Finance Technical Advisory Committee meeting

September 14, 2023

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Washington State Health Care Authority

Washington State Health Care Authority

Finance Technical Advisory Committee

Meeting Materials

September 14, 2023
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

P.O. Box 45502 • Olympia, Washington 98504-5502 • www.hca.wa.gov • HCAUniversalFTAC@hca.wa.gov

Tab 1

Washington State Health Care Authority

September 14, 2023
2:00 p.m. – 4:00 p.m.
Zoom Meeting

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

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 07/13/2023	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	4	Liz Arjun, Senior Consultant Health Management Associates
2:30-2:50 (20 min)	Large employer perspectives on state-based universal health care • FTAC Q&A	5	Bill Kramer, Director for Health Policy at the Purchaser Business Group on Health
2:50-3:30 (40 min)	ERISA Considerations for Washington • FTAC Q&A	6	Erin C. Fuse Brown, JD, MPH Catherine C. Henson Professor, Director of the Center for Law, Health & Society Georgia State University College of Law
3:30-3:45 (15 min)	FTAC vote on ERISA recommendations to the Commission	7	Pam MacEwan, FTAC Liaison
3:45-4:00 (15 min)	The Commission's guidance on Medicaid • FTAC discussion	8	Liz Arjun, Senior Consultant Gary Cohen, Principal Health Management Associates
4:00	Adjournment		Pam MacEwan, FTAC Liaison

Tab 2

Finance Technical Advisory Committee (FTAC) Meeting Summary

July 13, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 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
Roger Gantz

Members absent

Esther Lucero
Robert Murray

Call to order

Pam MacEwan, FTC Liaison, called the meeting to order at 2:01 p.m.

Agenda items

Welcoming remarks

Pam MacEwan, FTAC Liaison, began with a land acknowledgement, welcomed FTAC members to the fourth meeting, and provided an overview of the agenda.

Meeting Summary review from the previous meeting

One revision was proposed to clarify language in the May 2023 meeting summary. Members present voted by consensus to adopt the meeting summary as amended.

Public comment

Roger Collier asked if costs doubling for some employers via a payroll tax could be deemed as "exorbitant" and in violation of the Employment Retirement Income Security Act of 1974 (ERISA). Roger Collier also asked how far out federal court processes to resolve ERISA preemption would be from Washington's passing of universal health care legislation.

Warren George, former member of Oregon's Task Force on Universal Health Care, encouraged further regional cooperation between Oregon and Washington and noted the benefits of a single-payer system.

Cris Currie, retired RN, remarked that ERISA is only an issue within the context of a single-payer system and encouraged FTAC to clarify with the Commission whether a single-payer health care system is their goal. His report on handling ERISA in a single-payer context is in the written public comments of the May meeting materials.

Marcia Steadman, Health Care for All Washington, noted that Washington's 2023-2025 operating budget allocated funding to support FTAC's work and expects to see a revised workplan and more robust meeting agendas. FTAC members were encouraged to follow Oregon's Task Force on Universal Health Care's example to address ERISA.

Presentation: Updates from the Commission's June meeting and goals of this meeting

Liz Arjun, Health Management and Associates (HMA)

FTAC heard updates from the Commission's June meeting, including the Commission's adoption of FTAC's guidance on Medicare eligibility, transitional solutions, and the Commission's ERISA questions for FTAC. This meeting focused on gathering information on ERISA in preparation for FTAC's discussion in September to develop recommendations for the Commission on ERISA eligibility options. FTAC member Roger Gantz suggested that the Commission coordinate with and leverage the resources of the Health Care Cost Transparency Board to examine ways to address rising health care costs and affordability for consumers.

Presentation: A brief history of ERISA and health care policy

Carmel Shachar, Asst. Clinical Professor of Law and Faculty Dir., Health Law and Policy Clinic, Harvard Law School

ERISA was not intended to be a health care statute but is one. ERISA, a federal statute, governs employer-sponsored health care plans or insurance plans where an employer covers the full financial risk of its employees' claims for health care benefits (known as self-funded). Regulation of ERISA plans is "exclusively a federal concern" and preempts "all state laws insofar as they…relate to any employee benefit plan" (one of the broadest preemption clauses ever written). Most Americans receive health care coverage through this type of health plan.

Prior to the 1990's, a state's statute was deemed in violation of ERISA preemption when it had a connection with or reference to an employer covered benefit plan. In *New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Co*., the state tried to make enrollment in Blue Cross Blue Shield (Blue) plans more attractive by imposing a 24 percent surcharge for hospital services for patients covered by anything other than a Blue plan compared to an 11 percent surcharge for Blue plans. The Supreme Court determined that ERISA did not apply because the law had an indirect economic impact on ERISA plans and did not mandate certain administrative structures or choices. ERISA statute refers to a fee/penalty becoming so "exorbitant" that it's no longer an indirect economic impact; however, there is no definition of "exorbitant."

In *Gobeille v. Liberty Mutual* (2016), the Courts made a more expansive preemptive decision (compared to Travelers). Liberty Mutual brought a case against Vermont that ERISA preempts reporting to the All-Payer Claims Database (APCD) because ERISA already has reporting requirements. In the Court's decision, and for the first time, potential *future* issues with uniformity were considered. Courts agreed with employers since the law governs a central matter of plan administration and interferes with nationally uniform plan administration.

Rutledge v. Pharmaceutical Care Mgmt. (2020) restored ERISA preemption jurisprudence of the 1990's and concerned Arkansas's regulation (Arkansas Act 900) of pharmaceutical benefit managers (PBMs) and drug pricing. PBMs argued that the state regulating what PBMs pay to pharmacies would be regulating ERISA plans since many of the health plans for which PBMs administer fall under ERISA. The Supreme Court decided that Arkansas's law did not "refer to" ERISA because it applied to PBMs "whether or not they manage an ERISA plan." The majority opinion relied heavily on the Travelers case. Professor Shachar noted that Rutledge may be good news for states hoping to innovate but cautioned not to count on it being the last word on ERISA preemption.

The Gobeille decision shows that ERISA fixes are unlikely. Congress could carve health plans out of ERISA, though they've shown little interest in doing so. The Dept. of Labor (DOL) and the Dept. of Health and Human Services (HHS) could create ERISA carve outs. However, reporting to the APCD is a smaller issue than moving to universal health care and if there's no proactive attempt to smooth the APCD path, it's unlikely that Congress or those federal agencies will be a solution to the problem.

Two cases illustrate ERISA's impact on universal health care attempts. In Maryland's *Retail Industry Leaders Assoc. v. Fielder* (2007), the law targeted Walmart, requiring employers with more than 10,000 employees to spend at least eight percent of their payroll on health care, or else pay the difference between the employer's health care expenditures and the eight percent threshold into a state Medicaid fund (an example of "pay or play"). The only rational choice for Walmart was to spend the required amount on health care benefits. The Fourth Circuit struck down Maryland's "fair share law" because it mandated benefits and did not have an *in*direct economic impact.

In *Golden Gate Restaurant Association v. City and County of San Francisco* (2009), San Francisco issued a tax based on hours worked where employers had discretion about how to spend the expenditures. One option was to pay into a new health care program for low to moderate income residents. The Ninth Circuit reversed the District Court's findings that this program violated ERISA because the ordinance applied regardless of whether employers offered an ERISA plan. Golden Gate was distinguished from Fielder (Maryland) because employers had a "meaningful alternative" to increasing their current health plans and had total discretion about how to spend their mandated contributions. The Ninth Circuit continues to be friendly to this line of thinking, but other Circuits are closer to the Fourth Circuit's thinking on Fielder.

ERISA creates discontinuities within access to reproductive care post the Dobbs decision. Self-funded plans cannot be regulated by states and can likely cover abortion services and care even in states that ban abortions. However, employees would struggle to find providers and it's unknown whether ERISA is a shield against criminal liability. States also can't require employer plans to offer reproductive care. It is possible that a future presidential administration that was anti-abortion could have its DOL issue regulations that no ERISA covered plan could support access to abortion services which could cause issues for a state-based universal health care system.

FTAC member Christine Eibner asked why the Golden State case didn't reach the Supreme Court. It was clarified that the case wasn't pressing enough at the time to be resolved by the Supreme Court.

FTAC member Roger Gantz asked about states' abilities to regulate providers. It was clarified that mandating that providers only bill the universal plan could invite resistance (and potentially lawsuits) from providers, but the state could provide incentives to providers to bill only the universal plan. FTAC member David DiGiuseppe asked whether a state could develop a universal pricing reimbursement scheme that is outside the purview of ERISA. This could be successful if it's keyed to the provider side versus the insurer side. It could have indirect economic impacts on ERISA plans, but the state wouldn't be mandating specific benefits.

David DiGiuseppe asked to clarify that the clear pathways to addressing ERISA challenges are an act of Congress (highly unlikely), and a pay/play/meaningful alternative. Professor Shachar responded that in the latter, and similar to Golden Gate, the universal plan would be the meaningful alternative where employers could design and offer their own benefits or pay into the universal plan for their employees to access health care.

FTAC member Eddy Rauser asked if Gobeille (APCD reporting) is a litmus test for ERISA being used as a shield against health care reform efforts. Eddy Rauser also asked whether Workers' Compensation is self-funded, and Pam MacEwan clarified that it is self-funded and does not fall under ERISA.

Presentation: ERISA issues in Washington

Commission member Jane Beyer, Senior Health Policy Advisory, Office of the Insurance Commissioner (OIC). Jane Beyer's presentation provided an understanding of what Washington state laws or policies have been tested or challenged, and what hasn't been challenged with regards to ERISA.

About one third of Washingtonians receive health coverage through a self-funded group health plan (SFGHP). The OIC regulates fully-insured small and large group health plans. OIC also has jurisdiction over health plans offered on the individual market. The Washington Legislature is the purchaser for the Uniform Medical Plan (UMP), a SFGHP for state employees that can be regulated by the state. Private SFGHPs are regulated by the DOL/Employee Benefits Services Administration (EBSA). State/local government SFGHPs are accountable to HHS/Centers for Medicare and Medicaid Services (CMS). Washington's future universal system would likely be regulated by an entity established by state law. OIC cannot regulate Taft-Hartley plans.

With regards to benefits, fully-insured health plans must provide benefits that are mandated by both federal and state law. Both private and state/local government SFGHPs must comply with federal laws including ERISA, the Mental Health Parity and Addiction Equity Act (MHPAEA), the Health Insurance Portability and Accountability Act (HIPAA), the Pregnancy Discrimination Act, Americans with Disabilities Act (ADA), Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), preventive services, and the No Surprises Act. The benefits for Washington's future universal system would be defined by state law, but the state-established regulatory entity would need to comply with federal laws that apply to all health plans.

For fully-insured health plans, "provider network adequacy" is defined in Washington state law, plus the Affordable Care Act (ACA) for qualified health plans (QHPs). For both private and state/local government SFGHPs, provider network adequacy is not directly regulated, though indirectly there is some network adequacy via federal laws, e.g., MHPAEA. Provider network adequacy must be defined in state law for the universal system.

The ACA and state law address eligibility for fully-insured health plans. For both private and state/local government SFGHPs, eligibility is set by the plan with certain federal laws such as HIPAA and the ADA playing an indirect role in eligibility. Eligibility for the universal system must be defined by the state.

ERISA was a prominent issue when the Washington Health Services Act (HSA) was enacted in 1993. The HSA included an employer mandate to offer coverage, starting with employers with more than 500 employees in 1995, and extending to all employers by 1997. Employers were required to purchase certified health plans or to enroll employees in the Basic Health Plan or health insurance purchasing cooperative established in the HSA. There was distinct treatment of Taft-Hartley trusts. The HSA directed the Governor to negotiate with Congress to obtain a statutory ERISA waiver. The employer mandate (and other provisions) was repealed in 1995 due to the 1994 election results. Washington did not have the opportunity to pursue an ERISA waiver with Congress.

The Washington Vaccine Association (WVA) (2010) has never brought an ERISA challenge despite SFGPHs being told how to administer benefits. Due to budget constraints in 2009, a group was created to develop a new funding mechanism for the state to continue purchasing and providing childhood vaccines. The WVA was created, where Washington universally purchases childhood vaccines for all children at volume discounted rates from the Centers for Disease Control (CDC) and delivers them to providers at no cost. Health insurers and TPAs of SFGHPs reimburse the WVA for vaccines administered to privately insured children via "dosage-based assessments." The WVA then transfers funds to the Washington Dept. of Health for bulk vaccine purchases. Payers are assessed at rates lower than reimbursing the costs of private purchase of vaccines which is a benefit to employers. All TPAs register with the WVA and there is no cost to patients.

The Partnership Access Line (PAL) has also never brought an ERISA challenge. PAL provides psychiatric consultations for certain providers caring for children and pregnant/postpartum individuals. PAL is insurance agnostic and was initially funded with Medicaid funds, despite some children being ineligible for Medicaid. The Washington Legislature developed an alternative funding mechanism. PAL is administered by the WAPAL Fund - a blend of Medicaid and assessment funding in proportion to the coverage source of people served. For privately insured children, there is quarterly covered-lives assessment on payers, including SFGHPs. The assessment per covered life for fiscal year 2024 is seven cents per-member per-month (PMPM).

Washington's behavioral health (BH) crisis system, also insurance agnostic, is largely funded by Medicaid, federal block grants, and state general funds. The 2023-2025 Operating Budget directs HCA, Medicaid managed care organizations (MCOs), BH administrative service organizations, carriers, self-insured organizations, and BH crisis providers to assess gaps in the current funding model and recommend options for addressing these gaps including, but not limited to, an alternative funding model, e.g., covered-lives assessment, for crisis services.

SB 5213 (did not pass, 2023) would've expanded regulation of PBMs to include contracts with SFGHPs and insurers regulated by OIC. Several states and Congress are examining PBMs' business practices. Some provisions in states' laws are also targeting plan design, e.g., consumer cost-sharing.

David DiGiuseppe asked whether the BH crisis assessment is likely to raise ERISA challenges. Jane Beyer noted that in both Travelers and Rutledge, the Courts allowed additional costs to be imposed on a plan, however it's a question of "how much is too much." By virtue of employers paying the BH assessment, they won't need to pay for those services. Like with the WVA and PAL, this benefits the employer.

David DiGiuseppe asked what an ERISA challenge looks like procedurally. A party files a case in federal district court to review and determine whether a state law violates federal law. The district court will determine whether to put a stay on implementation of the state law pending the court making its decision.

Roger Gantz asked to define "partially insured." Also known as a "level-funded" plan, risk is shared by both the employer (typically small employers) and their TPA and protected by stop-loss coverage. The "attachment point" is the predetermined amount at which the TPA will start to pay claims. OIC regulates how low the attachment can go.

Eddy Rauser asked what made the WVA successful. Jane Beyer replied that an entire legislative interim was spent with multiple stakeholders at the discussion table. Roger Gantz noted that the WVA is like a safe harbor test where the PMPM doesn't impair self-funded plans' ability to design their benefits.

Christine Eibner asked about the viability of taxing employers generally, if not specifically employers that currently offer health insurance. Hypothetically, a state could issue a general tax on all employers, put the revenue in a general fund, and use the fund for a given priority, which could be health care. Jane Beyer replied that that was Oregon's proposal, where it's in the employer's best interest to pay the tax and enroll employees in the universal plan.

Presentation: Next steps

Liz Arjun, HMA

At the Commission's August meeting, Pam MacEwan, FTAC Liaison, will share updates from this meeting. In September, FTAC will discuss and develop recommendations to the Commission on ERISA eligibility. HCA staff will send FTAC members informational materials in preparation of the September meeting.

Adjournment

Meeting adjourned at 3:58 p.m.

Next meeting

September 14, 2023

Meeting to be held on Zoom

2:00 p.m. – 4:00 p.m.

Tab 3

FTAC

Written Comments

Received From June 29

Written Comments Submitted by Email

Additional Comments Received at the July FTAC Meeting

- The Zoom video recording is available for viewing here: https://www.youtube.com/watch?v=MShTEbl3X4I

Public comments received since (June 29) through the deadline for comments for the September meeting (August 31)

Submitted by Cris Currie
07/13/2023

I'm Cris Currie, retired RN from Spokane, and I would like to remind the FTAC that ERISA is only really an issue within the context of a single-payer UHC system, since self-funded employer plans need to be "regulated" by the single-payer if that system is to be financially viable.

So I hope the Commission's interest in having you discuss the potential ERISA roadblocks this early in their process means that they are truly committed to the single-payer concept. Perhaps you can include this point in your report back to the Commission as a means of seeking clarification regarding the Commission's ultimate goal.

For an additional summary of how ERISA can be handled in the single-payer context, please see my report included in the 5/11/23 meeting materials, Tab 3, pgs. 4-8 that summarizes the Fuse Brown & McCuskey approach and applies it to the Washington Health Security Trust. Thanks.

Tab 4

Washington State
Health Care Authority

Washington's UHCC 2023 Workplan

January 2023 FTAC

- Charter review
- Overview of UHCC work to-date
- Mandatory OPMA training

February 2023 UHCC

- Current health programs in Washington and transitional solutions
- Eligibility
- Information from other states
- Key equity principles for eligibility considerations
- Identify priorities for FTAC

March 2023 FTAC

- Guidance and information from UHCC
- Pros and Cons of including Medicare (recommended topic)
  - Information from other states
  - Equity impacts
- Identify key topics and questions to for UHC related to Medicare

April 2023 UHCC

- Revisit options of interest from the February meeting and impacts
- Discuss equity impacts
- Other solutions to consider
- Possible briefing from FTAC including identified questions about eligibility and Medicare

May 2023 FTAC

- Additional questions from UHCC
- Consider options and provide feedback for Medicare for UHCC

June 2023 UHCC

- Equity Principles
- Briefing from FTAC and decision on Medicare
- Guidance for FTAC on ERISA (recommended topic)
- Legislative Update
- Prioritize 2023 transitional solutions

Workplan will change depending on progress made in each meeting

Washington's UHCC 2023 Workplan

July 2023 FTAC
- Consideration of ERISA plans
- Identify key topics and questions for UHCC related to ERISA

August 2023 UHCC
- Finalize content for 2023 report: transitional solutions
- Briefing from FTAC including identified questions about eligibility and ERISA plans
- Presentation from Whole Washington on Health Trust Bill

September 2023 FTAC
- Feedback from UHCC
- Agree on options for ERISA for UHCC

October 2023 UHCC
- Possible briefing from FTAC on ERISA options
- Decision on ERISA plans
- Vote on report
- Overview of Medicaid to develop guidance and questions for FTAC

November 2023 FTAC
- Guidance and key questions from UHCC on Medicaid
- Equity impact
- Information from other states
- Identify key topics and questions for UHCC related to Medicaid

December 2023 UHCC
- Possible briefing from FTAC on Medicaid
- Discussion about Medicaid
- 2024 preview
- Policies in motion
- 2024 UHCC workplan
- Revisit/repurpose FTAC (if applicable)

Workplan will change depending on progress made in each meeting

Tab 5

Large Employers' Views on State-based Universal Health Care (UHC)

Discussion with the Finance Technical Advisory Committee (FTAC) to the Washington State Universal Health Care Commission

Bill Kramer

September 14, 2023

The Challenges Faced by Large Employers

- Employee recruitment and retention: “The war for talent.”
- High cost of health benefits
- Lack of transparency
- New fiduciary responsibilities

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Daily Briefing

As health care costs boom, employers are in a 'street fight' to keep their staff

Posted on November 08, 2022

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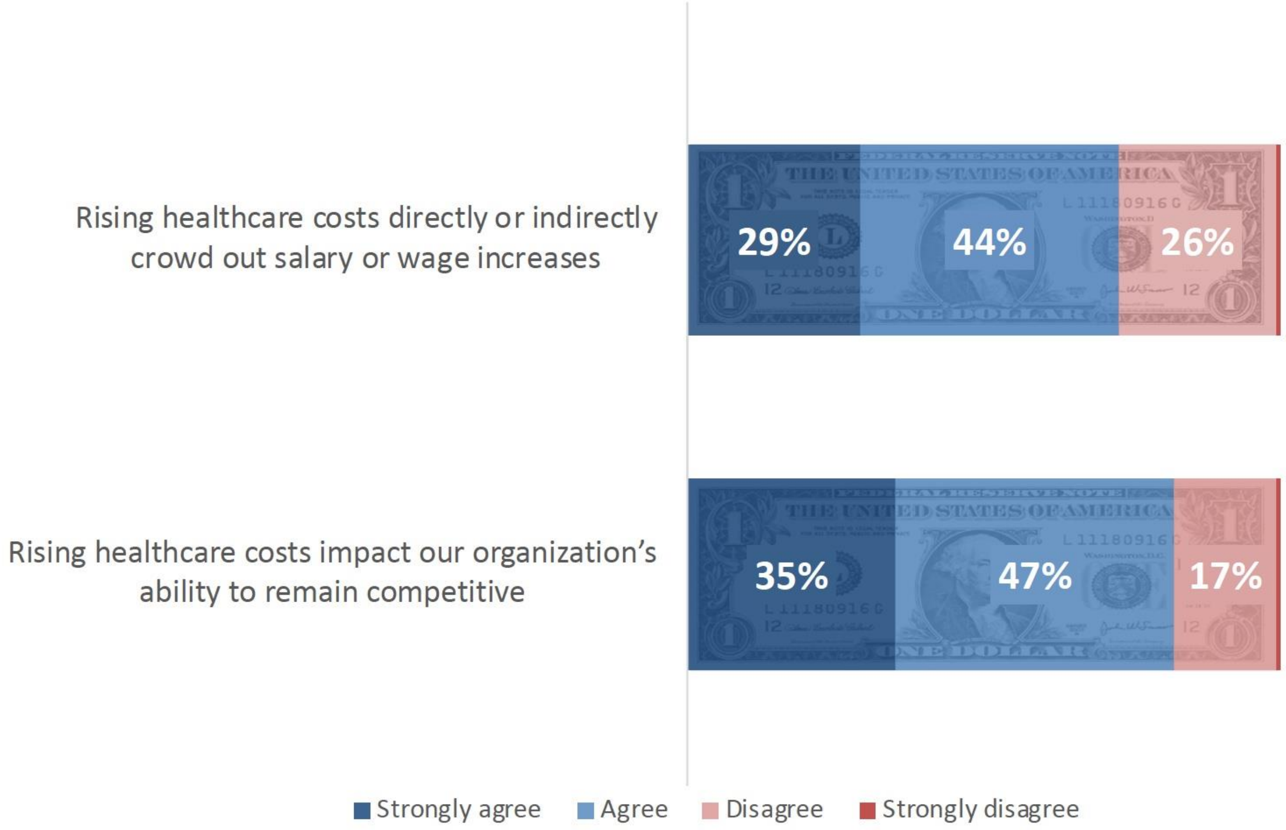
Health-Care Oversight Rule Changes Create Legal Risk for US Employers

Regulations aimed at boosting transparency allow greater control over spending, but companies could face lawsuits if they fail to use that information.

Rising healthcare costs impact employers' ability to remain competitive and increase wages for retention



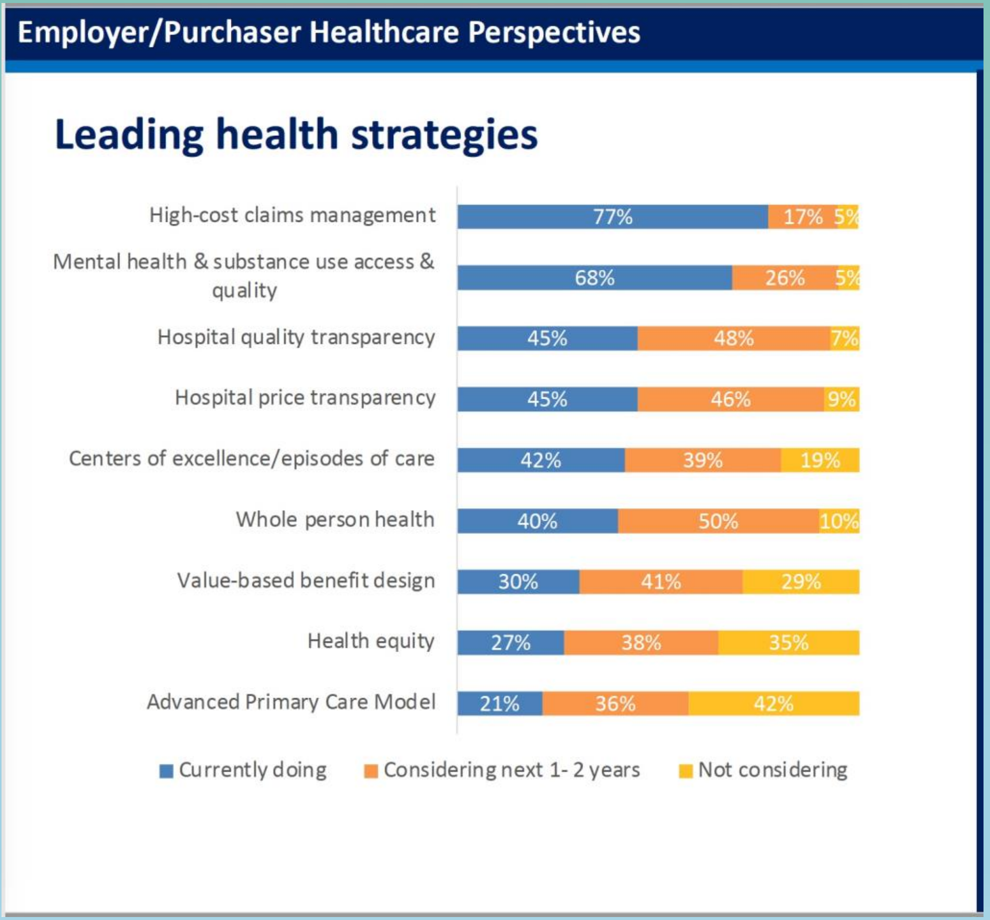
78% of employers strongly agree that attracting and retaining talent is a top priority, but rising healthcare costs prove to be a significant challenge

- Costs directly or indirectly crowd out salary or wage increases **(73%** agree**)**
- Costs impact our organization's ability to remain competitive **(82%** agree**)**

Source: National Alliance of Healthcare Purchasers Coalitions, "Pulse of the Purchaser" survey, Fall 2022

What Large Employers are Doing

- Accepting/embracing fiduciary responsibilities
- More aggressive cost containment strategies
- Quality improvements: behavioral health, maternity, advanced primary care
- Health equity



Source: National Alliance of Healthcare Purchasers Coalitions, “Pulse of the Purchaser” survey, Fall 2022

Large Employers' Likely Concerns with UHC

- Loss of differentiation in employee recruitment
- For multi-state employers
  - Administrative burden of complying with different state laws
  - Inequities between employees in different states
- Additional taxes
- Loss of control

Large Employers Will Fiercely Defend ERISA Pre-emption

ERIC | THE ERISA INDUSTRY COMMITTEE
Shaping benefit policies before they shape you.

ABOUT ERIC | HEALTH CARE | RETIREMENT & COMPENSATION | PAID LEAVE & STATE MANDATES | ADVOCACY & LITIGATION | EVENTS & MEETINGS

PROTECTING ERISA PREEMPTION

ERIC's core mission in its legal advocacy is to protect and uphold the principles of federal ERISA preemption.

The Employee Retirement Income Security Act (ERISA), enacted in 1974, allows multistate employers to design valuable health and retirement benefit plans tailored to their workforce and administer those plans uniformly – regardless of where employees live or work. It does so by preempting any state or local law that "relates to" an employee benefit plan subject to ERISA.

Employers' Reluctance to Shift Employees to the Exchanges

- "Control"
- "Paternalism"
- "Nobody wants to be first."

> "We liked to have control. We can do a better job with design than the exchanges."

When asked why employers did not embrace ACA exchanges to offload the responsibility of providing health benefits, benefits executives' responses echoed several themes. First, employers thought they could offer their workers a better deal than what employees could conceivably get on public exchanges. "We liked to have control. We can do a better job with design than the exchanges," explained a benefits executive at a health care company.

Second, many of the benefits executives viewed their companies as paternalistic. "[Employees] trust their employer, and that the employer will give them the tools and knowledge they need to navigate their care," said a benefits executive at a large financial services firm. Some also flagged complexity as a potential issue, given that public exchanges typically offer significantly more plans than employers do, and the vast array of choices may overwhelm workers. "Every survey we've done says that our workers want more choice, but when that choice comes, they want us to choose for them," explained a benefits executive at a telecommunications firm.

Finally, some employers simply took a wait-and-see approach to determine if other companies were willing to upend their employee health benefits. "A big part was trepidation," explained a benefits executive at an insurance company. "Nobody wanted to be first."

Source: Jake Spiegel and Paul Fronstin, *What Employers Say About the Future of Employer-Sponsored Health Insurance* (Commonwealth Fund, Jan. 2023). https://doi.org/10.26099/1ead-x061

What Might Make UHC Appealing or Acceptable to Large Employers

- Employers’ choice to continue to offer health benefits or join UHC
- Attractive UHC product features: provider network, benefits, price, choice of plans
- Better cost control
- Administrative simplicity

Questions

Tab 6

Washington State Health Care Authority

ERISA Considerations for Washington Universal Health Care Commission

Erin C. Fuse Brown, JD, MPH

Catherine C. Henson Professor, Director of the Center for Law, Health & Society

Georgia State University College of Law

Presentation to Financial Technical Advisory Committee

Sept. 14, 2023

Overview

- Refresher on ACA requirements for employers
- ERISA waiver – no such thing
- Options to include employers in a state universal health system
- ERISA implications and tradeoffs

ACA requirements for employers

- Big picture – ACA policymakers wanted to keep employer-based coverage intact
- Employer mandate*:
  - Penalty for all businesses with ≥ 50 employees that fail to provide "minimum essential coverage" that is "affordable" and offers "minimum value"
  - Penalty for every FTE employee who buys ACA Marketplace coverage with subsidy, if employer offers coverage that is not affordable and minimum value to that employee
- Subject to ACA § 1332 waiver
- Not preempted by ERISA because co-equal federal law

* 26 U.S.C. §§ 45R, 4890

ERISA § 514 Preemption

§514 preempts any and all state laws that relate to employee benefit plans if they either:

- (1) do not qualify as insurance regulation (Savings Clause); or
- (2) relate to self-funded employee health plans (Deemer Clause). ~1/3 of nonelderly U.S. population

No ERISA Waiver

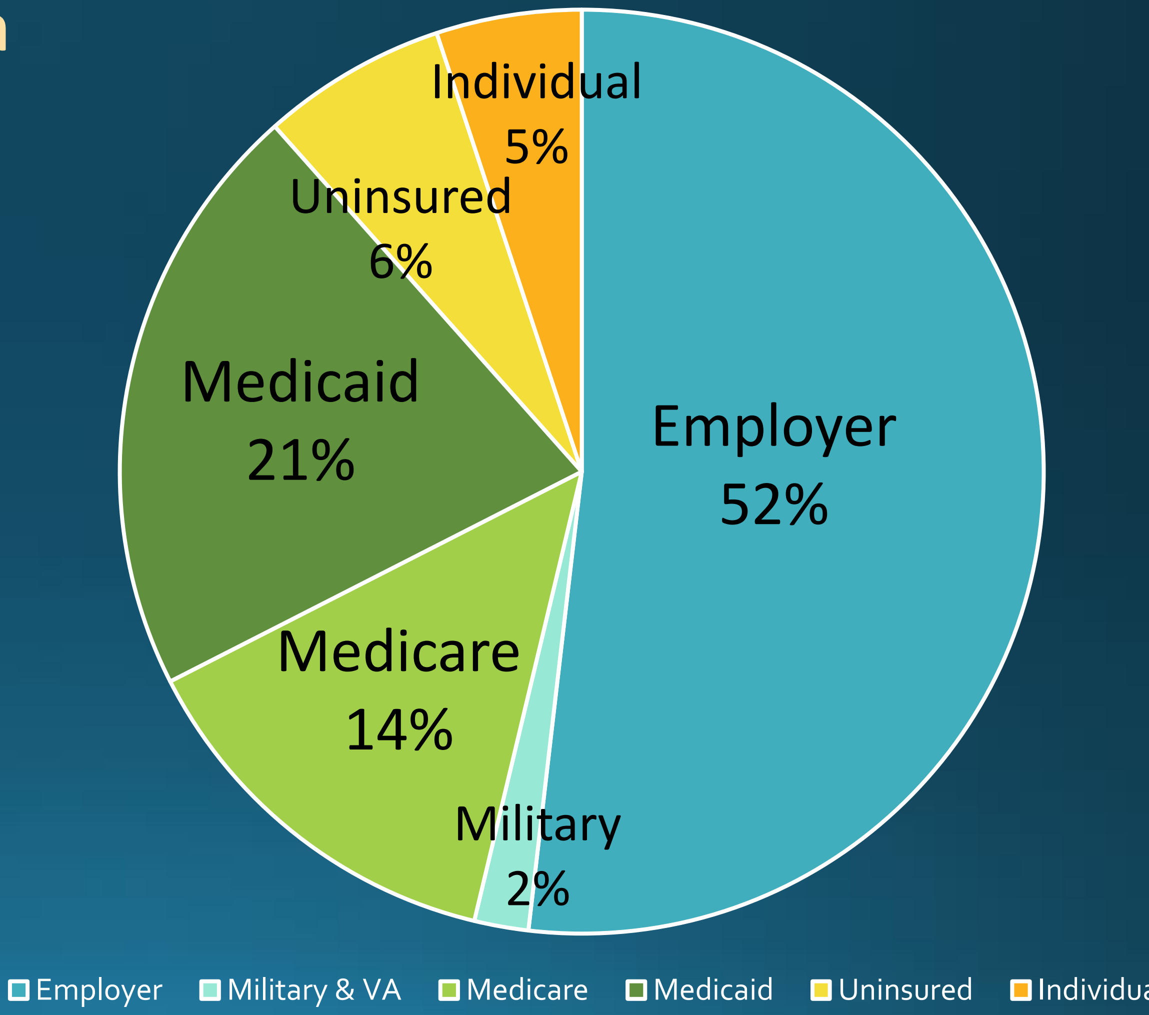
- Federal health care statutes with waivers
  - Medicare ✓
  - Medicaid ✓
  - ACA ✓
- ERISA does not contain a waiver
- Specifically, Dep't of Labor has no authority to waive ERISA preemption provisions

Policy goal: Include employers in WA UHC system

- Policy goal: include employers in Washington's Universal Health Care System
  - Why?
  - Without running afoul of ERISA preemption

- Other (possible) key goals
  - Universal (all residents eligible vs. enrolled)
  - Fiscally sustainable
  - Affordable
    - To residents - low or no premiums, cost-sharing, subsidies for low-income
    - To the society – control health care costs, spending
  - Equitable
  - Accessible (provider network)
  - Administrative simplification

WA Health Insurance Coverage (2021)



Spectrum of options for UHC

Limited Public Option

A government-standardized health plan that pays providers publicly determined rates and is offered to a small portion of the private health insurance market

(WA has this now with Cascade Select)

Comprehensive public option

A government-sponsored health plan that pays providers publicly determined rates and is offered to a substantial portion of the private health insurance market

State-based single payer

A single, government-administered payer that pays providers publicly determined rates and provides universal health care coverage for all residents in a state

Spectrum of policy goals and legal tradeoffs

Limited Public Option

- Plug holes in coverage on individual market
- Limited reach
- Multi-payer status quo
- Inject cost pressure in some markets
- Marketplace-focused
- No ERISA implications

Comprehensive public option

- Universal eligibility
- Broader market reach
- Multi-payer persists, but breaks link between job and coverage
- Possible glide path to single-payer
- Few legal difficulties under ERISA, but still need waivers

State-based single payer

- Universal enrollment
- Total market reach
- Administrative simplification
- What role for insurance carriers?
- More legal difficulty: ERISA, waivers

Capturing Employer Spend with Comprehensive Public Option

- Employer mandate - State mandate that employers offer state public option plan (preempted)
- Employer option to offer state plan (not preempted)
- Funding:
  - Payroll taxes (can exempt employers that offer coverage at least as affordable and comprehensive as state plan – "Pay or Play")
  - Individual premiums (if employer contribution or collection voluntary)
    - Note: employer vouchers for employee premiums ok, but need a 1332 waiver of ACA employer mandate if the state plan is offered on the Marketplace
- Policy Tradeoffs:
  - Payroll tax without exceptions accelerates market-shift to state plan, but increases ERISA difficulty (more like single-payer analysis)
  - Individual premium-only model doesn't capture employer's share, may not raise sufficient funds

Capturing Employer Spend with State Single-Payer Plan

- Employer mandate - State mandate that employers participate in single payer plan (preempted)
- Type A – Funding Plan. Impose a payroll tax on employers and/or income tax or premiums on individuals to fund single payer (probably not preempted – depends on how much is "exorbitant").
  - No exceptions, but no explicit prohibition on employers continuing to offer their own plans ("Pay *and* Play")
- Type B – Provider Restriction. All provider payments from single payer plan at SP rates.
  - Universal provider enrollment + ability to contract with alternate plans (probably not preempted)
  - Voluntary provider enrollment, but if they join state plan, they cannot participate in other plans (probably not preempted)
  - Universal provider enrollment without ability to contract with other plans (may be preempted)
- Type C – Pay and recoup provisions. Single payer plan can pay for services and seek reimbursement from other payers via secondary payer, assignment, or subrogation

Draft an ERISA-Resistant Universal plan

- Build from Comprehensive Public Option
- Single-payer plan should include combination of these features:
  - A funding plan with payroll taxes, income taxes and/or premiums
  - Provider payment restriction and incentives to participate
  - Pay-and-Recoup mechanism (Assignment, Subrogation, Secondary Payer)
  - Severability clause

What about non-duplication?

- Non-duplication – A prohibition on any self-funded health plan from offering coverage that duplicates state plan coverage is likely preempted
- But a prohibition on any state-regulated insurance carrier or plan from offering duplicative coverage is probably not preempted.
- To avoid making a preempted “reference” to ERISA plans, do not explicitly state that self-funded duplicative coverage is permitted (though it is).
- Complementary (e.g., supplemental coverage) that covers costs and services not covered by the state plan can be permitted.

Takeaways

- Universal health care is not achievable without capturing the employer market.
- This implicates ERISA. But there are ways to design a UHC plan that avoids ERISA preemption. Two main models:
  - Comprehensive Public Option (avoids ERISA if meaningfully optional)
  - State Single-Payer Plan (more difficult under ERISA, but possible)
- The policy design is driven by the state’s goals within legal, financial, and political bounds (i.e., there are tradeoffs).

Tab 7

Finance Technical Advisory Committee

Liz Arjun - HMA

September 14, 2023

Objectives

VOTE on recommendations to the Commission on pursuing a federal waiver at this time to include ERISA in Washington’s universal health care system.

VOTE on recommendations to the Commission on options to include ERISA in Washington’s universal health care system.

FTAC Member Vote
Recommendations to the Commission Regarding ERISA

Motion to recommend or not recommend:

1. **Federal waiver at this time**
2. Optional for employers to participate
3. Pay or play or meaningful alternative (comprehensive public option)
4. Provider regulation/incentives
5. Payroll tax on all employers
6. Combination of two or more options

Pam MacEwan, FTAC Liaison

FTAC Member Vote

Recommendations to the Commission Regarding ERISA

Motion to recommend or not recommend:

1. Federal waiver at this time
2. **Optional for employers to participate**
3. Pay or play or meaningful alternative (comprehensive public option)
4. Provider regulation/incentives
5. Payroll tax on all employers
6. Combination of two or more options

Pam MacEwan, FTAC Liaison

FTAC Member Vote
Recommendations to the Commission Regarding ERISA

Motion to recommend or not recommend:

1. Federal waiver at this time
2. Optional for employers to participate
3. **Pay or play or meaningful alternative (comprehensive public option)**
4. Provider regulation/incentives
5. Payroll tax on all employers
6. Combination of two or more options

Pam MacEwan, FTAC Liaison

FTAC Member Vote

Recommendations to the Commission Regarding ERISA

Motion to recommend or not recommend:

1. Federal waiver at this time
2. Optional for employers to participate
3. Pay or play or meaningful alternative (comprehensive public option)
4. **Provider regulation/incentives**
5. Payroll tax on all employers
6. Combination of two or more options

Pam MacEwan, FTAC Liaison

FTAC Member Vote
Recommendations to the Commission Regarding ERISA

Motion to recommend or not recommend:

1. Federal waiver at this time
2. Optional for employers to participate
3. Pay or play or meaningful alternative (comprehensive public option)
4. Provider regulation/incentives
5. **Payroll tax on all employers**
6. Combination of two or more options

Pam MacEwan, FTAC Liaison

FTAC Member Vote
Recommendations to the Commission Regarding ERISA

Motion to recommend or not recommend:

1. Federal waiver at this time
2. Optional for employers to participate
3. Pay or play or meaningful alternative (comprehensive public option)
4. Provider regulation/incentives
5. Payroll tax on all employers
6. **Combination of two or more options**

Pam MacEwan, FTAC Liaison

Tab 8

Medicaid

Medicaid is jointly regulated and financed by federal and state governments, presenting barriers to ensuring that all Washingtonians receive the same level of benefits under a *state-based* universal system. As the Commission continues to develop design elements of the new system, they requested FTAC's guidance on options to include Medicaid enrollees in the system design.

UHCC’s Medicaid Discussion on 8/10/23

Questions from the Commission for FTAC to provide guidance:

- Does a comparison of benefits exist for Medicare, Medicaid, and Public Employee Benefits (PEB)?
- What have other states done with 1115 waivers to expand eligibility?
- What are the reasons for Medicaid enrollees’ barriers to access, e.g., lower reimbursement rates?
- What barriers exist with regards to Medicaid provider rate increases, e.g., ongoing work to increase primary care rates?
- What federal barriers exist with regards to:
  - Asset limitations for enrollees of classic Medicaid?
  - Provider reimbursement?

Options for Medicaid

Questions from the Commission for FTAC's analysis

- How might the state provide Medicaid-eligible Washingtonians benefits equivalent to benefits under the universal health care system?
- How might this be structured?
- How might this be funded?
- What additional questions need to be addressed?
- What additional analysis would be needed to determine how this might be done?

If these questions can't be answered today:

- What actions and/or information will be necessary for FTAC members to bring to the November meeting so that these questions can be answered?

Next Steps

FTAC Liaison and HMA will share with the Commission at their October meeting information from today's discussion about:

- ERISA guidance
- Initial Medicaid discussion

November's FTAC meeting will be focused on surfacing options to include Medicaid in Washington's universal health care system.

Tab 9

ARTICLE

FEDERALISM, ERISA, AND STATE SINGLE-PAYER HEALTH CARE

ERIN C. FUSE BROWN & ELIZABETH Y. MCCUSKEY†

While federal health reform sputters, states have begun to pursue their own transformative strategies for achieving universal coverage, the most ambitious of which are state-based single-payer plans. Since the passage of the Affordable Care Act in 2010, legislators in twenty-one states have proposed sixty-six unique bills to establish single-payer health care systems. This paper systematically surveys those state legislative efforts and exposes the federalism trap that threatens to derail them: ERISA's preemption of state regulation relating to employer-sponsored health insurance. ERISA's expansive preemption provision creates a narrow, risky path for state regulation to capture the employer health care expenditures crucial for financing a single-payer system. While this paper illustrates how state proposals may survive ERISA, the threat of preemption drives states to structure their plans in convoluted ways that may undermine other systemic goals such as universality, solidarity, and streamlined administration.

This analysis demonstrates how ERISA's uniquely broad preemption, coupled with its lack of waiver authority, elevates the interests of private employers above those of sovereign states and diminishes states' abilities to serve as laboratories of health reform. We argue that this moment in health reform demands ERISA preemption reform. To restore balance to health care federalism and pave the way for

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state reforms of all kinds, this paper proposes federal legislative and jurisprudential solutions: amendments to ERISA's preemption provisions, the addition of a statutory waiver, and/or a reinterpretation of ERISA preemption consistent with congressional intent and the presumption against preemption.

INTRODUCTION

The Affordable Care Act (ACA) marked a seismic shift in the U.S. health care system. It dramatically increased coverage, enlarged the federal role in the regulation of private health insurance, and altered the public's expectations and belief that everyone should have access to affordable coverage that does not discriminate on health status.[1] Yet the ACA did not produce universal coverage, and as a federal settlement of health system regulation and design, it has proven unstable due to political and legal attacks undermining its effectiveness at health care coverage and cost control.[2] Still, a feasible federal replacement for the ACA has proven elusive.

Rather than wait idly by for federal progress, states have picked up the momentum on health reform, spurred both by necessity and an appetite for policy innovation. Of necessity, states have turned to their own reforms in response to federal governmental attempts to undermine the ACA's coverage and cost-containment policies since the Trump Administration took power in 2017.[3] States also are testing different models and serving as laboratories for alternative ways to pay for health care, including some ambitious proposed experiments in single-payer plans. While federal single-payer reform under "Medicare-for-All"[4] gains support and attention,[5] state legislators quietly have drafted and introduced dozens of single-payer bills.

This project surveys state efforts from 2010 through 2019 to establish single-payer health care, which we define as legislative attempts to achieve universal health care coverage for all residents in a state by combining

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1 *See, e.g.*, Lawrence O. Gostin, David A. Hyman & Peter D. Jacobson, *The Affordable Care Act: Moving Forward in the Coming Years*, 317 JAMA 19, 19-20 (2017); Timothy Jost, *Taking Stock of Health Reform: Where We've Been, Where We're Going*, HEALTH AFF.: HEALTH AFF. BLOG (Dec. 6, 2016), https://www.healthaffairs.org/do/10.1377/hblog20161206.057800/full/ [https://perma.cc/688V-HRVC].

2 *See generally, e.g.*, John A. Graves & Sayeh S. Nikpay, *The Changing Dynamics of US Health Insurance and Implications for the Future of the Affordable Care Ac*t, 36 HEALTH AFF. 297 (2017); Elizabeth Y. McCuskey, *Big Waiver Under Statutory Sabotage*, 45 OHIO N.U. L. REV. 213 (2019) [hereinafter McCuskey, *Statutory Sabotage*]; Jonathan Oberlander, *The End of Obamacare*, 376 NEW ENG. J. MED. 1 (2017); Sara Rosenbaum, *The (Almost) Great Unraveling*, 43 J. HEALTH POL. POL'Y & L. 579 (2018).

3 *See* Andrew B. Bindman, Marian R. Mulkey & Richard Kronick, *Beyond the ACA: Paths to Universal Coverage in California*, 37 HEALTH AFF. 1367, 1367 (2018) ("The passage of the ACA temporarily relieved states of the need to take the lead in expanding health care coverage. However, many states have returned to the issue in the wake of the threat by the administration of President Donald Trump to repeal the ACA.").

4 *See Medicare for All*, BERNIE SANDERS, http://web.archive.org/web/20190218074835/ https://berniesanders.com/medicareforall [https://perma.cc/T9JB-XQSP].

5 *See, e.g.*, Nicole Gaudiano & Maureen Groppe, *Democrats Back Medicare for All in About Half of House Races They're Contesting*, USA TODAY (Oct. 23, 2018), https://www.usatoday.com/story/news/politics/elections/2018/10/23/democrats-back-medicare-all-half-contested-house-races/1732966002 [https://perma.cc/K6EM-FRAB]; Liz Hamel, Bryan Wu & Mollyann Brodie, *Data Note: Modestly Strong but Malleable Support for Single-Payer Health Care*, HENRY J. KAISER FAM. FOUND. (July 5, 2017), https://www.kff.org/health-reform/poll-finding/data-note-modestly-strong-but-malleable-support-for-single-payer-health-care [https://perma.cc/3AT8-WYHP]*; Public Opinion on Single Payer, National Health Plans, and Expanding Access to Medicare Coverage*, HENRY J. KAISER FAM. FOUND. (July 30, 2019), https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage [https://perma.cc/M4PT-ZDQX].

financing for all health care services into a single, state-administered payer.[6] State legislative proposals to establish single-payer plans have been surprisingly robust both in volume and variation, with sixty-six unique single-payer bills introduced across twenty-one states since 2010.[7] Though state single-payer proposals also face steep political, practical, legal, and financial challenges,[8] the volume and detail of state bills suggest many of these are serious, nonsymbolic efforts. Our research particularly focuses on how these states seek to capture the employer-sponsored health insurance that currently covers forty-nine percent of Americans—a critical market for the solvency and viability of any single-payer plan.[9]

Even if individual states can muster the political will and popular support to pass single-payer bills, a federalism trap threatens to thwart their transformative experiments: the Employee Retirement Income Security Act of 1974 (ERISA),[10] a federal statute governing employer-based benefit plans. When state laws conflict with federal ones, preemption doctrine generally displaces the state law in favor of the federal.[11] But the express statement of preemption in ERISA sweeps even further, purporting to invalidate "any and all" state laws that "relate to" an employee benefit plan, not merely those which unavoidably conflict.[12]

This indeterminately broad preemption language in ERISA, combined with an obscure "savings" clause for state regulation of insurers and an equally obscure "deemer" clause interpreted to prohibit states from regulating employer benefit arrangements that mimic insurance, has spawned

6 Our methodology for identifying state single-payer bills is set forth in Section I.A. and Appendix B, *infra*.

7 *See infra* Section I.A.

8 A full discussion of these other challenges is beyond the scope of this Article. The most significant of these include: (a) the difficulty and necessity of securing waivers from the federal government to include Medicare, Medicaid, and Affordable Care Act marketplaces in the single-payer plan; (b) the need for states to raise taxes significantly to make up for the massive federal subsidy of employer-based health plans through the preferred tax treatment of these plans, which would be lost if these plans are shifted to the state single-payer plan; and (c) the fact that states, unlike the federal government, cannot deficit-spend and thus would struggle to finance single-payer programs in a recession when revenues decline. *See, e.g.*, Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L.J.F. 1 (2017); Lindsay Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 79 OHIO ST. L.J. 843 (2018).

9 *Health Insurance Coverage of the Total Population*, HENRY J. KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/F2N4-U4MP] (use "Refine Results" menu to select the timeframe 2017) [hereinafter *Health Insurance Coverage*].

10 *See* 29 U.S.C. § 1001 (2018).

11 *See, e.g.*, Caleb Nelson, *Preemption*, 86 VA. L. REV. 225, 225 n.3 (2000).

12 29 U.S.C. § 1144(a) (2018).

voluminous litigation and derailed state health reforms for decades.[13] States, for example, may not impose their own "employer mandates" to provide health benefits due to ERISA preemption; they therefore mostly had to wait for federal legislation (the ACA) to impose them. As another example, state laws establishing mandatory minimum health benefits "relate to" employer-provided health benefits; the "savings" clause avoids preemption when states enforce these minimum benefits laws against insurance companies selling insurance to employers, yet the "deemer" clause preempts their application to employers who self-insure their own health benefits.[14] ERISA preemption thus raises a daunting legal challenge and uncertainty for states trying to capture critical employer-based health spending and draw those with employer-based coverage into the single-payer system.

States are tying themselves in knots to avoid ERISA preemption in their health reforms. The state single-payer bills we studied feature several innovations to accomplish indirectly what ERISA prohibits them from doing directly, namely to mandate that employers participate in and cover all their employees through the state's single-payer plan.[15] State single-payer bills contain at least three types of provisions to capture employer health expenditures and move enrollees into the system: (A) funding plans that use payroll taxes, income taxes, or both to raise revenue to pay for the single-payer plan and to encourage employers and employees to shift from employer-based coverage to the state single-payer plan;[16] (B) provider regulations that restrict participating providers from billing any third party other than the single-payer plan at single-payer rates;[17] and (C) assignment/subrogation/secondary-payer provisions that allow the single-payer plan to pay for services for enrollees with dual coverage, and then seek reimbursement from the collateral source of coverage.[18]

This Article comprehensively catalogues state single-payer proposals and analyzes whether ERISA would preempt state efforts to capture the employer expenditures. There are strong arguments why each of these three types of provisions (A–Funding Plan; B–Provider Restriction; or C–Assignment/Subrogation/Secondary-Payer) should survive ERISA preemption. But courts' unpredictable, tortured, and at times contradictory application of

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13 *See, e.g.*, Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J.L. MED. & ETHICS 88, 89-90 (2009).

14 *Id.* at 90.

15 A state mandate that employers must provide health benefits to employees or, if the employer opts to provide benefits, cover employees under the state's single-payer plan would be preempted by ERISA because such a mandate would "relate to" an employee benefit plan, altering the structure of the employer's plan. *See infra* note 114.

16 *See infra* subsection I.B.1.

17 *See infra* subsection I.B.2.

18 *See infra* subsection I.B.3.

ERISA casts a pall of uncertainty over their durability and invites litigation.[19] Legal uncertainty amplifies the political challenges of establishing a state single-payer system because policymakers may struggle to pass such a sweeping legislative reform if key parts may be preempted.[20] ERISA preemption targets the primary funding provisions in these bills, further threatening the economic modeling and revenue stream upon which single-payer plans depend. Legal uncertainty over ERISA preemption thus narrows the eye of the political and economic needle a state must thread to establish single-payer health care.

ERISA is also an interloper in federal health insurance regulation—an employee-benefits statute not originally intended to govern health care, but which now exerts a powerful influence over it. Unlike most major federal health care statutes including Medicare, Medicaid, and the ACA, ERISA does not provide for waiver, state experimentation, or federal funding.[21] The Department of Labor, which administers ERISA, lacks the statutory authority to waive its preemption, even if the Department finds it would be beneficial.[22] Nor will the agency's enforcement discretion save a state's single-payer provision from preemption because employers or third-party administrators can raise ERISA preemption through litigation, enforced by courts.

The combined effect of ERISA's extremely broad preemption provision and its lack of a waiver thwarts all manner of state autonomy and flexibility in health reform. ERISA's obstruction stands at odds with other federal statutes that distribute authority and control between the national and state governments to allow state flexibility against a backdrop of federal standards and agency expertise in health care regulation.

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19 *See infra* subsection II.A.2.

20 *See* Brendan S. Maher, *The Benefits of Opt-In Federalism*, 52 B.C. L. REV. 1733, 1783 (2011) ("A state has a greater incentive to confirm the preferences of its own citizens or serve as a 'laboratory of benefits' if its regulatory decisions will not be reduced into nothingness by ERISA preemption.").

21 Elizabeth Y. McCuskey, *Agency Imprimatur & Health Reform Preemption*, 78 OHIO ST. L.J. 1099, 1102-03 (2017) [hereinafter McCuskey, *Agency Imprimatur*]; *infra* text accompanying notes 338–342; *cf.* Karl Polzer & Patricia A. Butler, *Employee Health Plan Protections Under ERISA*, 16 HEALTH AFF. 93, 93-94 (1997) (explaining that "ERISA was designed to establish uniform federal standards," but has the effect of "substantially deregulat[ing] employee health plans" due in part to its "lack of substantive requirements in the health area"). Other federal programs like the Veterans Administration, TRICARE (which covers active military members and their dependents), and federal employee health benefits, as well as statutes that exert profound but indirect influence on health insurance, like the Internal Revenue Code, do not have waivers, either.

22 *See infra* subsection III.B.2 and text accompanying notes 338–342; *see also* MANATT HEALTH & CALIF. HEALTH CARE FOUNDATION, UNDERSTANDING THE RULES: FEDERAL LEGAL CONSIDERATIONS FOR STATE-BASED APPROACHES TO EXPAND COVERAGE IN CALIFORNIA 5, 10 (2018) (noting that ERISA's "provisions are not waivable by administrative action" and that states seeking suspension of the statutory preemption "would likely need federal legislation to receive an exemption").

ERISA's broad preemption springs from a concern in 1974 that multistate employers would refuse to provide health benefits to their employees if subjected to state regulatory variations.[23] The conditions underlying this assumption, however, have shifted since the ACA significantly supplanted state health insurance regulation with federal standards and imposed a federal mandate for larger employers to offer health coverage.[24] While multistate employers' need for regulatory uniformity to continue offering coverage arguably has receded,[25] ERISA's continued insistence on national uniformity prevents states from effectuating major health system reforms that their citizens desire and still leaves self-funded employer plans largely unregulated. The breadth of ERISA preemption thus elevates the interests of private businesses above the interests and police powers of sovereign states.

In this Article, we do not argue that any state *ought* to establish single-payer health care or that state-based single-payer health care is preferable to a national effort or to other, more incremental reforms toward universal coverage and cost control.[26] Instead, our research reveals that even if a state's citizens *want* single-payer, the state faces a nearly insurmountable structural challenge from ERISA. Because ERISA thwarts state experimentation with single-payer models, it also denies an opportunity to gather evidence on *whether* single-payer systems have advantages or disadvantages over other reforms. State single-payer legislation provides a stark illustration of the federalism trap created by ERISA that has stymied states' health reform efforts—big and small—for decades.

We propose four solutions to clear the way for state health reforms and reduce ERISA's obstruction—three legislative and one jurisprudential. First, Congress could amend ERISA's preemption provisions with respect to health benefit plans, replacing its broad "any and all" preemption with "floor preemption," used in other federal health care statutes. Floor preemption, which displaces only those state laws that are less stringent than the federal

23 Phyllis C. Borzi, *There's "Private" and Then There's "Private": ERISA, Its Impact, and Options for Reform,* 36 J.L. MED. & ETHICS 660, 663 (2008).

24 *See* 26 U.S.C. § 4980H (2018) (containing the employer mandate); *id.* § 9815 (applying many of the ACA's health insurance requirements, codified at 42 U.S.C. § 300gg *et seq.* (2018), to group health plans governed by ERISA); 29 U.S.C. § 1185d (2018) (same).

25 *See, e.g.*, Mallory Jensen, *Is ERISA Preemption Superfluous in the New Age of Health Care Reform?*, 2011 COLUM. BUS. L. REV. 464, 516 (noting that "[i]n the [ACA's] implementation period, ERISA preemption will no longer have the same relevance for health law that it once did," in part because "many of the ACA's reforms will happen at a federal level").

26 Observers have considered the merits of a variety of approaches to health care reform. *See, e.g.,* Katie Gudiksen, *Single-Payer vs. Public Option: Can Either System Address Rising Health Care Prices?*, THE SOURCE ON HEALTHCARE PRICE & COMPETITION: THE SOURCE BLOG (Mar. 29, 2018), http://sourceonhealthcare.org/single-payer-vs-public-option-can-either-system-address-rising-health-care-prices [https://perma.cc/N8RZ-EATX].

standard (the "floor"), preserves uniformity in federal baseline regulations, balanced with state flexibility to enact laws consistent with and no less protective than the federal floor. Second, Congress could eliminate ERISA's "deemer clause"[27] for health benefits to correct Supreme Court interpretation that has built an impenetrable barrier of preemption around self-funded employer-based plans. Third, Congress could instead add a statutory waiver provision to ERISA, which would allow states to ask the federal government to suspend ERISA preemption for their proposed health reforms. As seen in other federal health care statutes, an ERISA waiver would allow the federal government to manage the degrees of uniformity and variation, while still permitting state experimentation in health policy. Floor preemption and deemer clause revisions to ERISA would produce the most direct and enduring reforms, but a waiver provision might offer the most politically expedient option, though far more limited in its effect.

Fourth, because the scope of ERISA preemption depends largely on jurisprudential interpretation of the statute, courts could curtail the scope of ERISA preemption and reinvigorate the "presumption against preemption" for health care regulation in a way that more accurately reflects Congress's original legislative intent for ERISA.[28] While we recognize this as a potential avenue for ERISA reform, we have little faith in its efficacy because of its fragmentary implementation and because the courts who broke ERISA interpretation are unlikely to effectuate its repair. If neither Congress nor the courts will address ERISA's obstruction, we recommend ways state legislators may build an ERISA-resistant single-payer plan using overlapping provisions to protect the system's viability in the event a court finds any single provision preempted.[29]

This Article proceeds in three parts. Part I presents the findings of a survey of state single-payer bills introduced from 2010 through 2019 and their key features, identifying three types of provisions that state single-payer proposals use to capture employer health expenditures and the forty-nine percent of Americans covered by employer plans: Type A (Funding Plan), Type B (Provider Restrictions), and Type C (Assignment/Subrogation/Secondary-Payer) provisions. Part II details the application of ERISA preemption analysis to each of these provisions and the degree to which each

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27 ERISA's broad preemption provision contains an exception, the "savings clause," which saves from preemption state insurance regulation. 29 U.S.C. § 1144(b)(2)(A) (2018). But the savings clause contains a further exception, the "deemer clause," which has been interpreted by courts to deem self-funded group health plans as not in the business of insurance, and therefore not subject to state insurance regulation. 29 U.S.C. § 1144(b)(2)(B) (2018); Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985).

28 *See infra* Section III.B.

29 *See infra* Section II.C.

should survive ERISA preemption. Part III then situates ERISA in the broader context of federal health insurance statutes. Although Congress did not intend ERISA to be a health care statute, ERISA's extraordinarily broad preemption, scant federal regulation, and lack of waiver flexibility create a federalism trap, obstructing state experimentation and autonomy in ways that undermine the health care federalism infrastructure of the ACA, Medicaid, and Medicare statutes. We offer four proposals to remove ERISA's obstructions to state health reform, infusing the federal regulatory scheme with greater flexibility and recalibrating its role in health care federalism.

Ultimately, we urge that the time has come to amend ERISA preemption in order to unshackle meaningful state health reforms from its outdated prohibitions.

I. STATE SINGLE-PAYER PLANS

State health reform momentum has only picked up steam after the ACA. State reform efforts range from patches for the individual market,[30] laws targeting surprise medical bills[31] and prescription drug prices,[32] proposals to allow any state resident to buy a public plan, such as Medicaid,[33] all the way to full transformation of the health care finance system in state single-payer proposals. This Part takes a deep dive into the ambitious end of state health reforms: state single-payer plans.

A. *The Recent Proliferation of State Single-Payer Proposals*

The volume of state interest and activity in single-payer health care, as measured by proposed legislation, has been substantial. Since the ACA was passed in 2010 through 2019, legislators in twenty-one states have proposed sixty-six unique single-payer bills.[34] Although our research turned up over 100 bills that can be characterized as proposing a state-based single-payer plan, removal of duplicates (i.e., substantially similar bills introduced in

30 *See Tracking Section 1332 State Innovation Waivers*, HENRY J. KAISER FAM. FOUND. (July 31, 2019), https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers [https://perma.cc/EQ99-FHWZ].

31 *See* Christina Cousart, *State Legislators Take Action to Protect Consumers from Surprise Billing*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Sept. 18, 2018), https://nashp.org/state-legislators-take-action-to-protect-consumers-from-surprise-billing [https://perma.cc/8MWM-UJL5].

32 *See* Robert Pear, *States Rush to Rein In Prescription Costs, and Drug Companies Fight Back*, N.Y. TIMES (Aug. 18, 2018), https://www.nytimes.com/2018/08/18/us/politics/states-drug-costs.html [https://perma.cc/8E2W-4WXY].

33 *See* Elisabeth Rosenthal, *Can States Fix the Disaster of American Health Care?*, N.Y. TIMES (Jan. 16, 2019), https://www.nytimes.com/2019/01/16/opinion/california-states-health-care.html [https://perma.cc/N8PD-8YR6].

34 See *infra* Appendix A for a table listing all the bills by state and year, and *infra* Appendix B for search terms and methodology for identifying state single-payer proposals.

different chambers in the same legislative session or bills assigned different numbers as they move through the legislative process) resulted in sixty-six bills. Although many bills explicitly stated that their purpose was to establish a single-payer health system, not all did.[35] We characterized bills as state single-payer proposals if they sought to establish universal health care coverage for all residents in a state by combining financing for all health care services into a single, state-administered payer. We excluded bills that did not meet this definition and thus did not purport to establish a single-payer plan, such as those that called for a study of single-payer, expressed support for a national single-payer plan, or attempted less-than-comprehensive health care reforms (for example, universal primary care).[36] None except Vermont's ill-fated single-payer plan[37] was passed, and no state has implemented a single-payer system.

The defining characteristics of state single-payer proposals are the combination of universal eligibility for state residents[38] and reliance on statutory waivers from Medicare, Medicaid, and the ACA to consolidate these sources of federal funding and their covered populations into the state single-payer plan.[39] Other common elements include: expansive provider eligibility;[40] administratively set or negotiated rates for providers and health

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35 *Compare* H.D. 1516, 2018 Leg., 438th Sess. § 1 (Md. 2018) ("It is the intent of the General Assembly that: (1) There be a comprehensive universal single-payer health care coverage program and a health care cost control system for the benefit of all residents of the State."), *with* H.R. 2436, 100th Leg., 2017–2018 Reg. Sess. (Ill. 2017) (providing, in synopsis, "that all individuals residing in the State are covered under the Illinois Health Services Program for health insurance").

36 See *infra* Appendix B for search terms and exclusion criteria.

37 *See* Act of May 26, 2011, 2011 Vt. Acts & Resolves 239 (enacting H.R. 202, providing for universal coverage in Vermont); John E. McDonough, *The Demise of Vermont's Single-Payer Plan*, 372 NEW ENG. J. MED. 1584, 1584 (2015) (identifying reasons that the plan's implementation was "abandoned").

38 *See, e.g.*, S. 562, 2017–2018 Leg., Reg. Sess. § 2 (Cal. 2017) (§ 100620(a)) ("Every resident of the state shall be eligible and entitled to enroll as a member under the program."); H.R. 440, 132d Leg., Reg. Sess. § 1 (Ohio 2017) (§ 3920.07(A)) ("All Ohio residents and individuals employed in Ohio, including the homeless and migrant workers, are eligible for coverage under the Ohio health care plan."); *cf. id*. (§ 3920.07(F) & (G)) (extending eligibility to nonresidents who work in the state or college students who attend university in the state).

39 Waiver reliance to include federal payers is nearly universal among the single-payer plans. *See, e.g.*, S. 2237, 2018 Leg., Reg. Sess. § 3 (R.I. 2018) (§ 23-95-12(d)) (providing that "[t]he director shall seek and obtain waivers and other approvals relating to Medicaid, the Children's Health Insurance Program, Medicare, the ACA, and any other relevant federal programs" to preserve and maximize federal funds available, while moving them into the state single-payer fund). Further, most state single-payer proposals would require a waiver from the U.S. Department of Health & Human Services of the Affordable Care Act's employer mandate, pursuant to the ACA's Section 1332 waiver provision. Wiley, *supra* note 8, at 863-64, 878.

40 *See, e.g.*, S. 1872, 2018 Leg., Reg. Sess. § 11 (Fla. 2018) ("Any health care provider who is licensed to practice in this state and is otherwise in good standing is qualified to participate in the program as long as the health care provider's services are performed within this state.").

care goods, such as prescription drugs;[41] low or no cost-sharing for patients;[42] comprehensive coverage of services;[43] and mechanisms for care coordination.[44]

The volume, variation, and detail of these state single-payer proposals is surprising. Although many of the states with single-payer proposals are controlled by Democrats, the single-payer bills are not exclusively from "blue" states. Most of the states with single-payer proposals expanded Medicaid under the ACA, so only a small fraction of their populations remain uninsured. So, there seems to be something else beyond universal coverage driving many of these single-payer bills. That something else appears to be an effort to control health care costs through expansive rate-setting authority for health care services and prescription drugs,[45] a reduction of administrative costs for the state and the health care industry by streamlining the multi-payer system into one,[46] and relieving citizens of their growing cost-sharing burdens from high deductibles, out-of-network bills, and co-insurance rates.[47] Figure 1 depicts the twenty-one states with at least one single-payer bill proposed between 2010 and 2019.

41 *See, e.g.*, A. 4738-A, 2017 Leg., Reg. Sess. § 3 (N.Y. 2018) (§ 4). Provider rates are commonly set through negotiation representatives of providers and the single-payer plan, along with formularies and negotiated prices for prescription drugs.

42 *See, e.g.*, S. 1014, 2017–2018 Gen. Assemb., Reg. Sess. § 503(c) (Pa. 2018) ("Participants are not subject to copayments, deductibles, point-of-service charges or any other fee or charge for a service within the package and shall not be directly billed nor balance billed by participating providers for covered benefits provided to the participant.").

43 *See, e.g.*, S. 5957, 65th Leg., 2d Spec. Sess. § 16 (Wash. 2017). The bills include, and go beyond, the ACA's essential health benefits, and typically include services covered by Medicare and Medicaid. *Compare* 42 U.S.C. § 18022(b)(1) (2018) (defining the ten "essential health benefits" that must be covered by nongroup health plans), *with* S. 219, 90th Leg., Reg. Sess. art. 3, § 1(2) (Minn. 2017) (defining thirty-one covered health benefits, including skilled nursing facilities and long-term supportive services currently covered under the state's Medicaid program).

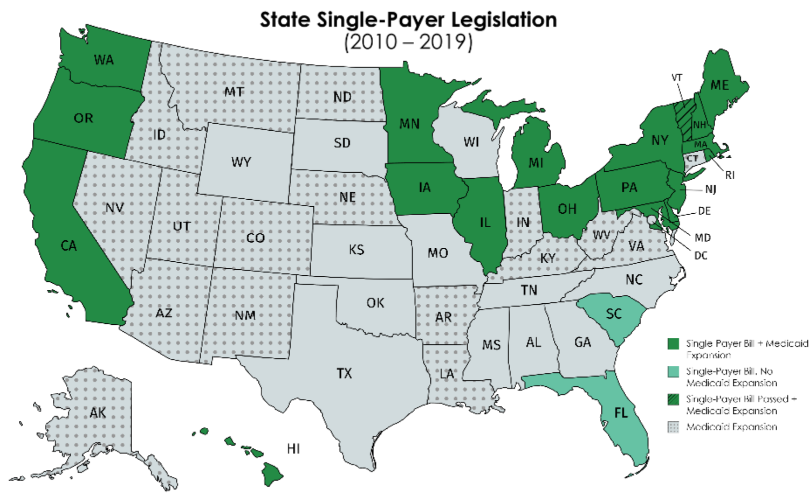
44 *See, e.g.*, H. 2352, 87th Gen. Assemb., Reg. Sess. § 16 (Iowa 2018). Some require eligible beneficiaries to enroll in a care coordinator, which can be their primary care physician, a "medical home," or an organization, such as an ACO or HMO. *See id.* § 2 (defining "care coordinator"); *id.* § 16 (providing requirements for care coordination).

45 *See, e.g.*, A. 5248, 2019 Leg., Reg. Sess. § 2 (N.Y. 2019) ("To address the fiscal crisis facing the health care system and the state and to assure New Yorkers can exercise their right to health care, affordable and comprehensive health coverage must be provided."); S. 786, 121st Gen. Assemb., 1st Reg. Sess. § 2 (S.C. 2015) (providing for the authority to establish rates for both health care providers that participate in the state program and those that do not).

46 *See, e.g.*, H. 2987, 190th Gen. Ct., 1st Reg. Sess. § 1(b) (Mass. 2017) ("Today's numerous private and public health insurance plans, with differing benefits and patient payment requirements, impose massive administrative burdens on doctors, hospitals, other health care organizations, as well as on patients, employers and other payers. Purchasing power is fragmented.").

47 *See, e.g.*, S. 2237, 2018 Leg., Reg. Sess. § 3 (R.I. 2018) (§ 23-95-1(e)) (stating in its Legislative Findings that "Rhode Island must act because there are currently no effective state or federal laws that can adequately control rising premiums, co-pays, deductibles and medical costs, or prevent private insurance companies from continuing to limit available providers and coverage.").

Figure 1: States with Single Payer Bills, by Medicaid Expansion Status



Although many, if not most, of these bills are political long-shots in their state legislatures, collectively they do not appear to be purely symbolic or precatory.[48] Many of the single-payer proposals are highly detailed, seemingly the products of a great deal of thought, analysis, political tradeoffs, and resources.[49] The impression of viewing these state single-payer bills in totality is that there is a nontrivial possibility that some state or states could

48 Of course, some bills may be totally symbolic or just manifest one legislator's policy position, while others have more support from multiple co-sponsors or coalitions and have advanced further along the legislative process. We did not assess the bills for their "seriousness" in terms of breadth of political support.

49 For example, some states have held hearings or have benefitted from in-depth economic assessments of their single-payer plans, demonstrating both the specificity of proposals and a commitment of significant resources to understand their economic impact. *See, e.g.*, ANDREW BINDMAN, MARIAN MULKEY & RICHARD KRONICK, A PATH TO UNIVERSAL COVERAGE AND UNIVERSAL HEALTH CARE FINANCING IN CALIFORNIA (2018), https://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/Report%20Final%203_13_18.pdf [https://perma.cc/XYK4-WB26]; JODI LIU ET AL., RAND CORP., AN ASSESSMENT OF THE NEW YORK HEALTH ACT: A SINGLE-PAYER OPTION FOR NEW YORK STATE (2018), https://www.rand.org/pubs/research_reports/RR2424.html [https://perma.cc/995S-EWK5]; JOHN SHEILS & MEGAN COLE, LEWIN GRP., COST AND ECONOMIC IMPACT ANALYSIS OF A SINGLE-PAYER PLAN IN MINNESOTA (2012), https://growthandjustice.org/images/uploads/LEWIN.Final_Report_FINAL_DRAFT.pdf [https://perma.cc/ZM39-TFUM]; CHAPIN WHITE ET AL., RAND CORPORATION, A COMPREHENSIVE ASSESSMENT OF FOUR OPTIONS FOR FINANCING HEALTH CARE DELIVERY IN OREGON (2017), https://www.rand.org/pubs/research_reports/RR1662.html [https://perma.cc/L8M2-HQLV].

thread the political, administrative, financial, and legal needles necessary to pass a single-payer plan in the coming years.

B. *How State Single-Payer Plans Capture Employer Health Expenditures*

The billion-dollar question, both in terms of dollars at stake and legal hurdles from ERISA, is how the state single-payer plan addresses employer-sponsored health coverage.[50] In the U.S., forty-nine percent of the population is covered by employer-sponsored coverage, which amounts to twenty percent of our total national health care expenditures.[51] Once the single-payer system starts covering this population, it must capture the vast employer and employee expenditures that pay for such coverage.[52] State legislation faces a big obstacle in achieving this critical task: ERISA preempts state law that "relates to" employer-sponsored benefits, as detailed in Part II below. Additionally, the population covered by employer-sponsored health benefits tends to be healthier than those covered by public programs, which is critical to balancing the risk pool for the single-payer plan.[53] Of those with employer-based coverage, more than sixty percent are covered by self-funded plans (also called self-insured plans), where the employer pays for the health benefits with its own funds, retaining financial or insurance risk.[54] As discussed in Part

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50 The other critical question is whether the federal Department of Health and Human Services (HHS) will grant states waivers to capture federal Medicaid (1115 waiver), Medicare (demonstration waivers), and ACA (1332 waiver) funds for the states' single-payer plans. These statutory waivers lie beyond the scope of this Article, but other scholars have provided analysis. *See, e.g.*, Wiley, *supra* note 8.

51 *Health Insurance Coverage*, *supra* note 9; CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES 2017 HIGHLIGHTS 2, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf [https://perma.cc/SX4S-6BQM] (last visited Nov. 20, 2019).

52 In addition to these direct expenditures, the federal government further subsidizes employer spending on health benefits by not taxing such expenditure as wages. *See generally Employee Benefits*, U.S. INTERNAL REVENUE SERVICE (Nov. 2, 2018), https://www.irs.gov/businesses/small-businesses-self-employed/employee-benefits [https://perma.cc/UC5E-BZJJ]. Although policy debates on the tax treatment of employee health benefits is beyond the scope of this Article, the larger point is that capturing what the system currently spends on employer health expenditures is critical for the financial viability of any single-payer plan.

53 Brief of Harvard Law School Center for Health Law & Policy Innovation, et al. as Amicus Curiae in Support of Petitioner at 19-20, Gobeille v. Liberty Mutual Ins. Co., 136 S. Ct. 936 (2016) (No. 14-181), 2015 WL 5261549, at *19-20; Victor R. Fuchs, *How to Make US Health Care More Equitable and Less Costly: Begin By Replacing Employment-Based Insurance*, 320 JAMA 2071, 2071 (2018).

54 GARY CLAXTON ET AL., HENRY J. KAISER FAM. FOUND., 2018 EMPLOYER HEALTH BENEFITS SURVEY 167 (2018), https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/167 [https://perma.cc/YN5Q-5KVJ]; *see also* CIGNA HEALTH & LIFE INS. CO., ADVANTAGES AND MYTHS OF SELF-FUNDING FOR EMPLOYERS WITH FEWER THAN 250 EMPLOYEES 2 (2014), http://www.cigna.com/assets/docs/business/small-employers/841956_b_self_funding_whitepaper_v8.pdf [https://perma.cc/YSW7-LNPJ] ("Traditional self-funding is defined as when an employer pays for their own medical claims directly, while a third-party administrator

II, ERISA's "deemer" clause has placed self-funded plans entirely beyond the reach of state regulation.[55]

To assess the distorting effect of ERISA preemption on states' health reform efforts, this project focuses on analyzing how states can capture employers' expenditures and transition the forty-nine percent of the population covered by employer-sponsored health plans into the state single-payer program.[56] We reviewed the sixty-six single-payer bills to identify their methods of capturing employer expenditures, as discussed below.[57] Eight of the sixty-six proposals purported to establish a single-payer program for the state, but did not contain an explicit mechanism to capture employer expenditures or move those with employer coverage into the single–payer program, for example by creating a state-based "Medicare-for-All" program, enrolling everyone in the state in an expanded version of Medicare.[58] Thus, we focused our analysis on the remaining fifty-eight state single-payer proposals for their methods of capturing employer expenditures and moving those covered by employee health plans into the single-payer program.

Due to ERISA preemption, discussed in Part II, states cannot simply mandate that employers adopt the single-payer plan as their employee health plan. However, states must capture employers' expenditures and shift those covered by employer-based health plans into the single-payer system, or else its single-payer plan is not truly a single-payer plan, and the economics will not work.

Unable to mandate that self-funded employers drop their benefit plans and participate in the single-payer plan under ERISA, state single-payer proposals mix and match the following tools to capture employer expenditures: (A) imposing a payroll tax on employers, an income tax on individuals, or both to fund the single-payer plan; (B) requiring or creating incentives for all provider payments to be made through the single payer entity at single-payer rates; and (C) subrogation, assignment, or secondary-payer provisions allowing the single-payer entity to pay for services and seek reimbursement from employer plans or other collateral sources.

In addition, most proposals contain nonduplication provisions prohibiting insurers from offering health benefits that duplicate those covered by the

administers the health plan by processing the claims, issuing ID cards, handling customer questions and performing other tasks.").

55 *See infra* Section II.A.

56 *Health Insurance Coverage*, *supra* note 9.

57 *See infra* Section I.B.

58 *See, e.g.*, S. 2598, 218th Leg., Reg. Sess. (N.J. 2018) (purporting to provide all New Jersey residents with federal Medicare coverage).

single-payer plan.[59] The idea behind nonduplication is that if insurers cannot sell plans that cover any of the services or benefits covered by the single-payer plan, then there are no competing private plans to choose from. Insurers may only sell so-called wraparound services that supplement the single-payer coverage. On its face, a nonduplication provision appears to do much of the work of shifting those with employer-based coverage to the single-payer plan, because employers would not have any health plan options to offer their employees in the single-payer state. However, as discussed in Part II, ERISA preemption likely would make the nonduplication provisions unenforceable against self-funded employer-based health plans.[60] Thus, state single-payer proposals must use other provisions to draw the self-funded employers' expenditures and their enrollees into the single-payer plan.

Appendix A contains a list of the single-payer bills proposed between 2010 and 2019 and their mechanisms to capture employer-sponsored health spending. Appendix B details our methodology for collecting and analyzing these state single-payer bills.

1. Type A—Funding Plan

The Type A—Funding Plan model captures employer expenditures and participation through a payroll tax, an individual income tax, or both. Payroll taxes are levied on employers and are calculated as a percentage of the wages that an employer pays its employees.[61] The fact that the payroll tax is based on wages and not the employer's spending on employee health benefits is significant for the ERISA preemption analysis below.[62] As tallied in Table 2, forty-five bills across sixteen states contain a Type-A funding plan.[63] State proposals may impose a flat[64] or graduated payroll tax rate,[65] which also may

59 *See*, *e.g.*, H. 2352, 87th Gen. Assemb., Reg. Sess. § 7(3) (Iowa 2017) ("An insurer, carrier, or health maintenance organization that is issued a certificate of authority by the commissioner of insurance may offer only the following: . . . Benefits that do not duplicate the health care services covered by the healthy Iowa program.").

60 *See infra* subsection II.B.4.

61 *Cf.* John A. Brittain, *The Incidence of Social Security Payroll Taxes*, 61 AM. ECON. REV. 110, 110 (1971) (noting that while payroll taxes may be imposed on the employer, some economists believe that they are typically paid by the employee in the form of reduced wages).

62 *See infra* subsection II.B.1.

63 *See infra* Table 2.

64 *See, e.g.*, S. 1014, 2017–2018 Gen. Assemb., Reg. Sess. § 904(a) (Pa. 2018) ("[A] tax of 10% is imposed on payroll amounts generated as a result of an employer conducting business activity within this Commonwealth."). Vermont's plan would have imposed a flat 11.5% payroll tax as well as a graduated income tax. *See* STATE OF VERMONT, GREEN MOUNTAIN CARE: A COMPREHENSIVE MODEL FOR BUILDING VERMONT'S UNIVERSAL HEALTH CARE SYSTEM 5 (2014), http://hcr.vermont.gov/sites/hcr/files/pdfs/GMC%20FINAL%20REPORT%20123014.pdf [https://perma.cc/4QTX-AR2C].

65 *See* A. 4738-A, 2017 Leg., Reg. Sess. § 4(2)(a) (N.Y. 2018); LIU ET AL., *supra* note 49, at 2.

apply to self-employed income.[66] Some states divide the payroll tax among employers and employees, with the employer paying a larger proportion of the tax, similar to the current division of premiums for employer-based coverage.[67] Other states would impose an income tax on employees to capture the employee share of spending on health coverage.[68] Income taxes may apply to unearned income to capture non-wage earnings, such as interest, capital gains, or dividends,[69] and can be progressively scaled to income levels. Sales and excise taxes are possible, but potentially more regressive than taxes scaled to individual income.

A payroll tax would lead many employers to drop their own coverage if they must pay the tax regardless of whether they offer their own employer-based plan.[70] The individual share of a payroll tax or an income tax is a way to replicate the employee's contribution to health care premiums and capture unearned income and income of state residents who are employed by out-of-state employers. If employees are required to pay a tax to fund the state single-payer program, many will elect to drop their employer-based plans so as to avoid double-paying for redundant coverage.[71]

The simplest form of Type A plan would rely solely on a payroll tax and/or income tax to capture employer expenditures and move enrollees to drop their employer coverage. These "Funding Only" proposals capture employers' health care expenditures directly via a payroll tax and assume that few employers would continue to offer their own coverage for employees subject to the payroll tax assessment, and even if they do, few employees will

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66 *See* S. 2237, 2018 Leg., Reg. Sess. § 3 (R.I. 2018).

67 *See id*.; LIU ET AL., *supra* note 49, at 14. The New York Health Act (NYHA) would divide the payroll tax, such that employers pay 80 percent, and employees pays 20 percent.

68 *See* STATE OF VERMONT, *supra* note 64, at 5 ("[T]he highest-income Vermonters would pay 9.5 percent of income through a public premium, up to a maximum of $27,500, while lower-income Vermonters would pay based on a sliding scale tied to a lower percentage of income ranging from 0 up to 9.5 percent.").

69 *See* S. 2237, 2018 Leg., Reg. Sess. § 3 (R.I. 2018) (§ 23-95-12(j)) ("There shall be a progressive contribution based on unearned income, i.e., capital gains, dividends, interest, profits, and rents. Initially, the unearned income RICHIP contributions shall be equal to ten percent (10%) of such unearned income."); *see also* LIU ET AL., *supra* note 49, at 2 ("Individuals would not pay premiums for [the New York Health program, or] NYH. Instead, the program would be financed by new graduated state taxes on payroll and nonpayroll income (such as interest, dividends, and capital gains) and redirected federal funding through waivers and state funding for current health care programs.").

70 *See* LIU ET AL., *supra* note 49, at 2, 50 (explaining that "[w]hile the NYHA does not prohibit employers from offering health insurance, it does include a mandatory employer payroll tax contribution to help fund NYH," and noting the assumption that the payroll tax will replace employer spending on employer-sponsored insurance, with overall employer spending on health care unchanged).

71 As discussed in Part II, a funding plan based on a payroll tax should avoid preemption by ERISA, but it is far from certain whether courts will agree. Income taxes generally would not implicate ERISA. *See infra* subsection II.A.2.

continue to take up employer coverage once they are covered by the state single-payer plan. An example of a Funding Only model is Washington's 2017 single-payer bill, which would fund its single-payer plan using a payroll tax for employers, with no exceptions.[72] Most of the state single-payer bills that contain a funding plan combine the financing mechanism with other tools, discussed below, to entice individuals into the single-payer plan and capture employer health expenditures.

The Type A—Funding Plan can be analogized to public school financing. All households must pay property taxes to fund public schools that all children are eligible to attend.[73] If certain households wish to pay for private school, they are free to do so, but it does not excuse them from their property tax. The public school analogy also reveals a nuance of the Funding Plan approach: unless the quality or choice of providers is the same or superior in the single-payer plan, there may be employers and employees who continue to maintain their employer-based plans, even when subject to the taxes to fund the single-payer plan.

2. Type B—Provider Restriction

A second variation, the Type B—Provider Restriction model, uses a form of provider regulation to draw individuals away from employer-based plans into the single-payer plan. Thirty-four of the single-payer bills across fourteen states contain a Type-B provider restriction.[74] Because provider regulation tends to fall beyond the reach of ERISA preemption,[75] state single-payer proposals use provider regulation to move individuals to drop their employer coverage. These provisions restrict participating providers from billing anyone other than the single-payer plan, whether the patient or any third-party payer, for services rendered to a patient with single-payer coverage. In addition, the provisions limit providers' payment rates to the single-payer rates. For example, California's S. 562 says that participating providers may not "charge any rate in excess of the payment established under this title for any health care service provided to a member under the program and *shall not solicit or accept payment from any member or third party for any health care service*, except as provided under a federal program."[76] The proposals may

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72 S. 5747, 65th Leg., Reg. Sess. §§ 16-17 (Wash. 2017).

73 *See* STATE OF VERMONT, *supra* note 64, at 11 (explaining the analogous relationship between public school financing and the Vermont single-payer plan, Green Mountain Care).

74 *See infra* Table 2.

75 *See infra* Section II.A.

76 S. 562, 2017–2018 Leg., Reg. Sess. § 2 (Cal. 2017) (§ 100639(e)(2)) (emphasis added). The proposed statute further states that "[t]his section does not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program." *Id.* In other words, for programs like TRICARE and the federal employee health

automatically enroll all residents in the state single-payer plan, or they may deem all residents presumptively eligible, but require an affirmative step to enroll.[77] Under either model, most plans assume all residents would be covered by the single-payer plan.

The Provider Restriction model creates incentives for patients to drop their employer-based coverage because if providers want to participate in the single-payer plan, they are barred from billing employer-based plans and would thus cease participating in those plans. If providers are unable to be paid from any other source, they will no longer see patients who have other coverage. The limitation on providers' charges to the single-payer rate also reduces incentives to continue to participate in other plan networks, such as employer-based plans, because they will not be able to earn more from those payers than from the single payer. Thus, the provider networks for the employer plans would shrink considerably, perhaps to the point where employer-based coverage is all but worthless to employees. Employees will drop employer coverage if it lacks a functioning provider network.

In some instances, we characterized single-payer proposals as Type B models even when they lacked an explicit limit on providers' ability to be paid from non-single payer sources. For example, a plan could be characterized as containing a Provider Restriction where it contained strong incentives for providers to participate exclusively in the program short of a mandate to do so, such as requirements that providers participate on an all-or-nothing basis[78] or onerous notification requirements.[79] Another example is South Carolina's bill, which would allow providers to be reimbursed at a higher rate if they participate in the single-payer plan's network than if they do not.[80]

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benefits programs, which do not provide waivers, presumably the provider would be permitted to bill these federal programs directly, and the state single payer could be the secondary payer.

77 *Compare* S. 2237, 2018 Leg., Reg. Sess. § 3 (R.I. 2018) (§ 23-95-5(a)(1)) (requiring the plan director to "identify [and] automatically enroll . . . qualified Rhode Island residents"), *and* H.R. 74, 147th Gen. Assemb., Reg. Sess. § 1611 (Del. 2013) (declaring "[a]ll Delaware citizens" entitled to benefits but establishing no enrollment procedure), *with* H.R. 1793, 165th Gen. Ct., 2d Sess. § 2 (N.H. 2018) (§ 404-J:4) (extending presumptive eligibility to "[a]ll individuals legally residing in New Hampshire" but requiring completion of an application for payment of benefits).

78 *See, e.g.*, H. 2436, 100th Leg., Reg. Sess. § 40(g) (Ill. 2017) ("Providers who accept payment from the Program for services rendered may not bill any patient for covered services. Providers may elect either to participate fully, or not at all, in the Program."); *see also* S. 2237, 2018 Leg., Reg. Sess. § 3 (R.I. 2018) (§§ 23-95-7(a)(2), 23-95-9(d)) (using nearly identical language).

79 *See, e.g.*, S. 1014, 2017–2018 Gen. Assemb., Reg. Sess. § 507(b) (Pa. 2018) (requiring a nonparticipating provider to notify patients of the provider's nonparticipation and to have the patient sign a form acknowledging he or she is solely responsible for amounts charged in excess of the approved single-payer rates, and imposing penalties of up to 200% of the amount billed to a patient for a provider's noncompliance).

80 S. 786, 121st Gen. Assemb., 1st Reg. Sess. § 2 (S.C. 2015) (§§ 44-18-920, 44-18-940).

Standing alone, the Provider Restriction model may move individuals into the single-payer plan and out of employer-based plans, but it does not capture employers' expenditures on health coverage. Thus, a provider restriction would almost certainly need to be paired with a payroll tax or other funding mechanism to capture employers' financial contributions. In effect, the provider restrictions in this model are designed to simulate the effects of a nonduplication provision through provider regulation: they limit the market for employer-based coverage by shrinking the provider networks for that coverage, but without triggering ERISA preemption.

3. Type C—Assignment, Subrogation, Secondary-Payer

A third variation, the Type C model, includes an explicit subrogation, assignment, or secondary-payer provision to facilitate the single-payer plan's ability to recover paid claims from collateral sources of coverage, including employer-based plans.[81] Twenty-five bills across nine states employ a Type-C subrogation, assignment or secondary-payer provision.[82]

Subrogation is the action, typically by an insurance carrier, to assert the rights of the insured to reimbursement or payment against a third party.[83] In the single-payer context, the single-payer plan could pay for the health care services of a member, and then assert a subrogation claim to recover those costs against a third party that is responsible for paying for the member's care, including collateral sources of health coverage. Oregon's most recent single-payer bill provides an example of a subrogation provision:

> (2) The Oregon Health Authority is subrogated to the rights of any participant that has a claim against an insurer, tortfeasor, *employer, third party administrator,* pension manager, public or private corporation, government entity or any other person that may be liable for the cost of health services provided to the participant and paid for by the Health Care for All Oregon Plan.
> (3) The authority may enter into an agreement with any person for the prepayment of claims anticipated to arise under subsection (2) of this section during a biennium. At the end of each biennium, the authority shall

81 Other collateral sources may include out-of-state coverage, government payers where a waiver is not secured, TRICARE, federal employee health benefit plans, tortfeasors, workers compensation plans, accident or auto insurance policies, or other plans that are not included in the single-payer plan.

82 *See infra* Table 2.

83 *Subrogation*, BLACK'S LAW DICTIONARY (10th ed. 2014) ("The principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy.").

> appropriately charge or refund to the payer the difference between the amount prepaid and the amount due.[84]

An assignment of benefits is a legal agreement where the individual agrees to transfer the right to reimbursement for his or her health care services to another party, typically to a provider.[85] In the single-payer context, an assignment provision would transfer to the single-payer plan the individual's right to reimbursement from another third-party payer, such as a health plan.[86]

Similarly, secondary-payer provisions make the single-payer plan the secondary payer to any other coverage the patient may have, including employer-based coverage.[87] This means that the collateral source of coverage has the first obligation to pay for the patient's services, and the single-payer plan will only pay for services not otherwise covered by the primary payer. The secondary-payer provision may be paired with a subrogation provision that authorizes the state single-payer plan to recover amounts that it paid that were the responsibility of the primary payer.[88]

To illustrate the mechanics of these provisions, assume an employee gets an MRI and a bill for $800 for the service. Her employer's plan agrees to pay up to $1,000 for an MRI. Under a subrogation provision, the state single-payer plan would pay the provider's bill of $800, then charge the employer $800.[89] Under an assignment provision, similarly, the state single-payer plan

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84 S. 631, 78th Leg., Reg. Sess. § 15(2), (3) (Or. 2015) (emphasis added).

85 *See* 46A C.J.S. *Insurance* § 2001 (Dec. 2019 update) ("A form authorizing a [health care provider] to receive payment of a patient's insurance benefits is sufficient to effect an assignment of the patient's claim against the insurance company to the [health care provider].")

86 See, for example, the single-payer bill introduced in Rhode Island in 2018, which provides:

> Receipt of health care services under the plan shall be deemed an assignment by the [Rhode Island single payer plan] participant of any right to payment for services from a policy of insurance, a health benefit plan or other source. The other source of health care benefits shall pay to the fund all amounts it is obligated to pay to, or on behalf of, the [Rhode Island single payer plan] participant for covered health care services. The director may commence any action necessary to recover the amounts due.

S. 2237, 2018 Leg., Reg. Sess. § 3 (R.I. 2018) (§ 23-95-12(g)).

87 *See, e.g.*, H.R. 887, 128th Leg., 1st Reg. Sess. pt. A (Me. 2017) (§ 7506) (providing that "Healthy Maine serves as a secondary payor" and that the total of primary and secondary payments "may not exceed the amount that Healthy Maine would pay if it were the only payor").

88 *See id.* ("Healthy Maine may recover health care payments from any other collateral source, such as a health insurance plan, health benefit plan or other payor that is primary to Healthy Maine.").

89 For an example of a bill with a subrogation provision, see S. 810, 2011–2012 Leg., Reg. Sess. § 1 (Cal. 2011) (§ 140302(a)), which provides that

> [U]ntil such time as the role of all other payers for health care services has been terminated, costs for health care services shall be collected from collateral sources whenever health care services provided to an individual are, or may be, covered services under a policy of insurance, health care service plan, or other collateral source

would assume the employee's right to receive $800 from the employer plan and would pay the provider on the employee's behalf, then assess an $800 charge on the employer to pay back the state fund.[90] Under a secondary-payer provision, the employer plan must pay the $800 bill and the state single-payer plan is relieved of its obligation to pay.[91]

In proposals using a Type C—Assignment/Subrogation/Secondary-Payer model, if a patient has dual coverage in both the single-payer plan and another plan, such as employer-sponsored coverage, the single-payer plan is able to seek reimbursement from the other plan (the collateral source of coverage) for any services provided. In states where providers are permitted to bill collateral sources, the single-payer plan would just be responsible for patient cost-sharing and services not covered by the collateral source. Using the MRI example from above, the MRI provider could bill the patient's employer plan $800 for the MRI. If the patient had a $500 deductible under her employer plan, the patient would ordinarily owe $500 to the MRI provider. However, the state single-payer plan, which does not permit patient cost-sharing, would then function as supplemental coverage and pay the patient's $500 cost-sharing, and the employer would pay $300.[92] Thus, the assignment, subrogation, or secondary-payer provision saves the single-payer plan money by turning first to collateral sources of coverage,[93] which may reduce the amount of payroll or other taxes required to fund the single-payer program. It also contains an implied acknowledgement that employers may continue to offer coverage if they so choose. The circuitous inefficiency of these Type C pay-and-recoup provisions illustrate the contortions that ERISA forces states into. These provisions would be unnecessary if the state could simply mandate that employers offer coverage to employees through the state single-payer plan or cease

available to that individual, or for which the individual has a right of action for compensation to the extent permitted by law.

90 *See, e.g.*, S. 2237, 2018 Leg., Reg. Sess. § 3 (authorizing the state single-payer plan's director to take "any action necessary" to recover these funds).

91 *See, e.g.*, H.R. 887, 128th Leg., 1st Reg. Sess. pt. A (Me. 2017) (providing that if the employer plan should have paid and did not, the state single-payer plan can pay and recoup the bill from the employer plan).

92 *See, e.g.*, S. 1014, 2017–2018 Gen. Assemb., Reg. Sess. §§ 503(c), 505, 506, 507 (Pa. 2018) (providing that the state plan is subrogated to and deemed an assignee of a participant's duplicate coverage, prohibiting providers from charging participants for cost-sharing, and not prohibiting providers from billing a participant's duplicate coverage).

93 *See, e.g.*, S. 1125, 91st Leg., Reg. Sess., § 3(3)(a) (Minn. 2019) (providing that "[t]he Minnesota Health Plan shall seek reimbursement from the collateral source for services provided to the individual . . . . Upon demand, the collateral source shall pay to the Minnesota Health Fund the sums it would have paid or expended on behalf of the individual for the health care services provided by the Minnesota Health Plan.").

providing employer-based coverage altogether because the possibility of dual coverage would be eliminated.

For administrative ease, however, providers may simply want to bill the single-payer plan for all services provided to dually covered patients, and the Assignment/Subrogation/Secondary-Payer provisions allow the single payer to pay the provider and then recover payment from the collateral source. This would allow the single-payer plan to recapture some of the employer expenditures: not what it spends on premiums, but the amount it pays in claims. The Assignment/Subrogation/Secondary-Payer model may be particularly useful to capture expenditures of out-of-state employers, who may not be subject to the state's payroll tax requirements.

Three states in our dataset—Ohio, Rhode Island, and Maine—had bills that combine Types B and C.[94] Ohio's single-payer bills contain provisions that require providers to seek payment only from the state single-payer plan, a provision subrogating the rights of the single-payer plan to all rights of a participant against a collateral source of payment, and a provision assigning from the participant to the single payer plan any rights to receive payment for services from any other source.[95] Combining Types B and C creates a mechanism to pull both employees and the employer expenditures into the single-payer plan: (1) participating providers are required to seek payment only from the single payer; (2) all services provided to state residents will be paid by the single payer at the established rates; and (3) if the patient is dually covered by an employer plan or other coverage, then the single-payer entity will seek reimbursement from the collateral source. In this way, the single-payer system can capture some of the employer expenditures on claims paid. For patients with dual coverage, it effectively transforms the single-payer plan into the billing agent of the provider. The employer can still pay claims to the single-payer plan if it elects to keep its private plan, but it may be easier and cheaper to simply stop covering the employees in that state and pay a payroll tax per employee instead. This model still relies upon a payroll tax or other way to capture the employer funds saved if an employer stops providing coverage to its employees, but it allows the single payer to capture health expenditures from third-party payers that continue to exist outside the single-payer system.[96]

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94 *See generally* H.R. 5611, 2019 Gen. Assemb., Reg. Sess. (R.I. 2019); H.R. 440, 132d Leg., Reg. Sess. (Ohio 2017); H.R. 962, 126th Leg., 1st Reg. Sess. (Me. 2013).

95 *E.g.*, H.R. 440, 132d Leg., Reg. Sess. § 1 (Ohio 2017) (§§ 3920.04(B)(15)(g), 3920.09(C)-(D), 3920.13).

96 As noted below in subsection II.A.3, however, application of these provisions to self-insured employer plans would be preempted.

A handful of bills only contain a Type C subrogation, assignment, or secondary-payer provision and no Funding Plan or Provider Restriction provisions.[97] A standalone Type C provision will do little to capture employer expenditures or move individuals into the single-payer plan and suggests that the state may anticipate the persistence of a multipayer system. Most of these Type-C-only plans provide for future development of the funding provisions, and such payroll or income taxes would do most of the work of moving people and funds into the state's plan. A standalone Type C provision, particularly secondary-payer, may even keep people in dual coverage longer than if they were paying for employer coverage that they rarely used (because the state plan would pay their claims). In some cases, other features suggest a standalone secondary-payer bill may not actually establish a single-payer system, but rather may establish a public option to compete with private plans without displacing private coverage altogether.[98]

A summary of the different types of mechanisms that state single-payer bills use to capture employer expenditures is listed in Table 1. The number of state proposals that contain each of the mechanisms (Types A, B, and C) are listed in Table 2. Note that proposals that feature more than one type of provision are counted more than once.

97 H.R. 316, 129th Leg., 1st Reg. Sess. (Me. 2019); S. 5222, 66th Leg., Reg. Sess. (Wash. 2019); H.R. 6285, 99th Leg., Reg. Sess. (Mich. 2018); H.R. 887, 127th Leg., 1st Reg. Sess. (Me. 2017); S. 631, 78th Leg., Reg. Sess. (Or. 2015).

98 For example, S. 5222 in Washington would allow employers that provide minimum essential coverage to employees to apply for an exemption from the payroll taxes to pay for the state plan. *See* S. 5222, 66th Leg., Reg. Sess. § 114(1) (Wash. 2019). Moreover, the bill does not contain a nonduplication provision and allows providers to continue to bill other payers. H.R. 6285 in Michigan creates a state plan that would be secondary to other coverage. H.R. 6285, 99th Leg., Reg. Sess. § 408(2)-(4) (Mich. 2018). Providers remain free to contract with and bill third-party payers, but only at rates less than the state plan's rates. *Id.* § 306(2). Employers may participate voluntarily. *Id.* § 202(1).

Table 1: Types of State Single-Payer Provisions

Type	Description
Type A – Funding Plan	Impose a payroll tax on employers and/or income tax on individuals to fund single-payer plan
Type B – Provider Restriction	Participating providers may only bill the single-payer system
Type C – Assignment/ Subrogation/Secondary Payer	Single payer can pay for services and seek reimbursement from other payers (pay-and-recoup provision)

Table 2: Number of State Single Payer Proposals by Type

Type	Proposals	# of Proposals	# of States
A (Funding Plan)	CA SB810, DE HB392, DE HB74, IA HF2352, IA HF96, IL HB207, IL HB311, IL HB942, IL HF2436, IL SB2177, MA HB1026, MA HB2987, MA SB501, MA SB515, MD HB1087, ME HP1026, MN SF8, MN SF912, MN SF2163, MN SF219, MN SF1125, NJ AB4945, NY AB5062, NYAB5248, NY AB5389, NY AB7860, NY SB4840, OH HB440, OH SB104, OHSB137, OH HB292, PA HB1688, PA HB2551, PA SB1014, PA SB400, RI HB5611, RI SB2237, RI SB 2824, SC SB786, VT HB202, WA HB1104, WA SB5224, WA SB5609, WA SB5741, WA SB5747	45	16
B (Provider Restriction)	CA SB562, FL SB1486, FL SB1872, IA HF2352, IA HF96, IL HB207, IL HB311, IL HB942, IL HF2436, IL SB2177, MA HB1026, MA HB2987, MA SB501, MA SB515, MD HB1087, MD HB1516, ME HP1026, ME HP962, NJ AB4945, NY AB5062, NY AB5248, NY AB5389, NY SB4840, OH HB287, OH HB440, OH SB104, OH SB137, OH HB292, RI HB5611, RI SB2237, RI SB2824, SC SB786, VT HB80, WA SB5957	34	14
C (Assignment, Subrogation, Secondary Payer)	ME HP1026, ME HP316, ME HP887, ME HP962, MI HB6285, MN SF8, MN SF912, MN SF2163, MN SF219, MN SF1125, OH HB287, OH HB440, OH SB104, OH SB137, OH HB292, OR SB631, PA HB1688, PA HB2551, PA SB1014, PA SB400, RI HB5611, RI SB2237, VT HB202, WA HB1104, WA SB5222	25	9

4. Summarizing the Models to Capture Employer Spending

The necessity of a payroll tax or other funding mechanism to capture employer expenditures means that most proposals combine a Funding Plan with either a Provider Restriction or Assignment/Subrogation/Secondary-Payer provision.[99] Other states have single-payer bills that lack a specific Funding Plan but contain a Provider Restriction or an Assignment/Subrogation/Secondary-Payer provision.[100] All Type B and C plans will eventually require a funding mechanism, even if the bills leave the details to be determined later. A proposal's lack of a specific revenue plan may reflect the political or technical difficulty of determining the precise levels of each type of tax needed to pay for the system. Thus, while it may be possible to design a single-payer plan without either a Provider Restriction or a Subrogation/Assignment/Secondary-Payer provision, it is not possible to imagine a viable single-payer plan that lacks a financing mechanism. The taxes in Type A proposals draw employees and employer expenditures into the single-payer plan, while the Type B and C proposals use provider regulation or assignment/subrogation/secondary-payer provisions to bolster the movement of people and funds into the single-payer plan.

All these models, particularly Types B and C, implicitly contemplate that some employers may continue to offer employer-based coverage, at least during a transition period before the system settles into equilibrium. As such, these models may also improve the ERISA-resistance of the single-payer proposal as a whole.

In response to ERISA, the emerging models for state single-payer plans use a combination of nudges and incentives operating on all the various actors in the health care transaction. Employers are encouraged, but not required, by the payroll tax to drop their employee coverage in the single-payer state. Providers are given incentives to participate in the single-payer plan and thus relinquish the ability to charge any other party for their services, including the individual patient or employer plans. Employees likely will choose the state-single payer plan and drop their employer plan, because the single-payer plan's broad provider network, lower cost-sharing, and comprehensive coverage will make it more attractive. Even if employees keep their employer-sponsored plans, the state single-payer plan may pay the providers and seek

99 *See, e.g.,* A. 4738-A, 2017 Leg., Reg. Sess. §§ 3-4 (N.Y. 2018) (combining a payroll tax, unearned income tax, and a provider restriction); S. 1014, 2017–2018 Gen. Assemb., Reg. Sess. §§ 505, 904, 905 (Pa. 2018) (combining a payroll tax, income tax, and subrogation and assignment provisions). *See also infra* Appendix A.

100 *See, e.g.*, H.D. 1516, 2018 Leg., 438th Sess. § 1 (Md. 2018) (providing for a revenue plan to be developed and a provider restriction); S. 631, 78th Leg., Reg. Sess. §§ 15, 16 (Or. 2015) (providing for a revenue plan to be developed and a subrogation provision).

reimbursement from this collateral source. The legal question we turn to in the next Part is whether ERISA preempts these nudges and incentives designed to pull employees and employer health spending through state single-payer plans.

II. ERISA'S OBSTACLES TO STATE SINGLE-PAYER PLANS

States' powers to regulate their health care systems are historic and expansive, but bounded by federal laws that limit state regulatory power through preemption. One federal law has erected a notorious obstacle to state regulation of health insurance: ERISA.[101] Congress enacted ERISA in 1974 to regulate pensions (hence the "Retirement Income Security" in its title),[102] but the statute's broad preemption language has wrought unintended consequences, blocking numerous state health reform laws over the past forty years as impermissibly "relat[ing] to" employer-sponsored health insurance. ERISA's formidable preemption barrier is not, however, impassible. The ERISA preemption scheme allows states to regulate some aspects of the insurance industry, provider payments, and general revenues. State laws that manage to wriggle through the narrow space between permitted targets of regulation and impermissible burdens on employer-sponsored plans may survive preemption.

Whether state-based single-payer plans survive ERISA preemption is the billion-dollar question posed in Part I. The logical answer is that ERISA preemption poses a substantial obstacle to these state efforts, but the plans should survive if carefully drafted to do so. The practical answer is that ERISA preemption doctrine and precedent have become so harsh and unstable that they cast a pall of uncertainty, jurisdiction by jurisdiction, and invite litigation challenging these state efforts no matter where they arise.

A. *The ERISA Preemption Labyrinth*

Preemption generally describes the displacement of one legal authority by another legal authority in an established hierarchy.[103] The U.S. Constitution's Supremacy Clause makes duly enacted federal law the

101 Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001–1461 (2018)).

102 *See, e.g.*, James A. Wooten, *A Legislative and Political History of ERISA Preemption, Part 1*, 14 J. PENSION BENEFITS 31, 31-35 (2006).

103 *Preemption*, BLACK'S LAW DICTIONARY (10th ed. 2014) (defining "preemption" as "[t]he principle (derived from the Supremacy Clause) that a federal law can supersede or supplant any inconsistent state law or regulation"); Nelson, *supra* note 11, at 225 n.3 (defining "preemption" as "the displacement of state law by federal statutes (or by courts seeking to fill gaps in federal statutes)").

"supreme law of the land," and subordinates state laws "to the contrary."[104] Preemption doctrine thus plays a crucial role in maintaining order in a federal system and policing the boundaries of authority.[105]

These boundaries, however, are porous, poorly defined, and disorderly at many important junctures.[106] Preemption doctrine has evolved a taxonomy of forms to determine which conflicts of authority have preemptive effect.[107] The taxonomy relies on divination of congressional intent behind the federal law,[108] identification of the federal law's points of friction with state laws, and selection of the degree to which the laws may coexist.[109] Congress may explicitly express its intention to preempt state law, or that intent may be implied.[110] Even when Congress expresses its wishes for preemption, those provisions invite plenty of ambiguity and room for interpretation.[111]

ERISA exemplifies the phenomenon of expressed but ambiguous preemption provisions because the statute's preemption is both forcefully-worded and inscrutable. Although passed primarily with pension benefits in

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104 U.S. CONST. art. VI, cl. 2; *cf. generally* Lauren E. Phillips, Note, *Impeding Innovation: State Preemption of Progressive Local Regulations*, 117 COLUM. L. REV. 2225 (2018) (discussing similar interactions between state laws and subordinate local laws).

105 *See generally* Richard A. Epstein & Michael S. Greve, *Conclusion: Preemption Doctrine and Its Limits*, *in* FEDERAL PREEMPTION: STATES' POWERS, NATIONAL INTERESTS 309 (Richard A. Epstein & Michael S. Greve eds., 2007); PREEMPTION CHOICE (William W. Buzbee ed., 2009).

106 *See* Elizabeth Y. McCuskey, *Body of Preemption: Health Law Traditions and the Presumption Against Preemption*, 89 TEMPLE L. REV. 95, 95, 96-100 (2016) [hereinafter McCuskey, *Body of Preemption*].

107 *See* David S. Rubenstein, *Delegating Supremacy?*, 65 VAND. L. REV. 1125, 1137-38 (2012) (explaining the Supreme Court's preemption taxonomy).

108 Gade v. Nat'l Solid Wastes Mgmt. Ass'n, 505 U.S. 88, 96 (1992) (plurality opinion of O'Connor, J.) ("The question whether a certain state action is pre-empted by federal law is one of congressional intent. The purpose of Congress is the ultimate touchstone." (internal quotation marks and brackets omitted)).

109 *See* McCuskey, *Body of Preemption*, *supra* note 106, at 96-97.

110 *See, e.g.*, Max N. Helveston, *Preemption Without Borders: The Modern Conflation of Tort and Contract Liabilities*, 48 GA. L. REV. 1085, 1088 (2014) ("Federal preemption occurs either when federal law explicitly states that it was intended to override state law (express preemption) or when continued enforcement of state law would conflict with federal law (implied, obstacle, or impossibility preemption)."); Daniel J. Meltzer, *Preemption and Textualism*, 112 MICH. L. REV. 1, 8 (2013) (describing implied preemption as resulting from an interpretation of the statute rather than its direct text).

111 *See, e.g.*, Geier v. Am. Honda Motor Co., 529 U.S. 861, 866, 872-73 (2000) (holding that implied preemption may be recognized even when the statute has different, express preemption provisions); Meltzer, *supra* note 110, at 30-31 (noting the variety of interpretive methods applied to express preemption provisions); Jamelle C. Sharpe, *Legislating Preemption*, 53 WM. & MARY L. REV. 163, 216 (2011) ("Although an express preemption or saving clause can be *clear* evidence of Congress's preemptive intent, it may not be *definitive* evidence."); *see also* Brendan S. Maher, *The Affordable Care Act, Remedy, and Litigation Reform*, 63 AM. U. L. REV. 649, 702 (2014) (observing that "[t]he doctrine of preemption—and obstacle preemption in particular—is quite muddled").

mind,[112] ERISA applies to all employer-sponsored benefits and expressly extends to plans that provide "medical, surgical, or hospital care or benefits," whether "through the purchase of insurance or otherwise."[113] ERISA's original purposes were to safeguard employees' pensions and to encourage employers' provision of pension benefits by establishing a uniform system of federal regulation and limiting employees' remedies.[114] ERISA, however, "does not go about protecting plan participants . . . by requiring employers to provide any given set of minimum benefits, but instead controls the administration of benefit plans"[115] if employers choose to provide them.

To promote uniformity[116] and encourage multistate employers to provide benefits, Congress wrote into ERISA a "terse but comprehensive"[117] provision expressly preempting "any and all" state laws[118] that "relate to" any "benefit plan[s]"[119] covered by the Act.[120] Even state laws friendly to ERISA's goals have run afoul of its preemption.[121]

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112 *See generally* ERIC M. PATASHNIK, REFORMS AT RISK: WHAT HAPPENS AFTER MAJOR POLICY CHANGES ARE ENACTED 74-77 (2008); Wooten, *supra* note 102.

113 29 U.S.C. § 1002(1) (2018); *see, e.g.*, N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 650-51 (1995) (citing 29 U.S.C. § 1002(1)). *But cf.* PATASHNIK, *supra* note 112, at 83 (noting scholarly disagreement about how far Congress intended ERISA to intrude on health insurance regulation, but agreement on "the importance of the preemption provision for health politics and policy").

114 See, for example, 29 U.S.C. § 1001(b), which declares ERISA's policy as being

> to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

See also id. § 1001a(a)(1) (declaring "multiemployer pension plans" to be targets of ERISA's policies); *id.* § 1001b(a)(1) (declaring "single-employer defined benefit pension plans" to be targets of ERISA's policies).

115 *Travelers*, 514 U.S. at 651.

116 *See* Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004) ("The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans.").

117 Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936, 943 (2016); *see also generally* Wooten, *supra* note 102.

118 ERISA defines state laws as "all laws, decisions, rules, regulations, or other State action having the effect of law," 29 U.S.C. § 1144(c)(1), and includes both states and "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 [ERISA]," *id.* § 1144(c)(2).

119 29 U.S.C. § 1144(a). The preemption provision was originally included as § 514 of ERISA. Pub. L. No. 93-406, § 514, 88 Stat. 829, 897 (1974), and is commonly referred to by its original section number, *e.g.*, Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983).

120 The preemption provision took effect on January 1, 1975. 29 U.S.C. § 1144(a); *cf. id.* § 1144(b)(1) (stating that ERISA does not apply retroactively from that date).

121 *See, e.g.*, Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 830 (1988) ("Legislative 'good intentions' do not save a state law within the broad pre-emptive scope of § 514(a).").

The "relates to" provision "may be the most expansive express preemption provision in any federal statute."[122] But ERISA contains a "savings clause," which exempts state regulation of "insurance" from preemption under the statute.[123] States may not, however, "deem[]" an employee benefit plan or trust "to be an insurance company . . . or to be engaged in the business of insurance" in order to regulate it under the savings clause.[124] In the health benefits context, courts have interpreted this to exempt employers' self-funded health plans from state "insurance" laws.[125] The preemption clause, savings clause, and "deemer" clause structure illustrate the whipsaw of ERISA preemption: the broadest preemption statement, followed by a broad exception to that preemption, finished with an exception to the exception, restoring preemption.[126]

The Court's ERISA preemption jurisprudence has, over the past four decades, attempted to navigate a workable course between the "broad scope Congress intended" and the "susceptibility to limitless application" its chosen words engender.[127] The quest for workable standards in light of the clause's "indeterminacy" has resulted in an ERISA preemption doctrine that rejects "uncritical literalism,"[128] but replaces it with a complex analytical framework whose outcomes can be difficult to predict. It is a mess.

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122 *Gobeille*, 136 S. Ct. at 947 (Thomas, J., concurring); *but cf.* Meltzer, *supra* note 110, at 20 (noting that other statutes like the Interstate Commerce Commission Termination Act of 1995 use "related to" preemption language, but that ERISA's is the "most frequently litigated").

123 Nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). This clause preserves states' ability to directly regulate the "business of insurance." *See, e.g.*, Ky. Ass'n of Health Plans v. Miller, 538 U.S. 329, 332, 339, 341-42 (2003) (holding that "any willing provider" laws were not preempted); Pharm. Care Mgmt. Ass'n v. Rowe, 429 F.3d 294, 299-305 (1st Cir. 2005) (holding that pharmacy benefit manager legislation was saved from preemption); *but see* Pharm Care Mgmt. Ass'n v. Gerhart, 852 F.3d 722, 732 (8th Cir. 2017) (holding that ERISA preempted Iowa's regulation of pharmacy benefit managers that provided services to ERISA plans). ERISA also contains a provision that expressly preserves other *federal* laws, stating that they are not preempted if ERISA's application would "alter, amend, modify, invalidate, impair, or supersede" them. 29 U.S.C. § 1144(d); *see Shaw*, 463 U.S. at 91, 101-06 .

124 29 U.S.C. § 1144(b)(2)(B).

125 *See infra* subsection II.A.2.b.

126 *See* Mary Ann Chirba-Martin & Troyen A. Brennan, *The Critical Role of ERISA in State Health Reform*, 13 HEALTH AFF. 142, 144-46 (1994) (explaining the "intricate three-step dance of the 'relate to,' 'savings,' and 'deemer' clauses").

127 *Gobeille*, 136 S. Ct. at 943; *see also id.* at 948 (Thomas, J., concurring) (noting how "uncomfortable" the Court became with the volume of state law preempted by a literal reading).

128 N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655-56 (1995); *see also* Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 336 (1997) (Scalia, J., concurring) (opining that the preemption clause's furthest literal interpretations produce infinite preemption that "no sensible person could have intended").

The Supreme Court has interpreted "relates to" broadly, while crafting limiting principles to deal with the "unhelpful" phrasing,[129] so that not every relationship to employee benefit plans invalidates a state law. Per the Court's interpretation, state laws impermissibly "relate to" employee benefit plans by making "reference to" those plans,[130] by "act[ing] immediately and exclusively upon ERISA plans," or by making "the existence of ERISA plans . . . essential to the law's operation."[131]

State laws also may "relate to" ERISA plans by having too strong a "connection with" them, such as when a state law "governs the payment of benefits, a central matter of plan administration," or "interferes with nationally uniform plan administration,"[132] or indirectly produces "economic effects" which would "force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers."[133] Thus, ERISA would preempt state laws that require employers to offer health benefits or impose requirements on the benefits offered as impermissibly relating to an employee benefit plan.[134] The concept of a forced choice or "Hobson's choice" plays an important role in distinguishing preempted state laws from permitted ones.[135] State laws that nudge too hard may leave employers with only the illusion of choice in whether to offer benefits and what to cover.[136] Those laws are preempted as impermissibly relating to

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129 *See Travelers*, 514 U.S. at 655-56 (calling the preemption language "unhelpful" and rejecting a literal reading of the phrase); *accord* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985) (acknowledging that the preemption provisions read together are "not a model of legislative drafting").

130 *Travelers*, 514 U.S. at 656 (quoting Shaw v. Delta Air Lines, Inc., 463 U.S. 86, 96-97 (1983)).

131 *Dillingham*, 519 U.S. at 325.

132 Egelhoff v. Egelhoff, 532 U.S. 141, 147-48 (2001).

133 *Travelers*, 514 U.S. at 668; *see Gobeille*, 136 S. Ct. at 943 (collecting cases where state laws were preempted on the basis of "impermissible 'connection[s] with' ERISA plans"); *see also Egelhoff*, 532 U.S. at 146-47 (reviewing the Court's previous applications of the "connection with" inquiry); *Shaw*, 463 U.S. at 97-100 (finding that laws effectively requiring employers to "pay employees specific benefits" are preempted).

134 *See, e.g.*, *Travelers*, 514 U.S. at 664 (noting that a "substantive mandate" on health benefits would be preempted); Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255, 292 (1990) (explaining that "state level employer mandates" are preempted).

135 *See, e.g.*, *Travelers,* 514 U.S. at 664 (noting that a state tax so high as to "leave[e] consumers with a Hobson's choice would be treated as imposing a substantive mandate"); Retail Indus. Leaders Ass'n v. Fielder, 435 F. Supp. 2d 481, 497 (D. Md. 2006) (determining that "[t]he 'choice' here is a Hobson's choice" and therefore preempted); *see also* Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 202 (4th Cir. 2007) (Michael, J., dissenting) ("Paying the assessment would . . . not be a financial burden that leaves Wal–Mart with a Hobson's choice, that is, no real choice but to increase health insurance benefits.").

136 *See Travelers*, 514 U.S. at 664.

ERISA plans.[137] But state laws that merely make certain choices more attractive than others may survive;[138] their connection is "too tenuous, remote, or peripheral" for preemption.[139]

Additionally, beyond ERISA's capacious express preemption provisions, the regular doctrine of conflict preemption would invalidate those state efforts that impermissibly conflict with or create obstacles to ERISA rules.[140] Even good arguments for why novel state efforts should slip through are doubtful, due to the breadth of the preemption, courts' singular focus on uniformity, and the statute's unfortunate wording. In the realm of ERISA, courts usually resolve indeterminacy to favor preemption.

In a health reform landscape already fraught with uncertainty and indeterminacy,[141] ERISA has wreaked havoc on state health regulation and reform efforts.[142] The expansive "relates to" provision has preempted everything from direct mandates for employer benefits to statutory rules of general applicability that indirectly burden employers' decisions about their plans and how much those plans will cost. In its most recent ERISA opinion in *Gobeille*, for example, the Supreme Court held that ERISA preempted Vermont's requirement that "all health insurers, health care providers, health care facilities, and governmental agencies" report data on health care costs to

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137 *Retail Indus. Leaders Ass'n*, 475 F.3d at 193-94 ("Because the Fair Share Act effectively mandates that employers structure their employee healthcare plans to provide a certain level of benefits, the Act has an obvious 'conection with' employee benefit plans and so is preempted by ERISA.").

138 See, for example, *Travelers*, 514 U.S. at 664, which upheld a state law against an ERISA preemption challenge on the basis that

> [N]o showing has been made here that the surcharges are so prohibitive as to force all health insurance consumers to contract with the Blues. As they currently stand, the surcharges do not require plans to deal with only one insurer, or to insure against an entire category of illnesses they might otherwise choose to leave without coverage.

139 Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 n.21 (1983).

140 *See* John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank, 510 U.S. 86, 99 (1993) (finding that Congress did not intend to "fundamentally . . . alter traditional preemption analysis" when it wrote ERISA's express preemption language); *see also* Boggs v. Boggs, 520 U.S. 833, 841-44 (1997) (applying conflict preemption to ERISA).

141 *See* McCuskey, *Body of Preemption*, *supra* note 106, at 96-100; *see also* Scott L. Greer & Peter D. Jacobson, *Health Care Reform and Federalism*, 35 J. HEALTH POL. POL'Y & L. 203, 206 (2010) (recognizing "that the distressing litany of historical failure at both the state and federal levels provides no guidance in answering the question of federalism in health care reform").

142 *See, e.g.*, Gregory Acs et al., *Self-Insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums*, 15 HEALTH AFF. 266, 267 (1996) ("ERISA preemption is very controversial."); Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U. L. REV. 433, 465 (2010) (noting that ERISA's provisions "regularly capture[]" the Supreme Court's attention); Bobinski, *supra* note 134, at 278 (explaining that ERISA's "complex and somewhat opaque" preemption provisions have "spawned extensive litigation, as employers and states struggle to define the limits of state power to regulate health insurance").

an "all-payer claims database," even where the plans already collected the data at issue and self-funded plans contracted with an insurance company affiliate to do so.[143]

Yet explicit references to employer plans are not always fatal to state laws,[144] nor are the dividing lines for coercive versus permitted economic effects clearly drawn.[145] State and local health insurance reforms prior to the ACA met a multitude of fates when challenged in court. These reforms include regulations targeting providers (hospitals and doctors), employer contribution provisions (also called pay-or-play laws), and regulation of insurance coverage and administration.[146]

1. Provider Regulation

State regulation of health care providers typically falls outside ERISA's reach, despite substantial indirect economic effects on employee benefit plans. Regulation of provider rates, taxation of health care facilities, medical quality-control regulations, and general health care delivery regulations are not preempted.[147] As with most other applications of ERISA, however, the analysis is not always so straightforward when insurance reimbursement gets involved.

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143 Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936, 941, 947 (2016).

144 *Compare* District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 130 (1992) (holding state law specifically referring to ERISA-regulated employee benefit plans preempted "on that basis alone"), *with* Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 328 (1997) (holding that state law which can function irrespective of ERISA plans does not impermissibly "reference" ERISA plans).

145 State legislative purpose is "relevant only as it may relate to the 'scope of the state law that Congress understood would survive'" preemption or "'the nature of the effect of the state law on ERISA plans.'" *Gobeille*, 136 S. Ct. at 946 (quoting N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995); *Dillingham*, 519 U.S. at 325); *see also* Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 830 (1988) ("Legislative 'good intentions' do not save a state law within the broad pre-emptive scope of" ERISA preemption).

146 *See generally* Chirba-Martin & Brennan, *supra* note 126; Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J.L. MED. & ETHICS 88 (2009). States have endeavored to reform other aspects of their health care systems, especially cost structures, which are not as obviously related to the single-payer insurance reforms discussed here. *See, e.g.*, Pharm. Care Mgmt. Ass'n v. District of Columbia, 613 F.3d 179, 190 (D.C. Cir. 2010) (holding a district law regulating pharmaceutical benefits managers to be partially preempted); Pharm. Care Mgmt. Ass'n v. Rowe, 429 F.3d 294, 301-05 (1st Cir. 2005) (holding that similar legislation was not preempted); *see generally* Erin C. Fuse Brown & Jaime S. King, *ERISA as a Barrier for State Health Care Transparency Efforts*, *in* TRANSPARENCY IN HEALTH & HEALTH CARE IN THE UNITED STATES 301 (Holly Fernandez Lynch et al. eds., 2019).

147 *See, e.g.*, De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 808-09 (1997) (holding that state tax on gross receipts of health care facilities is not preempted by ERISA); *Dillingham*, 519 U.S. at 330-31 (noting that traditional areas of state action such as medical care quality standards and hospital workplace regulations are too remote to affect choices made by ERISA plans); *Travelers*, 514 U.S. at 659-65 (reasoning that surcharges are non-preempted economic influences because they do not require plans to deal with only one insurer).

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, the Supreme Court established both the modern understanding of the "connection with" preemption standard, and the modern analysis of how provider regulation may indirectly impact employer-sponsored health benefits.[148] The New York law challenged in *Travelers* imposed a twenty-four percent surcharge on hospital bills for patients covered by commercial insurance other than Blue Cross or Blue Shield ("Blue plans") to cover the externalized costs—borne by Medicaid, Blue plans, and community hospitals—that enabled commercial insurers and HMOs to charge lower rates and enroll healthier populations.[149] Although the surcharge was based on providers' bills and was collected by the providers, it was designed to impact the cost structure for third-party payers of those bills and in particular to make Blue plans more attractive.[150] Thus, the surcharge had an "indirect economic effect on choices made by insurance buyers, including ERISA plans."[151] *Travelers* held that this indirect economic incentive to buy Blue plans did not trigger ERISA preemption because it did not "bind plan administrators to any particular choice" of plan and did not "force" employers to contract with Blue plans.[152]

Travelers established that general health care regulations' indirect economic influence over employer health insurance choices may survive preemption, but only to a degree. While the twenty-four percent surcharge on hospital services was not "so prohibitive as to force all health insurance consumers to contract with" Blue plans, the Court posed that "there might be a point at which an exorbitant tax leaving consumers with a Hobson's choice would be treated as imposing a substantive mandate" on employers' insurance choices and therefore preempted.[153]

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148 514 U.S. at 651-62; *see also* Amy B. Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 KAN. L. REV. 1203, 1208 (2007). This decision came after multiple states attempted to include employers in health care reform without triggering ERISA preemption.

149 *Travelers*, 514 U.S. at 649-50. The law included an additional assessment on HMOs directly, varying with the number of Medicaid enrollees in the HMO, which was paid by the HMO to the state's general fund. *Id.* at 650. At the time, New Jersey enacted a similar rate-setting statute that had survived preemption analysis in the Third Circuit. *See id.* at 654 (noting the Third Circuit decision and its conflict with the Second Circuit decision below in *Travelers*).

150 *See id.* at 659 (observing that the "surcharges . . . make the Blues more attractive . . . as insurance alternatives"); *see* Monahan, *supra* note 148, at 1208 (finding that state laws with connections to ERISA plans may relate to such plans even if ERISA is not explicitely referenced).

151 *Travelers*, 514 U.S. at 659.

152 *Id.* at 659, 664; *see also id.* at 664 ("[T]he surcharges do not require plans to deal with only one insurer, or to insure against an entire category of illnesses they might otherwise choose to leave without coverage.").

153 *Id.* at 664.

After *Travelers*, analysis of connection between state laws and ERISA plans has focused on the practical degree of choice left to the employer. A state tax on hospital gross receipts, for example, was among the "'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute."[154]

2. Employer Contributions

State and local governments' efforts to nudge employers to contribute to their employees' health care costs have not fared as well as provider regulations under ERISA preemption.[155] Prior to the ACA's federal employer mandate, several state and local governments enacted "fair share"[156] or "pay-or-play" provisions requiring that employers offer a certain level of health benefits (*play*) or pay an assessment to the state for the difference (*pay*).[157] These laws' fates under ERISA preemption thus far have turned on the nature and strength of the *pay* incentives and on employers' political support.[158]

Massachusetts's 2006 comprehensive health reform statute,[159] for example, included a requirement that employers with more than ten employees make "fair and reasonable premium contribution[s]" to employees' health insurance coverage, or else pay an assessment of $295 per employee into a state fund.[160] A few years after Massachusetts enacted its reforms, the Affordable Care Act enacted a federal "pay-or-play" provision modeled on

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154 De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 815 (1997) (citing *Travelers*, 514 U.S., at 668); *see id.* at 815-16 & n.16 (concluding that while the tax would have some influence on the ERISA fund's decision to provide benefits by operating clinics, its influence would not be so strong as to force a particular decision).

155 *See generally* Mary Ann Chirba-Martin, *ERISA Preemption of State "Play or Pay" Mandates: How PPACA Clouds an Already Confusing Picture,* 13 J. HEALTH CARE L. & POL'Y 393, 404-17 (2010) (finding that most state legislative attempts to bypass ERISA by encouraging employers to offer employee health coverage either were voted down in state legislatures or faced continuous § 514 challenges in the courts).

156 *See generally* Julia Contreras & Orly Lobel, *Wal-Martization and the Fair Share Health Care Acts*, 19 ST. THOMAS L. REV. 105 (2006) (evaluating Maryland's Fair Share Health Care Act, which required corporations of a certain size to either fund their own health care program or pay the difference into a state fund, and which was ultimately found to be preempted by ERISA).

157 *See* Monahan, *supra* note 148, at 1205-06 (predicting that a Massachusetts's pay-or-play law, with a relatively weak "pay" provision that would not be viewed as a disguised mandate, would be more likely to survive an ERISA preemption challenge).

158 *Id.* at 1211-20; *see* Chirba-Martin, *supra* note 155, at 408-11 (noting that employers' political support has sustained the Massachusetts health reform law both financially and legally by deterring litigation challenges).

159 Massachusetts Health Care Reform Act of 2006, 2006 Mass. Acts 77.

160 MASS. GEN. LAWS ch. 149, § 188(a), (c)(10) (2009) (repealed 2013). Employers who do not arrange pre-tax payroll deductions for their employees' health benefits face an additional assessment if their employees use the state-funded Health Safety Net program. *Id.* ch. 149, § 188(c)(10).

the Massachusetts statute,[161] now colloquially referred to as the "employer mandate."[162] The Massachusetts employer mandate "[s]omewhat surprisingly" went unchallenged under ERISA,[163] perhaps because the health reform bill enjoyed widespread political support from employers.[164]

Elsewhere, employer trade groups have readily challenged pay-or-play legislation in court, leading to divergent approaches in the federal circuit courts starting in 2007.

Maryland's Fair Share Health Care Act,[165] aimed at Walmart,[166] 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.[167] Walmart's trade association sued.

The Fourth Circuit in *Retail Industry Leaders Association v. Fielder* held that ERISA preempted Maryland's pay-or-play law.[168] The *Fielder* majority concentrated on the extent to which Maryland's law impacted Walmart's ability to uniformly administer its benefits nationwide.[169] *Fielder* framed the inquiry in terms of choice: A state law that "directly regulates or effectively mandates some element" of employer plans is preempted, while a law that "creates only indirect economic incentives that affect but do not bind the

161 *Massachusetts Health Care Reform: Six Years Later*, at 1, HENRY J. KAISER FAM. FOUND. (May 1, 2012), https://www.kff.org/health-costs/issue-brief/massachusetts-health-care-reform-six-years-later [https://perma.cc/HTX2-MZHL].

162 *See, e.g.*, *Employer Shared Responsibility Provisions*, INTERNAL REVENUE SERV., https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions [https://perma.cc/KCA6-XD3E] ("The employer shared responsibility provisions are sometimes referred to as 'the employer mandate' or 'the pay or play provisions.'").

163 Jacobson, *supra* note 146, at 93-94. There exists ample speculation, however, about how such a challenge would be resolved, if litigated. *See, e.g.*, Chirba-Martin, *supra* note 155, at 410-11 (arguing that the law is vulnerable to ERISA preemption because it explicitly targets almost all employers and requires some level of health benefit payment, causing it to resemble an "effective mandate"); Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption and Experimentation*, 49 WM. & MARY L. REV. 229, 232 (2007) (reaching the "regrettable conclusion" that ERISA preempts the Massachusetts law).

164 *See* Chirba-Martin, *supra* note 155, at 410. Vermont enacted a provision similar to the Massachusetts employer mandate in 2006 and similarly met no litigation challenges. *Id.* at 412.

165 *See* MD. CODE ANN., HEALTH-GEN. § 15-142 (West 2019).

166 *See* Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 198 (4th Cir. 2007) (Michael, J., dissenting) ("Maryland enacted the Fair Share Health Care Fund Act . . . in 2006 to require very large employers, such as Wal–Mart Stores, Inc., to assume greater responsibility for employee health insurance costs that are now shunted to Medicaid."). Suffolk County, New York enacted a similar "Wal-Mart law." *See* Jacobson, *supra* note 146, at 94 (explaining that Suffolk County's provision applied only to non-unionized retailers).

167 Contreras & Lobel, *supra* note 156, at 105-06; *see* MD. CODE ANN., HEALTH–GEN. § 15-142(d), (f), (g) (2019); MD. CODE ANN., LAB. & EMPL. §§ 8.5-102–8.5-106 (2019).

168 475 F.3d 180, 183 (4th Cir. 2007).

169 *Id.* at 183, 194-95, 198.

choices of employers" is not.[170] Maryland's law gave Walmart the choice of offering eight percent of its payroll in health benefits to its employees or paying that amount into the state Medicaid fund.[171]

The Fourth Circuit found that "playing" by increasing benefits was, "[i]n effect, the only rational choice."[172] Offering the required level of health benefits would make Walmart a more attractive employer and help it recruit and retain employees,[173] but "paying" that money to the state instead would not produce any benefit for Walmart, and might actually harm its employee morale and public reputation.[174] Because the "pay" option was so undesirable for the employer, the Fourth Circuit held that the Act "effectively mandates that employers structure their employee healthcare plans to provide a certain level of benefits," and therefore formed an impermissible "connection with" ERISA plans.[175]

The Maryland Act "directly" targeted an employer, and nudged too hard on Walmart's benefits decisions by failing to offer "meaningful alternatives" for compliance.[176] Further, the majority in *Fielder* expressed concern that permitting Maryland to enforce its law would invite other states to regulate similarly and "force Wal-Mart . . . to monitor these varying laws and manipulate its healthcare spending to comply with them."[177]

State pay-or-play laws now must navigate around *Fielder* to survive preemption challenge. Shortly after *Fielder* in 2007, a New York district court held that although its decision was "not bound by the decision of the Fourth Circuit in *Fielder*," a county-level play-or-pay regulation targeting Walmart was "substantially similar to the Maryland Act" and the court therefore held it to be preempted.[178] But in 2008, San Francisco's Health Care Security

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170 *Id.* at 192-93.

171 *Id.* at 193.

172 *Id.*

173 *Id.*

174 *Id.*

175 *Id.* at 193-94; *see also id.* at 193 ("The Act thus falls squarely under *Shaw's* prohibition of state mandates on how employers structure their ERISA plans." (citing *Shaw*, 463 U.S. at 96-97)); *but see id.* at 201-02 (Michael, J., dissenting) ("The Act expresses no preference for one method . . . or the other . . . . The Act does not compel an employer to establish or maintain an ERISA plan . . . . The Act does not impede an employer's ability to administer its ERISA plans under nationally uniform provisions . . . . The Act does not mandate a certain level of ERISA benefits.").

176 *Id.* at 196-97; *see* Retail Indus. Leaders Ass'n v. Suffolk Cty., 497 F. Supp. 2d 403, 417 (E.D.N.Y. 2007) ("Although the Act provides employers with various alternative options to comply . . . , 'the only rational choice employers have under [the Act] is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold.'" (quoting *Fielder*, 475 F.3d at 193)); *but see Fielder*, 475 F.3d. at 202 (Michael, J., dissenting) (concluding that the "choice is real" under the Maryland statute because the "pay" amount is not "exorbitant").

177 *Fielder*, 475 F.3d at 197.

178 *See, e.g.*, *Suffolk Cty.*, 497 F. Supp. 2d at 416.

Ordinance successfully avoided preemption before the Ninth Circuit in *Golden Gate Restaurant Ass'n v. City and County of San Francisco*.[179]

San Francisco's 2006 version of pay-or-play survived largely due to its inclusion of the "meaningful alternatives" missing in *Fielder*.[180] If *Fielder* represents the preempted Hobson's choice or forced choice for employer contributions, *Golden Gate* represents the non-preempted "meaningful" or true choice.

The San Francisco Health Care Security Ordinance established a city-run health care program for low-to-moderate income residents.[181] To help capture and maintain employer health care contributions in funding the program, the ordinance requires that employers make "required health care expenditures" to or on behalf of employees at regular intervals.[182] The ordinance set the "health care expenditure rate"[183] based on the number of hours worked, but left up to the employers what type of expenditures to make.[184] Employers had "discretion" in choosing among all possible commercial and private options.[185] Employers also could choose a mix of different expenditures, as long as they met the required rate in total spend.[186]

The Ninth Circuit observed that the ordinance did not force "creation" of ERISA plans, require employers to start offering health plans or change any existing health plans, or demand they provide specific benefits in any particular way.[187] Rather, the ordinance prescribed only the dollar amount employers must spend and did not scrutinize much about *how* they spend the money or the "benefits derived from those dollars."[188] Combining a required expenditure rate with such broad discretion in how to spend it constituted an "even less direct . . . influence" on employer benefit decision than the one the Supreme Court upheld in *Travelers*.[189]

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179 546 F.3d 639, 642 (9th Cir. 2008).

180 *Id.* at 660 ("In stark contrast to the Maryland law in *Fielder*, the City-payment option under the San Francisco Ordinance offers employers a meaningful alternative that allows them to preserve the existing structure of their ERISA plans.").

181 S.F., Cal., Ordinance 218-06 (Aug. 5, 2006) (adding Chapter 14, §§ 14.1-14.8 to the San Francisco Administrative Code).

182 S.F., CAL., ADMIN. CODE § 14.3(a) (2019) (capitalization altered); *see Golden Gate*, 546 F.3d at 642-43.

183 S.F., CAL., ADMIN. CODE § 14.1(b)(6).

184 *Golden Gate*, 546 F.3d at 644 (quoting City & County of S.F., Office of Labor Standards Enf't, Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance (ESR), Reg. 4.1(A)) (quotation marks omitted).

185 *Id.* at 644-45 (citing S.F., CAL., ADMIN. CODE § 14.1(b)(7); ESR Reg. 4.2(A)).

186 *Id.* at 645-46.

187 *Id.* at 646-47, 649-52.

188 *Id.* at 647.

189 *Id.* at 656 (citing N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 658-59 (1995)).

The nature of the choices facing San Francisco employers distinguished the ordinance from Maryland's preempted law. The two laws differed little in the ultimate expenditure they required from employers, with Maryland's calculated as a percentage of payroll and San Francisco's calculated as a flat dollar amount per hour worked. The Maryland law, however, offered nothing new for the employer who chose the "pay" option, effectively rendering it a penalty for not offering suitable health insurance benefits.[190] By contrast, the ordinance establishing San Francisco's city-run benefits program "offer[ed] employers a meaningful alternative" to an ERISA plan and "provide[d] tangible benefits to employees when their employers [chose] to pay the City."[191] Employers who already offered health care benefits could keep their ERISA plans, and employers who did not could simply pay the tax and their employees could rely on the city program.[192] Employers who relied on the city program would have a way to keep their employees healthy without the burden and complexity of selecting and administering their own ERISA plans.

Pay-or-play laws thus survive or fail ERISA preemption based on the nature of the employer choices they establish and courts' characterizations of them.[193] Two years after the *Golden Gate* opinion, Congress enacted a federal-level employer mandate in the Affordable Care Act, likely obviating the urgency for many more states to pursue pay-or-play regulations.[194] Massachusetts repealed its state employer mandate during the initial years of Affordable Care Act implementation.[195] Some cities and counties, meanwhile, have continued to pursue expanded health care programs with some pay-or-play features, likely designed with the *Fielder–Golden Gate* split in mind. For example, in 2016, the City of Seattle enacted a *Golden Gate*-style ordinance aimed at employer health care contributions for hotel workers.[196] The ERISA Industry Committee has sued the City, relying on *Fielder* to argue that ERISA preempts the ordinance; the litigation remains ongoing.[197] Massachusetts revived its pay-or-play mandate in 2018, suggesting that the

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190 *Id.* at 659-60.

191 *Id.* at 660.

192 *Id.*

193 *See* Monahan, *supra* note 148, at 1205-06.

194 *See* Wiley, *supra* note 8, at 859 ("The [pay-or-play preemption] issue became moot when the ACA federalized the employer mandate, so the question remains unresolved.").

195 Benjamin D. Sommers, Mark Shepard & Katherine Hempstead, *Why Did Employer Coverage Fall in Massachusetts After the ACA? Potential Consequences of a Changing Employer Mandate*, 37 HEALTH AFF. 1144, 1145 (2018).

196 Carmen Castro-Pagan, *Seattle Faces Legal Test Over Hotel Worker Insurance Mandate*, BLOOMBERG LAW (Aug. 14, 2018), https://news.bloomberglaw.com/employee-benefits/seattle-faces-legal-test-over-hotel-worker-insurance-mandate [https://perma.cc/KKN8-9MD7].

197 *Id.*; *see also, e.g.*, ERISA Indus. Comm. v. City of Seattle, No. 2:18-cv-01188, 2018 WL 4237773 (W.D. Wash. Sept. 6, 2018).

preemption of pay-or-play provisions remains a relevant concern despite the ACA's federal employer mandate.[198]

The Supreme Court has not considered ERISA preemption in the pay-or-play context, and litigation outcomes remain unpredictable when navigating the distinctions between the diverging circuit court opinions in *Fielder* and *Golden Gate*.[199] The pair of cases has reverberated beyond the Fourth and Ninth Circuits. Other courts rely on *Fielder* and *Golden Gate* in a variety of ERISA contexts as exemplars of preempted and permitted employer incentives impacts, respectively.[200]

3. Insurance Regulation Versus Self-Funded Plans

ERISA's express preemption provision contains an exception: a "savings" clause that saves from preemption state laws that regulate insurance.[201] However, the savings clause contains an exception-to-the-exception, the "deemer" clause, which has been interpreted to exempt self-funded employer plans from the state insurance regulations saved by the savings clause.[202] The upshot of the convoluted interplay between ERISA's savings and deemer clauses is that states may regulate so-called "fully insured" employee health plans, but self-funded plans are completely beyond the reach of state law.

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198 Katie Lannan, *Mass. Employers Face New Health Care Assessments in 2018*, WBUR: COMMONHEALTH (Dec. 29, 2017), https://www.wbur.org/commonhealth/2017/12/29/mass-employers-face-new-health-care-assessments-in-2018 [https://perma.cc/P522-UT3J].

199 *See, e.g.*, Golden Gate Restaurant Ass'n v. City & Cty. of S.F., 558 F.3d 1000, 1004 (9th Cir. 2009) (Smith, J., dissenting from denial of rehearing en banc) ("Our decision in this case creates a circuit split . . . , renders meaningless the test the Supreme Court set out in *Shaw* . . ., conflicts with other Supreme Court cases . . ., and, most importantly, flouts the mandate of national uniformity in the area of employer-provided healthcare that underlies the enactment of ERISA."); *id.* at 1001 (Fletcher, J., concurring in denial of rehearing en banc); Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 203 (4th Cir. 2007) (Michael, J., dissenting) (lamenting the inconsistency of ERISA preemption holdings); *see also* Chirba-Martin, *supra* note 155, at 411 (observing "the unfortunate reality that when it comes to ERISA preemption litigation, anything can happen"); Catherine L. Fisk & Michael M. Oswalt, *Preemption and Civic Democracy in the Battle over Wal–Mart,* 92 MINN. L. REV. 1502, 1514–20 (2008) (arguing that the Fourth Circuit's majority analysis in *Fielder* is inconsistent with recent Supreme Court holdings in other ERISA preemption cases); Jacobson, *supra* note 146, at 95 (observing that "[a]s with the courts, health law commentators are split on whether pay-or-play laws are likely to survive an ERISA preemption challenge" before the Supreme Court).

200 *See, e.g.*, Self-Ins. Inst. of Am., Inc. v. Snyder, 761 F.3d 631, 636 n.1 (6th Cir. 2014) (emphasizing that the state law in question was permissible because, unlike the law at issue in *Fielder*, it did not "force a plan to provide a certain level of benefits"), *vacated,* 136 S. Ct. 1355 (2016), *aff'd*, 827 F.3d 549 (6th Cir. 2016).

201 29 U.S.C. § 1144(b)(2)(A) (2018).

202 29 U.S.C. § 1144(b)(2)(B); *see* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985) (explaining that the recognition of "a distinction between insured and uninsured plans . . . merely give[s] life to a distinction created by Congress in the 'deemer clause'").

ERISA's savings clause preserves significant spheres of state regulatory authority over health insurance. The statute does not define "insurance,"[203] but under current ERISA precedent, it saves state laws that are "specifically directed toward entities engaged in insurance" and that "substantially affect the risk pooling arrangement between the insurer and the insured."[204]

Thus, employers who provide health benefits by buying insurance policies for their employees must abide by state health insurance regulations that govern those policies. This method of providing employee health benefits is known as a "fully-insured" plan because the employer purchases insurance policies for its employees from an insurance company, who takes on the contracted risks in exchange for premiums.[205] For these fully insured plans, states retain broad authority to regulate. For example, state insurance rules prohibiting subrogation by health insurance plans affect employer plans' calculation of benefits but nonetheless avoid preemption under the savings clause.[206] States also can regulate the insurance policies available for purchase by employers. States may require that insurers cover certain services,[207] set rules for underwriting and administration[208] (such as mandatory open enrollment, community rating, and risk-pooling[209]), and require that insurers accept all providers willing to meet the plan's terms ("any willing provider" laws).[210]

Many employers, particularly larger employers, now offer health benefits a different way: they agree to pay for some portion of their employees' health care needs directly from an employer fund, instead of purchasing insurance

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203 *Compare* 29 U.S.C. § 1144(b)(2)(A) ("[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance."), *with id.* § 1002 (definitions section for Title 29 with no entry defining "insurance").

204 Ky. Ass'n of Health Plans v. Miller, 538 U.S. 329, 341-42 (2003).

205 *E.g.*, CLAXTON ET AL., *supra* note 54, at 175.

206 *See* FMC Corp. v. Holliday, 498 U.S. 52, 59-61 (1990).

207 *See* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 731, 746-47 (1985) (holding that states may require specified mental-health-care benefits be provided to residents in certain employee health care plans).

208 *See, e.g.*, Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 359, 370-87 (2002) (holding state law requiring external appeals process for benefit disputes was enforceable against HMO providing employer-sponsored coverage).

209 *See, e.g.*, Safeco Life Ins. Co. v. Musser, 65 F.3d 647, 648 (7th Cir. 1995) (holding that Wisconsin high-risk pool regulations were not preempted by ERISA); NYS Health Maintenance Org. Conference v. Curiale, 64 F.3d 794, 803 (2d Cir. 1995) (holding that New York's community rating and open enrollment regulations were not preempted because their only connection to employer plans was an "indirect effect on rate diversification among insurers").

210 *See* Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 337-39 (2003) (upholding state "any willing provider" law as within the "business of insurance" under ERISA); *cf.* Pharm. Care Mgmt. Ass'n v. Tufte, 297 F. Supp. 3d 964, 982 (D.N.D. 2017) (holding that ERISA does not preempt state regulation of pharmacy benefit managers—insurance intermediaries engaged in the "business of insurance"); *but cf.* Pharm. Care Mgmt. Ass'n v. Gerhart, 852 F.3d 722 (8th Cir. 2017) (holding an Iowa law regulating pharmacy benefit managers to be preempted by ERISA).

policies for them.[211] This form of employer-sponsored health benefit is known as "self-funded"[212] or "self-insured,"[213] with the "self" referring to the employer. In 2018, sixty-one percent of Americans with employer-sponsored health care coverage were covered by self-funded plans.[214] By contrast, in the 1970s when ERISA was passed, only seven percent of those with employer-sponsored health coverage were in self-funded plans.[215] Although the deemer clause does not mention self-funded plans, the Supreme Court has held that the self-funding mechanism does not sufficiently replicate the "business of insurance" for the purpose of regulation, and thus states may not "deem" self-funded plans to be providing insurance for the purpose of regulating them.[216]

This interpretation of ERISA's savings and deemer clauses means states may enforce their insurance regulations against fully insured, but not self-funded, employer-sponsored health plans.[217] In essence, ERISA preemption catalyzed the growth of self-funded plans by opening a loophole through which employers could provide their employees with health benefits and avoid state insurance regulation.[218] Further, courts have allowed employer plans to be "self-insured in name only, with the [employer] bearing minimal risk and most of the risk borne by the insurer" providing stop-loss coverage to the employer.[219]

ERISA's savings clause thus allows states to regulate forty percent of the employer-sponsored insurance market that is fully insured, but the deemer

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211 *Self-Insured Group Health Plans*, SELF-INS. INST. OF AM., INC., https://www.siia.org/i4a/pages/index.cfm?pageID=4546 [https://perma.cc/96RL-XQCY] (last visited Oct. 19, 2019).

212 CLAXTON ET AL., *supra* note 54, at 167. Employers often safeguard their funds by purchasing "stop loss" insurance, to protect them if their employees' health care claims exceed the fund amount. *See id.*

213 *See* Timothy Stoltzfus Jost & Mark A. Hall, *Self-Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options*, 68 N.Y.U. ANN. SURV. AM. L. 539, 554-55 (2013) (noting that no definition of "self-insured" was included in ERISA, but tracing definitions through the Internal Revenue Code and Affordable Care Act).

214 CLAXTON ET AL., *supra* note 54, at 167.

215 Borzi, *supra* note 23, at 661.

216 *See* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985) (holding that self-insured plans are exempt from state insurance regulation under the "deemer" clause).

217 *See* FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990) (reading the deemer clause "to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause," and thus finding preempted a state antisubrogation law as it applied to self-funded plans).

218 *See* Chirba-Martin & Brennan, *supra* note 126, at 146 (characterizing this loophole as "creat[ing] an almost irresistible incentive to employers to self-fund"); Jost & Hall, *supra* note 213, at 552-54 (providing an overview of the relationship between ERISA and self-insured plans); *cf.* Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another"*, 5 YALE J. HEALTH POL'Y L. & ETHICS 90 (2005) (proposing that regulators use a different "loophole" in the savings clause to "reduce the desirability to employers of exploiting the deemer clause loophole"). *But see FMC Corp.*, 498 U.S. at 68 (Stevens, J., dissenting) (noting that "[t]he number of self-insured employee benefit plans grew dramatically in the 1960's and early 1970's.").

219 Jost & Hall, *supra* note 213, at 554.

clause preempts the same state regulation as applied to the remaining sixty percent of employer self-funded plans.[220] The diminishing practical distinction between fully insured and self-insured plans strains credulity.[221] Yet this technical distinction triggers ERISA preemption for self-funded plans and thereby frustrates state efforts to enact uniform health care reforms,[222] as self-funded plans have swallowed the savings clause.

ERISA thus painfully illustrates how indeterminate an express preemption provision can be, spawning a dense, shifting body of precedent with relatively little predictive value.

B. *State Single-Payer Plans Under ERISA*

The intricate threat of ERISA preemption appears to have informed state legislative drafting in the most recent waves of single-payer legislation.[223] Many provisions in the single-payer plans outlined in Part I fall well beyond ERISA's preemptive reach because they address the state's operation of its own plan and do not "relate to" employer-sponsored health plans, including the resident eligibility, cost-sharing, comprehensive coverage, and care coordination provisions.[224] Similarly, the provider eligibility and rate-setting provisions, as well as rate setting for medical goods like prescription drugs, target core features of the health care market without regard to employer plans, and with permissibly tangential effects on them.[225] They have strong

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220 *See* Korobkin, *supra* note 218, at 136.

221 *See FMC Corp.*, 498 U.S. at 65 (Stevens, J., dissenting) ("The Court's construction of the statute draws a broad and illogical distinction between benefit plans that are funded by the employer (self-insured plans) and those that are insured by regulated insurance companies (insured plans).").

222 *See, e.g.*, Bobinski, *supra* note 134, at 294 ("[W]hile ERISA itself does not require that employers establish employee health insurance plans, it does effectively preclude state statutes that would mandate such plans."); *see also* Acs et al., *supra* note 142, at 267 (observing that ERISA "limits many of the health care financing and cost containment initiatives that states have considered," and that "[b]ecause self-insured plans do not have to comply with state-mandated benefits, ERISA prevents states from legislating a minimum benefit package for all of their residents").

223 As detailed in Part I, *supra*, state single-payer plans establish broad eligibility and coverage rules, then employ one or more types of provisions to fund the plans and draw enrollees from private coverage into the plan. These provisions typically involve payroll and income taxes (Type A–Funding Plans), restrictions on provider reimbursement outside the state plan (Type B–Provider Restrictions), and some means of recouping state-plan payments for those who continue to maintain employer coverage (Type C–Assignment/Subrogation/Secondary-Payer). *See supra* Table 1.

224 *See supra* Section I.A (listing examples of these common provisions); *cf.* Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 359, 370-87 (2002) (holding state law dictating plan administration was enforceable against HMO providing employer-sponsored coverage); Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 727, 758 (1985) (holding state-mandated coverage of particular services, as applied to employer plans, not preempted as regulating insurance).

225 *See supra* Section I.A (providing examples).

foundations in Supreme Court precedent[226] and should easily survive litigation challenging them.

The crucial provisions for capturing employer health care spending and moving employees onto the state single-payer plan, however, face a difficult path through the ERISA preemption labyrinth. As the analysis below concludes, the Type A, B, and C provisions *should* survive preemption under current ERISA doctrine and precedent. Yet the opaque nature of ERISA doctrine, courts' unpredictable application of it, and employer trade associations' propensity to sue also mean that litigation is virtually guaranteed, while the result in any particular litigation is not.

1. Type A—Funding Plans

State individual income taxes, meant to capture employees' contributions to premiums and cost-sharing, do not trigger ERISA preemption because they do not target or impact employers. Employer payroll taxes also *should* easily survive preemption under *Travelers*. Payroll taxes keyed to employers' health care expenditures, however, may need to navigate through the impenetrable hash of appellate precedent on pay-or-play laws, which obscures prediction.

Although states enjoy fairly wide latitude on how they raise revenues, Type A's payroll taxes ultimately could influence employers' benefit decisions and therefore may run afoul of ERISA preemption. Assessments targeting particular employers and offering the employer nothing in return, as in *Fielder*,[227] and/or setting the tax rate exorbitantly high[228] may exert a preempted level of influence on the employer's benefit plan decisions. On the other hand, laws that preserve discretion for employers on how to meet a required health care expenditure rate and that offer tangible options for employers that choose to pay instead of play, as in *Golden Gate*, create the kind of "legitimate alternative[s]" that survive preemption.[229]

The payroll taxes in Funding Plans have several structural advantages over the pay-or-play assessments in *Fielder* and *Golden Gate*. First, payroll tax provisions do not depend on the existence or amount of employers' health benefits and need not make any mention of them. Payroll taxes are calculated

226 *E.g.*, Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 337-39 (2003); De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 808-10, 816 (1997); Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 329-30 (1997); N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 659-65 (1995).

227 *See* Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 196 (4th Cir. 2007).

228 *See Travelers*, 514 U.S. at 664 (speculating that "an exorbitant tax" might leave employers "with a Hobson's choice," but holding that the tax at issue was not exorbitant).

229 *See* Golden Gate Restaurant Ass'n v. City & Cty. of San Francisco, 546 F.3d 639, 660-61 (9th Cir. 2008).

as a percentage of the wages paid to employees.[230] The lack of an explicit reference to employer plans, and the fact that the tax is assessed without regard to existing ERISA plans or plan choices helps legislation of Type A pass through ERISA preemption's first "relates to" hurdle.[231]

Second, a payroll tax is far less likely than a pay-or-play assessment to have an impermissible "connection" to ERISA plans via its indirect economic effects on employers' decisions whether to offer health benefits.[232] In *Travelers*, the Supreme Court posited that ERISA would preempt a hypothetical state law that did not directly regulate ERISA plans, but still "produce[d] such acute, albeit indirect, economic effects . . . as to force an ERISA plan['s]" choice of substantive coverage or source of insurance.[233] This hypothesis may guide states' calculation of the amount of a payroll tax: Set the payroll tax too low, and employers may still want to provide health benefits to attract employees. This could preserve a "meaningful choice" for employers, as in *Golden Gate*, but may compete with the state's plan and erode the goals of a single-payer system.[234] A higher payroll tax should make it less rational for an employer to continue to offer its own health benefits and pay the tax, though still should not run afoul of ERISA preemption by its indirect economic effects. At some point, a payroll tax could become so "exorbitant" as to leave only a "Hobson's choice," but the Supreme Court has yet to define that point and the state single-payer laws surveyed here do not appear to approach it.[235]

For courts still tempted to find preemption of the indirect incentives of a payroll tax, Type A's establishment of a state health insurance program should help such taxes survive preemption under the reasoning of *Golden Gate* and *Fielder*. While Maryland's pay-or-play law created only one "rational" choice for employers because the "pay" option still left their employees without insurance,[236] the establishment of a public insurance program in

230 *See* Brittain, *supra* note 61, at 110.

231 *See Dillingham*, 519 U.S. at 325 (warning that laws may "relate to" ERISA plans if they "act[] immediately and exclusively upon ERISA plans" or if "the existence of ERISA plans is essential to the law's operation."); *Travelers*, 514 U.S. at 656 (using "reference to" as one definition of "relates to" (quoting Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983)).

232 Egelhoff v. Egelhoff, 532 U.S. 141, 146-48 (2001); *Travelers*, 514 U.S. at 668.

233 *Travelers*, 514 U.S. at 668. The Supreme Court in *Travelers* speculated that an "exorbitant" tax would force a Hobson's choice, but upheld a less-than-exorbitant one. *Id.* at 664.

234 Payroll taxes are all *pay*—the choice is either *pay* or *pay-and-play*. The employer pays the state fund either way.

235 *See Travelers*, 514 U.S. at 650, 664 (upholding a state surcharge of up to twenty-four percent on commercial insurance claims paid to hospitals).

236 Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 193 (4th Cir. 2007). The Fourth Circuit apparently ignored the fact that many Walmart employees would be eligible for Medicaid.

Golden Gate created the "meaningful alternative" essential to the pay-or-play law's survival.[237]

The Type A payroll tax has a third advantage over pay-or-play laws, which is that it is not tied to any particular benefit levels or coverage decisions by employers.[238] Circuit courts have upheld taxes of general applicability with indirect impacts on employer choices.[239] And the ordinance in *Golden Gate* dictated that employers spend a certain *amount* on employee health care, allowed them to satisfy their expenditure by offering benefits, and gave them wide discretion about how to do so if they chose. The Type A payroll tax does even less nudging than the *Golden Gate* ordinance because it does not dictate that employers spend funds on employees at all. The payroll tax would thus have little or no impact on decisions about covered services, funding levels, or plan administration.

Last, the payroll tax enjoys some advantage because it does not impose additional administrative or compliance burdens on employers or their ERISA plans. Instead, it might actually relieve some existing burdens. If an employer chooses to offer benefits and pay the tax, its benefits plan would not be subject to any additional compliance requirements in the single-payer state. If an employer chooses to pay the tax and drop coverage, it sheds some existing compliance burdens under both ERISA and state laws. Reliance on a state program in one state creates "disuniformity" for multistate employers' benefit plans, but does so in a way that would ease the employers' burdens in the single-payer state, furthering a "primary objective" of ERISA to minimize administrative burden.[240] Concerns for nationwide uniformity and multistate

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237 Golden Gate Restaurant Ass'n v. City & Cty. of San Francisco, 546 F.3d 639, 660-61 (9th Cir. 2008).

238 State taxes specifically targeting employee benefit plans or based on the value of benefits provided by a plan have been invalidated. *See* Birdsong v. Olson, 708 F. Supp. 792, 798-99 (W.D. Tex. 1989) (determining that a state tax on the insurance company administrative fees for ERISA plans was preempted); National Carriers' Conference Comm. v. Heffernan, 454 F. Supp. 914, 915, 918 (D. Conn. 1978) (finding that ERISA preempted state law imposing tax on employers maintaining employee benefit plans, based on the amount of benefits the employers paid annually). *But see* Gen. Motors Corp. v. Cal. State Bd. of Equalization, 815 F.2d 1305, 1309-10 (9th Cir. 1987) (holding a premium tax on insurance companies, which included ERISA plans, not preempted under the savings clause).

239 *E.g.*, Self-Ins. Inst. of Am., Inc. v. Snyder, 827 F.3d 549, 553, 557-558 (6th Cir. 2016) (holding that Michigan's one–percent tax on all "paid claims" by "carriers" or "third party administrators" for services rendered was not preempted because the tax "does not directly regulate any integral aspects of ERISA.").

240 *See Fielder*, 475 F.3d at 191 (describing uniformity and minimizing administrative burden as ERISA's "primary objective[s]"); *see also* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985) (explaining that ERISA's savings clause inevitably embraces state-by-state "disuniformities"); *cf.* FMC Corp. v. Holliday, 498 U.S. 52, 60 (1990) ("To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits.").

compliance burdens helped doom the pay-or-play law in *Fielder*, the antisubrogation laws in *FMC Corp.*, and the all-payer claims database in *Gobeille*, while *Golden Gate* found that some light recordkeeping and reporting did not rise to the level of concern.[241]

As the Supreme Court has recognized, "[a]ny state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute."[242] Despite strong arguments that a general payroll tax preserves employer discretion and decreases the burdens of providing benefits, its underlying intent to nudge employers to drop coverage in favor of the state's single-payer plan means that states should expect litigation challenges. The actual outcome of those challenges, especially in circuits other than the Fourth and Ninth,[243] remains difficult to predict.

2. Type B—Provider Restriction

State laws that channel all payments to providers through the single-payer entity likewise should survive preemption, though their operation still raises some ERISA preemption concerns. Type B legislation restricts providers from accepting payment from any third parties other than the state program.[244] These provider restrictions avoid explicit "reference to" employer insurance[245] and by targeting providers, rather than employers, situate themselves in the realm of provider regulation that typically avoids ERISA preemption.[246]

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241 *See Golden Gate*, 546 F.3d at 645, 657 (noting that employers providing self-funded health plans could use an average expenditure rate and not track actual per-employee spending, and that the ordinance's recordkeeping and inspection requirements did not create conflicting directives that would burden employers or their plans because those recordkeeping requirements exist regardless of the ordinance). *But see* Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936, 943-45 (2016) (holding claims data reporting requirements preempted even though self-funded plan administrators already collected the required data).

242 De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 816 (1997).

243 And probably the Sixth, too. *See Self-Ins. Inst.*, 827 F.3d at 553-54 (affirming, after a remand for reconsideration in light of *Gobeille*, the dismissal of a challenge to Michigan's payroll tax and the associated reporting requirements).

244 *See supra* subsection I.B.2. The Type B proposals commonly contain an exception for federal programs that lack an approved waiver.

245 *See* N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995) (explaining that a "reference to" an ERISA plan can constitute an impermissible "relat[ion] to" ERISA (quoting Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983) (quotation marks omitted))).

246 *See, e.g.*, *De Buono*, 520 U.S. at 813-16; Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 329 (1997); *Travelers*, 514 U.S. at 658-64; *cf.* Mass. Med. Soc'y v. Dukakis, 815 F.2d 790, 790–92 (1st Cir. 1987) (holding that the Medicare Act did not preempt a state law prohibiting balance billing because provider regulation is traditionally a state concern).

A provider restriction would, by design, have an indirect influence on ERISA plans because those plans would no longer be able to find a network of providers who could accept their reimbursement. Whether this influence crosses the preemptive coercion line from *Travelers* and *De Buono*[247] will determine the preemption question. Prohibiting providers from accepting reimbursement from commercial payers, including employer plans, should effectively force employers to drop coverage,[248] or at least to make major modifications in how they administer their plans.[249] The shift wrought by the provider restriction could invite litigation based on the murky precedent on what constitutes an impermissible "connection with" ERISA plans. The most logical reading of provider restrictions, however, is that they avoid ERISA preemption by targeting providers.

3. Type C—Assignment, Subrogation, Secondary-Payer

The addition of a subrogation, assignment, or secondary-payer provision, typically included in Type C legislation, mitigates the state law's coercive impact by giving the employer plan a way to exist, funneling the plan's reimbursements through the state single-payer entity. Although mostly similar in function, subrogation may prove slightly more suspect than assignment or secondary-payer provisions due to some tricky precedent.[250]

None of the Type C provisions changes the amount the employer plan will spend on claims—by design, they maintain employer plans' existing calculation of benefits.[251] Secondary-payer provisions also do not alter the process of payment, while subrogation and assignment provisions merely redirect the existing payments from providers to the state single-payer entity. Type C provisions thus minimize the impact on claims payment, though they

247 *See, e.g.*, *Travelers*, 514 U.S. at 658-64; *De Buono*, 520 U.S. at 813-16.

248 *See Travelers*, 514 U.S. at 668.

249 *See* Egelhoff v. Egelhoff, 532 U.S. 141, 148 (2001) (holding that ERISA preempts state laws that "govern[] . . . a central matter of plan administration" or "interfere[] with nationally uniform plan administration").

250 *See id.* at 147 (holding that the "payment of benefits [is] a central matter of plan administration" and a state law requiring plan administrators to go beyond the plan documents to determine beneficiaries is a preempted burden); FMC Corp. v. Holliday, 498 U.S. 52, 60-61 (1990) (holding that a state law prohibiting insurer subrogation from a tort claimant's recovery was "related to" employer plans because it would interfere with the plan's usual financial calculations in that state and "frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide," and holding further that ERISA's savings clause saved the state antisubrogation law only with respect to fully insured plans because it "directly control[led] the terms of insurance contracts").

251 *See, e.g.*, *FMC Corp.*, 498 U.S. at 61.

pose some preemption risk because claim payment is a sacred and "central matter of plan administration."[252]

In *Egelhoff*, for example, the Supreme Court held that ERISA preempted a state probate statute automatically assigning a beneficiary after divorce because the law created too much of an administrative burden on multistate employers.[253] The majority in *Egelhoff* was particularly concerned that because of the state law, "[p]lan administrators cannot make payments simply by" reading the plan documents, but rather had to "familiarize themselves with state statutes" to determine whether state law had "revoked" the status of the plan's named beneficiary.[254]

The secondary-payer provisions in Type C preserve the status quo of claim payment for employers who choose to continue offering benefits and therefore do not implicate ERISA. The subrogation and assignment provisions in the Type C category in some circumstances redirect payments from an ERISA plan and therefore could invite litigation, though they, too, ought to survive preemption challenges under the logic of Supreme Court precedent. Type C provisions do not intrude on any provisions in ERISA plan documents as between the plan and its beneficiaries—they primarily govern the relationship between the single-payer plan and the individual, allowing the single payer to assert the individual's right to payment for covered services.[255] They do not, therefore, "bind[] plan administrators to a particular choice of rules for determining beneficiary status," as the law found preempted in *Egelhoff* had.[256] If, however, an ERISA plan contains a provision prohibiting the beneficiary from assigning rights, several courts of appeals recently held these clauses enforceable, despite the fact that ERISA itself "does not provide clear guidance" on the issue.[257]

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252 *See* Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936, 945 (2016) (holding that a state regime for reporting details of claim information "intrudes upon 'a central matter of plan administration'" and therefore was preempted (quoting *Egelhoff*, 532 U.S. at 148)); Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9 (1987) (recognizing that "making disbursements" is central to plan administration). *But cf.* S. 631, 78th Leg. Assemb., 2015 Reg. Sess. § 15(2), (3) (Or. 2015) (explicitly referencing employer plans in subrogating the state entity "to the rights of any participant that has a claim against an . . . employer, third party administrator, . . . or any other person that may be liable for the cost of health services provided to the participant").

253 *Egelhoff*, 532 U.S. at 148-49, 150.

254 *Id.* at 148-49.

255 *Cf.* N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 661, 662, 664 (1995) (reasoning that a state law with indirect economic effects is not preempted when "[s]uch state laws leave plan administrators right where they would be in any case").

256 *Egelhoff*, 532 U.S. at 147.

257 Univ. Spine Ctr. v. Aetna, Inc., 774 F. App'x 60, 63 (3d Cir. 2019) (citing Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield, 890 F.3d 445, 451 (3d Cir. 2018)); *see also* Dialysis Newco, Inc. v. Cmty. Health Sys. Grp. Health Plan, 938 F.3d 246, 260 (5th Cir. 2019). Note also that subrogation does not create a preempted state remedy under ERISA's § 502, 29 U.S.C. § 1132(a) (2018), the statutory section including an integrated enforcement mechanism that the Supreme

Further obscuring the arguments, the Supreme Court has opined that ERISA does not preempt minimal burdens imposed on plan administration by the need to review different state law requirements.[258] But it has not clarified principles for triviality, which invites litigation. Type C's assignment and subrogation provisions will redirect ERISA plan payments, but whether they may do so without significantly burdening plan administration in the eyes of a court remains unclear.

Ultimately, the combination of the features of Types A, B, and C, like in Ohio's bill,[259] creates an even more "meaningful alternative" or "legitimate choice" for employers in the single-payer system. The existence of the subrogation mechanism in the unified provider-payment system opens an avenue for employers to maintain their plans' relationships with providers, as well as to make use of the state plan infrastructure supported by the payroll tax revenue. Further, combining the tax in Type A with a Type B provider-payment system enables a state to achieve the desired results with a lower tax rate. The lower the tax rate, the less likely it will be held to be "exorbitant" and therefore preemptively coercive of employer benefits decisions.[260] At a lower tax rate, an employer could rationally choose to both pay the tax and continue offering its ERISA plan.

While the arguments against preemption for subrogation, assignment, and secondary-payer provisions are the stronger ones, the impenetrable pile of ERISA precedents and courts' difficulty applying them frustrate predictability, while fueling litigation.

4. Nonduplication Provisions

Many of the bills of all three types contain nonduplication provisions prohibiting insurers from offering state-plan-covered health benefits. These backstop provisions are intended to remove commercial competitors to the single-payer plan benefits and permit insurers only to offer "wraparound"

Court has held completely preempts parallel state remedies. *See, e.g.*, Aetna Health Inc. v. Davila, 542 U.S. 200, 208-09 (2004). ERISA does not address the assignment of beneficiaries' claims and the use of a state subrogation provision in these circumstances does not create inconsistencies with ERISA's underlying policies. *See, e.g.*, Brown v. Am. Int'l Life Assur. Co. of N.Y., 778 F. Supp. 912, 917 (S.D. Miss. 1991) (explaining that courts should develop federal common law of ERISA with the aid of state law, as long as state law is consistent with ERISA's goals).

258 *E.g.*, De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 815 (1997) (explaining that "'myriad state laws' of general applicability . . . impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them" to trigger preemption (quoting *Travelers*, 514 U.S. at 668)); *Egelhoff*, 532 U.S. at 151 (debating whether an administrative burden was "trivial" or preempted).

259 H.R. 440, 132d Gen. Assemb., Reg. Sess. (Ohio 2017); *see also supra* note 95 and accompanying text.

260 *De Buono*, 520 U.S. at 814-15; *Travelers*, 514 U.S. at 664.

services that supplement the single payer's coverage. Nonduplication provisions directly target insurers, rather than employers, but have the intended effect of eliminating employer-based coverage and shifting covered employees to the single-payer plan. Employers still could choose to self-fund health insurance for their employees, or to rely on the state plan and offer wraparound insurance as a benefit. Like other types of insurance regulation, the preemption analysis of states' nonduplication provisions would diverge for fully insured and self-funded plans.

Assuming a court would find nonduplication provisions have an impermissible connection to employer-sponsored insurance, ERISA's savings clause would restore the nonduplication provision for those employers offering fully insured health benefits. To avoid preemption, a state law must (1) be specifically directed toward entities engaged in insurance, and (2) substantially affect the risk-pooling arrangement between insurer and insured.[261] The nonduplication provisions impose prohibitions on insurers, satisfying the first requirement. The prohibition on covering state-plan services and benefits substantially affects the risk-pooling arrangement by removing the state-plan services from coverable risks. The only risks an insurer *may* cover under nonduplication are those wraparound services not covered by the state plan. While nonduplication provisions prohibit coverage, the savings clause logic saves them in precisely the same way that laws requiring coverage or underwriting have been saved.[262] As long as state regulation of the insurance industry affects risk-pooling, it does not matter whether the law expands or contracts risks in the pool.

As to self-funded plans, however, the nonduplication provision would remain preempted and therefore ineffective. For example, California's S.B. 562 contained a nonduplication provision that prohibited "carriers" from offering coverage for services that are covered under the state's single payer plan.[263] The bill's definition of "carrier" included insurers licensed by the state's insurance department and "health care service plans" as defined under the state's managed care law, the Knox-Keene Act.[264] Prior cases have held that the Knox-Keene Act's regulation of "health care service plans" is preempted by ERISA with respect to self-funded employer plans.[265] With existing precedent carving self-funded employee health benefit plans from

261 Ky. Ass'n of Health Plans v. Miller, 538 U.S. 329, 334-39 (2003).

262 *See id.* at 336 n.1; Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 370-87 (2002); Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 729-32, 740-47 (1985); Pharm. Care Mgmt. Ass'n v. Tufte, 297 F. Supp. 3d 964, 981-82 (D.N.D. 2017).

263 S. 562, 2017–2018 Leg., Reg. Sess. § 2 (Cal. 2017) (§ 100612(g)).

264 *Id.* (§ 100602(f)).

265 *E.g.*, Hewlett-Packard Co. v. Barnes, 425 F. Supp. 1294, 1295-96, 1300 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir. 1978).

California's definition of a "health care service plan," S.B. 562's nonduplication provision for health care service plans would also be inapplicable to self-funded ERISA plans.

The application of the deemer clause means that employers could offer self-funded benefit plans that duplicate the state single-payer plan, as well as covering additional services. If employers chose to continue self-funding under the state single-payer system, preemption would keep this significant segment of lower-risk people out of the state plan's risk pool, threatening its sustainability.[266] Because of ERISA preemption, nonduplication provisions will not work to move self-funded employers to the single-payer plan. Thus, states must turn to other tools, such as the payroll taxes in Type A or the provider restrictions in Type B to make the choice to self-fund benefits offered by the state plan considerably less attractive to employers, yet this meaningful choice would remain available in both theory and reality.

* * *

Types A, B, and C logically should survive preemption, and nonduplication provisions may be preempted only as to self-funded plans. But the muddle of ERISA jurisprudence renders actual outcomes uncertain. The only certainty in ERISA preemption is that there will be litigation.

C. *Drafting ERISA-Resistant Single-Payer Legislation*

A state single-payer proposal's ability to survive an ERISA preemption challenge is an important consideration for financing the single-payer plan, as well as for achieving the solidarity aims of single-payer coverage. The most ERISA-resistant single-payer program would contain all three elements described above: (A) a funding plan; (B) a provider restriction; and (C) an assignment, subrogation, and/or secondary-payer provision. The more diversified or redundant the state's portfolio of policy tools to achieve single-payer, the more resistant it may be to challenges to any one of the provisions.

266 *Cf.* Amy B. Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 146-53 (2011) (explaining how even employers with large-group plans can engage in risk selection among employees). *See generally* EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 168 (Marilyn J. Field & Harold T. Shapiro eds., 1993) ("In general, because large employers almost universally provide health benefits and have more predictable costs, large groups present fewer problems with risk selection than either individuals or small groups.").

States would be well served to exclude any explicit references to employers' benefit plans in their employer-contribution provisions,[267] but courts ultimately will judge state efforts on how they impact ERISA plans.[268] A funding plan combining payroll and income taxes captures employer expenditures and individual spending, which provides incentives for both employers and employees to drop their employer-based coverage in favor of single-payer coverage. Payroll taxes *should not* be preempted by ERISA, but courts have reached contradictory conclusions, which invite litigation. By combining individual income taxes, which are never preempted, with payroll taxes, state single-payer plans can set a lower payroll tax rate more likely to survive challenge.

Provider-restriction provisions create additional incentives for employees to drop their employer-plans by shrinking the network of participating providers in employer-based plans. ERISA generally does not preempt provider regulation, even if it has indirect effects on employee benefit plans.[269] Compared with nonduplication provisions prohibiting the sale or offer of coverage that duplicates benefits covered by the single payer, a provider restriction is less likely to be preempted with respect to self-funded ERISA plans. If they survive, provider restrictions could fill an important gap created by ERISA preemption of nonduplication provisions, shrinking consumers' demand for employer-based plans and creating incentives for participation in the single-payer plan.

A provider restriction becomes more powerful when paired with an assignment/subrogation/secondary-payer provision to allow the single payer to capture additional employer and other third-party-payer expenditures by seeking reimbursement for claims paid by the single payer for patients with dual coverage.[270] There are strong arguments that the way assignment/subrogation/secondary-payer provisions work in the single-payer context would not be preempted by ERISA.[271] Thus, pairing a Type B (Provider Restriction) provision with a Type C (Assignment/Subrogation/ Secondary-Payer) provision would create additional mechanisms beyond tax incentives to pull individuals into the single-payer plan *and* to capture third-

267 *See, e.g.*, District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 130 (1992) (holding D.C. law specifically referring to ERISA-regulated employee benefit plans preempted "on that basis alone").

268 *E.g.*, Cal. Div. of Labor Standard Enf't v. Dillingham, 519 U.S. 316, 328 (1997) (holding that state law which can function irrespective of ERISA plans does not impermissibly "reference" ERISA plans).

269 *See supra* text accompanying notes 147–154.

270 *See supra* notes 81–98; text accompanying notes 81–89.

271 *See supra* notes 249–258 and accompanying text.

party expenditures, both of which would be resistant to ERISA preemption.[272]

A state may want to pursue an A-B-C, belt-and-suspenders approach to increase the overall durability of the plan through diversification of policy tools. For example, having elements of Type B and Type C provisions could preserve the single-payer system even if a Type A payroll tax is preempted by ERISA.[273] If a court erroneously invalidated a payroll tax, a severability provision in the state statute might permit conversion of the state's mandatory single-payer payroll tax into a pay-or-play option, like the San Francisco ordinance upheld in *Golden Gate*.[274] Under those circumstances, a state with a pay-or-play payroll tax would be better off if it also has a provider restriction and a subrogation/assignment/secondary-payer provision, because the latter elements could take on more of the work of pulling enrollees and employer expenditures into the single-payer system. In a pay-or-play system, many more employers and employees would likely retain their employer-based coverage, so the incentives created by the Type B and C elements would become more critical to creating a broad and unified single-payer system.

Given the tenuousness of the politics of establishing a single-payer system, a state legislature may be interested in building a redundant system, utilizing an A-B-C approach, that can continue to stand even if preemption erodes one mechanism to move money or enrollees into the system. The legislature may be better able to patch or fix a system that continues to function, even in a diminished form, rather than return to the voters and the floor of the chamber to design a new single-payer system from scratch. It is better to build a durable program that can withstand some degree of attack, letting the endowment effect of newly acquired benefits take hold to protect the system from political repeal in the face of a challenge.[275]

III. ERISA REFORM AS HEALTH REFORM

The recent wave of state single-payer legislation painfully illustrates how ERISA preemption—and the uncertainty that swirls around it—undercuts states' potential role in health reform. This project focuses on state single-payer bills as emblematic of the kind of bold experimentation and testing

272 *See supra* text accompanying notes 94–95.

273 We think this is the wrong result, as explained above, but ERISA jurisprudence is nothing if not incoherent and unpredictable.

274 *See supra* text accompanying notes 178–191.

275 *See, e.g.*, Erin C. Fuse Brown, *Developing a Durable Right to Health Care*, 14 MINN. J.L. SCI. & TECH. 439, 481-85 (2013) (explaining the anticipated operation of the endowment effect, in the context of the ACA).

ground often associated with state law in a federal system,[276] and on ERISA preemption's subversion of that role. Over the past fifty years, federal health care statutes have established a regulatory infrastructure with baseline protections and federal funding sources, inviting states to participate in implementation and experimentation.[277] ERISA, meanwhile, prohibits state experiments largely without substituting a comprehensive federal scheme for employer-sponsored health benefits, leaving a regulatory void.

ERISA preemption sets a federalism trap that can derail ambitious state reforms—particularly those state reforms focused on universal coverage and cost control. After exposing the trap, we propose four potential federal reforms to ERISA that would pave the way for meaningful state health reform within the federal system.

A. *The Federalism Trap*

Volumes have been written about the role of federalism in health care.[278] The debates often conceive of a scale of power between states at one pole and the federal government at the other and focus on determining either the optimal balance point between the poles or what legal or policy structures promote or inhibit federalism's various goals.[279] This Article sidesteps those federalism questions, and instead starts with an assumption that some degree of health care federalism—a division of power between the federal government and the states—is desirable to achieve health policy goals, whether they are increasing coverage, controlling costs, improving quality, or broader equitable aims.[280] Federalism can improve policy by allowing states to innovate, test, and learn from experimental models.[281] Federalism also can

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276 *See, e.g.*, Abbe R. Gluck & Nicole Huberfeld, *What is Federalism in Health Care For?*, 70 STAN. L. REV. 1689, 1689 (2018); Kristin Madison, *Building a Better Laboratory: The Federal Role in Promoting Health System Experimentation*, 41 PEPP. L. REV. 765, 766 (2014).

277 *See* Gluck & Huberfeld, *supra* note 276, at 1703-06.

278 *See generally, e.g.*, Bagley, *supra* note 8; Bobinski, *supra* note 134; Gluck & Huberfeld, *supra* note 276; Greer & Jacobson, *supra* note 141; Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 CONN. L. REV. 115 (1995); Richard P. Nathan, *Federalism and Health Policy*, 24 HEALTH AFF. 1458 (2005); Wendy E. Parmet, *Regulation and Federalism: Legal Impediments to State Health Care Reform*, 19 AM. J.L. & MED. 121 (1993).

279 *See, e.g.*, Bagley, *supra* note 8, at 4 ("For health reform, the federal government really is the only game in town."); Mashaw & Marmor, *supra* note 278, at 117 ("What is both practical and desirable varies enough to make federalist variation both normatively attractive and politically wise as an alternative to national stalemate.")

280 *See* Gluck & Huberfeld, *supra* note 276, at 1788 (noting that access, costs, and quality are "some of many potential outcome metrics commonly used—and fought over—in health policy circles").

281 *See* New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (describing states as laboratories for experimentation).

enhance democratic goals of self-governance, divided power, pluralism, and government responsiveness.[282]

In health care, there are numerous political, economic, and historical reasons to prefer federal reforms. Politically, state "health reform" cuts both ways—some states aim for universal coverage and patient protections, others pass health laws restricting access, perpetuating discrimination, and responding to inaccurate assumptions.[283] Though federal legislation is not inherently prone to protecting access, federal baseline protections can guard against discrimination and codify evidence-based solutions, counteracting local prejudices.[284] Economically, federal reforms enjoy the advantages of economies of scale and deficit spending, as well as cost-control power in interstate markets.[285] Historically, the decades before the ACA witnessed the widespread failure of state regulation to rein in costs and expand access to care, with the exception of Massachusetts's bold universal coverage experiment and a handful of other state reforms.[286] The ACA then built comprehensive federal reforms on the results of Massachusetts's experiment.[287] The decade since the ACA's enactment has also witnessed some of federalism's pitfalls, as a shift in the federal Executive has undermined the ACA's core protections and encouraged states to pursue variations that contradict the purposes of federal laws, while receiving funding provided by those laws.[288]

So, without deciding where the balance between state and federal authority should lie, we accept that some level of power-sharing between states and the federal government is normatively desirable, both as an

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282 Robert R.M. Verchick & Nina Mendelson, *Preemption and Theories of Federalism*, *in* PREEMPTION CHOICE, *supra* note 105, at 13, 13-14.

283 *See, e.g.*, J. Craig Wilson & Joseph Thompson, *Nation's First Medicaid Work Requirement Sheds Thousands from Rolls in Arkansas*, HEALTH AFF.: HEALTH AFF. BLOG (Oct. 2, 2018), https://www.healthaffairs.org/do/10.1377/hblog20181001.233969/full [https://perma.cc/S3WW-M8L6].

284 *See, e.g.*, Elizabeth Y. McCuskey, *The Body Politic: Federalism as Feminism in Health Reform*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y 303, 306 (2018); Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care Act*, 36 B.C. J.L. & SOC. JUST. 235, 275–76 (2016).

285 *See* Bagley, *supra* note 8, at 10-11; Greer & Jacobson, *supra* note 141, at 217.

286 *E.g.*, Niraj Chokshi, *Historians Take Note: What America Looked Like Before Obamacare*, WASH. POST: GOVBEAT (Mar. 26, 2014), https://www.washingtonpost.com/blogs/govbeat/wp/2014/03/26/historians-take-note-what-america-looked-like-before-obamacare [https://perma.cc/LZF7-BDQL]. Some part of states' historical struggles to effectively manage health care costs and access stems from ERISA's preemption hamstringing system-wide reforms. *See supra* Section II.A.

287 *See* Jonathan Oberlander, *Implementing the Affordable Care Act: The Promise and Limits of Health Care Reform*, 41 J. HEALTH POL. POL'Y & L. 803, 805 (2016).

288 *See, e.g.*, Nicole Huberfeld, *Can Work Be Required in the Medicaid Program?*, 378 NEW ENG. J. MED. 788-91 (Mar. 1, 2018); Timothy S. Jost, *Using the 1332 State Waiver Program to Undermine the Affordable Care Act State by State*, COMMONWEALTH FUND: TO THE POINT (Oct. 30, 2018), https://www.commonwealthfund.org/blog/2018/using-1332-state-waiver-program-undermine-affordable-care-act-state-state [https://perma.cc/7RVN-V3DB].

instrumental means to improve health of the population and as a democratic ideal of diffusion of power and allowing diversity of policy solutions to reflect a diversity of political preferences.

This project's central federalism concern is that ERISA is an extremely antifederalist statute,[289] which contravenes nearly all federal health care statutes by not allowing for state flexibility, variation, or indeed any state regulation of self-funded ERISA plans.[290] In health care regulation, ERISA is an interloper. ERISA was not originally intended to target health care, but the expansion of employer-sponsored health benefits to reach forty-nine percent of the U.S. population has wrought unintended consequences.[291]

Most federal statutes that intentionally regulate health care coverage, like Medicare, Medicaid, and the ACA, contain provisions that enable states to pursue policy experiments, while ERISA does not.[292] For example, Medicare heavily favors federal control without obstructing states' interests.[293] By contrast, ERISA is both heavily federal and largely deregulatory for health care benefits,[294] so the balance is struck not in favor of federal regulation over state regulation, but in favor of deregulation over state regulation.

Indeed, as interpreted by the courts, ERISA preemption places self-funded employer plans beyond the reach of all manner of state health regulation: not just those that seek to mandate health benefits, but also reforms that seek to increase health coverage, to control health care costs, or

289 Brendan S. Maher, *The Benefits of Opt-In Federalism*, 52 B.C. L. REV. 1733, 1765 (2011) ("ERISA, in effect, lashes much of the country's benefit rules to a single federal mast in a ship captained by judges. It is a classic piece of anti-federalism.").

290 *See supra* Section II.B.

291 *See, e.g.*, Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?*, 74 TUL. L. REV. 951, 952-53 (2000); Wooten, *supra* note 102, at 31-35; *see also Health Insurance Coverage*, *supra* note 9.

292 *See* McCuskey, *Agency Imprimatur*, *supra* note 21, at 1103-05. Further, ERISA significantly affects the U.S. health care financing system, yet it is administered by the Department of Labor, rather than the U.S. Department of Health & Human Services. *See Fact Sheet: What Is ERISA*, U.S. DEPARTMENT OF LABOR, https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/what-is-erisa [https://perma.cc/9H23-ETWU] (last visited Nov. 12, 2019) ("ERISA is administered and enforced by three bodies: the Labor Department's Employee Benefits Security Administration, the Treasury Department's Internal Revenue Service, and the Pension Benefit Guaranty Corporation.").

293 *See* Parmet, *supra* note 278, at 143-44.

294 *Id.* at 135-36, 140. ERISA preemption has a particularly deregulatory tilt for health care benefits as opposed to pensions (which it heavily regulates), but federal preemption generally has a deregulatory effect. *See* Ernest A. Young, *Federal Preemption and State Autonomy*, *in* FEDERAL PREEMPTION, *supra* note 105, at 249, 263 ("[P]reemption will generally have a deregulatory impact."). The ACA diluted ERISA's deregulatory effect on employee health benefits by extending several health plan benefit and administrative rules to employer-based health plans, as well as by increasing state regulatory authority over non-group plans. *See* Jensen, *supra* note 25, at 516; Brendan S. Maher & Radha A. Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance Under the ACA*, 31 YALE L. & POL'Y REV. 275, 276-77 (2013); *see also supra* note 24.

even to seek information about health care prices.[295] While the rest of the federal health law infrastructure invites some level of state regulation, ERISA obstructs the potential benefits of state experimentation and policy diversity. States that seek to enact reforms to expand access or rein in their health care costs are needlessly hamstrung because ERISA preemption places a large portion of the market entirely beyond their regulatory reach.[296] ERISA preempts state reforms without regard to policy or party—if, for example, a state wanted to pass a law prohibiting employers from offering contraceptive coverage, ERISA would preempt that, too. But ERISA preemption's effects have a lopsided impact on state efforts aimed at expanding access to insurance.

One risk of ERISA's federalism trap is regulatory failure for health care—particularly stasis and a system that fails to reflect the preferences of the states' citizens.[297] If the federal government fails to act, ERISA's broad preemption means the states cannot step in to solve the problem. Broad federal preemption eliminates beneficial institutional diversity from federalism: "[i]f one set of regulators fails to address the problem, another set provides an alternative avenue for relief."[298]

Further, ERISA preemption doctrine's elevation of the 1974 Congress's concern for multistate employers and interstate commerce have had the effect in health reform of elevating the interests of private employers above those of a sovereign state: in essence, placing Walmart's preferences above California's and giving private businesses the power to veto state laws in the absence of congressional action.[299]

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295 *See* Erin C. Fuse Brown & Ameet Sarpatwari, *Removing ERISA's Impediment to State Health Reform*, 378 NEW ENG. J. MED. 5, 6 (2018).

296 *See* Borzi, *supra* note 23, at 661 (noting that even as of the 1990s, "about half of covered workers were in self-insured plans, beyond the reach of state insurance regulators"); Parmet, *supra* note 278, at 135-36 (noting that ERISA's preference for interstate uniformity and antiregulatory bias creates doubt as to the viability of state single-payer health reform). Note, however, that many other forces complicate states' ability to achieve these goals, such as the federal tax preference given to employer-sponsored health insurance and many states' inability to deficit-spend in times of recession due to balanced-budget laws. *See* TIMOTHY STOLTZFUS JOST, DISENTITLEMENT?: THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 78-80 (2003); Bagley, *supra* note 8, at 10-11.

297 *See* William W. Buzbee, *Asymmetrical Regulation: Risk, Preemption, and the Floor/Ceiling Distinction*, 82 N.Y.U. L. REV. 1547, 1576 (2007) (noting that, with regard to "broad federal preemption," "recent ceiling preemption assertions create heightened risks of dysfunction and stasis").

298 Robert A. Schapiro, *From Dualism to Polyphony*, *in* PREEMPTION CHOICE 344 (William W. Buzbee, ed., 2009); *see also* Buzbee, *supra* note 297, at 1576 (critiquing "broad federal preemption" for how it "displaces multilayered institutional arrangements offering different actors, venues, and modalities for addressing a social problem").

299 Broad schemes of federal preemption tend to benefit the deregulated industry while sacrificing the preferences of states. *See* Buzbee, *supra* note 297, at 1590-92. Congress could, of course,

The common policy justification for ERISA's sweeping preemption is that nationally uniform employee benefit rules enable multistate employers to offer health coverage.[300] But this emphasis on national uniformity is overblown and outdated. As Justice Blackmun recognized in *Metropolitan Life Insurance Co.*, state-by-state disuniformities "are the inevitable result of the congressional decision to 'save' local insurance regulation."[301] ERISA's legislative history does not indicate that Congress intended total national uniformity for health benefit plans, or for multistate employers to defeat this traditional area of state regulation for such a broad swath of the population.[302] To the extent that Congress thought about health benefit plans at all when it drafted ERISA, it would have assumed that the vast majority of employers would continue to use fully insured plans and be subject to varying state insurance laws under the savings clause.[303] Over time, interpretations of the deemer clause have left almost thirty percent of the population's health coverage untouchable by state laws, including state health reforms.[304]

Just as the 1974 Congress did not contemplate the exemption of self-funded employer health plans when it passed ERISA, it likewise responded to very different employer incentives to provide health benefits in the first place. In the past four decades, the ACA's national employer mandate, the creation of a sizeable tax-break for employers' health benefits, and shifting labor market demands cast doubt on the assumption that employers will abandon health coverage in response to state regulations.[305] Further, many

remedy these failings by imposing federal regulations. Thus subsequent Congresses should share some of the blame for this failure.

300 Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 402 (2002) (Thomas, J., dissenting) ("[T]he Court would do well to remember that no employer is required to provide any health benefit plan under ERISA . . . . [The state law] provisions could create a disincentive to the formation of employee health benefit plans, a problem that Congress addressed by making ERISA's remedial scheme exclusive and uniform.").

301 Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985).

302 *See, e.g.*, Bogan, *supra* note 291, at 952-53, 964-65; Borzi, *supra* note 23, at 663; *see also* FMC Corp. v. Holliday, 498 U.S. 52, 65-66 (1990) (Stevens, J., dissenting) ("Had Congress intended [to preempt regulation of self-funded plans], it could have stated simply that 'all State laws are preempted insofar as they relate to any [self-funded] employee plan.'").

303 *See* Borzi, *supra* note 23, at 661 ("[E]ven if some in Congress had thought about [ERISA's] effect on health plans, they probably would have believed that the insurance savings clause in ERISA's preemption provisions would have been sufficient to address any future problems.").

304 For the statistic that 49% of the population has employer-sponsored coverage, see *Health Insurance Coverage*, *supra* note 9. For the observation that 61% of those with employer-sponsored coverage are in self-funded plans, see CLAXTON ET AL., *supra* note 54, at 167. So 49% * 61% = 29.89% of the U.S. population.

305 *See, e.g.*, Michelle Long et al., *Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999–2014*, HENRY J. KAISER FAM. FOUND. (Mar. 21, 2016), https://www.kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014 [https://perma.cc/Z7X7-AV2H] (observing that the percentage of the population covered by

single-state and small firms self-fund to take advantage of the regulatory vacuum without any claim to the advantages of multistate uniformity.[306]

In sum, ERISA elevates the convenience of employers over state sovereignty and sacrifices the federalism benefits of states as engines of policy innovation.[307] The upshot of courts' voluminous and tortured ERISA preemption jurisprudence is that ERISA is so concerned with shielding multistate employers from having to comply with fifty states' employee benefit regulations that it is willing to trade away the ability of a sovereign state to shape the health care system for its millions of citizens.

B. *Clearing a Path for State Health Reform*

ERISA preemption is a federal problem that demands a federal solution to clear the way for meaningful state health reforms. We explore four possible solutions targeting health benefits—three legislative and one jurisprudential. First, Congress could replace ERISA's broad "any and all" preemption with conventional "floor preemption," congruent with other federal health care statutes. Second, Congress could eliminate ERISA's deemer clause for health benefit plans to remove the impenetrable barrier of preemption that currently shields self-funded employer-based plans from any state health regulation. Third, Congress could add a statutory waiver provision to ERISA that would allow states to apply to the federal government for approval to deviate from federal requirements in provision of health coverage. Fourth, as a fallback option if the first three legislative solutions are unavailing, courts could curtail the scope of ERISA preemption and reinvigorate the "presumption against preemption" for state authority over health care regulation in a way that is closer to Congress's original legislative intent for ERISA. The first solution,

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employer-sponsored insurance had declined since 1999, but offering several potential causes for that decrease).

306 *See, e.g.*, Jan Greene, *Even Small Employers Are Striking Out on Their Own*, MANAGED CARE MAG. (May 28, 2019), https://www.managedcaremag.com/archives/2019/6/even-small-employers-are-striking-out-their-own [https://perma.cc/69PW-XB9P]. Indeed, because of the ready availability of stop-loss insurance, smaller employers can self-fund for an extremely narrow band of risk, in order to take advantage of the deemer clause. *Id.*

307 There are critiques of the "state sovereignty" account of federalism. However, even critics acknowledge that states play a key democratic role in today's federalism. For example, Heather Gerken observes:

> The state's democratic role is just as important as its regulatory one. To be sure, states aren't independent mini-polities, resolving their own questions entirely as they see fit. But they aren't just convenient polling places for national debates, either. Instead, states are the front lines for national debates, the key sites where we work out our disagreements before taking them to a national stage. States aren't pushed aside by national politics; instead, they *fuel* it.

Heather K. Gerken, *Federalism 3.0*, 105 CALIF. L. REV. 1695, 1722 (2017).

ERISA floor preemption, is the most elegant and would restore state flexibility and remove ERISA's barriers to state innovation and health reform. However, the third solution, ERISA waiver, might be the most politically achievable.

1. Altering ERISA's Preemption Provisions

Congress could address these problems by heeding the frequent calls to amend ERISA's regulatory preemption provision, § 1144 (also known as § 514) in a couple of ways. These statutory fixes ultimately are elegant but likely not politically feasible in the foreseeable future.

The first potential amendment would be for Congress to replace ERISA's broad "relates to" express preemption with traditional floor preemption.[308] Floor preemption allows the federal government to establish a national standard that displaces less stringent state laws, but it permits more stringent state regulation.[309] Floor preemption acts as a "one-way ratchet," preserving only those state laws more protective than the federal floor.[310] By contrast, ERISA's current express preemption provision displaces "any and all" state laws that "relate to" employee benefit plans,[311] which means all state laws that make reference or bear a connection to employer-based health plans are preempted, whether or not they conflict with federal requirements.[312]

Floor preemption would restore some power-sharing between the state and national authorities and would be more consistent with other federal health care statutes' approaches to federalism and preemption.[313] It also allows a degree of federal uniformity in the setting of the floor, but balances

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308 To implement floor preemption in ERISA, 29 U.S.C. § 1144(a) could be amended as follows:

> 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.~~ only to the extent that such State laws actually conflict with the provisions of this subchapter and subchapter III. State laws that impose requirements in addition to the provisions of this subchapter and subchapter III shall not be superseded.

309 *See* Buzbee, *supra* note 297, at 1554 ("Federal floors preclude less stringent state and local regulation, but allow for additional and more stringent regulation and typically are accompanied by savings clauses and cooperative regulatory structures.").

310 *Id.* at 1566.

311 29 U.S.C. § 1144(a) (2018).

312 *See* Fuse Brown & Sarpatwari, *supra* note 295, at 6-7.

313 *See* McCuskey, *Agency Imprimatur, supra* note 21, at 1122-23 (discussing the use of conflict preemption—a type of floor preemption—elsewhere in amendments to ERISA and in the ACA, HIPAA, and other federal statutes).

this federal standard with state flexibility, so long as the state laws are consistent with and no less protective than the federal floor. Floor preemption offers a more desirable solution than broad federal preemption because multiple levels of governments bring institutional diversity, more opportunities for regulatory reexamination, and can serve as antidotes to regulatory stasis or failure.[314] In the context of single-payer health care, changing ERISA preemption to floor preemption would allow states with the political will to reform their health care systems to do so, for other states and the federal government to learn from these state experiments, and for diversity in policy choices that may better reflect the desires of the people in those states. Floor preemption also increases interaction between the federal and state governments, which improves policymaking through joint regulation, mutual learning, regulatory improvement, and regulatory competition.[315]

To be sure, there are critics of floor preemption, namely from the business community. One critique is that floor preemption sacrifices the uniformity and certainty of a single national standard. Broad federal preemption often tilts toward deregulation, particularly if the federal law acts as a ceiling—a regulatory maximum—rather than as a floor.[316] If the national standard serves as a floor and not as a ceiling, then it eliminates the possibility that states will engage in pro-business deregulatory competition.[317] Thus, the alignment between business interests and state autonomy[318] will fracture if the states are only able to innovate in a pro-regulatory direction under the one-way ratchet of floor preemption. Of course, the ordinary workings of conflict preemption doctrine would still preempt state regulations that contradict federal law in ERISA, and our floor preemption proposal could state so explicitly.[319]

Second, Congress could amend ERISA's deemer clause to eliminate its applicability to health benefit plans.[320] This could be accomplished by simply

314 *See* Buzbee, *supra* note 297, at 1576 (suggesting that floor preemption, as an alternative to ceiling preemption, utilizes institutional diversity and is less likely to risk dysfunction).

315 Gerken, *supra* note 307, at 1720.

316 *See* Buzbee, *supra* note 297, at 1579.

317 *See* Michael S. Greve, *Business, The States, and Federalism's Political Economy*, 25 HARV. J.L. & PUB. POL'Y 895, 903 (2002).

318 *See, e.g.*, John O. McGinnis & Ilya Somin, *Federalism vs. States' Rights: A Defense of Judicial Review in a Federal System*, 99 NW. U. L. REV. 89, 107 (2004) ("The jurisdictional competition among states fostered by federalism provides state officials the incentive to permit the local autonomy necessary to attract businesses and people from other states.").

319 *See* John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank, 510 U.S. 86, 99 (1993) (finding that "traditional preemption analysis" applies even in context of ERISA's express preemption language); *supra* note 308.

320 *See* Bobinski, *supra* note 134, at 342-43.

deleting 29 U.S.C. § 1144(b)(2)(B), or by adding language to the clause stating that it does not protect employers' self-funded health benefit plans.[321]

Either revision would close the deemer clause's loophole in the savings clause, the-exception-within-an-exception that shields self-funded health plans from state insurance regulation. Thus all health benefit plans, whether self-funded or fully insured, would be subject to state insurance laws that are saved by ERISA's savings clause. The deemer clause, as interpreted by the Court, deems self-funded health benefit plans to operate outside the business of insurance, and exempts them from state insurance regulations.[322] As noted above, when Congress wrote ERISA and the deemer clause in 1974, most employer-based health plans were fully insured, not self-funded.[323] Moreover, the text of deemer clause is not a model of clarity and was only interpreted to exempt self-funded plans from the state insurance regulation by the Court more than a decade after ERISA was passed.[324]

Eliminating the deemer clause would not automatically open up employer-based plans to *all* state regulation—only to those state laws regulating insurance.[325] In the context of state single-payer plans, eliminating the deemer clause's distinction between self-funded and fully insured plans would allow the nonduplication provision to avoid preemption and could put the subrogation/assignment/secondary-payer provisions on surer footing.[326] However, it is less clear whether an employer mandate to participate in the state single-payer plan or payroll taxes would be considered health insurance regulation.

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321 For example, 29 U.S.C. § 1144(b)(2)(B) could be revised to read:

> 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. <u>This provision shall not apply to any "employee welfare benefit plan" established or maintained by an employer that provides medical care for participants or their dependents directly or through insurance, reimbursement, or otherwise.</u>

322 *See* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985) ("[O]ur 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 . . . has chosen not to alter."); *see also* FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990) ("We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause.").

323 *See supra* note 303 and accompanying text.

324 *See FMC Corp.*, 498 U.S. at 61; *Metro. Life Ins. Co.*, 471 U.S. at 739-40.

325 This is because the deemer clause is an exception from the savings clause, which only saves state insurance regulation from preemption. *See supra* subsection II.A.2.

326 *See supra* subsections II.B.3–II.B.4.

The main drawback of eliminating the deemer clause for health benefit plans is the loss of regulatory uniformity, which could increase the costs of these plans by exposing self-funded plans to state insurance laws, such as benefit mandates (for example, to cover fertility services) and state premium taxes.[327] This conventional policy argument in favor of broad ERISA preemption for self-funded plans is not clearly supported by the empirical literature.[328] State benefit mandates' effect on firms' decisions to self-fund their health benefits is mixed,[329] and self-funded premiums are not necessarily cheaper than premiums for purchased insurance.[330] Other factors beyond avoiding state regulations also drive employers' decisions whether to self-fund or purchase insurance.[331] In short, it is unclear that exposing self-funded health plans to state insurance laws would increase the costs of these plans. Without a deemer clause, employers could still self-fund their health plans to take advantage of nonregulatory financial incentives; they would just be subject to state health insurance laws. There is no evidence that the employers would drop coverage altogether given labor market demands, favorable tax-treatment of health benefits, and the ACA's employer mandate.[332] Nevertheless, large self-funded firms argue that their costs would increase if their health plans were subject to state regulation.[333]

A more practical concern is the political difficulty of convincing Congress to eliminate the deemer clause's applicability to self-funded health plans. Large, multistate employers would likely oppose any change to ERISA that would expose them to additional state regulations. This group's powerful

327 Roger Feldman, *Why Do Employers Self-Insure? New Explanations for the Choice of Self-Insurance vs. Purchased Health Insurance*, 37 GENEVA PAPERS ON RISK & INS. 696, 697 (2012). According to industry self-report, the other incentive to self-fund is to retain the "float" of interest on funds not paid as premiums to an insurer. *Id.*

328 *Id.* at 697-98, 709-10.

329 Christina M. Dalton & Sara B. Holland, *Why Do Firms Use Insurance to Fund Worker Health Benefits? The Role of Corporate Finance*, 86 J. RISK & INS. 183, 187 (2019).

330 Feldman, *supra* note 327, at 708.

331 For example, firm size, the ability of employers to engage in risk assessment to negotiate fees with third-party administrators and the availability of external capital to fund firm investments may contribute to decisions to self-insure. *See* Dalton & Holland, *supra* note 329, at 185 ("[W]hen firms face costly external finance, they are more likely to purchase insurance. Purchasing insurance reduces the risk that health benefit payouts will tie up internal funds and force the firm to raise additional outside investment capital."); Feldman, *supra* note 327, at 709 (attributing the recent rise in self-insurance to employers' "use of risk assessment to negotiate premiums with self-insured health-plan administrators").

332 *See* Long et al., *supra* note 305 (noting that data from the National Health Interview Survey does not indicate that employer coverage is "diminishing in its importance" despite the changes that accompanied the ACA).

333 *See Self-Insured Group Health Plans*, *supra* note 211 (observing that employers who self-fund do so in part to avoid "conflicting state health insurance regulations/benefit mandates" and "state health insurance premium taxes, which are generally 2-3 percent of the premium's dollar value").

lobby would argue that any alteration to ERISA preemption that subjects employers to multiple state regulations would increase their administrative burden and stifle private market forces.[334]

2. Adding an ERISA Waiver

Alternatively, Congress could preserve ERISA's preemption baseline, but add a statutory waiver mechanism authorizing the Secretary of Labor to waive ERISA preemption provisions for states pursuing health care reforms. A statutory waiver would not clear the path for all state reforms; it would lift the gate for certain state efforts, based on review and approval by federal agencies. And it would complement the waivers in other federal statutes (notably Medicaid and the ACA) necessary to fully fund a state single-payer plan.[335]

Congress has used statutory waivers with increasing frequency over the past few decades to infuse statutory structures with flexibility,[336] to mitigate the federalism impacts of nationwide rules,[337] to encourage supervised state experimentation,[338] and sometimes to suspend preemption.[339] Waivers may support state experiments with federal funding, as well as access to the nationwide perspective and substantive expertise of federal agencies,[340] a model frequently employed in federal health care coverage statutes. Amending ERISA to add a statutory waiver mechanism for its preemption provisions in 29 U.S.C. § 1144 could accomplish all of these goals.

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334 *See* Bagley, *supra* note 8, at 12 ("[B]ecause of the intensity of the business lobby's resistance to limiting ERISA's preemptive scope, Congress is very unlikely to amend the law to address the concern.").

335 *See, e.g.*, Wiley, *supra* note 8, at 849-50, 863-64, 867 (discussing the operation of these existing waiver provisions and noting that "the drafters of public option bills have assumed that one or more administrative waivers could be necessary").

336 *See* David J. Barron & Todd D. Rakoff, *In Defense of Big Waiver*, 113 COLUM. L. REV. 265, 270, 277-78 (2013) (identifying the phenomenon of "big" waivers that suspend the core tenets of federal statutes and explaining their appeal).

337 *See id.* at 270; Martin A. Kurzweil, *Disciplined Devolution and the New Education Federalism*, 103 CALIF. L. REV. 565 (2015) (discussing waivers in federal education law).

338 *See, e.g.*, 42 U.S.C. §§ 1315, 1396n (2018) (Medicaid's state experimentation waivers); *id.* § 18052 (ACA's "State Innovation" waiver); *see also* Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in* National Federation of Independent Business v. Sebelius, 93 B.U. L. REV. 1, 29 (2013) (discussing the role of waiver in Medicaid); McCuskey, *Agency Imprimatur*, *supra* note 21, at 1127-37 (describing the purposes and effects of the ACA's State Innovation waiver); Sidney D. Watson, *Out of the Black Box and Into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion*, 15 YALE J. HEALTH POL'Y L. & ETHICS 213, 214 (2015) (discussing the role of the "1115 waiver" in Medicaid).

339 *See* 42 U.S.C. § 6297(d) (Energy Policy and Conservation Act); *id.* § 7543(b) (Clean Air Act); 49 U.S.C. § 5125(e) (federal transportation code).

340 *See* McCuskey, *Agency Imprimatur*, *supra* note 21, at 1151-56.

ERISA currently has no waiver provision and arguably delegates no waiver authority to the Department of Labor over state regulations.[341] Although ERISA allows the federal agency to coordinate with states on enforcing the federal statute,[342] ERISA does not expressly delegate the power to waive its preemptive effects, as many other statutes have done.[343] Absent such an express delegation or waiver, an agency's power to *waive* preemption is hazy at best,[344] despite the fact that an agency's views on the preemptive *effect* of its substantive regulations may merit some deference.[345] The statute does contain one exemption for Hawaii's 1974 health reform law, which does not operate as a waiver. On June 12, 1974—three months before ERISA was enacted[346]—Hawaii passed a law requiring employers in the state to provide health coverage for employees, by either purchasing a state-approved plan or funding their own.[347] In 1983, Congress amended ERISA to exempt Hawaii's 1974 law from the "relates to" preemption provision,[348] but narrowed the exemption with several corollary provisions.[349] No other state has a statutory

341 ERISA does not expressly provide authority for federal agencies to waive statutory requirements for states. ERISA does, however, authorize the Secretaries of Labor and Treasury to waive certain substantive and administrative requirements for employers, plans, and participants. 29 U.S.C. § 1023(a)(3)(A), (4)(A) (2018); *id.* § 1024(a)(2)(A), (a)(3); *id.* §§ 1082(c)–1084; *id.* § 1132(c)(10); *id.* § 1132(*l*)(3); *id.* § 1202(b); *id.* § 1202a(a); *id.* § 1203(a). And the statute expressly saves a few specific categories of state laws on insurance and fraud. *E.g.*, 29 U.S.C. §§ 1144a; *id.* § 1150; *id.* § 1191(a)(1), (b)(1)–(2).

342 29 U.S.C. § 1136(a).

343 *See* 21 U.S.C. § 360k (2018) (Medical Devices Amendments of 1976); 42 U.S.C. § 6297(d) (2018) (Energy Policy and Conservation Act); *id.* § 7543(b) (Clean Air Act); 49 U.S.C. § 5125(e) (2018) (federal transportation code).

344 *Cf.* Nicholas Bagley, *The Labor Department and* Liberty Mutual v. Gobeille, THE INCIDENTAL ECONOMIST BLOG (Jan. 6, 2016), https://theincidentaleconomist.com/wordpress/the-labor-department-and-liberty-mutual-v-gobeille [https://perma.cc/E73U-VVRH] (arguing that Justice Breyer's suggestion "that the Labor Department should have a say in whether [state] law is preempted" is correct and that Justice "Scalia's concerns about the Labor Department's authority are misplaced").

345 *See* Wyeth v. Levine, 555 U.S. 555, 577 (2009) ("The weight we accord the agency's explanation of state law's impact on the federal scheme depends on its thoroughness, consistency, and persuasiveness." (citing United States v. Mead Corp., 533 U.S. 218, 234-35 (2001); Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944)); Catherine M. Sharkey, *Products Liability Preemption: An Institutional Approach*, 76 GEO. WASH. L. REV. 449, 471-72 (2008) (illustrating that Supreme Court decisions on products liability preemption since 1992 have "aligned with the relevant underlying federal agency's take on preemption").

346 President Ford signed ERISA into law on September 2, 1974 (Labor Day). Pub. L. No. 93-406, 88 Stat. 829, 829 (1974).

347 *See* Hawaii Prepaid Health Care Act §§ -3, -11, -12, 1974 Haw. Sess. Laws 460, 460-61, 464. Hawaii employers must pay "at least one-half of the premium" and the employees' remaining share cannot exceed 1.5% of their wages. HAW. REV. STAT. § 393-13 (2018).

348 *See* 29 U.S.C. § 1144(b)(5)(A).

349 First, the Hawaii exemption applies only to the original 1974 state law and administrative updates to it. 29 U.S.C. § 1144(b)(5)(B)(ii). Second, the Hawaii exemption does not extend to "any State tax law relating to employee benefit plans." *Id.* § 1144(b)(5)(B)(i). Third, the Hawaii exemption

exemption from ERISA. Without a state waiver mechanism, the issue of state flexibility mostly gets hashed out in the chaotic and reactive realm of preemption litigation.[350]

An ERISA preemption waiver could mirror some of the substantial flexibility in other federal health care statutes, including Medicare, Medicaid, and the ACA, emphasizing the value of state policy innovation by allowing states to apply to the federal government for approval to deviate from federal standards.[351] These waivers delegate to an agency the power to suspend certain core statutory rules by approving state applications for waivers.[352] To receive a waiver, states typically must demonstrate the ways in which their proposed variations would further federal goals.[353] An ERISA waiver could create a process whereby states apply to the Department of Labor for a waiver of any or all of § 1144's preemption provisions to pursue state reforms. To focus an ERISA waiver on health reform,[354] the provision could specifically apply only to state laws impacting employee welfare benefit plans, excluding pension plans. Our proposed statutory revision, which the National Council of Insurance Legislators has made available on their website, provides an example of how to reform ERISA with a waiver.[355]

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states that ERISA reporting requirements and fiduciary responsibilities *do* supersede the Hawaii Act, but notes that the Department of Labor may use its "cooperative arrangements" delegation to "assist" Hawaii "in effectuating the policies" of those state provisions still subjected to preemption. *Id.* § 1144(b)(5)(C).

350 *See supra* Section II.B; *see also* McCuskey, *Agency Imprimatur*, *supra* note 21, at 1153-57 (considering agencies' and courts' comparative competencies to decide whether federal or state law should govern a given application).

351 *See, e.g.*, 42 U.S.C. § 18052 (2018) (providing for the ACA's State Innovation waivers); McCuskey, *Agency Imprimatur*, *supra* note 21, at 1127-37 (providing an overview of the State Innovation waiver's operation); *see also* Barron & Rakoff, *supra* note 336, at 277-78 (describing paradigm "big" waivers).

352 McCuskey, *Agency Imprimatur*, *supra* note 21, at 1127-37.

353 *See id.* at 1133-37; *cf.* Christen Linke Young, Note, *Pay or Play Programs and ERISA Section 514: Proposals for Amending the Statutory Scheme*, 10 YALE J. HEALTH POL'Y L. & ETHICS 197, 235 (2010) (arguing that "any system of federal agency de-preemption would require statutory criteria by which state or local programs could be evaluated").

354 And potentially to diminish objections to the amendment based on pension concerns.

355 Elizabeth Y. McCuskey & Erin Fuse Brown, *ERISA Preemption—Health Reform Waiver Proposal* (Dec. 7, 2018), http://ncoil.org/wp-content/uploads/2018/12/ERISA-1144-Waiver-Proposal-12.7.18.pdf [https://perma.cc/8VP9-YF3J] [hereinafter *Health Reform Waiver Proposal*]; Memorandum from Elizabeth Y. McCuskey to NCOIL Health, Long Term Care and Health Retirement Issues Committee (Dec. 7, 2018), http://ncoil.org/wp-content/uploads/2018/12/McCuskey-memo-to-NCOIL.pdf [https://perma.cc/5FQV-AAU9] (summarizing arguments supporting the addition of a statutory waiver to ERISA and explaining features of the Health Waiver Reform Proposal). NCOIL adopted a resolution in support of amending ERISA to include a waiver provision on March 17, 2019. National Council of Insurance Legislators, Resolution in Support of Amending ERISA to Enable State Policymakers to Enact More Meaningful State Healthcare Reform (Mar. 17, 2019), http://ncoil.org/wp-content/uploads/2019/03/ERISA-Resolution-FINAL.pdf [https://perma.cc/NR3X-2FZ3]; *see also* Press Release, Nat'l Council of Ins. Regulators, NCOIL

From a federalism perspective, an ERISA waiver offers several theoretical benefits. Federal baseline regulation with an option for state waivers restores some of states' autonomy and ability to experiment with policy solutions to benefit their citizens.[356] From an institutional competence perspective, an ERISA preemption waiver would shift some of the authority over state health reform options from courts to agencies, relying on agencies' substantive expertise rather than courts' preemption precedents.[357] This shift portends benefits not only in the availability of state health care reforms, but also in the transparency, participation, and federalism dimensions of health care regulation.[358] Because Congress initiates the statutory waiver, this mechanism also has advantages over agency preemption clarifications or rulemaking,[359] namely that it explicitly authorizes the agency action and conclusively effectuates the suspension of preemption for approved applications.[360]

To maximize these benefits, the statutory waiver should provide for coordination between the Departments of Labor, Treasury, and Health & Human Services (HHS) for purposes of both expertise and efficiency. A coordination provision would enable Labor to draw on the health insurance and market expertise of HHS in determining which waiver applications satisfy the substantive criteria.[361] And a provision for cross-referencing states' ERISA waiver applications with their ACA, Medicaid, and Medicare waiver applications would enable states to pursue all the waivers needed for transformative health system changes, while giving the federal agencies a comprehensive view of each state's proposal.[362]

Passes Resolution to Amend ERISA (Mar. 28, 2019), http://ncoil.org/2019/03/28/ncoil-passes-resolution-to-amend-erisa [https://perma.cc/AGK3-EM5C] (stating that the Health Reform Waiver Proposal "spurred the dialogue that led to [the] Resolution").

356 *See supra* Section III.B.

357 *See* McCuskey, *Agency Imprimatur*, *supra* note 21, at 1153-56; Meltzer, *supra* note 110, at 39; *see generally* Thomas W. Merrill, *Preemption and Institutional Choice*, 102 NW. U. L. REV. 727 (2008).

358 *See* McCuskey, *Agency Imprimatur*, *supra* note 21, at 1162-64.

359 *See, e.g.*, Michael Serota & Michelle Singer, *Maintaining Healthy Laboratories of Experimentation: Federalism, Health Care Reform, and ERISA*, 99 CALIF. L. REV. 557, 600-04 (2011) (arguing for Department of Labor clarification of preemption via guidance or rulemaking).

360 *See* McCuskey, *Agency Imprimatur*, *supra* note 21, at 1157-62 (detailing the reviewability and review process of agency decisions under the ACA's 1332 waiver provision). *Cf.* Wyeth v. Levine, 555 U.S. 555, 576-78 (2009) (refusing deference to agency's statement about the preemptive intent of its authorizing statute and the preemptive effect of its own regulations).

361 *See* McCuskey, *Agency Imprimatur*, *supra* note 21, at 1155-56.

362 *Cf.* 42 U.S.C. § 18052(a)(5) (2018) (providing for combined Medicaid 1115 and ACA 1332 waiver applications to go to HHS). *But see* McCuskey, *Agency Imprimatur*, *supra* note 21, at 1152-53 (warning about allowing the Medicaid 1115 waiver's expansive outlook to "bleed over" into consideration of the narrower ACA 1332 waiver); Marea B. Tumber, *The ACA's 2017 State Innovation Waiver: Is ERISA a Roadblock to Meaningful Healthcare Reform*, 10 U. MASS. L. REV. 388, 424 (2015) (advocating for reform that would "permit states to apply for a specific ERISA waiver").

Of course, the details of legislative drafting will matter enormously, and the guardrails imposed on agency discretion to grant or deny state waiver applications will determine the ultimate efficacy of any waiver mechanism.[363] As the administration of Medicaid and ACA waivers have illustrated, an agency's discretion in granting waivers may prove exceedingly political and threaten the statute's core infrastructure.[364] Yet this may prove less of a concern in the context of ERISA preemption waivers because the provision being waived—preemption of *additional* state regulatory efforts—arguably threatens only the uniformity of regulation large employers enjoy, and does not threaten ERISA's regulations protecting employee benefits.

Proposals to add a waiver to ERISA are neither new, nor entirely academic. In the early 1990s, as states pursued reforms to deal with rising health care costs and growing ranks of uninsured citizens,[365] several members of Congress introduced proposals for ERISA waivers that would permit specific universal coverage reforms in their own states,[366] reminiscent of the Hawaii exemption Congress had enacted in 1983.[367] Others introduced more ambitious legislation that would catalyze and fund state universal health care efforts, supported by administrative waivers of ERISA.[368] When those bills stalled, several members of Congress tried to pass two-year ERISA waivers for their states' reforms,[369] but those stalled, too.[370] After the Clinton Administration's efforts at federal health reform failed in 1994,[371] a bipartisan group of senators introduced another bill that would fund state reform efforts,

363 *See* McCuskey, *Agency Imprimatur*, *supra* note 21, at 1151-53; *see also, e.g.*, *Health Reform Waiver Proposal*, *supra* note 355.

364 *See* Rachel Sachs, *Medicaid Expansion Through Section 1115 Waivers: Evaluating The Tradeoffs*, HEALTH AFF.: HEALTH AFF. BLOG (Mar. 15, 2016), https://www.healthaffairs.org/do/10.1377/hblog20160315.053925/full [https://perma.cc/3XDX-SXT2]; *see generally* McCuskey, *Statutory Sabotage*, *supra* note 2; Watson, *supra* note 338.

365 *See generally* Lawrence D. Brown & Michael S. Sparer, *Window Shopping: State Health Reform Politics in the 1990s*, 20 HEALTH AFF. 50 (2001) (articulating three phases of state health reform from 1990 to 2000).

366 *See* Devon P. Groves, *ERISA Waivers and State Health Care Reform*, 28 COLUM. J.L. & SOC. PROBS. 609, 635-44 (1995) (cataloging legislative proposals to waive aspects ERISA for certain state experiments—all of which "failed miserably" to pass in 1992-1993).

367 Act of January 14, 1983, Pub. L. No. 97-473, § 301, 96 Stat. 2605, 2611-12 (codified at 29 U.S.C. § 1144(b)(5)(A)-(C) (2018)).

368 *E.g.*, State Care Act of 1992, S. 3180, 102d Cong. (1992) (introduced by Vermont Senator Patrick Leahy); State Care: State-Based Comprehensive Care Act of 1992, H.R. 4218, 102d Cong. (1992) (introduced by Washington Representative Jim McDermott). *See* Groves, *supra* note 366, at 638-42 (discussing both of these proposed bills).

369 H.R. REP. NO. 103-111, at 109-12 (1993).

370 *See* Groves, *supra* note 366, at 643-44.

371 Jonathan Oberlander, *Learning from Failure in Health Reform*, 357 NEW ENG. J. MED. 1677, 1677 (2007); *see id.* at 1677-79 (describing the failure of the Clinton Health Security Act); Walter A. Zelman, *The Rationale Behind the Clinton Health Care Reform Plan*, 13 HEALTH AFF., Spring (I) 1994, at 9 (describing the plan before its failure).

supported by expansion of the savings clause and specific preemption waivers for Hawaii, Oregon, Minnesota, Washington, and Connecticut.[372] That bill also died in Congress.[373]

The Affordable Care Act era has seen some recent revival of ERISA waiver legislation, couched in efforts to tweak the ACA's section 1332 waiver process. In 2018, a group of Democratic representatives introduced the State-Based Universal Health Care Act (SBUHCA), which would, among other provisions, add an ERISA preemption waiver within the ACA's 1332 waiver infrastructure.[374] The ACA's existing 1332 waiver provision already permits HHS to waive the ACA's federal employer mandate under certain circumstances,[375] but the proposed SBUHCA modification would give the Department of Labor some authority to suspend ERISA preemption for states enacting ACA-replacement legislation.[376] Couching the ERISA preemption waiver within the ACA 1332 infrastructure would slightly limit the scope of the preemption waiver because a state's application must be part of an effort to replace the ACA and the Department of Labor's grant of any such waiver must stay within the guardrails established by the ACA.[377] SBUHCA, too, died in Congress without a vote.[378]

Despite these efforts, ERISA preemption stands untouched as an obstruction of health care federalism, and an obstacle to state health reform efforts—even to those that further the aims of existing federal law. As our research illustrates, the post-ACA wave of state single-payer proposals interacts with ERISA preemption obstacles in some ingenious ways.[379] But the indeterminacy of ERISA's preemption language, the opacity of ERISA preemption jurisprudence, and the centrality of employer-based health care funding force state legislation to contort and wriggle through exceedingly narrow pathways with the expectation of a potential challenge through

372 Health Innovation Partnership Act of 1994, S. 2452, 103d Cong. (1994), *reprinted in* 140 CONG. REC. 25,616 (1994); *see also* Health Innovation Partnership Act of 1994, H.R. 5119, 103d Cong. (1994) (the companion House bill to S. 2452); Groves, *supra* note 366, at 644-48 (discussing this proposal).

373 *See* H.R. 5119, 103d Cong. (1994); *All Actions: H.R. 5119—103rd Congress (1993-1994)*, CONGRESS.GOV, https://www.congress.gov/bill/103rd-congress/house-bill/5119/all-actions [https://perma.cc/5XJT-KVTB] (showing that the bill has not been enacted).

374 State-Based Universal Health Care Act of 2018, H.R. 6097, 115th Cong. (2018).

375 McCuskey, *Agency Imprimatur*, *supra* note 21, at 1129, 1131-33; *see* 26 U.S.C. § 4980H (2018) (enacting the federal employer mandate).

376 H.R. 6097, 115th Cong. § 2(a) (2018) (proposing § 1332(a)(2)(J)).

377 *See* McCuskey, *Agency Imprimatur*, *supra* note 21, at 1133-37 (articulating the limitations on agency discretion in the ACA 1332 waiver process).

378 *All Actions: H.R. 6097—115th Cong. (2017-2018)*, CONGRESS.GOV, https://www.congress.gov/bill/115th-congress/house-bill/6097/all-actions [https://perma.cc/8JET-ZMGW] (last visited Oct. 20, 2019).

379 *See supra* Section I.B.

litigation.[380] An ERISA preemption waiver would alleviate some of the pressure of ERISA preemption for promising state experiments, while maintaining a federal baseline of preemption.[381]

As with any statutory revision, its implementation depends on political will.[382] Recent Congresses with majorities politically opposed to the ACA have shown increased appetite for statutory waiver and state experimentation, at least rhetorically.[383] But the current administration has granted statutory waivers in ways that erode statutory goals, arguably exceeding the delegated authority.[384] Additionally, the ACA's imposition of a nationwide employer mandate and other insurance-related requirements draw from some of the baseline arguments about ERISA's deregulatory "uniformity" function for the majority of fully insured plans.[385] And the ACA's creation of opportunities for pass-through funding and other statutory waivers for states signals that waivers and state experimentation are core features of ongoing reform efforts.[386] Amending ERISA with a statutory waiver for preemption seems even more urgent and more feasible at this moment in health reform.

3. Shoring up ERISA Preemption Jurisprudence

Even without congressional intervention, courts could strike a better balance between federalism and national uniformity in ERISA preemption by restoring some gestalt principles of ERISA preemption jurisprudence. As described in Part II, courts could more precisely apply the Supreme Court's ERISA precedent from *Travelers*[387] by limiting "relates to" preemption only for those state statutes that eliminate all meaningful choice of health benefits

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380 *See supra* Section II.B.

381 Note that we have not proposed the case-by-case statutory exemptions granted to Hawaii and sought by Massachusetts and other states in the early 1990s. *Cf.* Sidney D. Watson et al., *The Road from Massachusetts to Missouri: What Will It Take for Other States to Replicate Massachusetts Health Reform?*, 55 KAN. L. REV. 1331 (2007).

382 *Cf.* Linke Young, *supra* note 353, at 221 (arguing that debate of the ACA in 2010 offered an opportunity and "legislative vehicle" for altering ERISA).

383 McCuskey, *Agency Imprimatur*, *supra* note 21, at 1139-40, 1164-67; McCuskey, *Statutory Sabotage*, *supra* note 2, at 233-36; *cf.* Exec. Order No. 13,765, 82 Fed. Reg. 8351 (Jan. 24, 2017) (emphasizing state flexibility and instructing HHS to exercise its waiver authority "[t]o the maximum extent permitted" by law).

384 *See* Huberfeld, *supra* note 288, at 788-91; Sidney D. Watson, *Medicaid, Work, and the Courts: Reigning in HHS Overreach*, 46 J.L. MED. & ETHICS, 887, 888-89 (2019).

385 *See, e.g.*, N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995) ("The basic thrust of the pre-emption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."); Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 191 (4th Cir. 2007) (emphasizing uniformity); McCuskey, *Agency Imprimatur*, *supra* note 21, at 1144-45 (describing how the ACA filled some of the regulatory void ERISA had created).

386 *See* McCuskey, *Agency Imprimatur*, *supra* note 21, at 1101-08.

387 514 U.S. 645 (1995).

for employers,[388] rather than extending preemption to state laws that merely make one choice less economically desirable than another.[389]

And courts could return to some jurisprudential principles which militate in favor of state regulation, namely the presumption against preemption and the broader intent behind the ERISA statute. Supreme Court ERISA jurisprudence since *Travelers* has framed preemption analysis with the longstanding presumption against preemption, which the Supreme Court has acknowledged applies with even greater force to regulation in historical spheres of state authority, such as insurance and health care.[390] While the presumption against preemption does not itself save state laws,[391] it should favor preservation of historical state authority—such as regulation of insurance, health care providers, and raising general revenue—in close cases.[392] Self-funded plans, however, remain nearly unreachable by state laws under existing interpretations of deemer and savings clauses, despite the presumption against preemption.[393]

On a more fundamental level, courts could interpret ERISA's preemption provisions with greater fidelity to the statute's context and history, which suggest that employee benefit protection and the preservation of state insurance laws ought to feature more prominently than the current obsession with uniformity. Congress's primary concern in enacting ERISA was "promot[ing] the interests of employees and their beneficiaries in employee benefit plans."[394] To gain support from large employers toward that broader goal, ERISA included the employer-friendly preemption clause designed "to permit the nationally uniform administration of employee benefit plans."[395] The inclusion of the savings clause, however, explicitly contemplated a regulatory regime embracing state-by-state "disuniformities" in the law of

388 *E.g.*, *Fielder*, 475 F.3d at 193.

389 *See* Golden Gate Restaurant Ass'n v. City & Cty. of San Francisco, 546 F.3d 639, 660-61 (9th Cir. 2008).

390 *See Travelers*, 514 U.S. at 654-55; *see also, e.g.*, De Buono v. NYSA—ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 813-14 (1997).

391 *See, e.g.*, *Fielder*, 475 F.3d at 191 (holding a state law preempted, but "recognizing that ERISA is not presumed to supplant state law, especially in cases involving 'fields of traditional state regulation,' which include 'the regulation of matters of health and safety'" (quoting *De Buono*, 520 U.S. at 814 n.8)).

392 *See* McCuskey, *Body of Preemption*, *supra* note 106, at 108-112; *see also, e.g.*, *Golden Gate*, 546 F.3d at 647-48 (reviewing the operation of this historical presumption in the field of health care regulation).

393 *See* FMC Corp. v. Holliday, 498 U.S. 52, 61-63 (1990).

394 Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 90 (1983); *see* 29 U.S.C. § 1001(c) (2018); *see also* Massachusetts v. Morash, 490 U.S. 107, 115 (1989) (identifying the "mismanagement of funds accumulated to finance employee benefits and the failure to pay employees beenfits from accumulated funds" as ERISA's "primary concern"); 120 CONG. REC. 29,193 (1974) (statement of Sen. Biaggi) (describing ERISA as "an emancipation proclamation" for employees).

395 *Travelers*, 514 U.S. at 657; *see* Wooten, *supra* note 102.

health insurance.[396] Courts analyzing preemption often focus on the goal of employer-friendly uniformity and neglect both the savings clause and the statute's broader employee-protection goal.[397] Courts would do well to recognize the import of ERISA's savings clause and the statute's broader employee-protection goal, as measured against the bounded uniformity in the concession to employers.

In the end, we see little reason to expect that courts can fix the dysfunction they have added to a dysfunctional statutory provision. While these jurisprudential adjustments might help clear some way for state single-payer reforms without legislative intervention, they lack the clarity and predictability that statutory revisions can offer.[398] Most of the necessary jurisprudential adjustments would need to come from new Supreme Court opinions,[399] which is an unlikely prospect. And jurisprudential changes deal only with the symptoms of ERISA's obstructionism, not the root cause: the statute's wording, which courts so frequently have lamented and called on Congress to revise,[400] as we do now.

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396 Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985); *see also* Self-Ins. Inst. of Am., Inc. v. Snyder, 827 F.3d 549, 555 (6th Cir. 2016) ("ERISA, in other words, does not 'create a state–law–free zone around everything that affects an ERISA plan.'" (quoting Associated Builders & Contractors v. Mich. Dep't of Labor & Econ. Growth, 543 F.3d 275, 280 (6th Cir. 2008))).

397 *Compare Travelers*, 514 U.S. at 657 (emphasizing uniformity), *FMC Corp.*, 498 U.S. at 60 ("To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits."), *and* Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 191 (2007) (describing uniformity and minimizing administrative burden as ERISA's "primary objective[s]"), *with* Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 56 (D. Mass. 1997) (lamenting that "in the health insurance context, ERISA has evolved into a shield of immunity which thwarts the legitimate claims of the very people it was designed to protect"), *and Self-Ins. Inst.*, 827 F.3d at 555 (contesting the notion that ERISA could fully shield ERISA-regulated plans from state regulation, "particularly in areas of traditional state concern" like "a state tax and its ancillary requirements").

398 *See* Sharpe, *supra* note 111, at 230 (noting, in the context of a different statutory scheme, the "complex interplay between statutory interpretation and federalism default rules that largely drives the Supreme Court's preemption decisions").

399 *Cf.* Egelhoff v. Egelhoff, 532 U.S. 141, 152-53 (2001) (Scalia, J., concurring) (lamenting that Supreme Court precedents provide no clear guidance and recommending a return to "ordinary pre-emption jurisprudence" instead of ERISA exceptionalism).

400 For example, Judge Young observed in *Andrews-Clarke*:

> This case, thus, becomes yet another illustration of the glaring need for Congress to amend ERISA to account for the changing realities of the modern health care system. Enacted to safeguard the interests of employees and their beneficiaries, ERISA has evolved into a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits.

984 F. Supp. at 53.

CONCLUSION

The Affordable Care Act has catalyzed a new era of health reform momentum in state and local governments, as evidenced by the voluminous and robust state single-payer legislation catalogued here. While states may successfully contort their health reform efforts to avoid ERISA preemption, they should not have to do so any longer. ERISA preemption has outlived its utility as applied to health insurance and has elevated the preferences of private businesses above the interests of sovereign states in ways that subvert federalism. The time has come to remove ERISA's obstructions and to unlock states' capacities as laboratories of health reform.

Appendix A: State Single-Payer Proposals, 2010–2019[401]

State		Proposal		Date	A	B	C	Plan Type
1.	CA	SB	562	05/2017		•		B
	CA	SB	810	01/2012	•			A
2.	DE	HB	74	04/2013	•			A
	DE	HB	392	06/2012	•			A
3.	FL	SB	1486	03/2019		•		B
	FL	SB	1872	01/2018		•		B
4.	HI	HB	1286	01/2019				–
	HI	SB	2207	01/2018				–
5.	IA	HF	96	01/2019	•	•		A B
	IA	HF	2352	02/2018	•	•		A B
6.	IL	HB	207	01/2019	•	•		A B
	IL	HF	2436	02/2017	•	•		A B
	IL	SB	2177	10/2015	•	•		A B
	IL	HB	942	01/2013	•	•		A B
	IL	HB	311	01/2011	•	•		A B
7.	MA	HB	2987	01/2017	•	•		A B
	MA	HB	1026	01/2015	•	•		A B
	MA	SB	515	01/2013	•	•		A B
	MA	SB	501	01/2011	•	•		A B
8.	MD	HB	1087	02/2019	•	•		A B
	MD	HB	1516	02/2018		•		B
	MD	SB	667	01/2014				–
9.	ME	HP	316	01/2019			•	C
	ME	HP	887	04/2017			•	C
	ME	HP	962	04/2013		•	•	B C
	ME	HP	1026	04/2011	•	•	•	A B C
10.	MI	HB	6285	08/2018			•	C
11.	MN	SF	1125	01/2019	•		•	A C
	MN	SF	219	01/2017	•		•	A C
	MN	SF	2163	05/2015	•		•	A C
	MN	SF	912	02/2013	•		•	A C
	MN	SF	8	01/2011	•		•	A C

401 Legend: **A** = Funding Plan; **B** = Provider Restriction; **C** = Assignment/Subrogation/Secondary-Payer Provision.

State		Proposal		Date	A	B	C	Plan Type
12.	NH	HB	697	02/2019				–
	NH	HB	1793	01/2018				–
	NH	HB	686	01/2015				–
13.	NJ	SB	2598	05/2018				–
	NJ	AB	5310	12/2017				–
	NJ	AB	4945	06/2017	•	•		A B
14.	NY	AB	5248	02/2019	•	•		A B
	NY	SB	4840	02/2018	•	•		A B
	NY	AB	5062	04/2016	•	•		A B
	NY	AB	5389	04/2013	•	•		A B
	NY	AB	7860	05/2011	•			A
15.	OH	HB	292	06/2019	•	•	•	A B C
	OH	HB	440	12/2017	•	•	•	A B C
	OH	SB	137	04/2015	•	•	•	A B C
	OH	SB	104	04/2013	•	•	•	A B C
	OH	HB	287	06/2011		•	•	B C
16.	OR	SB	631	02/2015			•	C
17.	PA	SB	1014	02/2018	•		•	A C
	PA	HB	1688	11/2015	•		•	A C
	PA	SB	400	01/2013	•		•	A C
	PA	HB	2551	07/2012	•		•	A C
18.	RI	HB	5611	02/2019	•	•	•	A B C
	RI	SB	2237	02/2018	•	•	•	A B C
	RI	SB	2824	03/2016	•	•		A B
19.	SC	SB	786	05/2015	•	•		A B
20.	VT	HB	202	05/2011	•		•	A C
	VT	HB	80	01/2011		•		B
21.	WA	SB	5222	02/2019			•	C
	WA	HB	1104	01/2019	•		•	A C
	WA	SB	5957	06/2017		•		B
	WA	SB	5747	02/2017	•			A
	WA	SB	5741	01/2015	•			A
	WA	SB	5609	02/2013	•			A
	WA	SB	5224	01/2013	•			A
			Proposals		**A**	**B**	**C**	**Any**
Total No.			66		45	34	25	58

Appendix B: Search Methodology to Identify State Single-Payer Bills

State single-payer bills were identified through multiple searches, conducted between June 2018 and September 2019, of four Westlaw databases: (1) proposed legislation; (2) enacted legislation; (3) historical proposed legislation; and (4) historical enacted legislation. The first two contain bills and sessions laws, respectively, from states' current or most recent legislative sessions, whatever those dates may be. The second two contain materials from prior sessions going back to 2005 or before.

Within each database two sets of search terms were used: << advanced: (single-pay*r OR (universal +7 (access OR coverage)) /p health-care) & DA(aft 03-24-2010) >> and << advanced: (all /5 (residents +7 eligib!) AND health) & DA(aft 03-23-2010) >>. After the initial search in June 2018, the "date after" term was updated to the date of the prior search, to capture new bills on a rolling basis over the study period.

Applying the search terms to the four state legislative databases in June 2018 yielded 572 results. Because the databases are continually updated with recent legislation, repeating the search today using the initial search strings will return a different number of results.

From the set of results, we first removed duplicate entries that were found by both sets of search terms. Then, we removed duplicate bills that either were given different designations as they moved through the legislative process (but that were otherwise identical), or substantially similar bills introduced in different chambers in the same state legislative session. Next, using metadata, abstracts, and longer textual reviews where necessary, we then excluded those bills captured by our search terms that did not purport to be a single-payer plan. The most common alternative purposes of such bills were to (1) call for a study, commission, or some other clearly prefatory inquiry into the form or feasibility of a single-payer plan; (2) propose a health care reform initiative where the sponsors explicitly disavowed an intention to create a single-payer system; (3) call for the state legislature to support some proposed national single-payer effort; (4) attempt to thwart national reform efforts, which were often characterized as a "first step" toward a single-payer system; (5) attempt a less-than-comprehensive health system reform or to effect universal access to some specific service (e.g., HIV prevention, primary care, mental health services); or (6) establish exchanges or otherwise implement aspects of the ACA, such as those designating a single state agency for the coordination of care.

The above search, removal, and exclusion steps were performed each time a search was conducted during the study period.

After exclusions, sixty-six proposals remained and were analyzed for their provisions to capture employer health expenditures and/or move individuals with employer-based coverage into the single-payer plan. While comprehensive, this set is not necessarily a census of all unique legislative proposals during this period. Some bills may have been missed during the initial search and others erroneously removed during the subsequent exclusion process.