Washington State Health Care Authority

Finance Technical Advisory Committee

July 13, 2023

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Finance Technical Advisory Committee

Meeting Materials

July 13, 2023
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

Tab 1

Washington State Health Care Authority

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Finance Technical Advisory Committee (FTAC) to the Universal Health Care Commission

July 13, 2023
2:00 p.m. – 4:00 p.m.
Zoom Meeting

AGENDA

FTAC Members:					
☐	Pam MacEwan, FTAC Liaison	☐	Eddy Rauser	☐	Kai Yeung
☐	Christine Eibner	☐	Esther Lucero	☐	Robert Murray
☐	David DiGiuseppe	☐	Ian Doyle	☐	Roger Gantz

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome and call to order	1	Pam MacEwan, FTAC Liaison
2:05-2:08 (3 min)	Roll call	1	Angela Castro, Senior Health Policy Analyst Health Care Authority
2:08-2:10 (2 min)	Approval of Meeting Summary from 05/11/2023	2	Pam MacEwan, FTAC Liaison
2:10-2:25 (15 min)	Public comment	3	Pam MacEwan, FTAC Liaison
2:25-2:30 (5 min)	• Review of 2023 workplan • Updates from the Commission's June meeting	4 5	Liz Arjun, Principal, Health Management Associates
2:30-3:10 (40 min)	A Brief History of ERISA & Health Care Policy • FTAC Q&A and discussion	6	Carmel Shachar, JD, MPH, Assistant Clinical Professor of Law Faculty Dir., Health Law and Policy Clinic, Harvard Law School
3:10-3:50 (40 min)	ERISA Issues in Washington State • FTAC Q&A and discussion	7	Jane Beyer, JD Senior Health Policy Advisor, Office of the Insurance Commissioner
3:50-4:00 (10 min)	Recap and next steps	8	Liz Arjun, Principal, Health Management Associates
4:00	Adjournment		Pam MacEwan, FTAC Liaison

Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Commission has agreed this meeting will be held via Zoom without a physical location.

Tab 2

Finance Technical Advisory Committee (FTAC) Meeting Summary

May 11, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
3:00 p.m. – 5:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the FTAC webpage.

Members present

Christine Eibner
David DiGiuseppe
Eddy Rauser
Ian Doyle
Kai Yeung
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Esther Lucero

Call to order

Pam MacEwan, FTAC Liaison, called the third meeting to order at 3:00 p.m.

Agenda items

Welcoming remarks

Pam MacEwan began with a land acknowledgement, reviewed the agenda, and shared the goals of the meeting.

Meeting Summary review from the previous meeting

Two revisions were submitted and shared onscreen to clarify language in the March 2023 meeting summary. Members present voted by consensus to adopt the meeting summary as amended.

Public comment

Kathryn Lewandowsky, RN, remarked on the political challenges in the current health care system and urged FTAC to focus on designing a non-profit universal health care system (and eventually, a single-payer system).

Cris Currie, retired RN, Health Care for All, recommended that the Commission begin engaging with federal authorities to enact legislation for necessary waivers and put Medicare decisions on hold for the time being.

Roger Collier asked whether a waiver is required for a Medigap option, how a direct reimbursement option would be funded, and asked about the likelihood of waiver approvals by lawmakers and Medicare enrollees.

Maureen Brinck-Lund noted that there has been little to no mention of single-payer design despite provisions in SB 5399 to do so, and urged the Commission to begin planning for waiver(s) submission to include federal funding.

Sarah Weinberg remarked that Medicare enrollees would find a universal system favorable relative to the current system and cautioned against using population-based payments or value-based payment arrangements.

Consuelo Echeverria suggested that the next five months be spent developing a single-payer model rather than considering the Employee Retirement Income Security Act of 1974 (ERISA).

Presentation

FTAC Member Christine Eibner, Senior Economist, RAND Corporation
It is important to include Medicare enrollees in Washington's universal health care system to achieve parity both in terms of cost sharing and benefit design. Six proposed options (and the pros and cons of each) were outlined to include Medicare enrollees in the universal system. Options were ordered from least feasible to most feasible.

Options 1 and 2 are variations on waivers. Option 1, an act of Congress/comprehensive waiver, would enable Washington to redirect federal funding for Medicare into the universal system. However, legal advisors to the state of California on this topic found no clear statutory or regulatory pathway enabling the Centers for Medicare and Medicaid Services (CMS) to redirect Medicare funds to a state, even via waiver.

Option 2 is a demonstration waiver, where Washington could develop a payment-focused reform with CMS to be implemented via a waiver, enabling the capture of federal Medicare funding. However, it is unclear how this could be used to cover premiums and cost-sharing or additional benefits. This option may also be subject to legal challenges and could create administrative burdens for the state.

Members discussed additional pros and cons of Options 1 and 2. FTAC Member Roger Gantz noted that budget neutrality is a key component of 1115a waivers. FTAC Member David DiGiuseppe noted that the Commission's 2022 report explored Medicare as a vehicle to lower commercial fee schedules and extract savings systemwide, and suggested that Option 1, although politically challenging, is the only option to achieve this objective. Christine Eibner remarked that Option 2 may also achieve that objective but would give the state less flexibility and control over the system. Maryland has implemented Option 2 to modify the fee schedule to achieve one rate. Roger Gantz suggested Option 1 as a north star and Option 2 as a potential pathway to a comprehensive waiver. FTAC Member Robert (Bob) Murray asked whether any of the options proposed were mutually exclusive. Christine Eibner responded that in general, some options could be combined. David DiGuiseppe was drawn to pursuing Option 1 or 2 in the long-term and potentially partnering with Oregon and California for leverage with CMS and Congress.

Options 3 and 4 are variations on a state-run Medicare Advantage (MA) plan. In Option 3, the state's MA plan would be the only option for Washington Medicare enrollees. To the extent that MA rules allow, this option could be designed to match the universal system. However, a waiver is needed to allow Medicare enrollees a choice between traditional Medicare and MA, and a mechanism to preclude private MA plans from entering the market. The state would need to apply to become a Medicare Advantage Organization (MAO) or contract with an existing MAO, adding administrative costs. Option 3 could be subject to legal challenges if enrollees were denied access to traditional Medicare.

Option 4 maintains Medicare enrollees' choice and the state could design and offer an MA plan with benefits parity to the universal system with fewer legal challenges. However, the state would still need to design and manage the MA plan in addition to the universal system, and MA pricing and benefit design requirements could limit flexibility. Again, the state would either need to apply to be an MAO, or contract with an existing MAO.

Members discussed additional pros and cons of Options 3 and 4. FTAC Member Eddy Rauser asked how either option would function out of state. Current MA rules would apply, and the existing MA delivery system would need to be contended with. Christine Eibner added that it would be difficult for the state to bid competitively enough to achieve benefits parity with the universal system. David DiGiuseppe posed that Option 4 could be a step towards a universal system where the state can gather more experience. Roger Gantz added that there is no existing infrastructure for the state to administer an MA plan. Pam MacEwan noted challenges in restricting consumer choice, though more value can be extracted from a plan when choice is restricted.

Option 5 is a state operated Medigap plan which could be offered by the state to achieve benefits parity between Medicare and the universal system. However, the Medigap plan must have one of 10 specific designs which would not include dental, vision, or drug coverage. Additionally, due to federal rules, this option could not cover the Medicare Part B deductible, nor be available to MA enrollees, nor recoup federal funding.

Under Option 6, the state would reimburse Medicare enrollees directly for Medicare cost-sharing and for services covered in the universal system but not covered by Medicare. However, since enrollees' Part B deductibles couldn't be covered, this option may invite federal scrutiny. This would also be administratively complicated and directly reimbursing enrollees for some services could cause MA carriers to shift rebates to non-reimbursable services.

Members discussed additional pros and cons of Options 5 and 6. Roger Gantz shared that the Medicare Savings Program (MSP) is an existing program that covers out-of-pocket costs for Medicare enrollees up to 100 percent of the federal poverty level (FPL) and could be used as a vehicle to achieve objectives under both Options 5 and 6. For Option 6, eligibility for dual Medicare-Medicaid coverage could be extended. The state could pay the difference for higher income individuals, giving the state flexibility to tailor the income threshold. Kai Yeung noted that Medigap plans would increase fee-for-service (FFS) usage. Roger Gantz stated that the universal system benefit design has not yet been designed which poses a challenge.

Regardless of the approach, it is important to maintain federal funding for low-income enrollees. Dual eligibility is available to low-income Medicare enrollees. The federal government also provides cost-sharing and premium subsidies for low-income Part D enrollees (low-income subsidy (LIS) status). Dual and LIS enrollees could be auto-enrolled and/or reassigned to lower-premium plans.

Introduction to FTAC Member vote

Liz Arjun, HMA

This vote is not about whether Medicare will be included in the universal system, rather it is intended to provide guidance to the Commission on options that allow the design process to advance while ensuring benefits parity for Medicare enrollees now. This vote is not binding forever.

FTAC Member vote: recommendations to the Commission regarding Medicare

Pam MacEwan, FTAC Liaison

Motion to recommend or not recommend Option 1, an act of Congress or comprehensive waiver at this time.

Roger Gantz recommended not pursuing Option 1 at this time due to timing and resources. Though, this is not to suggest that Medicare shouldn't be part of the comprehensive system. Members agreed and recommended that the new system design continue to be developed, recognizing that eventually Medicare will be part of it.

Motion to recommend or not recommend Option 2, a demonstration waiver at this time.
Christine Eibner recommended that Option 2 not be explored as a means to include Medicare enrollees, though this could be explored in the future to reduce costs. Bob Murray agreed, adding that this may be an option for a payment model and Members agreed.

Motion to recommend or not recommend Option 3, a state-operated MA and Part D plan as the only option for Washington Medicare enrollees.
Eddy Rauser questioned the feasibility in the short-term and Kai Yeung noted the significant administrative burden. Pam MacEwan added that this option also restricts Medicare enrollees' choice. Members agreed that the Commission should not pursue Option 3.

Motion to recommend or not recommend Option 4, a state-operated MA and Part D plan that would compete with private MA plans and traditional Medicare.
Kai Yeung noted the administrative burden and questioned the feasibility. Eddy Rauser posed whether this option would be an opportunity for the state learn more, though the state would be competing in a mature market. A majority of Members agreed that though there are several hurdles, this option warrants further examination and should not be taken off the table. Roger Gantz voted no on Option 4 at this time due to a lack of infrastructure/ capacity and potential for exposing the state to downside risks.

Motion to recommend or not recommend Option 5, a state operated Medigap plan.
Bob Murray supported this option, noting the greater political feasibility. Kai Yeung supported this as a short-term option, potentially pairing with Option 1 or 2 in the long-term. However, this option wouldn't apply to MA enrollees which may invite pushback from MA carriers. Eddy Rauser remarked that managed care enrollment has grown significantly, noting several considerations in transitioning to an FFS structure. Roger Gantz voted no on Option 5 at this time, recommending that the Commission continue to endorse the legislature's work to expand the MSP. Pam MacEwan was not supportive of Option 5 at this time, though supported further examination.

Motion to recommend or not recommend Option 6, directly reimbursing or insuring beneficiaries for gaps.
Members generally supported Option 6 with further examination by the Commission. This option could be combined with Option 1 or 2 in the future to support the Commission's long-term goals. Roger Gantz recommended getting a second opinion to analyze the politics of these options and that the Commission connect with Oregon to advance this work. There are existing pathways to move towards what Options 5 and 6 could accomplish.

Presentation

Liz Arjun, HMA
FTAC heard updates from the Commission's April meeting. FTAC's next topic after Medicare is ERISA eligibility. FTAC Members with expertise on ERISA and who could present to the Committee at the July meeting were encouraged to reach out to HCA.

Presentation: Creating and sustaining a universal health care system – introduction to system cost containment strategies

Bob Murray, Assoc. Health Services Researcher, University of California College of the Law, San Francisco.
Bob Murray presented several cost containment models in order of intensity from lowest to highest. Cost growth targets (used in Washington) set a maximum target for the rate at which total health care expenditures can increase in a year. This model provides some transparency and identifies cost drivers but is unlikely to be effective in controlling price growth.

As modeled by Rhode Island, affordability standards authorize the Office of the Health Insurance Commissioner to reject premium rate increases exceeding the consumer price index (CPI-Urban). However, there is no control over providers other than hospitals.

Out-of-network (OON) price caps are a maximum payment which applies when a patient obtains care from a provider outside their insurance network. This gives insurers leverage to negotiate lower in-network prices. This is a lower intensity approach because it regulates such a small sector of the market.

Hospital global budgets are a prospectively determined cap on annual revenues. Global budgets can be 100 percent fixed during a performance year (as done in universal systems in Europe and Canada) or semi-variable, e.g., flexible global budgets. Maryland sets fixed global budgets, which may incentivize shifting care to non-hospital providers or may increase wait times for emergency elective procedures as experienced in Europe.

Recently, prominent economists proposed a system of very high price caps. With this approach, it's recommended that limits on price growth (directed at commercial prices) are imposed. However, this is an intensive regulatory approach since price caps are set on all services. This requires significant data collection and compliance, and both regulatory and legislative authority. There is nuance to how this could be implemented.

A population-based payment system (PBP) is a highly integrated finance and delivery system designed to meet population-level cost and quality targets. This requires significant regulatory oversight. Kaiser is an example of a PBP model and may integrate well with a universal system.

Some of the more complex regulatory systems can be prone to regulatory failure, but states have to start somewhere. The Center for Medicare and Medicaid Innovation (CMMI) will soon propose a model for states to implement global budgets. Bob Murray advocated for a flexible approach to global budgets. Roger Gantz asked whether selective contracting has successfully constrained costs in other states. Bob Murray replied that West Virginia's system regulated commercial payers, setting a rate floor (based on providers' reported cost levels) and a rate ceiling. However, the program was not cost-effective because the rate of growth allowed was not restricted over time. This approach also doesn't control health care volumes. Kai Yeung asked why administrative burdens for price caps couldn't be reduced by implementing caps for services with high price variance. Bob Murray replied that this would still require a significant amount of data collection. Bob Murray offered to provide a more in-depth presentation on select cost containment models in the future.

Adjournment

Meeting adjourned at 5:11 p.m.

Next meeting

July 13, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Tab 3

Washington State Health Care Authority

Washington State Health Care Authority

FTAC

Written Comments

Received From April 27

Written Comments Submitted by Email

Additional Comments Received at the May FTAC Meeting

- The Zoom video recording is available for viewing here: https://www.youtube.com/watch?v=Bh3ANu3vm1w

Public comments received since (April 27) through the deadline for comments for the July meeting (June 29)

Submitted by Consuelo Echeverria

05/11/2023

Submitted by Consuelo Echeverria
05/11/2023

Dear FTAC Members,

First thank you all very much for your work on the FTAC.

I would like to address a few points on the May 2023 FTAC Agenda.

1. Workplan:
As it is currently scheduled ERISA is on the agenda from June till Nov. While ERISA has de-railed 21 state-based single payer efforts since 2010, Brown and McCuskey, (2019) outline The A,B,C Strategy along with the Non-duplication Provision that should not take five months, almost a half a year, to discuss. Cris Currie's summary of Brown & McCuskey, 2019 in the May 11, 2023, Meeting Materials succinctly lays out The A,B,C Strategy along with the Non-duplication Provision that has already been tried in other states.

Furthermore, in the April UHCC meeting, Jane Beyer, who shared that she has years of experience with ERISA, suggested a vote to put ERISA aside. However, that suggestion was rejected as not all commissioners were present due to the end of the legislative session.

I can not emphasize enough that the next 5 months would be better spent putting ERISA aside and focusing on the vision of the unified, universal health care system we are trying to build. In other words the Washington Health Security Trust. It is within this unified system that immediate needs can be addressed such as developing a plan to purchase PEBB and SEBB benefits together to showcase the State's capacity for managing a unified health care system as suggested by Roger Gantz in the FTAC meeting of March 2023.

2. Medicare: Motion to recommend or not recommend: Number 1 Act of Congress or comprehensive waiver at this time.
I urge the commission to vote for Option Number 1 as communication with DHHS can guide the iterative process of preparing the groundwork in Washington State for a:
"A comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under section 1332 of PPACA and a detailed 10-year budget plan that is deficit neutral."
(https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf)

Ms. Eibner's presentation highlights the real barriers of no precedent and unclear federal support. I would just say that while yes, there is no precedent and unclear federal support, Option 1 is, as the California report says, the "North Star" that should guide all of our efforts. Furthermore, in her presentation there is no mention of the fact that almost 70% of Americans support Medicare for All as the COVID-19 pandemic has revealed the extreme gaps in the US healthcare system. This is not the time to be timid but a time for us to be visionary and gather forces for the "moon-shot" to state based universal health care.

Furthermore, it is unclear to me how a waiver for Washington state would endanger the whole federal program of Medicare. I think that Medicare would still be 'preserved' in the other 49 states.

3. Population-Based Payment and Capitation
We should not be adapting the Population-Based Payment model as it is an iteration of Value Based Payments with the same and new issues that do not exist under a fee-for-service model. Some of the most egregious issues are highlighted below.

Patients do not receive needed care:
Unlike fee-for-service payment where providers are paid for providing services, in the Population-Based Payment model the revenue a provider receives is based on the number of patients cared for, not how many services or types of services used. Therefore, the Population-Based Payment model incentives providers to treat those that are healthy and drop those that are sick as the provider saves money when fewer services are delivered. While looking at this from an equity lens, we know that those who are the sickest are often the oldest, poorest and from minority (BIPOC) communities and from rural communities. In fact, McWilliams et al, highlights that setting population-based payments a current levels risks entrenching levels that are **proven to be insufficient to mitigate** the impact of social determinants on health care use." (McWilliams et al, 2023).

Penalizes providers who care for higher-need patients:
Fee-for-service payment allows providers to be paid for additional services for patients with multiple and complex needs that many poor, old and BIPOC and rural patients have. Conversely, population-based payment models may not adjust payments for patients with new, multiple and or complex problems or those who face non-medical barriers to care as can be the case for many rural patients. This can and does penalize providers who care for high-need patients.

Incentivizes investors and other financial intermediaries:
"Because of the high levels of financial risk associated with population-based payment systems, private investors and financial intermediaries can profit on fixed capitation payments if they can find ways to cherry-pick patients and increase the risk scores assigned to patients, rather than by improving the quality of healthcare services." (CFHCR, accessed May 5, 2023)

Sources
Fuse Brown, E. C., & McCuskey, E. Y. (2019). Federalism, ERISA, and State Single-Payer Health Care. *U. Pa. L. Rev.*, *168*, 389

Schulte, G. (n.d.). *Poll: 69 percent of voters support Medicare for All* . What Americans Think Poll: 69 percent of voters support medicare for all. https://thehill.com/hilltv/what-americas-thinking/494602-poll-69-percent-of-voters-support-medicare-for-all/
McWilliams, J. M., Weinreb, G., Ding, L., Ndumele, C. D., & Wallace, J. (2023). Risk Adjustment And Promoting Health Equity In Population-Based Payment: Concepts And Evidence: Study examines accuracy of risk adjustment and payments in promoting health equity. Health Affairs, 42(1), 105-11
The Center for Healthcare Quality and Payment Reform (CFHCR). (n.d.). *Overview of patient-centered payment*. Patient-Centered Payment. https://patientcenteredpayment.chqpr.org/Overview.html

Submitted by Cris Currie
05/11/2023

I'm Cris Currie, HCFA-WA volunteer from Spokane. In the meeting materials, Christine Eibner cites Brown, Peisch & Seidenberg (page 94) as saying there is no clear statutory pathway enabling CMS to redirect Medicare funds to a state, however those same authors later state that it might be possible (p. 98), given CMMI's broad authority for granting waivers. The April 2022 California Commission's final report therefore recommends that the state actively engage federal authorities to gain a better understanding of what could be accomplished with existing waivers and then work with these authorities to enact legislation for additional desired waivers (pgs. 75-78). This is exactly what many of us have been advising all along. Regardless of what arrangements for federal funding might look best for us today, nobody will know what is actually possible until we begin an iterative, ongoing conversation with those authorities. The Commission should initiate this soon and put any decisions about Medicare on hold. Determining the vision and designing the model are far more important right now. Use the Washington Health Securities Trust as the template!

It should also be noted that California Assemblymember Ash Kalra (last page) obtained encouraging information during his 2021 visit to HHS, and Governor Newsom has requested help from President Biden to create new federal waivers. There is much we can learn from both Oregon and California!

Submitted by Roger Collier
05/30/2023

Submitted by Roger Collier
05/30/2023

Submitted by Roger Collier
06/20/2023

ERISA and the 2.5 million self-funded Washingtonians

Four questions for FTAC:

1. What payroll tax will be needed?

2. **Will this tax result in preemption?**
3. **Can pay-or-play avoid preemption?**
4. **When will we know the answers?**

ROGER COLLIER ***rcollier@rockisland.com***

1. **What payroll tax will be needed?**

Other states' single-payer designs have tried to replicate the present split between employer and employee and other individual contributions (plus federal funds). For example, Vermont and Oregon each proposed a mix of payroll tax and increased income tax, but this is not possible in Washington since any income tax is unconstitutional.

The Washington Health Security Trust proposal includes a mix of an unspecified percentage payroll tax along with a "health security premium" for residents with incomes over 200 percent of FPL, but the latter could be construed as a form of state income tax (and criticized as regressive if the premium is a fixed amount).

Washington's SB5335 proposal includes a 10.5 percent payroll tax and 8.5 percent tax on capital gains over $15,000 (along with tax on sole proprietor income), but the latter could be criticized as a "tax on retirees" and construed also as including an unconstitutional state income tax.

With no ability to levy an income tax, Washington may be more dependent than other states on payroll taxes. As discussed in the next section, the question is how high can these be without triggering ERISA preemption as being "exorbitant"?

2. Will this tax result in preemption?

ERISA preempts (i.e. overrules) any state regulation that "relates to" private employer sponsored benefits. The US Supreme Court in 1997[1] set as a test for preemption a case in which state law "mandates employee benefit structures or their administration."

Federal courts have not ruled on whether a state single-payer plan would be preempted but have issued some relevant decisions:

- **ERISA does *not* preempt pay-or-play regulations requiring employers to pay workers additional compensation unless they provide a minimum level of benefits[2] (discussed in the next section).**
- **ERISA does *not* preempt regulations that merely increase costs or change incentives for employer plans without forcing them to adopt any particular coverage scheme[3].**
- **ERISA does *not* automatically preempt regulations that impose additional taxes on employer plans, *but* there might be a point at which an "exorbitant" tax forcing a "Hobson's choice" would be treated as a substantive mandate in violation of ERISA[4].**

The third ruling may offer the most serious preemption threat to a Washington single-payer plan with a payroll tax perhaps close to ten percent. The expert legal opinion on Oregon's single-payer proposal claimed that it should not be preempted since, although payroll taxes based on a percent of wages would encourage a shift to the state plan, they would not reference an employer's plan nor require a change to an employer plan. However, this opinion failed to consider the wide

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[1] De Buono v. NYSA-ILA Med. & Clinical Servs. Fund

[2] ERIC v City of Seattle 2022

[3] Metropolitan Life v Massachusetts 1985

[4] New York Blue Cross and Blue Shield Plans V Travelers Insurance 1995

range of benefits offered by self-funded employer plans and their *effective* costs to employers.

***According to the Kaiser Family Foundation 2022 Employee Benefit Survey* only 60 percent of employees are covered even where benefits are offered, while some employers offer benefits that are far less generous than others. The KFF results show that even for individual coverage, more than 20 percent of employees are required to pay at least a quarter of their premiums and 4 percent must pay at least half.**

For example, based on current typical single coverage premiums of close to $8,000, and assuming 60 percent enrollment and a 30 percent employee contribution, the employer's per employee current cost would be $3,360, compared with a possible single-payer payroll tax[5] of 10.5 percent[6] of $57,200 or approximately $6,000.

It's impossible to know how federal courts might rule, but the example shows that a state single-payer plan could result in some employers facing a doubling of their healthcare benefit costs, something that they would almost certainly consider "exorbitant," and leaving them with no rational choice other than to abandon their self-funded plans.

3. Can pay-or-play avoid preemption?

Pay-or-play models typically impose levies on employers who fail to meet a benchmark standard of coverage of their employees (or who provide no coverage at all)[7]. The Supreme Court has not ruled on state

[5] Based on 2023 Washington statewide average wages
[6] As proposed by SB 5335
[7] Note that the term is also used in the context of IRS regulations for the ACA

pay-or-play models but four cases have been decided at the federal appellate or district court level, with two models preempted and two not.

- **The Ninth Circuit in 2008 found that a San Francisco ordinance requiring certain employers to meet a specified level of payments for health care or health insurance was *not* preempted by ERISA because it did not require employers to establish or modify ERISA plans and was concerned only with dollar amounts rather than specific benefits.**
- **The Ninth Circuit in 2021 found that a Seattle ordinance requiring certain hotel employers to meet a specified level of payments for health insurance or make similar cash payments was *not* preempted by ERISA since it did not require establishment or modification of ERISA plans, and gave the option of cash payments to employees.**
- **The Fourth Circuit in 2007 found that a Maryland law that required corporations with more than 10,000 employees to spend 8 percent of payrolls on health insurance or pay into a state fund *was* preempted by ERISA since it conflicted with ERISA's goal of uniformity and would force an employer to revamp its self-funded benefit plan.**
- **The federal district court for Suffolk County, New York, also in 2007, found that an ordinance that required large retail employers to make prescribed per-employee healthcare expenditures or be subject to penalties *was* preempted by ERISA since, like the Maryland case, it would force an employer to revamp its self-funded benefit plan.**

These cases suggest that a state pay-or-play plan might avoid ERISA preemption if there was no need for an employer to modify their self-

funded plan. For example, a model like Seattle's option of cash payments to under-insured employees might escape preemption (although there is no certainty that the Supreme Court would necessarily agree). There are other issues, however:

- **Monitoring cash payments (if this option were selected) on a statewide scale in order to ensure compliance might be very difficult.**
- **Situations where family members have multiple employers could present problems. For example, one spouse might have family coverage under one employer's self-funded plan, while the other spouse has no need of coverage under a second employer's plan. How would pay-or-play rules be imposed on the second employer?**
- **The pay-or-play proposals cited above were all aimed at larger employers. How could pay-or-play be made to cover the self-employed or very small businesses?**
- **Employers currently offering less generous benefits might still argue that the effect of pay-or-play is "exorbitant."**
- **A pay-or-play plan would not comply with the UHCC's mandate for a universal financing approach.**

Some form of pay-or-play model may have the potential for reducing the number of uninsured (as with the State's 1993 attempt at healthcare reform) but seems unlikely to achieve universal coverage.

4. When will we know the answers?

Assuming the UHCC concludes that inclusion of currently self-funded employees in a State single-payer plan would have a

reasonable chance of *not* being preempted by ERISA, what may happen and when?

Three major steps will be involved:

- **First, the UHCC must complete its work with a final report to the Legislature, but it is unclear when this might occur. SB5399 specified no deadlines, and there is no UHCC workplan beyond a vague outline for 2023. However, the UHCC budget expires in 2025 so this may determine the timeline for the final report.**
- **Second, the Legislature must take action to create a single-payer plan, including determining financing. Appropriate legislation must pass the State House and Senate and be signed by the Governor. If this legislation is to be based on the UHCC final report, the earliest it could be passed is 2025 (and might well be delayed to 2026).**
- **Third, the single-payer legislation must survive court challenges. Given the potential impact of single-payer on insurers and on many businesses, such challenges are almost certain, and some are likely to focus on the ERISA preemption issue. A reasonable expectation is that an initial challenge will be filed in Federal district court, followed by an appeal by the losing party to the federal Ninth Circuit, and then potentially to the US Supreme Court, if the Court takes up the case.**

  Based on the recent City of Seattle ERISA case, the court process alone could take up to four years, meaning that the ERISA single-payer preemption issue might not be settled until 2029 or even 2030. (This timeline could be further extended if challenges to the constitutionality of the single-payer funding mechanism are first filed in State courts.)

Tab 5

Washington State Health Care Authority

Updates from the Commission's June Meeting

- **Medicare recommendations**
  - Pam MacEwan, FTAC Liaison, shared with the Commission an overview of FTAC's examination of Medicare eligibility and FTAC's recommendations.
  - The Commission voted to adopt the guidance outlined in FTAC's Medicare Memo pending clarification that Option 6 be explored in conjunction with one of the waiver options (seven members for, one member opposed).
- **Transitional solutions**
  - FTAC's list of proposed ideas were shared with the Commission. At their August meeting, the Commission will begin discussions to prioritize the combined list (Commission/FTAC) of transitional solutions.

Updates from the Commission's June Meeting

- **FTAC's examination of ERISA eligibility over the July and September meetings:**
  - How ERISA law has evolved, areas of the law that are unchanged since the last analysis done on the topic, and any new approaches with potential areas of opportunity.
  - Since employer funding contributions may be optional, FTAC could examine how any employer contributions could be captured under the various ERISA eligibility options (and estimated dollar values for each option) to fund the new system.
  - "Pay or play" option where employers have a choice to continue providing coverage to employees
    - What are the implications of ACA mandated employer responsibilities?
    - If employers choose to continuing providing coverage to employees, could the state mandate that the minimum essential coverage required under the ACA match the coverage (TBD) provided under the new system?
    - Quality and equity implications of differing benefits between UHC and employer coverage
  - An option where employers pay into the universal system and employees are covered by the universal system

Updates from the Commission's June 2023 Meeting

FTAC's Medicare recommendations

The Commission greatly appreciated FTAC's work to assess options to include Medicare in Washington's future universal health care system, as well as the development of the Medicare Memo. At the Commission's June meeting, Pam MacEwan, FTAC Liaison, summarized the six options assessed by FTAC at their May meeting.

- One member of the Commission expressed concerns with voting to adopt FTAC's guidance given the unanswered questions regarding larger system design.
- Commission members accepted FTAC's recommendations as guidance with the understanding that the Commission's discussions of how to fill gaps in services, benefits, and cost-sharing for Medicare enrollees will need to occur after the Commission determines the universal system's benefits and services.
- The Medicare Memo noted that some options could be explored in conjunction with one of the waiver options, however this was not specifically noted in the Memo's description of Option 6.
- The Commission voted to adopt FTAC's guidance in the Medicare Memo pending clarification that Option 6 could be explored in conjunction with one of the waiver options (seven for, one opposed).

Guidance to FTAC on ERISA

In addition to the revisions and adoptions on next steps for Medicare, the Commission was asked to revisit and refine questions they would like FTAC to explore regarding ERISA. Below is a summary of the Commission's questions for FTAC to surface options to include ERISA in Washington's universal system:

- "Pay or play" option where employers have a choice to continue providing coverage to employees
  - What are the implications with ACA mandated employer responsibilities?
  - If employers choose to continue providing coverage to employees, could the state say that the minimum essential coverage mandated under the ACA match the coverage (TBD) provided under the new system?
  - Quality and equity implications of differing benefits if employers can continue to offer coverage
- An option where employers pay into the universal system and employees are covered by the universal system
- How ERISA law has evolved, areas of the law that are unchanged since the last analysis done on the topic, and any new approaches with potential areas of opportunity.
- Since employer funding contributions may be optional, FTAC could examine how any employer contributions could be captured under the various ERISA eligibility options (and estimated dollar values or each option) to fund the new system.

Transitional solutions

FTAC's proposed ideas were shared with the Commission. Transitional solutions were grouped into the following categories: affordability/cost containment/pricing; capacity/infrastructure; coverage/enrollment; providers; purchasing; and subsidies. However, the Commission ran out of time at this meeting and did not have a chance to discuss or analyze further. In preparation for the next meeting (August), the Commission was asked to think about whether any transitional solutions or categories were missing, and which solutions or categories should be focused on and/or prioritized.

Tab 6

Washington State Health Care Authority

CENTER FOR HEALTH LAW & POLICY INNOVATION
Harvard Law School

A BRIEF HISTORY OF ERISA AND HEALTH CARE POLICY

CARMEL SHACHAR
ASSISTANT CLINICAL PROFESSOR OF LAW
FACULTY DIRECTOR, HEALTH LAW AND POLICY CLINIC
HARVARD LAW SCHOOL

JULY 13, 2023

Center for Health Law and Policy Innovation

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Overview

- Introduction
- Major SCOTUS Cases
- Impact on Universal Care Initiatives
- Impact on Reproductive Health Services

INTRODUCTION

WHAT IS ERISA

ERISA Background

- **Employment Retirement Income Security Act of 1974 (ERISA)**
  - Federal statute setting minimum standards for most voluntarily established pensions and other employee benefit plans
  - Regulation of ERISA plans "exclusively a federal concern."
  - Standardized financial disclosure and reporting requirements, standards of conduct, responsibility and obligation
  - Preemption clause – "'all state laws insofar as they . . . relate to any employee benefit plan"
- **The ERISA preemption clause**
  - Preemption clause – "'all state laws insofar as they . . . relate to any employee benefit plan"
  - The purpose was to allow multistate employers to offer a single, consistent plan to all of their workers, reducing administrative and regulatory burdens while keeping administrative costs low

ERISA AND HEALTH CARE

- **ERISA was never intended to be a health care statute but is one**
  - ERISA does govern employer-sponsored health care plans, or insurance plans in which an employer covers the full financial risk of its employees' claims for health care benefits, because they are a type of employee benefit plan
  - Employer-sponsored insurance covers almost 159 million nonelderly people
  - In 2022, 65 percent of workers who got their health insurance through their employer were enrolled in plans that were at least partially self-funded
  - Larger companies are more likely to offer employer-sponsored health care plans (20% of covered workers at small firms and 82% in large firms are enrolled in plans that are self-funded)

ERISA JURISPRUDENCE THROUGH THE 1990'S

SETTING THE PREEMPTION TEST

ERISA Background

- **Three cases in 1990's articulated the preemption test for many years**
  - New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Co.
  - California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.
  - De Buono v. NYSA-ILA Med. & Clinical Servs. Fund
- **Supreme Court's interpretation of ERISA preemption clause**
  - State law is preempted if "it has a connection with or reference to such a[n employee benefit] plan."
  - Preemption limited to "state statutes that mandate[] employee benefit structures or their administration."
  - If the state law does not force a plan administrator to adopt certain structures or administrative choices, then ERISA does not apply

GOBEILLE V. LIBERTY MUTUAL (2016)

AN EXPANSIVE PREEMPTIVE DECISION

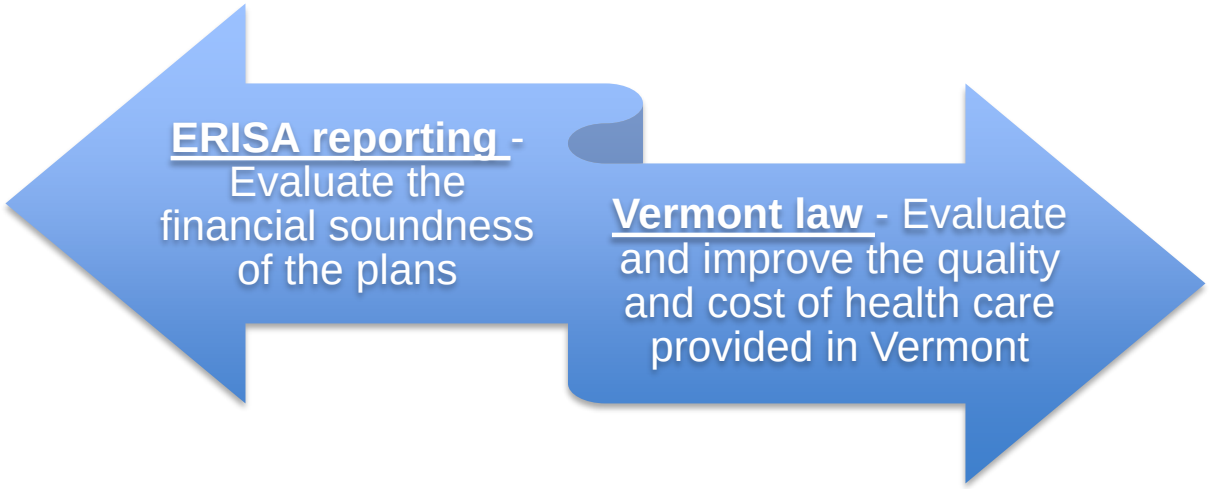
GOBEILLE

- **Majority Opinion (Kennedy, J.)**
  - ERISA preempts Vermont's APCD
  - Vermont law has a "connection with" ERISA plan
    - ✓ "governs . . . a central matter of plan administration" (reporting, disclosure, and recordkeeping)
    - ✓ "interferes with nationally uniform plan administration"

- **Gobeille was a major expansion of ERISA's reach into health policy**
  - The first time the Court considered future problems with uniformity in ERISA preemption jurisprudence, rather than focusing on whether the state law as currently applied resulted in uniformity issues

GOBEILLE

- **Dissent (Ginsburg, J.)**
  - ERISA does **NOT** preempt Vermont's APCD
  - Vermont law did not "impermissibly intrude on ERISA's dominion over employee benefit plans"
    - ✓Law does not impose a "substantial burden" on ERISA
    - ✓Vermont law and ERISA's reporting requirements "elicit different information and serve distinct purposes"



RUTLEDGE V. PHARMACEUTICAL CARE MANAGEMENT (2020)

RESTORING ERISA PREEMPTION JURISPRUDENCE

- **Majority Opinion (Sotomayor, J.)**
  - ERISA do NOT preempt Arkansas's regulation of pharmaceutical benefit managers and drug pricing
  - Arkansas Act 900 did not "refer to" ERISA because it applied to PBMs "whether or not they manage an ERISA plan."

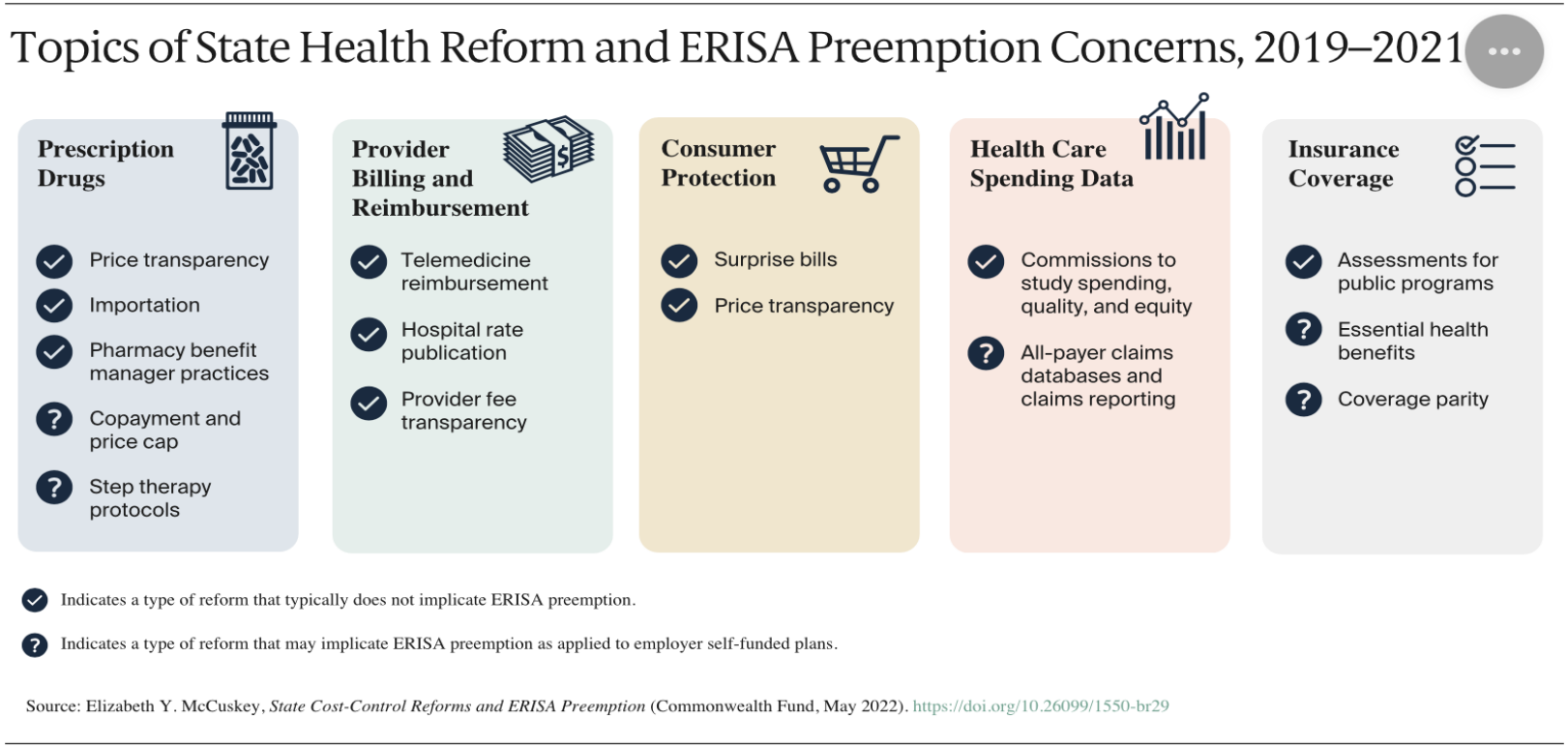
- **Sotomayor walks ERISA jurisprudence back from Gobeille to Travelers**
  - Sotomayor argued that, "[l]ike the New York surcharge law in Travelers, . . . [Arkansas Act 900] is merely a form of cost regulation" and not "primarily concerned with pre-empting laws that require providers to structure benefit plans in particular ways."
  - Only mentions Gobeille three times, in passing

IMPACT ON HEALTH CARE REFORM

WHAT CAN STATES DO?

ERISA IS A BARRIER TO INNOVATIVE POLICIES

ERISA preemption continues to deprive states from regulating a significant portion of their health insurance market: employer self-funded plans



Impact of ERISA Preemption

- **Gobeille as a test case**
  - Gobeille has significantly reduced the volume of claims data available to APCDs
  - As a response to Gobeille, some states have asked employers to voluntarily submit data to APCDs by entering into data-sharing agreements
  - However, many employers and insurance companies acting as third-party administrators are not willing to share their claims data because they are concerned about liability for violating non-disclosure agreements with employers, as well as state and federal privacy laws
- **Gobeille shows ERISA fixes are unlikely**
  - Congress could carve health plans out of ERISA
  - DOL and HHS could work together to create carve outs

Impact on Universal Care

- **Retail Industry Leaders Association v. Fielder (2007)**
  - Law required employers with more than 10,000 employees to spend a minimum of eight percent of their payroll on health care, or else pay the difference between the employer's actual health care expenditures and the eight percent threshold into a state Medicaid fund
  - Fourth Circuit struck down Maryland's "fair share law"
    - Only rational choice was to spend the required amount on health care because employer got no benefit if it just gave the money to the state

- **Golden Gate Restaurant Ass'n v. City and County of San Francisco (2009)**
  - Ninth Circuit reversed the District Court's finding that this program violated ERISA, relying on
    - The presumption against federal preemption of matters that generally fall within a state's police powers
    - That since the ordinance applied regardless of whether the employer had an ERISA plan, it did not "relate to" ERISA governed health plans
    - Distinguished from Fourth Circuit because employers had total discretion about how to spend their mandated contributions

Impact on Reproductive Care

- **ERISA creates strange discontinuities within access to reproductive care, post-*Dobbs***
  - Self-funded plans can likely cover abortion services and care, even in states that ban abortions
    - BUT employees would struggle to find providers
    - BUT no one knows if ERISA is a shield against criminal liability
- **Could an anti-abortion Department of Labor issue regulations saying no ERISA covered plan could support access to abortion services?**

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Tab 7

Washington State Health Care Authority

ERISA Issues in Washington State

UHCC Financial Technical Advisory Committee
Jane Beyer, Senior Health Policy Advisor

July 13, 2023

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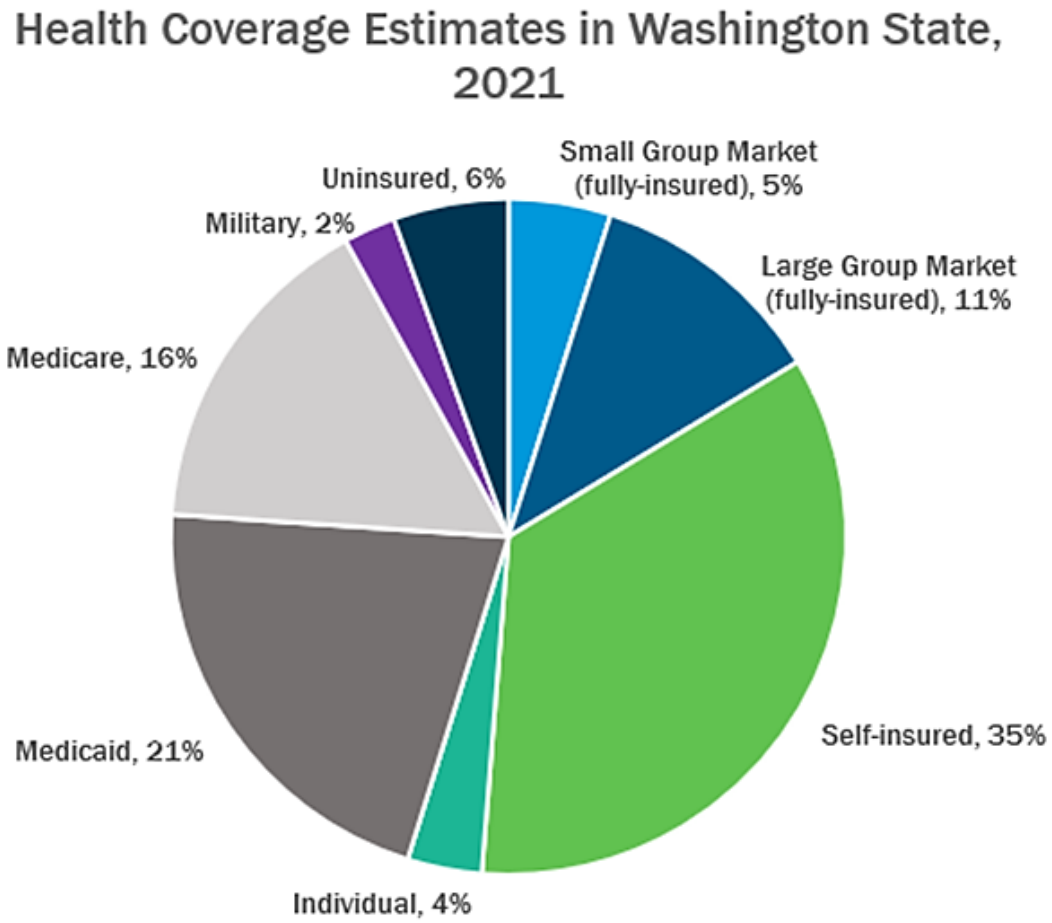
WASHINGTON STATE

Health care coverage in Washington

Health Care Coverage in WA State



ERISA & Washington state health policy

Health Plan Regulation

	Fully-insured health plans	Private SFGHPs	State and local government SFGHP	Universal health care
Who regulates?	State insurance regulators – e.g. OIC	Dept. of Labor/EBSA	HHS/Centers for Medicare and Medicaid Services	Entity established by state law
Required benefits	Federal & state laws	Federal (e.g.ERISA, HIPAA, COBRA, ADA, MHPAEA, preventive services, Pregnancy Discrimination Act, NSA)	Same as private plans	Defined by state law
Provider network adequacy	Defined by state law, plus ACA for qualified health plans (QHPs)	Not directly regulated Indirect: e.g. MHPAEA	Same as private plans	Defined by state law
Eligibility	ACA & state law	Set by SFGHP Indirect: e.g. HIPAA, ADA	Same as private plans	Defined by state law

WA Health Services Act (HSA)

Enacted in 1993.

Employer mandate to offer coverage, starting with employers of 500+ in 1995, extending to every employer by 1997.

Via employer purchase of "certified health plans" or enrollment in the Basic Health Plan or heath insurance purchasing cooperative established in the HSA. Distinct treatment of Taft-Hartley trusts.

Directed Governor to negotiate with Congress to obtain statutory ERISA waiver.

Employer mandate (and other provisions) repealed in 1995.

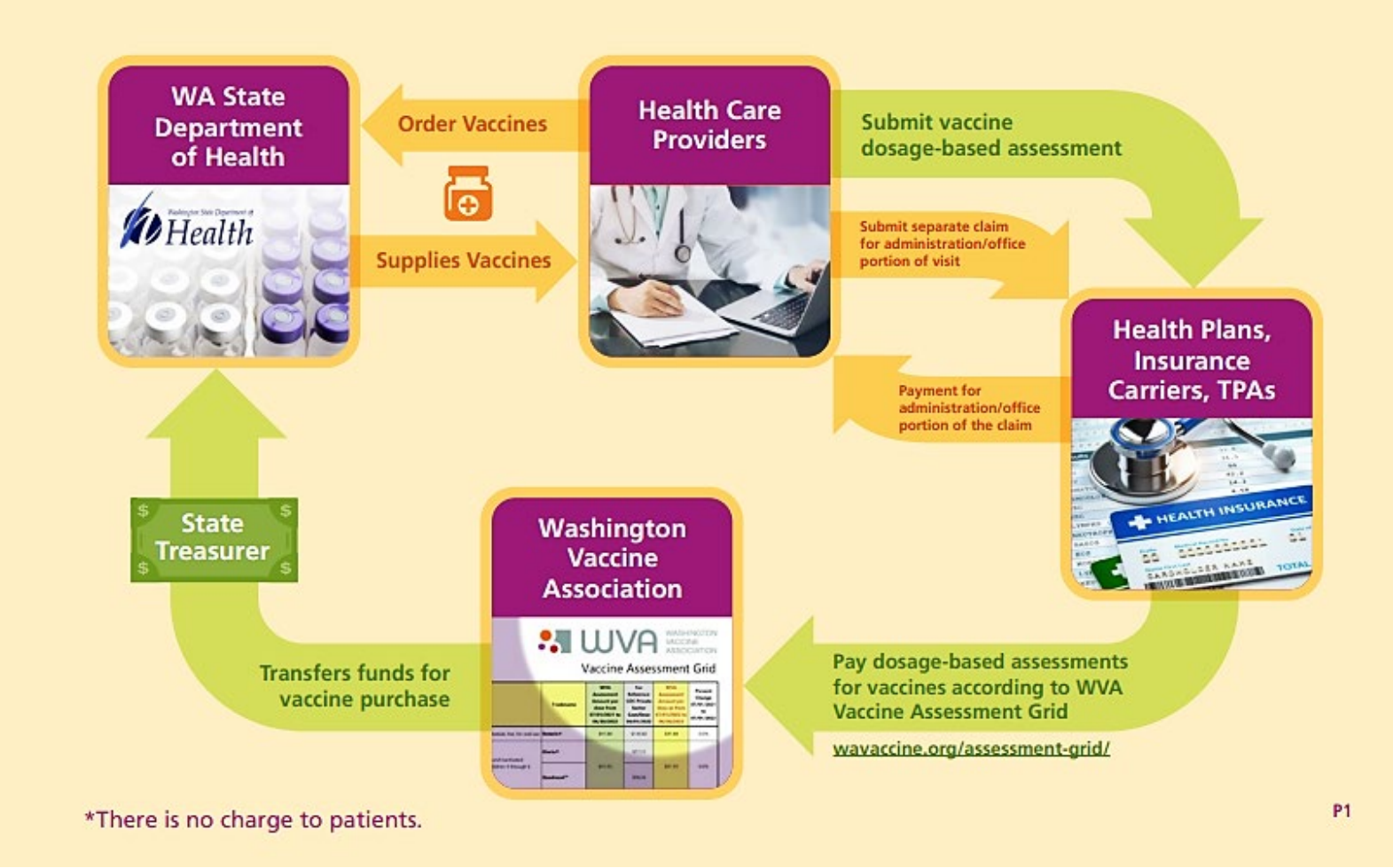
Washington Vaccine Association (WVA)

WVA law enacted in 2010.

- Enables Washington state to universally purchase childhood vaccines. Washington purchases vaccines for all children at volume discounted rates from the CDC and delivers them to providers at no cost.
- Health insurers and third-party administrators (TPAs) of SFGHPs reimburse the WVA for vaccines administered to privately insured children. The WVA in turn transfers funds to the WA DOH for bulk vaccine purchases. Assesses payers at rates lower than reimbursing the costs of private purchase of vaccines.
- Uses a "dosage-based assessment" rather than a "covered lives" approach.
- TPAs must register with WVA.

Chap. 70.290 RCW

How WVA Assessment works



Psychiatric consultation and referrals

Funding source for:

- **Partnership Access Line (PAL) – RCW 71.24.061**: Psych consults for PCPs, OB-GYNs, pediatricians & mental health providers caring for children and pregnant/postpartum people; mental health referral service for children.
- **Psychiatry consultation line – RCW 71.24.062**: Psych consults for hospital EDs, PCPs and local jails.

Psychiatric consultation and referrals

Program is “insurance blind”

Funding – RCW 71.24.064

- Administered by WAPAL Fund
- Blend of Medicaid and assessment funding, in proportion to coverage source of people served.
- For privately insured, assessment on “payers”, i.e. health insurers & employers or other entities that provide health care, including SFGHPs.
- Payers report quarterly via “covered lives” assessment. “Lives” include Washington residents for whom the entity administers or covers health care services, unless excepted by Washington statute.
- Per covered life assessment: Annual cost of program, less proportion funded by Medicaid (approx. $3.5m), divided by total number of covered lives.
- Assessment per covered life FY 2024: $0.07 (7 cents)

BH Crisis system funding

Direction in ‘23-’25 operating budget (SB 5187, §215(19):

HCA, Medicaid MCOs, BH-ASOs, carriers, self-insured organizations, OIC and BH crisis providers to assess gaps in the current funding model for crisis services and recommend options for addressing these gaps including, but not limited to, an alternative funding model for crisis services.

BH Crisis system funding (cont.)

Direction in ‘23-’25 operating budget (SB 5187, §215(19):

In the development of an alternative funding model, HCA and OIC must explore mechanisms that:

- (i) Determine the annual cost of operating BH crisis services and collect a proportional share of the program cost from each health insurance carrier
- (ii) Differentiate between crisis services eligible for Medicaid funding from other non-Medicaid eligible activities.

Preliminary report due to the legislature by December 1, 2023; final report by December 1, 2024.

Pharmacy benefit manager regulation

SB 5213 (2023 – did not pass)

- Would have expanded regulation of PBMs to include contracts with SFGHPs as well as with insurers regulated by OIC
- PBM business practices, such as pharmacy contracting & payment, "spread pricing"
- Plan design, such as preferential cost sharing for PBM mail order pharmacies, consumer cost-sharing.
- Awaiting Tenth Circuit decision re Oklahoma PBM law in *PCMA v. Mulready*

Questions?

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Senior Health Policy Advisor

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Tab 8

Washington State Health Care Authority

Next Steps

August (UHCC)

- Pam MacEwan, FTAC Liaison, will share with the Commission updates from FTAC's first discussion on ERISA. These updates will be included in the 2023 legislative report.

September (FTAC)

- Second ERISA discussion and development of recommendations
  - Recommendations will be included in *2024* legislative report

October (UHCC)

- Vote to adopt the 2023 legislative report

Tab 9

Washington State Health Care Authority

Restoring The Preemption Status Quo: *Rutledge*, ERISA, And State Health Policy Efforts

Carmel Shachar, I. Glenn Cohen

DECEMBER 17, 202010.1377/FOREFRONT.20201216.308813

On Dec 10, 2020, the Supreme Court issued its opinion in *Rutledge v. Pharmaceutical Care Management*. While this case was perhaps overshadowed by recent election litigation, it is an important development in the ongoing tug of war between state health care policy initiatives and the federal Employment Retirement Income Security Act (ERISA) of 1974. ERISA's very broad preemption clause has been used to block state efforts to regulate certain types of health insurance plans on several occasions. Before *Rutledge*, the last major ERISA health care case, *Gobeille v. Liberty Mutual Insurance*, allowed these health plans to use ERISA as a shield against state health care policy initiatives.

Rutledge represents a step back from the expansive application of ERISA preemption found in *Gobeille*. That is very welcome news to states looking to control pharmaceutical pricing in health insurance plans and (likely to a lesser extent) to states considering other major health policy initiatives. Nevertheless, *Rutledge* represents a return to ERISA preemption status quo rather than a new path forward in balancing ERISA and state health care reforms. There is still a significant need for Congress to reconsider the broad preemption mandate it created in ERISA, especially in the context of health care policy.

ERISA, Preemption, And State Health Care Reform Efforts

ERISA is a federal statute designed to set minimum standards for voluntarily established pensions and other employee benefit plans. ERISA is perhaps mostly notable because it includes one of the broadest preemption clauses of any federal statute. This clause blocks any state regulation of the administration of these employee benefit plans in favor of federal regulation. The purpose of this clause was to allow multistate employers to offer a single, consistent plan to all of their workers, reducing administrative and regulatory burdens while keeping administrative costs low.

While it was never intended to be a health care statute, ERISA does govern employer-sponsored health care plans, or insurance plans in which an employer covers the full financial risk of its employees' claims for health care benefits, because they are a type of employee benefit plan. These types of health insurance plans represent a significant portion of the health insurance market. In 2018, 61 percent of workers who got their health insurance through their employer were enrolled in plans that were at least partially self-funded and fell into this category. (Partially self-insured plans require employers to pay claims costs but feature individual and aggregate stop-losses that limit employer liability.)

Larger companies are more likely to offer employer-sponsored health care plans, which means that in this age of consolidation and challenging economic circumstances for small businesses, more employees are likely to find themselves enrolled in these plans. Therefore, it is vital for states to be able to regulate these plans in order to effectively regulate their health insurance markets and direct health care policy, goals that a robust reading of the ERISA preemption clause imperils.

The Limits Of ERISA Preemption

To be clear there are some limits to ERISA's reach. The regulation in question must be shown to "relate to" to an employee benefit plan. A previous Supreme Court case concluded that a state law "relates to an ERISA plan if it has a connection with or reference to such a plan." This standard is fairly vague and perhaps not helpful.

To better articulate when a state law relates to an employee benefit plans, the Supreme Court in three cases from the mid-1990's (*New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Co.*, *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.,* and *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*) articulated the modern test for ERISA preemption of state laws: the Court held that a state law is preempted by ERISA when it "mandates employee benefit structures or their administration." If the state law does not force a plan administrator to adopt certain structures or administrative choices, then ERISA does not apply.

Setting The Stage For *Rutledge*

In 2016, the Supreme Court expanded the application of ERISA preemption to health care laws in *Gobeille v. Liberty Mutual Insurance*. The Court concluded that ERISA preempted a Vermont state law mandating that all health care plans report claims data to the Vermont all-payer claim database. The Court was concerned that different state claims-reporting regulations would not allow for a "single uniform national scheme for the administration of ERISA plans without interference from laws of the several States even when those laws, to a large extent, impose parallel requirements."

Gobeille was an expansion of ERISA's preemptory reach, striking down the Vermont state law because it *could* result in wasteful administrative costs, thereby frustrating ERISA's purpose. This was expansive because it was the first time the Court considered *future* problems with uniformity in ERISA preemption jurisprudence, rather than focusing on whether the state law as currently applied resulted in uniformity issues.

There was significant concern that *Rutledge* would follow *Gobeille* in extending the reach of ERISA into state health care reform efforts. In this case, the potentially preempted state statue was Arkansas Act 900, which sought to regulate drug pricing by imposing requirements on pharmacy benefit managers (PBMs) such as Caremark. The purpose behind Arkansas Act 900 was to ensure that PBMs do not undermine pharmacies by reimbursing them less than what it costs pharmacies to procure drugs from wholesalers. This statute was not novel or unique to Arkansas.

The challengers argued that Arkansas Act 900 was ERISA-preempted because PBMs often work on behalf of employer sponsored health plans. If this proved enough for ERISA preemption, an amplification of the *Gobeille* approach, the result would have been a major obstacle to future health reform efforts given, the importance of pharmaceutical spending to cost control and the high percentage of Americans enrolled in an employer-sponsored health insurance plan. Many attempts by states to control or regulate the payment of pharmaceuticals in these types of health insurance plans would be preempted.

A Return To The Preemption Status Quo

Fortunately, the Court, in a short and unanimous opinion (Justice Barrett did not participate), rejected the argument that ERISA blocks the application of Arkansas Act 900 to employer-sponsored health insurance plans. To arrive at this conclusion, Justice Sonia Sotomayor used an ERISA analysis that drew heavily on the cases from the 1990s, such as *Travelers Insurance*. In fact, she drew significant parallels between *Rutledge* and *Travelers*, which concluded that a New York State law imposing a

13 percent surcharge on hospitals that used non-Blue Cross/Blue Shield insurers did not violate ERISA.

Justice Sotomayor stated that "[t]he logic of *Travelers* decides this case." Sotomayor argued that, "[l]ike the New York surcharge law in *Travelers*, . . . [Arkansas Act 900] is merely a form of cost regulation" and not "primarily concerned with pre-empting laws that require providers to structure benefit plans in particular ways." In fact, Sotomayor noted, "Act 900 is less intrusive than the law at issue in *Travelers*, which crated a compelling incentive for plans to buy insurance from the Blues instead of other insurers. Act 900, by contrast, applies equally to all PBMs and pharmacies in Arkansas." Therefore, Arkansas Act 900 did not have an impermissible connection with ERISA.

Similarly, Sotomayor concluded that Arkansas Act 900 did not "refer to" ERISA because it applied to PBMs "whether or not they manage an ERISA plan." She again drew parallels to *Travelers*, noting "Act 900 is therefore analogous to the law in *Travelers*, which did not refer to ERISA plans because it imposed surcharges 'regardless of whether the commercial coverage [was] ultimately secured by an ERISA plan, private purchase, or otherwise.'" Lastly, Sotomayor rejected the challengers' argument that Arkansas Act 900 "directly affect[s] central matters of plan administration and interfere[s] with nationally uniform plan administration."

Interestingly, Sotomayor's opinion does little to engage with *Gobeille*, referencing it merely three times. The most significant engagement with this case occurs only briefly in a footnote in which she notes that, unlike in *Gobeille*, no one alleged that Arkansas Act 900's enforcement mechanisms overlapped with a fundamental component of ERISA's regulation of plan administration. By contrast, Justice Clarence Thomas, in his concurrence, discusses *Gobeille* at great length but mostly to critique the overall direction of ERISA preemption jurisprudence as "offer[ing] little guidance or predictability." In his view the Court would do better to return to the text of ERISA, and he would have decided this case on a more straightforward ground that there is no "ERISA provision that governs the same matter as Act 900."

What Next?

It is clear that the Justices were unhappy with the reading of *Gobeille* offered by the challengers to Arkansas Act 900. State regulators and policymakers no doubt breathed a sigh of relief that the Court suggested more of a return to its 1990's ERISA preemption jurisprudence, case law that is more favorable to health care reform efforts. But it is far too soon to declare victory – while today *Gobeille* may not be extended, it has not been interred in whole or in part. It remains murky how far a state can go in health reform without foundering on the shoals of ERISA preemption.

In an ideal world Congress could step in with ERISA-reforming legislation that articulates better boundaries for preemption's reach, acknowledging explicitly or

implicitly that ERISA was never intended to regulate health care. But even if, unfortunately, Congressional reform of ERISA preemption is unlikely, the latest Supreme Court decision signals to health care reformers that the ERISA obstacles may not prove as formidable as they did before.

APPENDIX A. ANALYSIS OF ERISA PREEMPTION ISSUES FOR UNIVERSAL HEALTH PLAN PROPOSAL MEMO

To: Oregon Joint Task Force on Universal Health Care
From: Elizabeth Y. McCuskey & Erin C. Fuse Brown
Date: July 25, 2022
Re: Analysis of ERISA Preemption Issues for Universal Health Plan Proposal (June 2022)

This memorandum analyzes the Oregon Joint Task Force on Universal Health Care's (the "Task Force") June 2022 Universal Health Plan Proposal (the "Proposal") in light of potential preemption by the federal Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1144(a). Pursuant to the Statement of Work for the PO Numbers referenced above, this memorandum covers revenue mechanism design options, while focusing on ERISA preemption analysis for the design choices reflected in the Proposal.

In addition to the materials discussed during our live presentations to the Task Force on January 6, 2021 and February 4, 2022, the Task Force has provided us with the following documents:

- Universal Health Plan Proposal – June 2022
- Universal Health Plan – Questions and Answers
- Summary of Policy Decisions
- Task Force Meeting Slides – May 19, 2022.

The analysis in this memo proceeds as follows:

SUMMARY

To finance and maintain universal health plans, states must grapple with the existence of employer-sponsored insurance and ERISA's broad preemption of state regulation that "relates to" employer-sponsored benefits. The Proposal's funding mechanism of a payroll tax on employers, keyed to wages, is likely to avoid the kind of connection to employers' benefit choices that would trigger ERISA preemption. The Proposal preserves employers' ability to offer benefits outside the Universal Health Plan, which further severs the Proposal from any preempted "relation to" employers' benefit decisions.

ERISA Preemption Issues & Design Options for State Single-Payer Plans

The Task Force's goal of designing a publicly-funded universal health plan for all Oregon residents requires consideration of mechanisms to consolidate the existing sources of health care funding into one publicly-funded program. The major source of private health care coverage is employer-sponsored health benefits, which currently cover nearly half of the people in Oregon.[125]

Employer-sponsored benefits are largely governed by federal law through the Employee Retirement Security Act of 1974 (ERISA).[126] ERISA supplies some rules that private employer-sponsored plans must follow, but ERISA does not apply to governmental employers or churches as employers.[127] Most notably, however, ERISA preempts state regulation that "relates to" private employer-sponsored benefits.[128] The Supreme Court has held that state laws impermissibly "relate to" employee benefit plans by making "reference to" those plans,[129] when they "act immediately and exclusively upon ERISA plans," or make "the existence of ERISA plans essential to the law's operation."[130] State laws also may "relate to" ERISA plans by having too strong a "connection with" them, such as when a state law "governs a central matter of plan administration," "interferes with nationally uniform plan administration,"[131] or indirectly "force[s] an [employer] plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers."[132] ERISA does, however, allow states to regulate insurance carriers that may sell plans to employers. But the preemption provision has been held to prohibit states from applying their insurance regulations to "self-funded" plans in which the employer assumes the financial risk of providing health benefits and typically uses a third-party contractor to administer the benefits.[133]

ERISA preemption is complex and opaque. A state seeking to consolidate employers' health care spending into a publicly-financed plan must therefore design the plan to avoid the preempted "relation to" employer-sponsored benefits. The Supreme Court recently offered some welcome clarity, holding that a state law with indirect economic effects on employer plans did not have a "connection with" those plans that would trigger ERISA preemption.[134] The Court reinforced that "ERISA does not pre-empt state [] regulations that merely increase costs or alter incentives for [employer] plans without forcing plans to adopt any particular scheme of substantive coverage."[135]

While a state-law mandate that employers provide certain benefits or cease providing benefits would almost certainly be preempted because it directly interferes in employers' benefit decisions, there are many other design options that do not directly interfere. Primarily, those options include payroll taxes, provider restrictions, and assignment or secondary-payer provisions.[136]

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[125] Oregon Health Authority, Health Insurance Coverage in Oregon, *Types of Health Insurance Coverage* (Jan. 2022) (survey data from 2021 show 47.2% of people covered by group plans, down from 49.3% before the COVID-19 pandemic).

[126] 29 U.S.C. § 1001 *et seq*.

[127] *See* 29 U.S.C. § 1002.

[128] 29 U.S.C. § 1141(a).

[129] New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995).

[130] Cal. Div. of Labor Standards Enf't v. Dillingham Contr., N.A., Inc., 519 U.S. 316, 325 (1997).

[131] Egelhoff v. Egelhoff, 532 U.S. 141, 148 (2001).

[132] *Travelers*, 514 U.S. at 668. *See* Shaw v. Delta Air Lines, 463 U.S. 85, 97–100 (1983) (laws effectively requiring employers to "pay employees specific benefits" are preempted).

[133] Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985); FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990).

[134] Rutledge v. Pharmaceutical Care Management Ass'n, 141 S.Ct. 474 (Dec. 2020).

[135] *Id*.

[136] For an extended analysis of these options, consider Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. Pa. L. Rev. 389 (2020).

States have wide latitude to levy taxes. In Oregon's Proposal, a combination of payroll and income taxes does most of the work of capturing employer expenditures, individual health spending, and providing incentives for both employers and employees to drop their employer-based coverage in favor of single-payer coverage. The payroll taxes are calculated as a percentage of wages, and therefore do not reference an employer's health benefit plan. Nor do they require employers to alter their employee benefit plans – they merely encourage a shift to the state's health plan. With a payroll tax, the employer is not forced to drop its coverage, and it does not have to change anything about the way it structures or administers its plan.

The Ninth Circuit Court of Appeals, which covers Oregon, has particularly strong precedent upholding states' ability to enforce payroll taxes to fund public health care programs. Ordinances passed by the cities of San Francisco and Seattle required employers to contribute to public programs that would cover their employees if the employers did not offer their own coverage. The Ninth Circuit held that these so-called "pay-or-play" laws created economic incentives for employers, but not to the point that they would effectively force the employer to start or stop offering particular benefits.[137] While these ordinances calculated the taxes on employers in part based on the employers' benefit choices, the Ninth Circuit held that the establishment of a public-program alternative preserved the employers' benefit choices enough to avoid preemption.[138]

The Supreme Court has upheld states' abilities to regulate medical providers, despite the indirect impact that those provider regulations might have on employer-sponsored health plans' costs and incentives.[139] That leaves states with the design option of using provider restrictions to move networks and covered employees into the publicly-funded system. A provider restriction tells providers that if they participate in the single-payer plan, they can only bill the single-payer plan at single-payer rates. They cannot bill the patient or other payers, which also eases the administrative burden on providers from negotiating with and billing multiple payers. A provider restriction creates additional incentives for employees to drop their employer-plans because it could shrink the network of participating providers in employer-based plans.

Similarly, a state could make its public plan the secondary payer and seek reimbursement from existing employer plans as primary payers, meaning they have the primary obligation to pay for covered services. These pay-and-recoup provisions enable those employers who wish to continue providing benefits to do so and allows the single-payer plan to capture some of that spending. If a patient covered by the public plan also has employer coverage, the public plan can pay providers for services and then seek reimbursement from the employer plan as a collateral source of coverage, such as an employer-based plan. Combining this sort of secondary-payer provision with a provider restriction may help states survive ERISA challenge because the combination gives the employer plan a more plausible way to continue to exist. If the provider cannot bill the employer plan, then the single payer will pay for the care, then turn around and seek reimbursement from the employer plan for an enrollee with dual coverage.

Our analysis is that each of those design options could survive ERISA preemption, though some are trickier than others. In the end, there are good arguments for why each of these provisions would

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[137] *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 546 F.3d 639, 642 (9th Cir. 2008); *ERISA Indus. Comm. v. City of Seattle*, 840 Fed. Appx. 248 (9th Cir. 2021).

[138] The preemption status of such pay-or-play provisions has not been settled at the Supreme Court level. The plaintiffs in the Seattle case have petitioned the Supreme Court to review the Ninth Circuit's decision but as of the date of this memo, the Court has not decided whether to hear the case. And the Fourth Circuit has held that a differently-designed pay-or-play tax in Maryland was preempted.

[139] *See Rutledge* and *Travelers*.

survive an ERISA preemption challenge. However, ERISA cases are nothing if not unpredictable and inconsistent, so the result in any particular court is not guaranteed.

ERISA Preemption Issues in Universal Health Plan Proposal Provisions

Payroll Tax

The two most important ERISA preemption issues for payroll taxes are whether they are based on the private employers' benefits decisions, and whether the tax rate would be considered so "exorbitant" that it would in effect force the employer to make a particular choice about its benefits. The Proposal's plan to impose a payroll tax on employers to contribute to funding the Universal Health Plan seems to avoid both issues. By making the payroll tax progressively based on employee wages,[140] the Proposal's tax does not directly reference employers' benefit plans or make the tax contingent on them.

While there is no set threshold for when a tax becomes "exorbitant" for ERISA preemption purposes, the Supreme Court found that a 24% surcharge on commercial insurance claims to hospitals was not exorbitant.[141] The Ninth Circuit upheld a Seattle ordinance that required employers make a monthly expenditure of $420 per employee for health care,[142] and upheld a San Francisco ordinance that required employers contribute $1.17 to $1.76 per hour worked to cover employees' health care.[143] While the Supreme Court has left open the possibility that higher taxes could cross the threshold of "exorbitant," its most recent opinion in *Rutledge* suggests that the threshold would remain high and that the Court views such provisions with "indirect economic effects" on employer decisions as mostly not within the scope of preemption.

As of May 2022, the Task Force has considered marginal rates for the payroll tax of 7.25% for wages ≤$160K and 10.5% for wages above $160K.[144] Though payroll taxes may affect an employer's decision whether to offer its own supplementary health plan or change the financial incentives, the payroll taxes at this level do not force the employer's choice of substantive coverage or plan design. The existence of the Universal Health Plan as a meaningful alternative to employers offering their own private plans also weakens the ERISA preemption argument. The proposal would not require employers to spend any funds on health benefit plans at all, let alone dictate their covered benefits, funding levels, or plan administration.

The payroll tax will create some disuniformity for multi-state employers, but this is even less of a concern after *Rutledge*, which said, "Crucially, not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. That is especially so if a law merely affects costs."[145]

Thus a payroll tax can be imposed on a mandatory basis, as long as it is not at a rate high enough to force employers to drop or add coverage, and as long as it is not too directly based on the employers' benefits decisions. The household contribution to Plan funding via an income tax payment would not implicate ERISA preemption because it acts entirely on individuals, rather than employers or

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[140] Proposal at page 4.

[141] *Travelers*, 514 U.S. 645.

[142] *ERISA Indus. Comm. v. City of Seattle*, 2020 WL 2307481, at *1 (W.D. Wash. May 8, 2020), *aff'd*, 840 F. App'x 248 (9th Cir. 2021).

[143] *Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 546 F.3d 639, 644 (9th Cir. 2008).

[144] Task Force Meeting Slides – May 19, 2022.

[145] *Rutledge*, 141 S. Ct. at 480.

their insurers.[146] We understand the Proposal to apply the payroll tax to all employers, without exception.

Task force members have requested additional clarification about three aspects of the payroll tax and ERISA.

- First, on whether the payroll tax is employer-facing, employee-facing, or split between them—from an ERISA standpoint, it does not matter what share of the payroll tax is paid by the employer or employee, so long as the payroll tax does not reference or depend on the existence or amount of the employer's health benefit plan spending or cross the undefined threshold of exorbitance, discussed above. Nevertheless, the employee-share of a payroll tax, like a household income tax, would be subject to the federal cap on the deductibility of state and local taxes, which is beyond the scope of this project.
- Second, self-funded employer plans can be subject to the payroll tax to the same extent as fully insured employer plans. The ERISA analysis is the same for both types of plans.
- Third, *where* the payroll tax revenue is deposited (in a general fund vs. special fund for the universal health plan) does not meaningfully alter the ERISA analysis. To the extent that the tax is deposited in a special fund for the universal coverage plan, this may strengthen the case against ERISA preemption under the Ninth Circuit's precedents involving pay-or-play requirements in San Francisco and Seattle by offering employers the universal coverage plan as a legitimate choice and alternative to offering their own coverage.

Coverage Duplication

ERISA preemption cases have emphasized that state laws can avoid a preempted "connection with" employers' benefit plans by preserving meaningful choices for employers. The indirect economic effects on decision-making from a payroll tax is one way to avoid directly forcing employers' choices. Preserving employers' ability to decide whether or not to offer benefits is another way. So, a state law that expressly prohibited employers from offering health care benefits would almost certainly be preempted by ERISA because it directly references the employers' plans *and* directly targets the employer's decision about these benefits. But a law that preserves employers' ability to decide whether to offer benefits, but gives them economic incentives to drop coverage in favor of a public plan would likely avoid preemption.

Because ERISA allows states to enforce their regulations on insurers, a state law prohibiting *insurers* from offering plans that duplicate coverage from the state's public plan confidently avoids preemption. That, however, would leave employers able to self-fund plans that duplicate coverage and compete with the state plan. As the Proposal notes, "Employers would no longer need to provide health benefits. But they would have the option to offer self-funded plans.[147] To avoid making a preempted "reference" to employer-sponsored benefits, it is recommended that the state law not expressly state the fact that employers would still be allowed to self-fund substitutive coverage.

The coverage duplication provisions that the Task Force considered in its January 2022 Outstanding Design Elements would allow *complementary* private coverage for those services and costs *not* covered by the Plan. This provision maintains an additional aspect of employers' choice about

[146] Though it is beyond the scope of this project, we note below that personal income taxes may implicate the federal SALT (State and Local Tax exemption) for higher-income taxpayers.

[147] Proposal at page 4.

benefits by allowing them to offer complementary coverage as a benefit – either by purchasing it from an insurer or self-funding this coverage.

The Proposal thus preserves meaningful choice for employers along three lines: offer self-funded duplicative coverage, offer complementary coverage, offer no coverage and rely entirely on the Universal Health Plan.

Provider Participation & Reimbursement

The Supreme Court has held that state regulation of medical providers is largely outside the scope of ERISA preemption, even when that regulation influences the cost of services providers provide to employer plans.[148] The Court has not, however, considered whether a state law that deprives employer plans of a feasible provider network would effectively force the employer to drop its benefit plan.

The Proposal contemplates that the "Plan would pay providers directly" at rates set by region.[149] The Task Force's January 2022 Outstanding Design Elements described that the Plan would cover services from all providers licensed or authorized to practice in Oregon in good standing as "participating providers." If providers who participate in the state Plan are not permitted to continue contracting with (and being reimbursed by) self-funded employer-based plans, this may implicate ERISA if it is effectively forcing employers to drop their plans because there will be no providers to create a network for that plan.

If participating providers *are* allowed to continue contracting with (and being reimbursed by) employer plans, then a couple of policy-design questions about the status of complementary versus duplicative coverage (discussed in the previous section) would arise.

First, if participating providers provide services covered by the Plan to patients who also have employer-funded coverage, the Plan would need to rely on a mechanism to seek reimbursement from the employer-funded coverage as the primary payer. To the extent that substitutive employer-based coverage may continue to exist, the state may need to capture some the employers' expenditures on claims. It could also do so by designating the Plan as the *secondary payer*, so the primary obligation to pay falls on the substitutive form of coverage, and the Plan only must pay the difference to the provider if the amount paid by substitutive plan is less than the Plan's rate or pay for cost sharing (such as a deductible) that is not covered by the employer plan but is covered by the state Plan. A provision that makes the state Plan secondary to any other forms of substitutive coverage a beneficiary may have can also be paired with a *subrogation* provision that allows the Plan to assert the right of the beneficiary to reimbursement against the substitutive plan. This would allow the state Plan to pay for the services of a beneficiary, and then seek reimbursement via subrogation from the primary payer (the substitutive plan) that is responsible for paying for the care. Because secondary payer and subrogation provisions preserve the employers' options of maintaining their own plans and do not interfere with such plans' beneficiary status or benefit choices, they should avoid ERISA preemption.

Second, providers may value the reduced administrative burden of participating only in the state Plan. To avoid ERISA preemption challenges, the state may want to allow participating providers to contract with ERISA plans, bill them, and accept higher rates from them. Yet some providers may voluntarily stop contracting with ERISA plans because they value the administrative benefits of only participating in the single-payer plan. Other providers may want to keep participating in ERISA

[148] *Travelers*, 514 U.S. 645 (reaffirmed in *Rutledge*, 141 S. Ct. at 480).

[149] Proposal at page 2.

plans (to be able to earn more), but then those providers would need to bear the administrative burdens of negotiating with these plans, billing, and then repaying any amounts previously paid by the single-payer plan for beneficiaries with dual-coverage.

Third, to mitigate legal challenges, provider participation in the Plan can be made optional but exclusive, where provider's voluntary participation in the state Plan means they cannot participate in other plans of coverage offered within the state. Note that this is slightly different than the Proposal's presumptive *enrollment* of all providers that are licensed and in good standing in the Plan. This alternative would make all licensed providers presumptively *eligible* to participate in the Plan, but if they choose to do so, they would have to agree not to participate in other substitutive plans. Presumptive provider enrollment plus a prohibition on contracting with other plans raises greater legal risks, whereas presumptive provider eligibility with voluntary enrollment conditioned upon exclusive participation in the state Plan would mitigate some of these risks. The tradeoff is that while large providers (such as hospitals) that depend on patient volume may need to participate in the Plan, smaller providers (such as certain physicians or specialists) may choose not to participate in the Plan in order to maintain a concierge practice of private-paying purchasers.

CONCLUSION

Oregon's 2022 Universal Health Plan Proposal contains several elements to consolidate employer and employee spending on health care into the Universal Health Plan: (1) a payroll tax levied on all employers; (2) restrictions on coverage duplication by state-regulated health insurers; and (3) regulation of participating provider reimbursement. These elements are structured in a way that will likely survive ERISA preemption, while still encouraging employers and employees to shift to the Universal Health Plan. Finally, we have offered thoughts on provider reimbursement and participation to allow the Universal Health Plan to survive ERISA challenges, draw maximum provider participation, and allow the state to recoup payments for services from substitutive forms of coverage that may persist after the Universal Health Plan is implemented. While beyond the scope of our work on this Project, we laud the Task Force's careful consideration of policy design to advance health care equity and access for Oregonians while navigating the complicated labyrinth of ERISA preemption.

Thank you for attending the Finance Technical Advisory Committee meeting!

Washington State Health Care Authority