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## WHERE ARE WE GOING, AND WHERE SHOULD WE BE IN TEN YEARS?

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Employee Retirement Income Security Act (“ERISA”) section 514 generally preempts state tort and tort-like lawsuits against self-insured employment-based health care plans.<sup>1</sup> ERISA’s preemption rule also impedes state efforts to regulate and reform their health care systems. ERISA preemption has also been a key factor in making America’s health care system employment-based, unlike the health care systems in most other industrialized nations. This year, as we renew our debate about how to reform our health care system, we should reconsider whether and how to change the ERISA preemption rule.

At the outset, Part I of this article provides an overview of our current health care system. Part II explains how the ERISA preemption rule influences the structure of our current health care system. Finally, Part III considers the prospects for change.

### I. OVERVIEW OF THE HEALTH CARE SYSTEM

In 2006, national health expenditures totaled \$2,106 billion, 16% of the gross domestic product.<sup>2</sup> The per capita health care expenditure was \$7,026.<sup>3</sup> The United States currently spends about twice as much, per capita, on health care as other industrialized nations.<sup>4</sup>

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1. Employee Retirement Income Security Act (ERISA) of 1974 § 514, 29 U.S.C. § 1144 (2006).

2. NAT’L CENTER FOR HEALTH STAT., HEALTH, UNITED STATES 2008, 412 tbl.124 (2009), available at <http://www.cdc.gov/nchs/data/has/has08.pdf> (last visited May 14, 2009) (\$1,135 billion in private expenditures and \$970 billion in public expenditures [\$705 billion federal and \$265 billion from state and local governments]).

3. *Id.* (\$3,788 per capita in private expenditures and \$3,238 in public expenditures).

4. *See id.* at 411 tbl.123; OECD FACTBOOK 2008: ECONOMIC, ENVIRONMENTAL, AND

The principal coverage mechanisms are employment-based health insurance, Medicare, and Medicaid.<sup>5</sup> In 2007, for example, 177.5 million Americans (59.3%) were covered by employment-based private health insurance, 26.7 million (8.9%) bought their own private insurance, 83.0 million (27.8%) had government health insurance (i.e., Medicare, Medicaid, or military health care), and 45.7 million (15.3%) had no coverage.<sup>6</sup>

Most nonelderly Americans receive their health care coverage through employment-based coverage provided to workers and their families. For example, Table 1 shows that 164.8 million nonelderly Americans (62.9%) received their health care coverage through an employment-based plan in 2007.<sup>7</sup> Another 36.3 million (13.8%) were covered by Medicaid, and 7.1 million (2.7%) were covered by Medicare that year.<sup>8</sup> All in all, some 217.3 million nonelderly Americans (82.9%) had health coverage in 2007, while 45.0 million (17.1%) had no coverage.<sup>9</sup>

Table 1. Health Care Coverage of the Nonelderly, 2007<sup>10</sup>

<i>Source of Coverage</i>	<i>Millions</i>	<i>Percentage</i>
Total population	262.3	100.0
Employment-based coverage	164.8	62.9
Individually Purchased	17.1	6.5
Public	48.6	18.5
Medicare	7.1	2.7
Medicaid	36.3	13.8
Military health care	8.4	3.2
No health insurance	45.0	17.1

SOCIAL STATISTICS 211 (Organisation for Econ. Co-operation and Dev. ed., 2008), available at <http://lysander.sourceoecd.org/vl=3569513/cl=16/nw=1/rpsv/factbook> (last visited Feb. 19, 2009).

5. See CARMEN D. WAIT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007 61 (2008).

6. *Id.*

7. U.S. Census Bureau, Historical Health Insurance Tables, at tbl.HIA-2 (2008), available at <http://www.census.gov/hhes/www/hlthins/historic/index.html> (last visited May 14, 2009) [hereinafter Historical Health Insurance Tables].

8. *Id.*

9. *Id.*

The Medicare program provides nearly universal coverage for elderly Americans. For example, Table 2 shows that 93.2% of the elderly were covered by Medicare in 2007, and only 1.9% of the elderly were without health care coverage that year.<sup>11</sup> Also, in addition to Medicare, many elderly Americans are covered by employment-based retiree health insurance and/or individually-purchased Medigap policies.<sup>12</sup>

Table 2. Health Care Coverage of the Elderly, 2007<sup>13</sup>

<i>Source of Coverage</i>	<i>Millions</i>	<i>Percentage</i>
Total population	36.8	100.0
Employment-based coverage	12.6	34.1
Individually Purchased	9.5	25.9
Public	34.5	93.7
Medicare	34.3	93.2
Medicaid	3.3	8.9
Military health care	2.6	7.1
No health insurance	0.7	1.9

All in all, the federal government is heavily involved in providing health care assistance through Medicare, Medicaid, the State Children's Health Insurance Program<sup>14</sup> ("SCHIP"), veterans' benefits,<sup>15</sup> the

10. *Id.*

11. *Id.*

12. *Id.* Medigap Insurance is defined as supplemental health insurance coverage for Medicare beneficiaries. Center for Medicare Advocacy Inc., Medigap Update, (July 7, 2005), available at <http://www.medicareadvocacy.org/AlertPDFs/2005/07.07.05.Medigap.pdf>.

13. Historical Health Insurance Tables, *supra* note 7.

14. See, e.g., OFFICE OF MGMT. & BUDGET, EXECUTIVE OFFICE OF THE PRESIDENT, THE FY 2008 PERFORMANCE REPORT OF THE FEDERAL GOVERNMENT 16 (2009), available at <http://www.whitehouse.gov/omb/expectmore/2008Performance.pdf> (Dept. of Health & Human Services 2008 Budget); see also U.S. Dept. of Health & Human Servs., Human Res. & Serv. Admin., Children's Health Insurance Program, <http://www.ncsl.org/programs/health/chiphome.htm> (last visited May 14, 2009).

15. See U.S. Dept. of Veterans Affairs, Fact Sheet: Healthcare, <http://www1.va.gov/opa/fact/index.asp> (last visited on May 14, 2009).

exclusion for employment-based health care coverage,<sup>16</sup> the deduction of health care costs,<sup>17</sup> federal employee benefits,<sup>18</sup> and other mechanisms.<sup>19</sup> In 2001, for example, the federal government accounted for 32.9% (\$406.6 billion) of all personal health spending, and state and local governments picked up another 10.6% (\$130.4 billion).<sup>20</sup>

### A. *Employment-Based Health Care Coverage*

Employers are not required to provide health care coverage for their workers. Nevertheless, many employers provide coverage to attract and retain workers and to promote worker health and productivity. For example, in 2007, 60% of employers offered health care coverage to their workers,<sup>21</sup> and surveys show that health insurance is the fringe benefit that is most valued by workers and their families.<sup>22</sup> In 2008, the average annual premiums for employment-based health insurance were \$4,704 for single coverage and \$12,680 for family coverage.<sup>23</sup> Also of note, inflation-adjusted family health insurance premiums have increased by 58% since 2000, while real hourly earnings have increased just 3% over that period.<sup>24</sup>

While 62.2% of the nonelderly population had employment-based

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16. See *infra* note 32 and accompanying text.

17. See *infra* notes 33-39 and accompanying text.

18. See U.S. Office of Personal Management, Federal Employees Health Benefits Program, <http://www.opm.gov/INSURE/HEALTH/> (last visited May 14, 2009).

19. See, e.g., OFFICE OF MGMT. & BUDGET, EXECUTIVE OFFICE OF THE PRESIDENT, THE FY 2008 PERFORMANCE REPORT OF THE FEDERAL GOVERNMENT 16 (2009), available at <http://www.whitehouse.gov/omb/expectmore/2008Performance.pdf> (Dept. of Health & Human Services 2008 Budget).

20. COMMITTEE ON WAYS AND MEANS, 108TH CONG., 2004 GREEN BOOK: BACKGROUND MATERIAL AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS, app. C-1 at tbl.C-4 (Comm. Print 2004), available at <http://waysandmeans.house.gov/Documents.asp?section=813>.

21. Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey* 1, 5, 8 (EBRI, Issue Brief No. 321, 2008), available at [http://www.ebri.org/pdf/briefspdf/EBRI\\_IB\\_09a-2008.pdf](http://www.ebri.org/pdf/briefspdf/EBRI_IB_09a-2008.pdf).

22. See, e.g., Press Release, National Business Group on Health, *Most Workers Satisfied with Health Care Benefits, National Business Group on Health Survey Finds* (Apr. 12, 2007), available at <http://www.businessgrouphealth.org/pressrelease.cfm?ID=87> (finding that the health plan is esteemed to be the most important health benefit to 75% of workers).

23. KAISER FAMILY FOUNDATION AND HEALTH RESEARCH & EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 2008 ANNUAL SURVEY 20 (2008). For singles, the employee contribution averaged \$721, and the employer contribution averaged \$3,983; for families, the employee contribution averaged \$3,354, and the employer contribution averaged \$9,325. *Id.* at 14.

24. OFFICE OF MGMT. & BUDGET, A NEW ERA OF RESPONSIBILITY: RENEWING AMERICA'S PROMISE 13 fig.11 (2009) [hereinafter A NEW ERA OF RESPONSIBILITY].

health care coverage in 2007, coverage also varies dramatically depending on such factors as firm size, industry, and nature of employment.<sup>25</sup> For example, while 79.7% of employees at large private firms (1,000 or more employees) had health care coverage from their employers in 2007, only 58.7% of workers at firms with 10 to 24 workers received health care coverage from their employers that year.<sup>26</sup> Similarly, individuals typically have to work full time to obtain a job with health insurance. In 2007, for example, 72.8% of nonelderly full-year, full-time workers had employment-based health care coverage, compared with just 35.1% of part-time, part-year workers.<sup>27</sup>

Before World War II, relatively few workers had health insurance coverage.<sup>28</sup> “When wages were frozen during World War II, some employers began offering health insurance as a way of getting around government wage controls.”<sup>29</sup> Other significant factors in the development of the employment-based health care system were union support of health insurance and favorable tax treatment.<sup>30</sup> Additionally, employers are typically able to purchase group health insurance coverage at better rates than individual employees.<sup>31</sup>

### 1. Tax Advantages

The tax advantages associated with employment-based health care plans are another reason employment-based plans dominate the provision of health care to working-age Americans and their families. Workers generally must pay income tax on the compensation that they receive from an employer. To encourage employment-based health care coverage, however, employer contributions to health care plans are excluded from income.<sup>32</sup> Also, many employers provide cafeteria and flexible spending plans that enable employees to shelter their share of premiums and other health care costs.<sup>33</sup> Also of note, under the health care continuation rules provided by the Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”), former employees of firms

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25. Fronstin, *supra* note 21, at 1, 11.

26. *Id.* at 11, 12 fig.11.

27. *Id.* at 10 fig.9, 11.

28. *See, e.g.*, JONATHAN BARRY FORMAN, MAKING AMERICA WORK 246 (2006).

29. *Id.*

30. *Id.*

31. *Id.*

32. *See* I.R.C. § 106(a) (2006).

33. *See* I.R.C. §§ 125(a),(d)(2)(D).

with twenty or more workers are typically entitled to continue their health care coverage for awhile after leaving their firms,<sup>34</sup> and some employers also provide health care coverage for their retired workers.<sup>35</sup>

Self-employed individuals are also permitted to deduct 100% of their health insurance costs,<sup>36</sup> but there is no similar tax benefit for employees whose employers do not provide health care coverage.

The tax savings from being able to shelter \$5,000 or \$10,000 a year per family from the income tax makes employment-based health care coverage much more valuable than taxable cash taxed if her employer contributed \$10,000 on her behalf to an employment-based health care plan for her family.<sup>37</sup> On the other hand, that employee would have to pay \$2,500 in income tax on the receipt of \$10,000 in cash compensation ( $\$2,500 = \$10,000 \times 25\%$ ), leaving just \$7,500 after tax—hardly enough to buy a family health insurance policy in the individual market.<sup>38</sup> All in all, the U.S. Treasury loses over \$150 million a year because of the exclusion of employer contributions for health care and another \$5 million a year because of the deduction for self-employed health care premiums.<sup>39</sup>

## 2. Federal Preemption of State Laws

Another reason employment-based plans dominate the provision of health care to working-age Americans and their families is that federal law generally makes it extremely difficult for states to experiment with more universal systems for the provision of health care benefits. As more fully explained in Part II below, ERISA preempts “any and all State laws insofar . . . as they relate to any employee benefit plan.”<sup>40</sup>

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34. Employment Retirement Income Security Act (ERISA) of 1974 § 601, 29 U.S.C. § 1161 (2006).

35. See, e.g., Paul Fronstin, *The Impact of the Erosion of Retiree Health Benefits on Workers and Retirees* 1, 4 (EBRI, Issue Brief No. 279, 2005), available at <http://www.ebri.org/pdf/briefspdf/0305ib.pdf>.

36. See I.R.C. § 162(l).

37. See generally I.R.C. § 106(a) (“Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.”).

38. See generally I.R.C. § 4958(a) (“There is hereby imposed on each excess benefit a tax equal to 25[%] of the excess benefit”).

39. OFFICE OF MGMT. & BUDGET, EXECUTIVE OFFICE OF THE PRESIDENT, ANALYTICAL PERSPECTIVES, BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 2009 (2010), at 288, 290 tbl.19-1. Tax expenditures are defined by as ‘revenue losses attributable to provisions of the Federal tax laws which allow a special exclusion, exemption, or deduction from gross income or which provide a special credit, a preferential rate of tax, or a deferral of liability. *Id.* at 287.

40. Employee Retirement Income Security Act (ERISA) of 1974 § 514(a), 29 U.S.C. §

Although ERISA was largely intended to federalize pension law and had little to say about health care plans, this preemption rule enables employers to avoid state regulation by setting up “self-insured” plans.<sup>41</sup> State governments can dictate how health *insurance* plans work, but they are prevented from telling *self-insured* employment-based plans what to do.<sup>42</sup> The resulting inability of states to regulate all health care plans makes it difficult for the states to act as “laboratories of democracy” that could experiment with the whole range of approaches for expanding coverage.<sup>43</sup>

### B. Medicare

The Medicare program provides nearly universal coverage for elderly Americans and for certain disabled persons.<sup>44</sup> Medicare Part A provides hospital insurance coverage for almost everyone over age sixty-five and for certain disabled persons under age sixty-five.<sup>45</sup> Medicare Part B is a voluntary program that generally pays 80% of the doctor bills and laboratory tests for elderly and disabled individuals who choose to enroll and pay the monthly premium (\$96.40 in 2009).<sup>46</sup> In 2005, 42.5 million people were covered by Medicare, and total program outlays that year were \$336.4 billion.<sup>47</sup>

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1144(a) (2006).

41. See *FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990) (citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 n.19 (1981)).

42. *Id.* at 61.

43. See, e.g., Jon Forman, *Uncle Sam Should Let the States be Laboratories for Health Care Reform*, WASHINGTON EXAMINER, Mar. 2, 2007, at 21, available at [http://www.examiner.com/a-594760~Jon\\_Forman\\_Uncle\\_Sam\\_should\\_let\\_the\\_states\\_be\\_laboratories\\_for\\_health\\_care\\_reform.html](http://www.examiner.com/a-594760~Jon_Forman_Uncle_Sam_should_let_the_states_be_laboratories_for_health_care_reform.html).

44. See, e.g., U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES, *MEDICARE & YOU 2009*, at 12 (Mar. 2009), available at <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>.

45. *Id.* at 17.

46. See *id.* at 21, 25; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *MEDICARE PREMIUMS AND COINSURANCE RATES FOR 2009*, available at <http://www.medicare.gov/default.asp> (last visited May 14, 2009).

47. BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS, 2006 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 5 tbl.II.B1 (2008); see also *A NEW ERA OF RESPONSIBILITY*, *supra* note 24, at 117 tbl.S-3 (projecting a \$453 billion expenditure on Medicare in fiscal year 2010).

### C. Medicaid and the State Children's Health Insurance Program

Medicaid is a federal-state matching entitlement program that provides medical assistance for needy persons who are elderly, blind, disabled, members of families with dependent children, and certain other pregnant women and children.<sup>48</sup> The program is means-tested; that is, eligible recipients must have relatively low income and relatively few assets.<sup>49</sup> The program is financed by general revenues from federal and state governments.<sup>50</sup> States design and administer their programs within federal guidelines, and the federal government reimburses most of their costs.<sup>51</sup> In addition, SCHIP was enacted by Congress in 1997 to expand health care coverage for children in low-income families.<sup>52</sup> The program provides block grants to states in order to provide health care benefits for uninsured children, ineligible for Medicaid, whose families have low incomes.<sup>53</sup> In 2007, 49.1 million people were covered by Medicaid (including SCHIP), and total program outlays that year were \$333.2 billion.<sup>54</sup>

### D. Problems with Cost and Coverage

Far and away the biggest problem with the American health care system has to do with coverage. As noted above, in 2007, 45.7 million Americans (15.3%) had no health care coverage.<sup>55</sup> Clusters of individuals that tend to lack coverage include “employees of small business, workers who lose their jobs, workers who decline employer coverage, low-income parents, low-income childless adults, the near

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48. See, e.g., U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Medicaid Program—General Information, available at <http://www.cms.hhs.gov/MedicaidGenInfo>.

49. *Id.*

50. OFFICE OF THE ACTUARY, CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, 2008 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR MEDICAID 1 (2008), available at <http://www.cms.hhs.gov/ActuarialStudies/downloads/MedicaidReport2008.pdf> [hereinafter ACTUARIAL REPORT].

51. *Id.* at 2.

52. Center for Medicare & Medicaid Services, The Children's Health Insurance Program (CHIP), <http://www.cms.hhs.gov/LowCostHealthInsFamChild>.

53. *Id.*

54. ACTUARIAL REPORT, *supra* note 50, at iii (2008) (\$190.6 billion [57%] federal, and \$142.6 billion [43%] state). See also A NEW ERA OF RESPONSIBILITY, *supra* note 24, at 117 tbl.S-3 (projecting a \$290 billion federal expenditure on Medicaid in fiscal year 2010).

55. See *supra* note 6 and accompanying text.



elderly, young adults, children, and immigrants.”<sup>56</sup>

Part and parcel of the growing coverage problem is the fact that health care costs are spiraling out of control. Spending on health care will account for about 16% of gross domestic product in 2009 and is projected to reach 20% of GDP by 2017.<sup>57</sup> These ever-increasing costs have put pressure on employers, employees, and governments. For example, annual per capita health care expenditures are expected to increase from \$8,300 in 2009 to around \$13,000 in 2017.<sup>58</sup> Of particular concern, the administrative costs associated with the American health care system are “enormous,” with estimates ranging anywhere from \$90 billion to \$294 billion a year.<sup>59</sup> Every health care plan has a different set of rules, and it seems like every insurance company, every employer, every hospital, and every doctor has a different set of claim forms.

## II. OVERVIEW OF ERISA PREEMPTION

Under the U.S. Constitution’s Supremacy Clause, federal laws implicitly preempt and supersede any inconsistent state laws.<sup>60</sup> In the employee benefits area, Congress chose to make this preemption explicit. Accordingly, ERISA preempts “any and all State laws insofar as they . . . relate to any employee benefit plan . . . .”<sup>61</sup> In general, the United States Supreme Court has given this explicit preemption clause an expansive interpretation.<sup>62</sup>

A major exception is provided in the so-called “insurance savings clause” which provides that “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State

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56. STAN DORN, TOWARDS INCREMENTAL PROGRESS: KEY FACTS ABOUT GROUPS OF UNINSURED (2004), available at [http://www.esresearch.org/newsletter/facts\\_uninsured.pdf](http://www.esresearch.org/newsletter/facts_uninsured.pdf).

57. A NEW ERA OF RESPONSIBILITY, *supra* note 24, at 11.

58. Douglass W. Elmendorf, Dir. Cong. Budget Office, Testimony before the Senate Committee on the Budget: Expanding Health Insurance Coverage and Controlling Costs for Health Case, 8 (Feb. 10, 2009).

59. LEIF WELLINGTON HAASE, A NEW DEAL FOR HEALTH: HOW TO COVER EVERYONE AND GET MEDICAL COSTS UNDER CONTROL 25 (2005), available at <http://www.tcf.org/Publications/HealthCare/newdealhealth.pdf>.

60. U.S. CONST. art. VI, § 2; JOHN H. LANGBEIN, SUSAN J. STABILE, & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW 758 (4th ed. 2006).

61. Employment Retirement Income Security Act (ERISA) of 1974 § 514(a), 29 U.S.C. § 1144(a) (2006).

62. *See, e.g.*, *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 507, 526 (1981) (preempting a New Jersey law that undertook to regulate how an employee benefit plan computed benefits); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 88, 108 (1983) (preempting a New York law that forbade discrimination in employee benefit plans on the basis of pregnancy).

which regulates insurance, banking, or securities.”<sup>63</sup> The insurance exception is itself subject to an important exception under the so-called “deemer clause” which provides that employee benefit plans are not to be considered insurance for purposes of the insurance savings clause.<sup>64</sup>

Altogether, the net effect of the broad preemption provision and the insurance and deemer provisions is known as semi-preemption.<sup>65</sup> States can pass laws that regulate insurance, but they cannot regulate self-insured employee benefit plans.<sup>66</sup> In the health arena, this semi-preemption policy has been enormously important. Here’s how it works.

Basically, if an employer chooses to offer health care coverage for its employees, the employer can go to an insurance company and buy a group health policy. At its simplest, the employer pays premiums to the insurance company, and in exchange, the insurance company pays the health care bills of the employees. States are free to regulate the health insurance policies that regulate employees that live within their borders, and most states have extensive insurance laws that govern the kind of policies that can be written and offer protections for the insured employers and for employee-beneficiaries. A state could, for example, require health insurance policies sold in its state to pay for psychiatric or chiropractic services, or for acupuncture services.<sup>67</sup>

On the other hand, because of the deemer clause, employers that elect to self-insure can avoid those state-mandated benefits. Under a self-insured plan, the employer bears the responsibility for paying benefits. Typically, the employer hires an insurance company to actually administer the health care plan, in which case the insurance company is called a third-party administrator.<sup>68</sup> The employer pays for those administrative services and provides the funds needed to pay hospitals, doctors, and other health care providers. These payments are not premiums for insurance, however, and state laws governing

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63. ERISA § 514(b)(2)(A).

64. ERISA § 514(b)(2)(B).

65. Daniel M. Fox & Daniel C. Schaffer, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 AM. J. TAX POL’Y 47, 47-48 (1988).

66. See William Pierron & Paul Fronstin, *ERISA Pre-emption: Implications for Health Reform and Coverage* (EBRI, Issue Brief No. 314, 2008) at 4-5 & 6 available at [http://www.ebri.org/pdf/briefspdf/EBRI\\_IB\\_02a-20082.pdf](http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf).

67. See, e.g., *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727, 758 (1985) (upholding a Massachusetts law requiring insurers to provide for psychiatric services).

68. These third party administrators perform tasks such as “developing networks of providers, negotiating payment rates, processing claims, and so forth.” CONG. BUDGET OFFICE, KEY ISSUES IN ANALYZING MAJOR HEALTH INSURANCE PROPOSALS (2008), at 6 box 1-1 [hereinafter CONGRESSIONAL BUDGET OFFICE].

insurance do not apply to these plans.<sup>69</sup> In 2008, 55% of covered employees were in self-funded plans.<sup>70</sup> Needless to say, from the employee-beneficiary standpoint, these self-insured plans feel just like insured plans.

By design, ERISA's semi-preemption policy ensured that large employers and large unions could provide uniform benefit plans to their workers around the country and did not have to modify their plans to satisfy the parochial demands of the various states.<sup>71</sup> Implicitly, however, this grand compromise between business and labor took away the ability of states to fully regulate the provision of health care within their borders. Plans that self-insure are exempt from state benefit mandates and insurance regulation.<sup>72</sup> Meanwhile, the federal government has done little since 1974 to regulate health care in any sort of comprehensive way. Not surprisingly, after thirty-five years of ERISA-sanctioned neglect, we are far from achieving universal health care coverage, health care costs are spiraling out of control, and nobody is particularly happy with the current system.

More specifically, ERISA's semi-preemption policy has manifested itself in three principal ways. First, ERISA preempts virtually all state law remedies for wronged beneficiaries of employment-based health care plans. Second, ERISA impedes state efforts to regulate and reform the health care systems that operate within their borders. Third, the ERISA and Internal Revenue Code advantages for employment-based health care plans have all but made it all but impossible for alternative health care plans to develop. These are discussed in turn.

#### A. ERISA Preempts State Law Remedies

First, ERISA severely limits the likelihood and amount of

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69. See, e.g., *FMC Corp. v. Holliday*, 498 U.S. 52, 54, 65 (1990) (holding that a self-insured plan was not subject to a Pennsylvania anti-subrogation law). To be sure, many employers purchase so-called "stop-loss" insurance, which protects the employer from the risk that actual health care costs for its employees exceed some budgeted-for specified threshold. See, e.g., LANGBEIN ET AL., *supra* note 60, at 806-07.

70. KAISER FAMILY FOUNDATION AND HEALTH RESEARCH & EDUCATIONAL TRUST, *supra* note 23, at 155. See also Pierron & Fronstin, *supra* note 66 at 1; CONGRESSIONAL BUDGET OFFICE, *supra* note 68, at 6.

71. See, e.g., Michael S. Gordon, *The History of ERISA's Preemption Provision and Its Bearing on the Current Debate over Health Care Reform*, in *Health Care Reform: Managed Competition and Beyond* 28-30 (EBRI Issue Brief No. 135, 1993), available at <http://www.ebri.org/pdf/briefspdf/0393ib.pdf>.

72. See *FMC Corp.*, 498 U.S. at 61.

recoveries that are available to beneficiaries of employee benefit plans. In that regard, ERISA generally preempts virtually all state tort and tort-related causes of action against employee benefit plans.<sup>73</sup> According to the Supreme Court, ERISA provides a “comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans.”<sup>74</sup> To be sure, ERISA permits plan participants and beneficiaries “to recover benefits due him under the terms of the plan,” “to enforce his rights under the terms of the plan,” and to obtain “appropriate equitable relief.”<sup>75</sup> But participants and beneficiaries cannot recover consequential or punitive damages.<sup>76</sup> In short, you can sue to make the plan provide your benefits, but you cannot recover any extra damages for any wrongful denial of benefits, nor are you likely to get attorney fees.<sup>77</sup>

Pertinent here, traditional medical malpractice tort suits against doctors and other practitioners can survive preemption, but the employee benefit plan is virtually always exempt from such suits.<sup>78</sup> Also of note, beneficiaries are required to exhaust their administrative remedies before bringing a suit against an employee benefit plan,<sup>79</sup> the court will usually only overturn the plan administrator’s decision if it was arbitrary and capricious,<sup>80</sup> and it is virtually impossible to get a jury trial.

Of note, recent Supreme Court decisions have backed away from the Court’s earlier expansive view of the “relate to an employee benefit

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73. See, e.g., *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144, 148 (1985).

74. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 43, 54 (1987) (preempting a state cause of action based on the tort of bad faith denial). In *Russell*, the Supreme Court noted that ERISA has a “comprehensive and reticulated” remedial scheme. *Russell*, 473 U.S. at 146 (quoting *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361 (1980)). See also *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 60, 62-63, 66 (1987) (preempting state causes of action that fell within ERISA section 502(a)(1)(B)).

75. Employment Retirement Security Income Act (ERISA) of 1974 § 502(a)(1)(B), (3), 29 U.S.C. § 1132(a)(1)(B), (3) (2006).

76. See *Russell*, 473 U.S. at 144.

77. See *Russell*, 473 U.S. at 138. In *Alessi v. Raybestos-Manhattan, Inc.*, the Supreme Court noted that ERISA is concerned with both benefiting employees and controlling costs. 451 U.S. at 515.

78. See, e.g., *LANGBEIN ET AL.*, *supra* note 60, at 824-26; see also *Pegram v. Herdich*, 530 U.S. 211, 214, 237 (2000).

79. *Hickey v. Digital Equip. Corp.*, 43 F.3d 941, 945 (4th Cir. 1995) (citations omitted); *Comm’ns Workers of Am. v. AT&T Co.*, 40 F.3d 426, 432 (D.C. Cir. 1994); *Kross v. W. Elec. Co.*, 701 F.2d 1238, 1245 (7th Cir. 1983).

80. See HEALTH ADMINISTRATION RESPONSIBILITY PROJECT, STANDARD OF REVIEW OF DENIAL OF PLAN BENEFITS UNDER ERISA, <http://www.harp.org/erisaor.htm> (last visited Oct. 15, 2009).

plan” preemption language in ERISA section 514(a). For example, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,<sup>81</sup> the Supreme Court refused to preempt a New York law that imposed hospital surcharges which had an adverse impact on self-insured plans.<sup>82</sup>

The Supreme Court has also expanded the role of the “insurance savings” clause in ERISA section 514(b)(2)(A). In *Rush Prudential HMO, Inc. v. Moran*,<sup>83</sup> the Court held that ERISA did not preempt Illinois’ Health Maintenance Organizations Act which gave HMO beneficiaries the right to independent review of benefit denials; the court found that those independent reviews did not conflict with ERISA’s remedial scheme.<sup>84</sup> On the other hand, in *Aetna Health Inc., v. Davila*,<sup>85</sup> the Supreme Court reiterated that “a state law that can arguably be characterized as ‘regulating insurance’ will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA’s remedial scheme.”<sup>86</sup>

#### *B. ERISA Impedes State Efforts to Regulate and Reform Their Health Care Systems*

Second, ERISA impedes state efforts to regulate and reform their health care systems. Because of ERISA’s policy of semi-preemption, states are generally prohibited from imposing benefit mandates or otherwise regulating self-insured employment-based health care plans. The State of Hawaii enacted its Prepaid Health Care system in 1974, prior to the enactment of ERISA.<sup>87</sup> That system requires all employers in Hawaii to offer employees basic health care coverage, and Congress granted Hawaii a waiver from the ERISA provisions that would have otherwise interfered with its mandate.<sup>88</sup>

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81. 45 U.S. 645 (1995).

82. *Id.* at 649. *See also* De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 808-09 (1997) (refusing to preempt a tax of general applicability on medical providers).

83. 536 U.S. 355 (2002).

84. *See id.* at 359. Similarly, in *Kentucky Association of Health Plans v. Miller*, the Supreme Court refused to preempt a Kentucky “any willing provider” law that required health insurers and managed care organizations to reimburse all licensed physicians and other health professionals as long as they were willing and qualified to participate in the insurer’s network. 538 U.S. 329, 331-32, 334 (2003).

85. 542 U.S. 200 (2004).

86. *Id.* at 217-18.

87. CONGRESSIONAL BUDGET OFFICE, *supra* note 68, at 50.

88. *Id.* at 50 & n.1.

More recently, Maryland enacted legislation that would have required companies with at least 10,000 employees (i.e., Wal-Mart) to spend at least 8% of payroll on health care or give the difference to the state.<sup>89</sup> In 2007, however, the Court of Appeals for the Fourth Circuit struck that legislation down, ruling that it was preempted by ERISA.<sup>90</sup>

Massachusetts recently enacted a comprehensive health care law with individual mandates and employer mandates.<sup>91</sup> The new law requires every resident eighteen years of age or over to have health insurance (an individual mandate) and requires every employer with eleven or more employees to offer health insurance and offer a “cafeteria plan” so that employees can elect to exclude their premiums from income and payroll taxes (an employer mandate).<sup>92</sup> Employers must either “pay or play”; that is, they must either make a “fair and reasonable contribution” to the health insurance of their employees or pay the state of Massachusetts as much as \$295 per worker per year.<sup>93</sup> While the Massachusetts law seems like a perfectly reasonable way to promote universal health care coverage, I believe that the employer mandate is preempted by ERISA.<sup>94</sup>

Similarly, the City of San Francisco recently adopted a mandated health benefit ordinance.<sup>95</sup> The ordinance was immediately challenged by employers as preempted by ERISA, but the Court of Appeals for the Ninth Circuit has so far rejected claims that the ordinance is preempted by ERISA.<sup>96</sup> As there is now a split in the circuits, the issue is ripe for consideration by the Supreme Court.

### C. ERISA Favors Employment-Based Health Care

Third, ERISA and the Internal Revenue Code favor employment-

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89. See, e.g., JON O. SHIMABUKURO & JENNIFER STAMAN, LEGAL ISSUES RELATING TO STATE HEALTH CARE REGULATION: ERISA PREEMPTION AND FAIR SHARE LAWS 4 (2008); Editorial, *Beating Up on Wal-Mart*, WASH. POST, Jan. 12, 2006, at A20; Memorandum from the Groom Law Group on State Laws and ERISA Preemption 4 (July 27, 2007), available at [http://www.americanbenefitscouncil.com/documents/background\\_memo\\_on\\_erisa\\_preemption.pdf](http://www.americanbenefitscouncil.com/documents/background_memo_on_erisa_preemption.pdf).

90. Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 183, 197 (4th Cir. 2007).

91. CONGRESSIONAL BUDGET OFFICE, *supra* note 68, at 48.

92. *Id.* at 51.

93. *Id.*

94. See Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption and Experimentation*, 49 WM. & MARY L. REV. 229, 276-87 (2007).

95. S.F., Cal., HEALTH CARE SECURITY ORDINANCE §§ 14.1-14.8.

96. Golden Gate Rest. Ass'n v. City & County of San Francisco, 546 F.3d 639, 642, 661 (9th Cir. 2008). See also Edward A. Zelinsky, *Employer Mandates and ERISA Preemption: A Critique of Golden Gate Restaurant Association v. San Francisco*, 47 ST. TAX NOTES 603, 603 (2008).

based health care plans over other types of plans. ERISA governs employee benefit plans and provides, *inter alia*, preemption “protections” for employee benefit plans.<sup>97</sup> Similarly, the Internal Revenue Code provides extremely valuable tax benefits for employment-based health care plans.<sup>98</sup> Group health insurance rates are also much lower than individual rates. The bottom line is that there are tremendous price advantages for workers who get their health care coverage through employment-based plans. Moreover, since the tax and preemption provisions apply only to employee benefit plans, community groups and associations cannot offer group health care coverage at rates that are anywhere near as low as what employment-based plans can.

### III. PROSPECTS FOR REFORM

This section considers how Congressional efforts in the coming years might impact ERISA’s preemption rule. Other articles in this Symposium offer suggestions about how to persuade the Supreme Court to back away from its usual expansive readings of ERISA’s preemption clause and the deemer clause.<sup>99</sup> I view it as unlikely that the Supreme Court will reverse its expansive reading of ERISA preemption at this late date unless Congress actually amends ERISA. That said, I believe that Congressional efforts to reform the health care system are unlikely to result in much change to the current semi-preemption rule in ERISA.<sup>100</sup>

#### A. Health Care Reform Generally

To be sure, President Barack Obama and Congress both seem committed to addressing the current health care systems twin problems of coverage and cost. We are just now getting the details of President

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97. See JAMES WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY* 4-5 (2004) (discussing how ERISA was based on the “worker-security theory”).

98. I.R.C. § 162(a) (making employer contributions to a health care plan deductible by the employer as ordinary and necessary business expenses).

99. See, e.g., Paul M. Secunda, *Sorry, No Remedy: Intersectionality and the Grand Irony of ERISA*, 61 *HASTINGS L.J.* (forthcoming Dec. 2009) (manuscript at 33, on file with author).

100. See *Health Care Reform: AARP Official Sees Health Reform in '09, With ERISA Preemption Likely to Remain*, 36 *PENS. & BEN. REP. (BNA)* 45, 72 (2009) (quoting AARP policy director John Rother, stating that “[ERISA] preemption is not likely to be changed . . . during the reform process”).

Barack Obama's health care proposal,<sup>101</sup> and we are a long way from having any kind of comprehensive health care plan get through Congress. Still, I think we can already begin to see the direction that health care reform will take.

"While universal coverage [is] almost certainly . . . our ultimate goal," I believe that we will get there incrementally, for example, by "designing and expanding health care programs for particular groups of the uninsured."<sup>102</sup> For example, The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP") expands SCHIP health coverage to provide coverage to children with family incomes up to 300% of the federal poverty line.<sup>103</sup> The new law also allows states to provide premium assistance for employment-based group health coverage that is elected for SCHIP-eligible children.<sup>104</sup> Similarly, the American Recovery and Reinvestment Act of 2009 helps unemployed workers keep their employment-based coverage by providing a 65% subsidy for health insurance premiums for up to nine months.<sup>105</sup>

Along the same lines, we could "extend COBRA health care continuation coverage to 36 or more months or until eligibility for Medicare at age 65."<sup>106</sup> Another approach would be to "expand Medicaid or develop other programs to ensure seamless coverage for

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101. See, e.g., The White House, The Agenda—Health Care, [http://www.whitehouse.gov/agenda/health\\_care](http://www.whitehouse.gov/agenda/health_care); A NEW ERA OF RESPONSIBILITY, *supra* note 24, at 27-30.

102. Jonathan Barry Forman, *Making Universal Health Care Work*, 19 ST. THOMAS L. REV. 137, 142 (2006). See also CONGRESSIONAL BUDGET OFFICE, BUDGET OPTIONS VOLUME I HEALTH CARE 1 (2008) (outlining 115 budget options related to the financing and delivery of health care that do not have to do with preemption).

103. Pub. L. No. 111-3, § 114(a) (2009); Press Release, U.S. S. Fin. Comm., The Children's Health Insurance Program Reauthorization Act: Frequently Asked Questions (2009), available at <http://finance.senate.gov/sitepages/2009%20CHIPRA.html> (last visited Feb. 19, 2009). See also CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE, H.R.2 Children's Health Insurance Program Reauthorization Act of 2009 (2009), available at <http://www.cbo.gov/ftpdocs/99xx/doc9985/hr2paygo.pdf> (last visited Feb. 19, 2009) [hereinafter COST ESTIMATE]. Of note, the Children's Health Insurance Program Reauthorization Act amended ERISA to better coordinate the CHIP provisions with employment-based health care plans. See, e.g., Michael W. Wyand & Florence Olsen, *Expansion of CHIP Program Amends ERISA To Promote Coordination with Employer Plans*, 36 PEN. & BEN. REP. (BNA) 299 (Feb. 10, 2009).

104. Pub. L. No. 111-3, § 301(a)(1)(A) & (B); COST ESTIMATE *supra* note 103, at 1.

105. U.S. S. FIN. COMM., THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009: FULL SUMMARY OF PROVISIONS FROM SENATE FINANCE, HOUSE WAYS & MEANS COMMITTEES 16 (2009), available at <http://finance.senate.gov/press/Bpress/2009press/prb021209.pdf>.

106. Forman, *supra* note 102, at 143; see also Len M. Nichols, *Policy Options for Filling Gaps in the Health Insurance Coverage of Older Workers and Retirees*, in ENSURING HEALTH AND INCOME SECURITY FOR AN AGING WORKFORCE 456-57 (Peter P. Budetti et. al eds., 2001).



individuals making the transition from welfare to work.”<sup>107</sup> “The government might also be able to expand coverage for employees of small businesses by providing tax credits to employers that provide health insurance to their employees.”<sup>108</sup>

In the long run, we could achieve nearly universal coverage if we use two basic approaches. First, we would need to subsidize health insurance premiums, either through the tax system or through spending programs. Second, we would need to impose health insurance mandates. Certainly, we would need an “*individual* mandate[], requiring individuals to secure coverage from their employers or some other source”<sup>109</sup> and subjecting those individuals to financial penalties if they do not secure coverage. It might also make sense to have *employer* mandates. “Under this approach, all employers would be required to either provide health care coverage for their workers or pay a payroll tax so that the government could provide coverage (‘play or pay’).”<sup>110</sup>

We could, for example, move to a system which requires all individuals to have health insurance, requires all employers to offer health insurance for their employees, and uses tax credits to help pay for that insurance.<sup>111</sup> More specifically, the current exclusion for employment-based health care coverage could be “capped at a fixed-dollar amount and gradually replaced with a refundable [health care] tax credit”; “employers [could] be required to offer, but not necessarily pay for, at least one [approved] health insurance plan for [their] employees”; and “individuals [could] be required to get health insurance or lose tax benefits such as personal exemptions and standard deductions.”<sup>112</sup>

All in all, it seems unlikely that much will happen to ERISA’s

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107. Forman, *supra* note 102, at 142; *see also* JOEL F. HANDLER & YEHESEKEL HASENFELD, *WE THE POOR PEOPLE: WORK, POVERTY, AND WELFARE* 134 (The Twentieth Century Fund 1997). “For example, it could make sense to simplify transitional medical assistance by allowing former welfare recipients to continue their Medicaid coverage for months or even years after they start working, regardless of income level.” Forman, *supra* note 102, at 142.

108. Forman, *supra* note 102, at 143; *see, e.g.*, BOWEN GARRETT, LEN M. NICHOLS & EMILY K. GREENMAN, *WORKERS WITHOUT HEALTH INSURANCE: WHO ARE THEY AND HOW CAN POLICY REACH THEM?* 1, 25 (2001), <http://www.urban.org/publications/310244.html> (last visited Feb. 26, 2009).

109. Forman, *supra* note 102, at 145 (emphasis added).

110. *Id.* at 147.

111. *See, e.g.*, C. Eugene Steuerle, *A Workable Social Insurance Approach to Expanding Health Insurance Coverage in 3 COVERING AMERICA: REAL REMEDIES FOR THE UNINSURED* 97, 103-04 (2003) (proposing larger private and public spending on health care through tax credits, individual choices, and employer contributions).

112. Forman, *supra* note 102, at 149; FORMAN, *MAKING AMERICA WORK*, *supra* note 28, at 257-61.

preemption rule in the short run or in the long run.

*B. Little Chance for Expanded Remedies*

First, I view it as unlikely that Congress will relax the ERISA preemption rule to allow employee benefit plans to be sued under state tort and tort-like remedies. To be sure, the trial lawyers have often been described as major supporters of the Democratic Party,<sup>113</sup> and Democrats now control the House, Senate, and White House. Still, funds for health care are in short supply, and I just cannot imagine that the federal government will easily allow much of those precious resources to get side-tracked into paying consequential damages, punitive damages, or attorney fees. Moreover, large employers are adamantly opposed to giving up the preemption “protection” they get under ERISA,<sup>114</sup> and Republicans hold enough votes in the Senate to filibuster any legislation that does not have a bipartisan feel to it.<sup>115</sup>

Mind you, I am a believer in federalism, and before Medicare and ERISA, health care was traditionally a matter of state concern. Now, however, we have decades of federal involvement in regulating and paying for health care. I just cannot see why the federal government would now cede control of health care to the states.

Instead, if, in fact, Congress ever becomes concerned about the rights of participants and beneficiaries who are wronged by their health care plans, I believe that it will craft a federal solution. For example, as Professor Paul Secunda argues, Congress could expand the equitable remedies available under ERISA in appropriate cases, and Congress might even permit ERISA plaintiffs to receive consequential and punitive damages in certain instances.<sup>116</sup> Alternatively, Congress might require plans to provide more balanced procedures for handling disputes,

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113. See generally Bill Swindell, *Trial Lawyers Mount a Comeback*, NAT'L J. MAG. July 12, 2008, available at [http://www.nationaljournal.com/njmagazine/11\\_20080712\\_5109.php](http://www.nationaljournal.com/njmagazine/11_20080712_5109.php) (last visited Apr. 14, 2009) (discussing how trial lawyers “were demonized on Capitol Hill” during the Bush administration when Republicans held the majority in Congress).

114. See *Analysis & Perspective: Health Care Reform: Employers Enter Health Reform Debate Reluctant to Part with Tax Exclusions*, 36 PENS. & BEN. REP. (BNA) 196, 198 (Jan. 27, 2009); see generally THE ERISA INDUSTRY COMMITTEE, ERIC FIGHTS TO PRESERVE ERISA PREEMPTION (2008), <http://www.eric.org/forms/documents/DocumentFormPublic/view?id=E5F50000010> (last visited Apr. 14, 2009) (stating that employers support ERIC in fighting against attempts to weaken the preemptive effect of ERISA).

115. See, e.g., *Supporters Optimistic About Health Care Reform but Numerous Obstacles Ahead*, 36 PENS. & BEN. REP. (BNA) 146 (Jan. 20, 2009).

116. See Secunda, *supra* note 99, at 49.

perhaps by requiring employee benefit plans to make use of independent claim reviewers or outside arbitrators.

### C. *Some Chance That We Allow the States to Regulate Plans*

Second, while I view it as unlikely that the federal government would permit state tort and tort-like remedies against self-insured plans, I do believe that there is a slight chance that the federal government will relax the ERISA preemption rule to allow states to experiment with ways to achieve universal health care coverage. Historically, the states are our “laboratories of democracy,”<sup>117</sup> and allowing them to experiment with a knotty problem like health care reform might just lead us to a universal coverage solution faster and cheaper than the federal government alone ever could.<sup>118</sup>

I doubt that we would ever actually repeal the ERISA preemption rule to allow states the complete freedom to reregulate their health care systems. A more tentative approach would be to authorize the U.S. Department of Labor and/or the U.S. Department of Health and Human Services to allow the states to apply for waivers from ERISA’s broad preemption rule. That is what we did when we wanted to reform the welfare system in the 1990s, and the same approach might work for health care reform, too.<sup>119</sup> For example, Congress could pass legislation to allow the U.S. Department of Labor to waive the ERISA preemption

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117. See *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting); see also Forman, *supra* note 43.

118. Forman, *supra* note 43. See also *Health Care Reform: Recommendations to Improve Coordination of Federal and State Initiatives Before the Subcomm. on Health, Employment, Labor and Pensions of the H. Comm. on Education and Labor*, 110th Cong. 1, 5 (2007), available at <http://edlabor.house.gov/testimony/052207MilaKofmanTestimony.pdf> (last visited Apr. 16, 2009) (testimony of Mila Kofman, Associate Research Professor, Georgetown University’s Health Policy Institute).

119. “Between January 1993 and August 1996, the [U.S.] Department of Health and Human Services approved welfare [reform] waivers in 43 [different] states”—for everything from demonstration projects to comprehensive state-wide reforms. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, STATE WELFARE WAIVERS: AN OVERVIEW (2001), available at <http://aspe.hhs.gov/HSP/isp/waiver2/waivers.htm> (last visited Apr. 16, 2009). Along the same lines, the Medicaid statute authorizes the Secretary of Health and Human Services to grant exceptions to specific substantive requirements of the Medicaid program. Social Security Act § 1115, 42 U.S.C. § 1315(a) (2006) (providing authority to approve projects that test policy innovations likely to further the objectives of Medicaid); Social Security Act § 1915(b), 42 U.S.C. § 1396n(b) (2000) (providing authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals’ choice of provider under Medicaid); Social Security Act § 1915(c), 42 U.S.C. § 1396n(c) (2000) (providing authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings).

rule so that a state could carry out an experimental or pilot project to reform its health care system. Applications for waivers would be carefully reviewed, and all projects should be rigorously evaluated to see what works and what does not.

To be sure, large companies would go apoplectic over “the cost and difficulty of trying to comply with these rules if they varied in all 50 states (let alone 3,077 counties and 87,525 municipalities),”<sup>120</sup> and I still cannot see why federal officials or politicians would want to cede power to the states.<sup>121</sup> Nevertheless, the health care situation has gotten so close to a crisis that the federal government just might be willing to let the states experiment with some different approaches. The federal government might even be able to escape from some of the responsibility for paying for health care, for example, by giving the states the power to regulate their health care systems and the responsibility for ensuring that their workers, employers, and taxpayers bear more of the cost of that health care.

A more limited approach would be to allow the states to extend some of their insurance regulation provisions to self-insured plans. Recall, that in *Rush Prudential HMO, Inc. v. Moran*, the Supreme Court allowed Illinois to give beneficiaries of health care from certain HMOs the right to independent review of benefit denials.<sup>122</sup> Congress could amend ERISA section 514 to give the states the authority to regulate the benefits decisions of both insured and self-insured health care plans.

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120. *Health Care Reform: Recommendations to Improve Coordination of Federal and State Initiatives before the Subcomm. on Health, Employment, Labor and Pensions of the H. Comm. on Education and Labor*, 110th Cong. 5 (2007), available at <http://edworkforce.house.gov/testimony/052207KevinCovertTestimony.pdf> (last visited Apr. 16, 2009) (testimony of Kevin Covert, Vice President and Deputy General Counsel for Human Resources, Honeywell, on behalf of the American Benefits Council); see also *Health Care Reform: Recommendations to Improve Coordination of Federal and State Initiatives Before the Subcomm. on Health, Employment, Labor and Pensions of the H. Comm. on Education and Labor*, 110th Cong. 10 (2007), available at <http://edlabor.house.gov/testimony/052207AmyMooreTestimony.pdf> (last visited Apr. 16, 2009) (statement of Amy N. Moore, Partner, Covington & Burling LLP).

121. Giving up power is tantamount to giving up campaign contributions, and elections have become very expensive. See, e.g., Brody Mullins & T.W. Farnan, *After Costly Race, Groups Aim to Alter Public Financing for Presidential Runs*, WALL ST. J., Nov. 10, 2008, at 6A (noting that a record of \$5.3 billion was spent in the 2008 federal election). See also Rep. John Kline, *ERISA Proposals Do More Harm Than Good*, THE HILL, Sept. 23, 2008, available at <http://thehill.com/ops-eds/erisa-proposals-do-more-harm-than-good-2008-09-23.html>.

122. 536 U.S. 355, 359, 364 (2002).

*D. Some Chance of Moving Away from Employment-Based Coverage*

Finally, I think that there is some chance that the federal government will change ERISA and the Internal Revenue Code to give community groups and other nonprofits the same tax and regulatory advantages that are now available only to employment-based plans. In that regard, many observers believe that we could improve the current health care system by removing the current link between health care and employment.<sup>123</sup> Indeed, the United States is virtually the only industrialized nation that ties health care so closely to employment: most other industrialized nations have universal health care systems run by their governments.

I used to think that it was likely that we would also abandon employment-based health care altogether and move to a universal government-run system, and maybe we will, but not in the next decade. Neither employers nor politicians want to abandon the current employment-based system. In fact, the current system seems to be working pretty well for the vast majority of nonelderly Americans who are covered under employment-based plans. In that regard, employers mistrust a universal government-run system, and politicians do not want to do anything that shifts costs from employers to the government.<sup>124</sup>

It is also worth noting that there are also some real positive health externalities that come from having employers involved in providing health care benefits to their employees. In particular, employers actually care about the health of their employees and about the cost of their health care. Consequently, employers have incentives to promote healthy habits and lifestyles, as these can both reduce health care costs and improve employee well-being and productivity. Employers also regularly communicate with their employees and can give them opportunities for exercise, health advice, and testing (e.g., blood pressure, cholesterol, weight, and body mass). Moving away from an employment-based health care system would reduce these positive incentives that employers have to improve the health of their employees.

Still, it could make sense to encourage community groups and nonprofit organizations to offer health care plans, even if that means giving them the same tax and regulatory advantages that are now

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123. See, e.g., HAASE, *supra* note 59, at 25; see also David M. Cutler, *Public Policy for Health Care*, in *FISCAL POLICY: LESSONS FROM ECONOMIC RESEARCH* 159 (Alan J. Auerbach ed. 1997).

124. See, e.g., *Analysis & Perspective*, *supra* note 114; SENATE FIN. COMM., CALL TO ACTION: HEALTH REFORM 2009 (2008), at 16-17, available at <http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf> (last visited Apr. 14, 2009).

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available only to employment-based plans. In that regard, however, President George Bush repeatedly called for the creation of so-called “Association Health Plans” for small businesses that would have allowed associations, as well as employers, to offer health care plans.<sup>125</sup> Because those plans would have been given the same preemption “protections” that are accorded to self-insured employee benefit plans, many critics argued that the legislation would “gut state protections for patients,”<sup>126</sup> and that legislation went nowhere. Within the context of the current debate over comprehensive health care reform, however, Congress just might let community groups, associations, and other nonprofit organizations offer health care plans, even if that means giving them preemption protection and tax benefits.

#### IV. CONCLUSION

Most nonelderly Americans receive their health care coverage through employment-based plans that work tolerably well, and neither employers nor politicians want to abandon this employment-based system. Instead, health care reform will proceed incrementally. We will provide incentives for employers to cover more of their workers, and we will continue to expand SCHIP, COBRA, Medicare, and Medicaid. Eventually, we should be able to get remarkably close to universal health care coverage; and we should be able to put the brakes on rising health care costs.

Against this background, the prospects for relaxing the ERISA preemption rule are slim. We are unlikely to relax ERISA’s preemption rule to permit state tort and tort-like suits against self-insured employment-based health care plans, but we just might relax ERISA’s preemption rule to allow states some ability to experiment with approaches for regulating the provision of health care and for providing universal health care coverage.

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125. See, e.g., COUNCIL OF ECONOMIC ADVISORS, ECONOMIC REPORT OF THE PRESIDENT 2006, at 100 (2006).

126. Sarah Lueck, *Politics & Economics: Small Business Health Plans Advance in Senate—Measure Would Override State Rules to Let Groups Offer Low-Cost Insurance*, WALL ST. J., Mar. 13, 2006, at A6.