numbers of people would forgo socially optimal levels of coverage if given a choice. In addition, policy designers apparently presume that the optimal level of health care coverage is higher than that provided in the free market. Supporters of public intervention might note that the market does not reflect many of the external costs imposed by failure to obtain coverage. Public expenditures on uncompensated care, for example, mean that uninsured individuals might be able to obtain health care despite their decision to forgo coverage. The level of coverage provided by the market may also reflect informational deficiencies. Individuals may not realize, for example, that regular preventive and primary care can decrease later health care expenditures. *But see* Ehrlich, *On the Rationale for National Health Insurance: Where Did the Private Market Fail?*, in I. EHRlich, NATIONAL HEALTH POLICY: WHAT ROLE FOR GOVERNMENT? 228, 230-44 (1982) (contesting contention that health care market failures require government intervention).

²⁸⁷ Advocates in Wisconsin had hoped that Wisconsin would be the second state to adopt a comprehensive health plan to improve health care access for the state's estimated 550,000 uninsured residents. Knox, *supra* note 170, at 9, col. 1; *see also* WIS. STAT. ANN. § 146.90(1)(a) (West Supp. 1988) (authorizing design of new programs).

Under a plan considered by the state legislature, Wisconsin would have funded the program through a new tax on employers, from which employers

funding has been generally emulated by states adopting small scale or targeted access initiatives.²⁸⁹ Less ambitious attempts to

would have been able to deduct amounts spent on health insurance coverage. Knox, *supra* note 170, at 9, col. 1. An employer's liability for the tax could range from \$1,000-1,550 per worker, depending on the worker's salary. *Id.* The tax revenues would have funded a state pool to provide coverage for workers not covered by their employers. The legislature, however, did not endorse the plan. In its last session, the Wisconsin legislature considered another, less comprehensive initiative. Strand & Mickelsen, *supra* note 274, at M-14, col. 3. Under that measure, a basic plan, free of state mandates, would have been offered to some groups of uninsured, including low-income employees, employees of small businesses, and the unemployed. *Id.*

²⁸⁸ Some New York reformers advocated a Massachusetts-like system with a more powerful role for the state. Under their plan, the state, controlling both public and private funds, would serve as the single payer for all health care. See Beauchamp & Rouse, *Universal New York Health Care: A Single-Payer Strategy Linking Cost Control and Universal Access*, 323 NEW ENG. J. MED. 640 (1990); Strand & Mickelsen, *supra* note 274, at M-14, col. 3; Zoler, *New York Dilutes Insurance Goals*, MED. WORLD NEWS, Mar. 12, 1990, at 17 (contrasting UNY*Care system with more popular, if limited, NY CHILD proposal favored by Governor Cuomo). As originally formulated by the State's Health Commissioner, the plan would have emulated the UHCP by forcing businesses to either provide insurance or pay a tax. Bauder, *State Eyes Universal Health Care*, Buffalo News, Sept. 8, 1989, at A1, A1. The New York plan improved on the Massachusetts plan, however, by establishing the state as the bargainer for cost containment. *Id.* at A4.

Other states have also considered, but rejected, use of indirect employer mandates. See, e.g., *Deukmejian Won't Embrace State Plan to Cover Uninsured*, Managed HealthCare, Apr. 9, 1990, at 8 (discussing Massachusetts-like program to be sponsored in the California Legislature by Assembly Speaker Willie Brown); Mullen, *Tax Flap May Doom N.J. Plan on Uninsured*, Healthweek, Oct. 9, 1990, at 2, col. 1 (lawmakers unenthusiastic by plan to pay for hospital care received by uninsured through an employer tax system that would have imposed a penalty on those employers who did not provide health insurance benefits). One commentator has suggested that the Massachusetts plan has also served to "make[] other access improvements appear moderate." Sager, *supra* note 171, at 269.

²⁸⁹ Risk pools, like the one adopted by Washington to complement its Basic Health Program, are a very popular targeted access initiative. McEachern, *supra* note 165, at 1 (noting that 19 states have pools, and 15 states are considering adoption). These risk pools typically provide health insurance to the commercially uninsurable, such as those with cancer, diabetes, or heart ailments. Premiums are usually pegged at 150% of the commercial insurance rate, and the pools must still be subsidized — either by the state or by forced contributions from insurers within the state.

Not all publicly funded initiatives are modest — at least one state has considered a more radical public approach. The Ohio legislature has

improve access for smaller segments of the uninsured population are also being considered and approved in many states.²⁹⁰ Yet in a few states concern over cost containment has accompanied and even overcome efforts to improve access.²⁹¹ And state level solutions to the problems of the uninsured are unlikely to be a comprehensive solution to the problems of the uninsured. Thus,

considered adoption of a Canadian-type system, in which "a single state plan would provide universal health care coverage for all state residents." Strand & Mickelsen, *supra* note 274, at M-14, col. 2. Under the proposed system, private insurers would be barred from selling coverage of state offered benefits. *Id.*

²⁹⁰ One popular approach involves encouraging small employers to provide health insurance benefits for their employees by permitting them to offer less expensive plans that do not incorporate state mandated benefits, like coverage for mental health care. Freudenheim, *States Try to Cut Cost of Insurance for Medical Care*, N.Y. Times, Dec. 9, 1990, at 1. See, e.g., *O'Neill Signs Health Insurance Bill*, UPI, May 17, 1990 (available on LEXIS, NEXIS library, UPST89 file) (small employers in Connecticut permitted to avoid state benefit mandates if they obtain health insurance for their employees, Medicaid program also expanded); see also S. 239, 1990 Gen. Assem., Reg. Sess., 1990 Kentucky Acts 482 (establishing health care trusts which will broker basic health insurance [without mandated benefits], encourage employers to purchase insurance for employees, and require full- and part-time college students to acquire basic health insurance coverage). Virginia and Illinois recently passed provisions that would exempt some small employers from certain benefit mandates, and thus make it more feasible for them to provide employee insurance. See VA. CODE ANN. §§ 38.2-3425 to -4214 (Supp. 1990); H.R. 3528, 86th Gen. Assem., 1990 Sess. (1990) (amending Illinois Insurance Code to waive state benefit mandates for small businesses seeking to buy health insurance for their employees).

²⁹¹ Some states, recognizing that public funds for Medicaid are limited, are focusing their efforts on limiting the kinds of benefits that Medicaid recipients may receive. Instead of the implicit rationing that occurs when states run out of Medicaid money, these states are attempting to implement explicit rationing based on providing the broadest set of benefits possible to Medicaid recipients. Oregon has conducted public meetings across the state in an effort to capture the value placed on various medical services by its residents. This value scale will then be used to rank the kinds of services made available to the state's poor. See *Not Enough for All: Oregon Experiments With Rationing Health Care*, NEWSWEEK, May 14, 1990, at 53, 53; *Oregon Pushes Waiver Deadline Back on Rationing Plan*, Nation's Health, Aug. 1990, at 4, col. 1.

Colorado is considering a similar measure. The Colorado provision would expand Medicaid coverage to include all residents with income below the federal poverty level. Limitations on the kinds of benefits offered would accompany this expansion in coverage. McEachern, *Colorado May Ration Health Care*, Managed HealthCare, May 7, 1990, at 5, col. 1.

federal action is required, either through amendment of ERISA or adoption of some federal program to improve access.

B. Not National Health Insurance

The picture of health care financing thus far reveals a patchwork system of financing that leaves a significant number of individuals without any coverage or without adequate insurance coverage. The results are, predictably, less access to medical care and efforts to shift the economic burden for that care which is provided. The most obvious solution for these problems would be the design and implementation of a truly national health insurance: a unified, rational and public system of health care financing that could guarantee access to some minimum level of benefits for all.²⁹² It is just as clear, however, that political debate on this issue has a common ground: rejection of comprehensive federal action.²⁹³

²⁹² Efforts to raze the current structure of finance in favor of such a program have waxed and waned since the adoption of Social Security during the New Deal. See J. MORRIS, *SEARCHING FOR A CURE: NATIONAL HEALTH POLICY CONSIDERED* 16 (1984). Countless commentators have pondered the reasons for the rejection of a revamped system. See, e.g., *id.*; R. FEIN, *supra* note 191, at 33-51 (discussing history of efforts into the 1950s); T. MARMOR, J. FEDER & J. HOLAHAN, *NATIONAL HEALTH INSURANCE: CONFLICTING GOALS AND POLICY CHOICES* 7-12 (1980) (discussing political issues). Advocates for such a system gained strength in the 1970s as new national health care proposals were introduced, first by Senator Kennedy, and then by Presidents Nixon and Carter. R. FEIN, *supra* note 191, at 60-61, 155. Each of these proposals eventually failed, in part because of political fear of the creation of another burgeoning entitlement program. T. MARMOR, J. FEDER & J. HOLAHAN, *supra*, at 7-12.

²⁹³ In the 1980s, the Reagan revolution's antigovernment stance on most social policy issues dimmed hopes for a unified public national health care system, particularly in light of the soaring federal deficit. Reliance on private sector mechanisms and market solutions gained new respectability and new adherents. See, e.g., Poullier, *The Public-Private Mix in Health Care*, 8 *HEALTH POL'Y* 1 (1987) (editorial favoring adoption of some market-based incentives in Europe); Ron, *The Changing Public/Private Mix in Health Care*, 8 *HEALTH POL'Y* 13 (1987) (report on European Health Policy Forum, including discussions of greater use of public/private mix in health care system). Even Britain's National Health Service has not been immune from attack. McKibben, *Thatcher Offers Revamping of National Health Program*, *Boston Globe*, Feb. 1, 1989, at 3, col. 1. One common political ground in the early 1990s appears to be "not national health insurance." See, e.g., COMMITTEE ON LABOR AND HUMAN RESOURCES, *BACKGROUND INFORMATION ON THE BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT OF 1989* 5 (April

In the absence of new comprehensive federal initiatives, state programs are necessary to improve access for the 31 million people without health insurance. In this context, ERISA's preemption provision poses an insurmountable bar to politically and economically effective state solutions. The success of state programs thus still depends on Congressional action, in the form of a limited repeal of ERISA's preemption provision. Repeal of the preemption clause would permit states to either require employer-provided health insurance or to establish sensibly funded health insurance programs.²⁹⁴ The needs of the uninsured outweigh the limited goals served by the preemption clause's effect in this narrow area.

It is clear that Congress' attention in enacting ERISA was focused on the problems of pension plans rather than on employer provision of health insurance benefits.²⁹⁵ The preemption clause was designed to protect employers from the burden of complying with multiple and potentially conflicting state regulations.²⁹⁶ Relaxing the preemption rule in the welfare benefit plan context would mean that interstate employers might be confronted with "the threat of conflicting and inconsistent State and local regulation of employee benefit plans."²⁹⁷

The effect of the preemption provision's repeal could be over-

12, 1989) (stating, about Senator Kennedy's recent plan, "Basic Health Benefits is *not national health insurance*") (emphasis added); Rich, *HHS Secretary Rejects National Health Insurance Option*, *Boston Globe*, July, 24, 1990, at 1, col. 2. Today commentators regularly reject the specter of a "monolithic, Government-run health care delivery system" and advocate incremental additions to the somewhat-tattered patchwork quilt of coverage. Sigelbaum, *Universal Health Insurance: Poor Medical Care Is Poor Public Policy*, *N.Y. Times*, Sept. 18, 1988, § 3, at 2, col. 3; see also Enthoven & Kronick (pt. 2), *supra* note 3, at 94-95 (advocating incremental rather than radical change). Yet health care access advocates just as regularly suggest jettisoning the complex web of financing in favor of a federal program funded through taxes. Himmelstein & Woolhandler, *supra* note 3.

²⁹⁴ See, e.g., Bovbjerg & Kopit, *supra* note 20, at 907 (observing that ERISA could be amended to grant states right to require private health insurance coverage); Note, *Worker Well-Being*, *supra* note 64, at 850 (criticizing broad federal preemption of state regulation of substance of health benefits).

²⁹⁵ See Fox & Schaffer, *Health Policy*, *supra* note 47.

²⁹⁶ See *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983); 120 CONG. REC. 29,197, 29,933 (1974) (statements of Representative Dent and Senator Williams).

²⁹⁷ *Shaw*, 463 U.S. at 99; see *supra* notes 243-44.

stated, however, given that *Metropolitan Life* already permits conflicting and inconsistent obligations for those who purchase insurance coverage. Under *Metropolitan Life*, employers who provide health insurance coverage through a private insurer are already subject to varying state benefit and provider mandates.²⁹⁸ Only those employers who self-insure are actually free from conflicting state requirements. For these employers, repealing ERISA preemption would add some degree of complexity to the benefit process. But the burden seems reasonable, given that self-insured employers tend to be larger companies with greater fiscal and administrative resources.

Federal limitation of ERISA's preemption provision has been a recurring suggestion, although it is not reflected in any current bills.²⁹⁹ There are a range of possible federal actions. The first, and most limited, would be to provide express legislative exemptions for individual states. This is the tactic Congress eventually adopted to resurrect Hawaii's preempted employer mandate program. Despite Congress' explicit assertion that Hawaii's exemption should not be considered precedential, several other states have expressed an interest in an ERISA waiver.³⁰⁰ This technique has the advantage of permitting Congress to exercise some control over the kind of state initiatives adopted. Waivers could be denied, for example, if the state program would create onerous administrative or fiscal requirements for interstate employers. This advantage is also, of course, a disadvantage in that Congressional oversight would add another, probably stultifying, layer of special interest negotiation and bargaining. Few state level initiatives are likely to survive the gauntlet.³⁰¹

Another limited Congressional alternative would be to enact

²⁹⁸ See *supra* text accompanying note 117.

²⁹⁹ Congress' own study of the preemption provision resulted in a re-endorsement of broad preemption in the late 1970s. H.R. REP. NO. 1785, 94th Cong., 2d Sess. 46-49 (1976) (discussing ERISA preemption and need to retain federal authority and uniformity of regulation).

³⁰⁰ H.R. CONF. REP. NO. 984, 97th Cong., 2d Sess. 18, reprinted in 1982 U.S. CODE CONG. & ADMIN. NEWS 4603 (limited ERISA waiver to have no precedential effect); see also Comment, *Federal Preemption*, *supra* note 64, at 365-67 (discussing Minnesota's petition for ERISA preemption exemption); *supra* note 152 (discussing Hawaii's proposal for broader ERISA waiver); *supra* note 197 (discussing Massachusetts' initial hope for a federal waiver).

³⁰¹ See Fox & Schaffer, *Health Policy*, *supra* note 47 (discussing interest group influence). Despite considerable state interest, Hawaii has been the sole recipient of a federal waiver to date.

legislation permitting states to treat self-insured employee health plans as insurers under state law.³⁰² States would then be free to enact two different types of programs. First, states could impose benefit mandates on self-insured employee benefit plans. Theoretically, these mandates could rectify some of the problems of the underinsured.³⁰³ Second, states could require contributions from self-insured plans, along with other insurers, to finance state risk pools or other access initiatives. This change would eliminate one of the practical stumbling blocks to effective funding because employers could no longer avoid the costs of these initiatives by self-insuring.³⁰⁴

Finally, a more expansive federal approach would be to provide a specific waiver of preemption for any state program designed to address the problems of the uninsured.³⁰⁵ This waiver could specifically exempt employer mandate proposals, or employer tax proposals, or could leave the details of the programs to state invention.³⁰⁶ Congress could even require that state programs address the needs of specific segments of the uninsured population.³⁰⁷

³⁰² This would involve amendment of the "deemer" clause. 29 U.S.C. § 1144(b)(2)(B) (1988).

³⁰³ Opponents of benefit and provider mandates argue, however, that they have benefited providers instead of establishing the mandatory catastrophic coverage necessary to protect many of the underinsured. Cf. Frank & McGuire, *Mandating Employer Coverage of Mental Health Care*, 9 HEALTH AFFS. 31 (1990); *Lack of Health Insurance Due to State Regulation*, *supra* note 34 (study by the National Center for Policy Analysis, Dallas). The application of state mandate laws to self-insured plans would reduce the incentives employers have to self-insure to avoid the expense of providing some benefits.

³⁰⁴ See *supra* notes 134-39 and accompanying text. Ironically, raising mandatory contribution levels currently makes self-insurance even more attractive, and thus leaves an even smaller pool from which to fund initiatives.

³⁰⁵ This would require amendment of the savings clause to include a new class of state regulations because these state programs do not constitute state regulation of insurance that is already "saved" from preemption. See *supra* text accompanying notes 100-29.

³⁰⁶ Employers might cancel ERISA health benefit plans or decide not to institute them if they were subject to state regulation. Note, *Worker Well-Being*, *supra* note 64, at 851-52. This result could be prevented if states could mandate participation. Even without such a state mandate, however, employers might find it difficult to cancel their employees' health plans. *Id.*

³⁰⁷ For example, Congress might mandate coverage for low-income individuals or the medically uninsurable. If some federal oversight is

A broad ERISA waiver seems sensible from the policy standpoint. An expansive exemption for state initiatives has the advantage of permitting state experimentation. States would be free to adopt plans tailored to their special needs, economic circumstances, and political realities. Different states could adopt employer mandates, taxing schemes, or publicly funded initiatives, or some combination of approaches. The advantage of flexibility does entail a cost to uniformity; a broad waiver presents a greater threat to uniform regulation of health benefit plans.

Waiver of ERISA preemption is absolutely required if states are to be freed to develop fiscally and politically realistic solutions to the problems of the uninsured. With an ERISA waiver, states could enact benefit mandates, employer mandates, or more broadly financed access initiatives. Yet a waiver should not be viewed as a panacea for all the ills of the uninsured. There are important political and practical drawbacks to this approach.

First, a Congressional ERISA waiver proposal is likely to face a difficult political struggle. The Senate considered amending ERISA to remove "any and all preemption . . . of state health insurance laws" after the preemption of Hawaii's Prepaid Health Care Act.³⁰⁸ But political opposition from business and labor resoundingly defeated this amendment, along with one that would have permitted "any state to adopt a law 'substantially identical' to the Hawaii" Act.³⁰⁹ Thus, despite the strong legal and policy concerns supporting the enactment of a broad preemption waiver, ERISA's congressional history suggests that such a waiver would face formidable opposition.

Second, once an ERISA waiver is obtained, state level solutions for the problems of the uninsured face the very practical policy constraints imposed by our federal system. Individual states may fear that access initiatives will make them less attractive to business and more appealing to the currently uninsured. Access initiatives require the kind of redistributive policy that states historically have avoided.³¹⁰ Finally, those who view access to

desired, the waiver could be conditioned on certification of the state plans by the Department of Health and Human Services.

³⁰⁸ Fox & Schaffer, *Health Policy*, *supra* note 47, at 247; *see also supra* text accompanying notes 145-53.

³⁰⁹ Fox & Schaffer, *Health Policy*, *supra* note 47, at 247-49.

³¹⁰ *See, e.g.*, Thompson, *supra* note 50, at 648, 664. In some cases, states have adopted policies that seem calculated to increase, rather than reduce, the ranks of the uninsured. Low rates of Medicaid coverage, for example,

health care as a particularly important social benefit may be troubled by variations between state programs that will result in less access for citizens of some states than those of other states.

While an ERISA amendment or waiver currently represents the best hope for improved access, only a comprehensive federal initiative could ensure uniform access for all. Past federal incremental access initiatives have resulted in an uneven patchwork of coverage that serves too few.³¹¹ For that reason, the only alternative to an ERISA waiver is the even more politically difficult enact-

suggest that states like Mississippi, Alabama, and Texas are part of the problem rather than the solution. *See id.* at 661-62; J. HOLAHON & J. COHEN, *supra* note 26, at 38-40.

³¹¹ Congress has increased access to health insurance in several discrete areas. Congress has required, for example, that many employers continue to provide group health benefits to certain former employees and their dependents for 18 to 36 months. *See* 29 U.S.C. § 1162(2) (West Supp. 1990). At the end of this period these former employees would be offered a conversion policy, under which they could convert their group health insurance coverage to individual coverage. *Id.* § 1162(5). *See also, supra* note 61 (Congress acts to improve Medicaid coverage for low income pregnant women and children). Most recently, Congress acted to remedy the problems of some of the underinsured in passing the Medicare Catastrophic Coverage Act of 1988. Pub. L. 100-360, 102 Stat. 683 (1988). Designed to protect Medicare recipients from catastrophic hospital and physician expenses, the Act was quickly repealed after middle class Medicare recipients realized that they were being specially taxed to provide coverage for low-income participants. This last imbroglio may make Congress chary of future initiatives requiring observably increased tax burdens. President Bush's Director of Policy Development suggests that "[t]he Medicare Catastrophic Coverage Act, which was passed in 1988 but was repealed by Congress in late 1989, should teach us all a number of lessons. One of them is that not only is it important to develop a detailed policy proposal, but that such a plan must be sold to the millions of persons that it will affect." Roper, *supra* note 1, at 99.

These enactments have done little to improve the insured status of those without ties to employment, or of those who do not have access to health insurance through their employment. *See* EBRI, *supra* note 41, at 4. Meanwhile, Congress has reinforced the notion that insurance coverage is something to be allocated sparingly to isolated groups within the uninsured population. Despite widespread popular support for some type of universal health coverage, Congress consistently reinforces the conclusion that no general federal obligation to remedy the problem of all uninsured exists. *See* Blendon, Leitman, Morrison & Donelan, *supra* note 9, at 186-87. As Bovbjerg and Kopit note:

Each statute — Medicare, veterans' coverage, maternal and child health, and so on — carries with it greater or lesser entitlements to a more or less defined population. The negative implication

ment of some form of comprehensive federal program, either through adoption of employer mandates,³¹² a Canadian-style system,³¹³ or some other version of national health insurance.³¹⁴

In short, there is no painless and simple way to provide health care for the millions who currently do without. The end result is one of circularity and frustration. The federal government's failure to address the problems of the uninsured has forced state intervention. Yet, as this Article has indicated, ERISA preemption precludes effective state responses. This fact, in turn, requires the politically difficult federal enactment of an ERISA waiver provision. This solution, while only a partial one, is none-

of each program of special assistance is that no general federal obligation exists.

Bovbjerg & Kopit, *supra* note 20, at 874.

³¹² Federal mandates offer the advantage of an off-budget solution to the problems of a segment of the uninsured population. Universal coverage can be attained if mandates are combined with public funding for those uninsured without ties to employment. The most prominent current federal proposal, cosponsored by Senator Edward Kennedy and Representative Henry Waxman, is the Basic Health Benefits For All Americans Act of 1989 (BHB). S. 768, 101st Cong., 1st Session (1989); *see also* EBRI, *supra* note 41, at 11; Bovbjerg & Kopit, *supra* note 20, at 870-71. The BHB combines employer mandates with publicly financed health insurance for the poor or unemployed. The Pepper Commission has also endorsed employer mandates. *See* THE PEPPER COMMISSION, U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, A CALL FOR ACTION 54-55 (Final Report Sept. 1990) (available from the U.S. Gov't Printing Office).

³¹³ *See* Himmelstein & Woolhandler, *supra* note 3; Woolhandler & Himmelstein, *A National Health Program: Northern Light At the End of the Tunnel*, 262 J. A.M.A. 2136-37 (1989); *see also* Fuchs & Hahn, *How Does Canada Do It?*, 323 NEW ENG. J. MED. 884 (1990); Iglehart, *Canada's Health Care System Faces Its Problems*, 322 NEW ENG. J. MED. 562 (1990); Iglehart, *The United States Looks at Canadian Health Care*, 321 NEW ENG. J. MED. 1767 (1989); Terris, *Lessons from Canada's Health Program*, 11 J. PUB. HEALTH POL'Y 151 (1990).

³¹⁴ Representative Stark, for example, has proposed an entirely new government insurance program, called "Mediplan" that would replace Medicaid. H.R. 5300, 101st Congress, 2d Sess. (1990). *See also* Council on Medical Care, National Association for Public Health Policy, *A Progressive Proposal for a National Medical Care System*, 10 J. PUB. HEALTH POL'Y 533 (1989); Greenberg, *Eliminate Employer-Based Health Insurance*, HOSPITALS, Oct. 5, 1990, at 80 (favoring Dutch system, which adopts some of the consumer choice reforms long advocated by Professor Alain Enthoven of Stanford University); *A Proposal to Provide Health Insurance to All Children and All Pregnant Women*, 323 NEW ENG. J. MED. 1216 (1990) (proposal developed by the American Academy of Pediatrics).

theless required unless and until comprehensive federal initiatives are enacted.

CONCLUSION

Providing health care access for the uninsured or underinsured is a complicated and vital task. The uninsured themselves are represented in all income groups; they are employed and unemployed, families and individuals. This diversity results in complexity at the level of program design: comprehensive health care access programs generally must take into account the different causes of uninsurance to effectively implement change. Change is necessary to end or at least to limit the very real suffering that lack of access to health care yields.

Policies designed to improve access to health care fight for survival in an often hostile political and legal environment. The federal government has the resources and flexibility to design effective programs to increase health care access, but seems unwilling to do so. Yet, the constraints of federalism limit the potential success of any state level solution. As a policy matter, states tend to avoid redistributive programs because of fears that they will cause an influx of the needy and an exodus of businesses and the wealthy.³¹⁵ Nor are states uniformly concerned with increasing health care access. Leaving the problem to the state level is likely to perpetuate the inequalities in access that already exist between states.³¹⁶

Further, as a matter of law, ERISA presents a real statutory barrier to state enactment of some access initiatives.³¹⁷ Employer mandates face ERISA preemption, even though they may be politically more feasible than general tax increases and perhaps

³¹⁵ States that have designed redistributive programs have been acutely aware of migration problems. *See, e.g.*, MASS. GEN. LAWS ANN. ch. 118F, § 2 (West Supp. 1990) (definition of "resident" prohibits coverage of persons who enter state for the sole purpose of receiving health insurance benefits); R.I. GEN. LAWS § 42-62-4(n) (Supp. 1987) (providing that "[a] person who has moved to the state for the primary purpose of receiving benefits provided pursuant to [CHIP] shall not be considered to be a permanent resident unless such residency has been established pursuant to a judicial order to be a permanent residency").

³¹⁶ *See* Thompson, *supra* note 50, at 656-57; *supra* text accompanying notes 58-61.

³¹⁷ *See supra* text accompanying notes 130-43. ERISA concerns recently contributed to the failure of a Kentucky bill. Lipson, *supra* note 172, at 49.

more comprehensive than voluntary programs.³¹⁸ ERISA's preemption provision decreases program flexibility and effectiveness at the state level.

Federal inaction and ERISA preemption have foreclosed the development of effective state policies. A federal level solution offers the best hope of providing comprehensive coverage for all citizens. In the absence of such an initiative, amendment of ERISA to permit state regulation would revitalize state efforts to design comprehensive programs. In the end, the most politically feasible alternative may be forcing the federal government to step aside and let state initiatives through.

³¹⁸ Employer mandates also face opposition; even a Massachusetts-type plan imposing new payroll taxes might be politically untenable in some states. See Lipson, *supra* note 172, at 49 (observing that opposition of business interests in Minnesota would likely preclude a Massachusetts-type plan).