

1994

ERISA, Preemption and Comprehensive Federal Health Care: A Call for "Cooperative Federalism" to Preserve the States' Role in Formulating Health Care Policy

James E. Holloway

Follow this and additional works at: <http://scholarship.law.campbell.edu/clr>

 Part of the [Health Law and Policy Commons](#), and the [Labor and Employment Law Commons](#)

Recommended Citation

James E. Holloway, *ERISA, Preemption and Comprehensive Federal Health Care: A Call for "Cooperative Federalism" to Preserve the States' Role in Formulating Health Care Policy*, 16 CAMPBELL L. REV. 405 (1994).

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

ERISA, PREEMPTION AND COMPREHENSIVE FEDERAL HEALTH CARE: A CALL FOR "COOPERATIVE FEDERALISM" TO PRESERVE THE STATES' ROLE IN FORMULATING HEALTH CARE POLICY

JAMES E. HOLLOWAY*

With the dominance of federal medical care and the exclusivity of federal employee benefit regulation, the passage of comprehensive federal health care regulation, which establishes uniform and consistent administration of medical care, significantly threatens to interfere with state powers to develop innovative health care and to promote their public policy. This interference, in turn, would signal the decline of American federalism. Many commentators and government officials believe that a comprehensive federal health care policy will reform the nation's health care delivery system.¹ Although such reform is likely, its preemptive effects could be constitutionally damaging for two predominant reasons. First, the federal government must retain and exercise final regulatory authority over much state health care and other policy to establish uniform and consistent regulation of medical care. Second, the federal government already retains and exer-

* James E. Holloway, Associate Professor, Business Law, Department of Finance, School of Business, East Carolina University, Greenville, North Carolina 27858; B.S., North Carolina A & T State University, 1972; M.B.A., East Carolina University, 1984; J.D., University of North Carolina at Chapel Hill, 1983.

1. Mary Anne Boblinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255 (1990); J. Geisel, *Delays, Politics May Hobble Health Reform*, BUS. INS., May 10, 1993, at 57; J.B. Kenny & Sean Sullivan, *Health Care Reform: National, State and Local Direction*, EMPLOYEE BENEFITS J., June 1993, at 41.

Many causes have been put forth to explain the crisis of the national health care delivery system. See Christine Woolsey, *Doctor the Patient Is Critical*, BUS. INS., Oct. 30, 1992, at 20. Woolsey finds that the health care crisis was caused by several factors: the aging of the population, medical technology, poverty, medical malpractice, the capitalistic health care system, AIDS, and government intervention. *Id.* at 20-22. In addition, Woolsey finds that doctors, hospitals, lawyers, and insurance companies must bear much of the blame. *Id.* at 23-25.

cises final authority under employee benefit policy which presently preempts much state health care policy. In maintaining a consistent and uniform statutory framework which provides access to, compensates for, and insures the quality of health care, a comprehensive federal health care regulation could eventually preempt much state law and public policy (i.e., state health care, health care-related, tort, insurance, employment, and contract laws).² Therefore, national health care regulation could preempt more state law and public policy than regulations addressing employee benefit policy, which continue to decrease the scope of federalism.³

This article revisits the familiar theme of federalism and health care policy. It takes the position that federalism is decreasing and will decrease further under national health care that is fast becoming, if not already so, an exclusive field of federal regulation.⁴ The article draws this conclusion from three influences on federal regulation and policy: (1) the expanding preemptive effects of employee benefit regulation on state health care, as well as other law and public policy; (2) the increasing public policy favoring a comprehensive national health care policy; and (3) the existing dominance of federal medical care and assistance regulation in the field of health care. The article is a comment on the preemptive effect that federal employee benefit regulation pres-

2. See Rick Wartzman & Hillary Stout, *Clinton Health Plan Push Competition to be Ready to Regulate: Comprehensive Care Scheme Will Set Terms of a Battle Not Soon to Be Resolved—Strong Arm of Government*, WALL ST. J., Sept. 13, 1993, at A1 (stating that Clinton's comprehensive proposal extends the power of government and permits it to reach in some narrow places). For discussion of the expansive preemptive effects of a comprehensive federal health care policy on state law, see generally *infra* notes 203-14 and accompanying text (listing potential state fields of law and public policy that would be preempted, in whole or part, by a comprehensive health care policy).

3. Mark A. Hofmann & Meg Fletcher, *Reform Plan Takes Shape*, BUS. INS., May 17, 1993, at 1 ("including medical elements of workers comp, auto cover in system raises concerns"); Meg Fletcher, *Work Comp. Insurers Oppose Removing Medical Care From State System*, BUS. INS., May 17, 1993, at 24; see also Geisel, *supra* note 1, at 1.

4. This article does not challenge the importance of national health care. It seeks to heighten the debate regarding the constitutional dangers of a comprehensive federal health care policy. It observes that such a policy's effect on state law and public policy could eventually be broader than anticipated and thus threaten federalism.

ently has on state health care law and public policy.⁵ In addition,

5. One example of a comprehensive federal health care plan is the proposal offered by the current Federal Administration. AMERICAN HEALTH SECURITY ACT OF 1993, H.R. 1200, 103d Cong., 2d Sess. (1993). It is used as an example in this article to illustrate how comprehensive federal health care policy could eventually affect state-federal relations and thus undermine federalism through lessening states' powers. Most likely, other comprehensive policies will have similar advantages and disadvantages to the current Federal Administration's proposal. There are enough plans, with more to come, such as THE HEALTH SECURITY ACT, H.R. 3600, 103d Cong., 2d Sess. (1993) (the Clinton Plan); HEALTH EQUITY AND ACCESS REFORM TODAY ACT, H.R. 3652, 103d Cong., 2d Sess. (1993) (the Chafee-Dole plan); AMERICAN HEALTH SECURITY ACT, H.R. 1200, 103d Cong., 2d Sess. (1993) (the Wellstone-McDermott plan); and AFFORDABLE HEALTH CARE NOW ACT, H.R. 3080, 103d Cong., 2d Sess. (1993) (the House Republican Approach). See generally John Harwood, *Rival Plans Gain Strength But None Claim Majority*, WALL ST. J., Oct. 28, 1993, at A18. One thing is definite—everyone seems to have a plan, but no one seems to have a solution. Thus, this article will use the current Federal Administration's plan to illustrate both immediate and long-term constitutional concerns regarding the impact of comprehensive federal health care regulation on federalism and states' rights.

In September 1993, the current Federal Administration released its proposed national health care reform. The reform proposal is called The American Health Security Act (hereinafter Health Security Proposal). See The White House Domestic Policy Council, THE CLINTON BLUEPRINT: THE PRESIDENT'S HEALTH SECURITY PLAN 3, 1993 (Introduction by Erik Eckholm of The New York Times) (hereinafter President's Health Plan). The Health Security Proposal offers health care coverage to each American, by providing a comprehensive package of health care benefits. These benefits are purchased by regional health alliances that are operated by the states. These alliances purchase health benefits from local health plans within the states. *Id.* at x. The "Comprehensive Benefits [are defined as] [guaranteed benefits [that] should meet the full range of health needs, including primary, preventive and specialized care. *Id.* at ii.

It has been noted that the "[current Federal Administration's] proposal gives states considerable flexibility but envisions the federal government in a strong supervisory role." Edwin Chen & Robert A. Rosenblatt, *Health Plan Casts Wide Net*, THE NEWS AND OBSERVER, Sept. 11, 1993, at 1A (Authors are reporters for Los Angeles Times.). Under the Health Security Proposal, the federal government establishes minimum standards, while the states can implement their own plans. If, however, the states fail to implement a plan, the federal government will do so. The Health Security Proposal imposes an health care tax on employers which makes health care benefits a mandatory employer obligation. Furthermore, under the Health Security Proposal, individuals must pay a portion of their health care cost. For those individuals that cannot afford to pay for their health care, the Health Security Proposal provides for a government subsidy. The Health Security Proposal also requires individuals and some employers to enroll in state regulated health care plans through regional or corporate alliances. President's Health Plan, *supra*, at xi-xvi.

the article discusses the preemptive effect that comprehensive federal health care could eventually have on state law, public policy, and health care regulations.

The article begins by examining government obligations for, and federal regulation of, health care under the United States Constitution. It discusses federal medical assistance and employee benefit policies as well as state health care law and public policy. Part II examines the extent to which employee benefit regulation preempts state common law, insurance regulation, and other law. In addition, Part II discusses the exceptions to and exemptions from preemption under employee benefit regulation. Part III examines the preemption of specific state health care regulation by federal employee benefit regulation. Specifically, it analyzes federal court cases which addressed the issue of whether federal employee benefit regulation preempts state health care law. Part IV, using employee benefit regulation as an example of a comprehensive regulatory model, discusses the scope of federalism under employee benefit and proposed national health care policies. Part V discusses the expansive preemption of state law needed to establish uniform and consistent regulation of the administration of health care. In addition, it comments on the shared health care responsibilities of the state and federal governments under federalism. The article concludes by finding that the dominance of the federal regulation in the field of medical care, coupled with the expansive preemptive effects of both national health care and employee benefit policy, severely limit the states' powers to establish comprehensive health care policy. Such limitations accelerate the decline of federalism by restricting the states' ability to concern themselves with local medical care needs and to use local employment-based resources in formulating a comprehensive state health care policy.

On October 27, 1993, the current Federal Administration presented to Congress the Health Security Act (hereinafter Presented Health Security Act). Commerce Clearinghouse, *President Clinton's Health Care Reforms Proposal: Health Security Act as Presented to Congress on October 27, 1993*, CCH Professional Summary and Text of Bill (1993) (hereinafter Clinton's Health Care Reform). The Presented Health Security Act contains 11 titles that introduce and implement health care reform. "In addition, the White House has indicated that numerous technical corrections to this version of the legislation will be added when the bill is actually introduced." *Id.* at 3.

I. HEALTH CARE: THE GOVERNMENT'S OBLIGATION AND POLICY

During the last thirty years, the federal government has enacted two major medical assistance programs and reluctantly pursued national health care programs.⁶ On the other hand, states have enacted health care legislation to increase access to, control the cost of, and pay for medical care and services.⁷ At the same time, federal courts were finding that much state health care policy was preempted by federal employee benefit policies.⁸ The expansive preemption of state health care law by employee benefit policy, along with a lack of proposals for permitting states to develop their health care reform, suggests an eventual constitutional conflict regarding limitations on the exercise of powers by states under a comprehensive federal health care regulation. Such a conflict would signal a further decline in the scope of federalism. Federalism declines when states are not permitted to make comprehensive state health care policy that: (1) freely uses federal resources; (2) broadly relies upon private sources of revenues; (3) directly mandates employment-based obligations; and (4) truly reflects state and local public policy.

A. *The Influence of Federal Health Care Policy*

Federal employee benefit regulation and federal medical care regulation significantly influence existing state law and public policy. Federal medical care regulation permits the federal government to dominate the field of health care. Currently, federal medical care regulation consists mostly of social insurance and means-tested medical care and assistance programs. Federal regulation provides medical insurance to aged and disabled citizens and subsidizes medical assistance to indigent children and their families.⁹ Federal medical care regulation also permits limited state participation in health care administration and asks states

6. See Boblinski, *supra* note 1, at 340.

7. Michael S. Ackerman, *ERISA: Preemption of State Health Care Law and Worker Well-Being*, 1981 U. ILL. L. REV. 825 (1981); Boblinski, *supra* note 1, at 299-305; M.K. Keefe, *Three States Focus on Reform at Home*, EMPLOYEE BENEFIT PLAN REV., July 1993, at 38, 38-43; *Bill Would Authorize Implementation of Health Care Reform At The State Level*, EMPLOYEE BENEFIT PLAN REV., Nov. 1992, at 52, 53 (hereafter *Authorize Implementation*); see also *infra* notes 179-180 and accompanying text.

8. *Infra* notes 9-16 and accompanying text.

9. *Infra* notes 24-31 and accompanying text.

to establish health assistance programs in order to gain federal funds. Nevertheless, federal health care regulation is a patchwork of annual legislative amendments, lately affected by federal budget deficit reduction.

Employee health care benefits plans are regulated by federal employee benefit regulation, which is known as the Employee Retirement Income Security Act of 1974¹⁰ (hereinafter ERISA). ERISA regulates, inter alia, the administration of employee health care benefits¹¹ and provides a regulatory framework for the administration of employee benefit plans among the states.¹² The uniformity and consistency created by this framework justifies, as recognized by Congress and the Supreme Court, the invalidation of much state law and public policy.¹³ For those reasons, state officials, commentators, and scholars argue that ERISA goes too far.¹⁴ Specifically, they argue that the broad interpretation of ERISA's preemption clause, as contained in section 1144(a),¹⁵ prevents states from exercising their police and other powers to establish a comprehensive state health care policy.¹⁶ Although such an interpretation greatly decreases states' legislative means to increase access to or pay for health care needs, federal courts have consistently concluded that much state health care and health care-related regulations "relate to"¹⁷ ERISA-covered

10. 29 U.S.C. §§ 1001-1461 (1988 & Supp. IV 1992).

11. 29 U.S.C. § 1001(a) (1988 & Supp. IV 1992).

12. See *infra* notes 48-62 and accompanying text.

13. See *infra* notes 86-98 and accompanying text.

14. See, e.g., *Hearing on H.R. 1602 and H.R. 2782: Bills Relating to ERISA's Preemption of Certain State Laws*, 100th Cong., 2nd Sess., (1991) (hearing before the Subcommittee on Labor-Management Relations of the Committee on Education and Labor House of Representative); Ackerman, *supra* note 7, at 864-67; Boblinski, *supra* note 1, at 258-59; Laura J. Bond, Note, *ERISA-Preemption: Congress's Cue to Reassess ERISA's Preemption Effect*, 36 KAN. L. REV. 611, 611-25 (1988); Junda Woo, *Benefits Law Hurts Some It Aimed to Help*, WALL ST. J., Mar. 4, 1993, at B1; *Authorize Implementation*, *supra* note 7, at 52-53 (Senate Bill 1380 to amend ERISA).

15. 29 U.S.C. § 1144(a) (1988). This section provides:

(a) **Supersedure; effective date.** Except as provided in subsection (b) of this section, the provisions of this title and title IV 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 1003(b). This section shall take effect on January 1, 1975.

Id.

16. See *supra* note 14; see also *infra* notes 99-177 and accompanying text.

17. 29 U.S.C. § 1144(a) (1988).

employee benefit plans. As a result, these state health care laws interfere with the consistent and uniform regulation of the administration of employee benefit plans as intended by Congress.¹⁸ Thus, both the required compliance with federal subsidized medical assistance regulation and the broad preemptive effects of employee benefit regulation severely limit the content and enforceability of state health care policy.

B. The Federal and State Health Care Obligation

In examining the preemption of state health care policy and its impact on federalism, a critical question is whether the government has an enforceable obligation to provide and secure health care. If government has no obligation to secure health care, then governmental health care programs provide temporary benefits which may not be a legitimate state concern. But if a governmental obligation does exist, the issue becomes whether the state or federal government is responsible for that obligation under federalism's sharing of power. Thus, in analyzing the preemptive effects that employee benefit and national health care policies have on state law and public policy, two fundamental points need to be considered. First, whether government has an obligation to provide and secure health care for its citizens. And second, if government has this obligation, which government(s) in our federalist system should have an "affirmative obligation" to provide and secure health care for its citizens? Presently, the federal government provides health care insurance to the aged and disabled, while state governments implement health care programs and provide federally subsidized medical assistance to the needy.¹⁹

1. Government Responsibility for Medical Care

The former question, whether government has the duty to provide and secure health care, requires consideration first because if government has no health care responsibility then federal and state health care programs are not interminable obligations. While there has been much discussion about whether government has a public obligation, there is no agreement. Although few states have recognized an individual's right to medical care, most have voluntarily established medical care assist-

18. See *infra* notes 63-69 and accompanying text.

19. See *infra* notes 24-31 and accompanying text.

ance programs for parts of the general population.²⁰ However, federal courts have generally held that individuals do not have a constitutional right to receive federal or state medical care.²¹ In *Health Care and the Constitution: Public Health and the Role of the State in the Framing ERA*,²² Professor Parmet discussed public health law and political theories and concluded that government has an obligation to provide health care to its citizens.²³ Furthermore, Professor Parmet found that the Framers could have intended health care to be a state obligation, as opposed to federal. It is beyond the scope of this article to articulate a rationale for or against government responsibility for providing health care to its citizens. At this time, the federal and state governments are performing a health care role and seem unlikely to give it up or to expand it rapidly.

20. See Boblinski, *supra* note 1, at 306 n.174. Many states have established statutory and constitutional provisions that provide medical assistance to the poor. Michael A. Dowell, *State and Local Government Legal Responsibilities to Provide Medical Care for the Poor*, 3 J.L. & HEALTH 1, 3-7 (1988-89). Moreover, several states have begun to establish various types of health care programs for their citizens who cannot afford to purchase either health care or health care insurance. See *infra* notes 107-25 and accompanying text.

21. *Memorial Hosp. v. Maricopa County*, 415 U.S. 250 (1974); *Harris v. McRae*, 448 U.S. 297 (1980) (no constitutional right to have an abortion funded); *Wideman v. Shallowford Community Hosp., Inc.*, 826 F.2d 1030 (11th Cir. 1987) (no duty based on either the federal constitution or statutes to require states or counties to provide medical care for the medically indigent); *Elloit v. Enrlich*, 280 N.W.2d 637, 641 (Neb. 1979) (welfare benefits are not fundamental rights and neither the state nor the federal government are under any constitutional obligation to guarantee the minimum levels of support).

22. Wendy E. Parmet, *Health Care and the Constitution: Public Health and the Role of the State in the Framing Era*, 20 HASTINGS CONST. L.Q. 267, 319-30 (1993).

Some students of health care policy did not believe that states would provide effective health care programs. Frank J. Thompson, *New Federalism and Health Care Policy: States and the Old Question*, 11 J. HEALTH POL. POL'Y & L. 647, 647-48 (1986). Others believe that a comprehensive federal health care program could exceed federal authority. See David Rivkin, *Health Care Reform v. The Founders*, WALL ST. J., Sept. 29, 1993, at A19 ("If the legality of a health care package featuring federally mandated universal participation is litigated and the system is upheld, it will mark the final extension of an originally modest grant of federal authority.").

23. Parmet, *supra* note 22, at 319-30.

2. *Federal Responsibility for Medical Care*

During the last three decades, the federal government established two major medical care and assistance programs. One of these programs is Health Insurance for the Aged,²⁴ a federal social insurance program better known as Medicare. Medicare consists of two insurance programs: (1) Part A—Hospital Insurance Benefits for the Aged and Disabled,²⁵ and (2) Part B—Supplementing Medical Insurance Benefits For the Aged and Disabled.²⁶ Under both Parts A and B, individuals less than 65 years of age are not permitted to enroll in Medicare unless they are disabled.²⁷

The other major federal program is Grants to States for Medical Assistance Program,²⁸ is better known as Medicaid. Medicaid is a state health care assistance program subsidized by the federal government.²⁹ Medicaid provides medical assistance for the poor, disabled and aged, as well as minor dependent children and their parents.³⁰ The states establish minimum eligibility and medical service standards that must be consistent with federal guidelines.³¹ However, federal Medicare and Medicaid do not necessarily mean that constitutional authority rests with the federal government for providing and securing health care for the states and their citizens. Perhaps it just took the initiative, or the power.

Moreover, the expansive preemptive effect of employee benefit regulation does not mean that the federal government has a constitutional health care obligation. During the past three decades,

24. 42 U.S.C. §§ 1395-1396d (1988 & Supp. III 1991).

25. 42 U.S.C. § 1395c (Supp. III 1991).

26. 42 U.S.C. § 1395 (1988).

27. 42 U.S.C. §§ 1395c, 1395; (1988 & Supp. III 1991).

28. 42 U.S.C. §§ 1396-1396u (1988 & Supp. III 1991). Medicare does not preempt state administrative regulations that regulate the billing and amount physicians and hospitals charge patients receiving medical care and assistance under Medicare. *See* *Medical Soc'y v. Cuomo*, 976 F.2d 812 (2d Cir. 1992); *New York State Soc'y of Orthopaedic Surgeons, Inc. v. Gould*, 796 F. Supp. 67 (E.D.N.Y. 1992); *Massachusetts Medical Soc'y v. Dukakis*, 637 F. Supp. 684 (D. Mass. 1986), *aff'd*, 815 F.2d 790 (1st Cir. 1987), *cert. denied*, 484 U.S. 896 (1987). One federal court referred to the state regulation of billings and costs as "cooperative federalism." *See also* *Rebaldo v. Cuomo*, 749 F.2d 133, 140 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985).

29. 42 U.S.C. § 1396.

30. *Id.*

31. 42 U.S.C. § 1346a (1988 & Supp. III 1991).

Congress has steadfastly refused to enact a comprehensive health care program for the nation.³² Due to this inaction by Congress, the contents of employee benefit plans are still based upon free contract, not federal employee benefit regulation. Any relationship between health care policy and welfare benefit policy was created in the 1940s and 1950s³³ by employer's programs to recruit and retain employees.³⁴ Under ERISA and other employee benefit policy, Congress did not encourage this relationship nor did it entirely abrogate the common law.³⁵ Practically speaking, the preemption of state health care policy by ERISA is not designed to maintain federal regulatory dominance of health care, but to provide consistent and uniform regulation of the administration of employee benefit plans.³⁶

In conclusion, the better governmental obligation for the regulation of health care under federalism is to recognize that federal and state governments should share responsibilities for their citizens' health and welfare. However, state governments should

32. See Boblinski, *supra* note 1, at 340-41; Ackerman, *supra* note 7, at 826-29.

33. D.L. GIFFORD, & C.A. SELTZ, *FUNDAMENTALS OF FLEXIBLE COMPENSATION* 5 (1988). Gifford & Seltz describe the employers' rationale for gratuitously granting employee health care and other benefits as follows:

The 1940s produced dramatic changes. High wartime taxes on corporate income . . . rekindled employer interest in the deductibility of retirement plan contributions. In addition, . . . wage stabilization programs in place during World War II (and later the Korean Conflict) increased union receptivity to other forms of compensation provided by the employer—namely, fringe benefits. Later in the decade, court decisions made pension and welfare benefits a matter for collective bargaining. Finally, advances in medical technology not only increased the efficacy of medical care but also raised the price, making it difficult for individuals to afford the cost except on a group basis.

The result of these changes was a major shift in responsibility for security from the individual to the employer and widespread availability of employee benefit coverage.

Id. at 5.

34. Note, *Pension Plans and the Rights of the Retired Worker*, 70 COLUM. L. REV. 909, 917 (1970); Ferdinand S. Tinio, Annotation, *Private Pension Plan: Construction of Provision Authorizing Employer to Terminate or Modify Plan*, 46 A.L.R.3d 464, 464 (1972 & Supp. 1993); Gifford & Seltz, *supra* note 33, at 5p; David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV. 427, 437-40 (1987).

35. See 29 U.S.C. § 1051(1) (1988 & Supp. III 1991) (health care and other welfare benefits do not vest under ERISA); see also *infra* notes 48-62 and accompanying text.

36. See 29 U.S.C. § 1001(a) (1988 & Supp. IV 1992).

play the dominant role. Therefore, the federal law should allow, and then assist, states in designing comprehensive state health care policy.

3. *State Health Care Regulation*

During the past three decades, states have enacted considerable regulation mandating health care and health-related benefits. These regulations required benefits for drug and alcohol abuse, job-related disability, and physical and mental health care.³⁷ Finding that health care was inaccessible to many of their citizens, many states proposed state health care programs.³⁸ These programs require employers and others either to provide health care benefits under employee benefit plans³⁹ or to pass on health care costs, through imposing a surcharge on patients' medical bills, to employee benefit plans.⁴⁰ These plans provided employee health care benefits and were ERISA regulated plans.⁴¹ Thus, these state programs were, in many instances, successfully challenged as preempted by section 1144(a) of ERISA.⁴² Nevertheless, because of persistent problems involving health care, and increasing health care costs, effective health care policy still remains a priority for many states,⁴³ notwithstanding existing state medical

37. J. Ford, *State-Mandated Employee Benefits: Conflict With Federal Law*, Apr. 1992, MONTHLY LAB. REV. 38. "States have enacted more than 700 laws mandating provisions in health insurance plans . . . since 1965." *Id.* at 38. Several states have enacted legislation mandating treatment for alcohol and drug abuse. Forty states have mandated treatment for alcohol abuse, while 22 states have mandated treatment for drug abuse. Much state health care benefit legislation was enacted after the passage of The Employee Retirement Income Security Act of 1974 (ERISA). *Id.* at 40.

38. Christine Woolsey, *ERISA Used To Challenge State Health Laws*, BUS. INS., Sept. 28, 1992, at 1.

39. Ford, *supra* note 37, at 40; *See infra* notes 101-82 and accompanying text.

40. Woolsey, *supra* note 38, at 1 and 74.

41. 29 U.S.C. § 1002(2) (1988 & Supp. III 1991); *See infra* notes 48-50 and accompanying text.

42. 29 U.S.C. § 1144(a) (1988).

43. Jerry Geisel & M. Schacher, *States Seize Reins of Health Care Reform*, BUS. INS., June 15, 1993, at 1. State legislative efforts to increase access to health care are not new. Several states had passed comprehensive health care programs that were subsequently preempted by ERISA. Ackerman, *supra* note 7, at 826 n.13; *infra* notes 112, 190, and accompanying text. Currently, several states are pursuing a waiver to the ERISA preemption clause. In recent budget legislation, a House committee agreed to extend waivers to Hawaii, Minnesota, and New York. Mark A. Hofmann, *States Could Win Waivers of ERISA*, BUS. INS., May 17, 1993, at 1.

assistance for the needy and indigent,⁴⁴ voluntary state mandated-benefit regulation,⁴⁵ federal medical care for the aged and disabled,⁴⁶ and national health care reform.⁴⁷ Finally, much state health care law and public policy is directly affected by federal labor and employment law.

C. *The Influence of Federal Employment Policy*

As part of federal employment and labor regulation, ERISA regulates the administration of employee welfare⁴⁸ and pension⁴⁹ benefit plans. It requires employers and plan administrators to comply with administrative requirements and provides substantive rights for employees.⁵⁰ It neither regulates the contents of nor mandates employer-sponsored employee benefit plans.⁵¹ Simply, in regulating plan administration and creating benefit plan rights, it prevents employee benefit plan abuses.⁵² ERISA mandates reporting and disclosure requirements,⁵³ funding, participation, and vesting requirements,⁵⁴ and fiduciary standards⁵⁵ in the regulation of the administration of employee benefit plans.⁵⁶ ERISA grants employees, retirees, and their dependents the right to bring claims against employers and plan administrators; thus protecting rights and enforcing obligations owed under employee welfare and pension benefit plans.⁵⁷ By imposing requirements upon employers and relief for retirees and employees, ERISA establishes a uniform and consistent framework for the regulation of the administration of employee benefit plans.

To maintain uniform and consistent federal regulation, the preemption clause of ERISA supersedes all state law that

44. 42 U.S.C. §§ 1396a-1396s (1988 & Supp. 1991).

45. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727-30 (1985); Ford, *supra* note 37, at 39-40.

46. 42 U.S.C. §§ 1395-1396s (1988 & Supp. III 1991).

47. Hofmann & Fletcher, *supra* note 3, at 1; Fletcher, *supra* note 3, at 24; Geisel, *supra* note 1, at 1.

48. 29 U.S.C. § 1002(1) (1988 & Supp. III 1991).

49. *Id.* at § 1002(2).

50. *Id.* at § 1051-61.

51. *Metropolitan Life*, 471 U.S. at 732.

52. 29 U.S.C. § 1001(1) (1988 & Supp. III 1991).

53. *Id.* at §§ 1021-31.

54. *Id.* at §§ 1051-86.

55. *Id.* at §§ 1101-14.

56. See 29 U.S.C. § 1001(c).

57. *Id.* at § 1132(a)(1)(b).

"relate[s] to" employee benefit plans,⁵⁸ except for those laws addressed in sections 1144(b)(2)⁵⁹ and 1003(b)(3).⁶⁰ The United States Supreme Court has consistently given a broad interpretation to ERISA's preemption clause.⁶¹ In some instances, this interpretation allows federal courts to invalidate much state common law and public policy, for example health care law and policy.⁶²

II. THE PREEMPTION CLAUSE AND ITS INTERPRETATION

Section 1144(a) of ERISA does not preempt all state law and public policy. ERISA exempts certain state law and public policy from preemption, but it still prohibits states from making law that would either directly or indirectly regulate the contents of employee benefit plans. The preemptive effects have broadly invalidated many common law principles, legislative acts, and public policy. In short, ERISA limits the regulation of employee benefit plans by states, even though the state interest is a legitimate one, such as increasing accessibility to and paying for health care.

A. *The Preemption Clause, Section 1144(a)*

Section 1144(a) declares that ERISA "shall supersede any and all state laws insofar as they . . . relate to . . . any employee benefit plan . . .,"⁶³ and thus preempts a variety of state law, such as health care, tort, employment, and contract law.⁶⁴ The complexity of section 1144 and its express exemptions under sections 1144(b)

58. *Id.* at § 1144(a); Note, *supra* note 34, at 917.

59. 29 U.S.C. § 1144(b)(2)(B) (1988 & Supp. III 1991).

60. *Id.* at § 1003(b)(3). This section provides in pertinent part:

(b) The provisions of this subchapter shall not apply to any employee benefit plan if—

(3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws.

Id.

61. See, e.g., *Metropolitan Life*, 471 U.S. at 732; *infra* notes 85-98 and accompanying text.

62. *Infra* notes 86-98 and accompanying text.

63. 29 U.S.C. § 1144(a) (1988 & Supp. III 1991). In construing "relate to," the language of section 514(a), the Court gave "relate to" its ordinary meaning, "a connection with or reference to." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 97 (1983).

64. 29 U.S.C. § 1144(c) (1988 & Supp. III 1991).

and 1003(b) have resulted in considerable litigation determining whether or not state law is preempted by ERISA. ERISA has preempted state laws that "provide an alternative cause of action to employees to collect benefits protected by ERISA, which refer specifically to ERISA plans and apply solely to them, or interfere with the calculation of benefits owed to an employee."⁶⁵ ERISA usually has not preempted state common law and regulations that "are laws of general application—often traditional exercises of state power or regulatory authority— whose effect on ERISA plans is incidental."⁶⁶ Thus the state law preempted by ERISA falls into the two broad categories of traditional and nontraditional fields of legitimate state interest.

Health care policy is a nontraditional, or perhaps a lesser, area of state interest. But formulating health care policy at the state level is not new. At the time of ERISA's enactment in 1974, state comprehensive health care plans existed and others were being designed. Admittedly, however, health care regulation is not one of those traditional state functions that would be saved from the ERISA preemption clause.⁶⁷ On the other hand, many insurance, tort, contract, and employment regulations are traditional fields of state law. ERISA grants express exceptions for a few traditional state functions from its coverage under section 1003(b)(3).⁶⁸ In addition, ERISA provides for certain exemptions

65. *AETNA Life Ins. Co. v. Borges*, 869 F.2d 142, 146 (2d Cir. 1989), cert. denied., 493 U.S. 811 (1990).

66. See *Borges*, 869 F.2d at 146; see *infra* note 140 and accompanying text.

Federal courts have applied a multifactor test to determine whether or not ERISA "relate[s] to" and thus preempts state law. *Van Camp v. AT&T*, 963 F.2d 119, 122-123 (6th Cir. 1992); *Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341, 1344-45 (8th Cir. 1991) (list of factors to be considered in determining whether or not general state law "relates to" ERISA plan); *supra* note 140 and accompanying text.

67. *Infra* notes 110, 173, and accompanying text. The obligation of the states to provide health care for their citizens is not resolved. See *Parmet*, *supra* note 22, at 267. In *Standard Oil Co. v. Agsalud*, 442 F. Supp. 695 (N.D. Cal. 1977), the district court found that health care regulation was a traditional function of state government. The district court stated that:

Regulation of health insurance benefits available to workers is not a function like "fire prevention, police protection, sanitation, public health, and parks and recreation" which are "typical of those performed by state and local governments in discharging their dual functions of administering the public law and furnishing public services."

Id. at 710 (quoting *National League of Cities v. Usery*, 426 U.S. 833, 851 (1976)).

68. 29 U.S.C. § 1003(b) (1988 & Supp. III 1991); *infra* notes 79-84 and accompanying text.

from preemption under section 1144(b).⁶⁹ Health care law is neither excepted from coverage nor exempted from preemption under ERISA.

B. Statutory Exemptions and Exceptions to Preemption

Section 1144(a), the preemption clause, is limited by several exceptions and exemptions. Section 1144(b) grants explicit exemptions from section 1144(a) for banking, security, and insurance regulation.⁷⁰ Section 1144(b)(2)(A),⁷¹ which is actually a savings clause,⁷² provides, with one exception, that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities."⁷³ Under this provision states cannot declare employee benefit plans to be insurance or insurance-related and thus avoid preemption under ERISA. In addition, section 1144(b)(2)(B),⁷⁴ the deemer clause,⁷⁵ provides that no employee-benefit plan "shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any

69. 29 U.S.C. § 1144(b); *infra* notes 70-78 and accompanying text.

70. 29 U.S.C. § 1144(b)(2)(A). This section provides in pertinent part:

(b) Construction and application. (1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

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

Id.

71. *Id.*

72. See *Metropolitan Life*, 471 U.S. at 737-47.

73. 29 U.S.C. § 1144(b)(2)(A); see *Metropolitan Life*, 471 U.S. at 724.

74. 29 U.S.C. § 1144(b)(2)(B). This section provides in pertinent part:

(b) Construction and application. (1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) . . .

(B) Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) other than a plan established primarily for the purpose of providing death benefits), nor any trust established under any 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 regulated insurance companies, insurance contracts, banks, trust companies, or investment companies.

Id.

75. See *Metropolitan Life*, 471 U.S. at 724.

state purporting to regulate insurance companies [or] insurance contracts.⁷⁶ ERISA does not preempt insurance regulation but limits state power to declare employee benefit plans to be insurance indirectly regulating these plans. Next, section 1144(b)(4) grants an exemption for state criminal law.⁷⁷ Finally, section 1144(b) of ERISA grants a limited exemption for the Hawaii Prepaid Health Care Program.⁷⁸ Other states are requesting similar exemptions, but Congress has shown no willingness to grant them.⁷⁹

ERISA also grants exceptions from its coverage. Exceptions are granted for employee benefit plans of government,⁸⁰ state workers' compensation,⁸¹ state disability benefits,⁸² and employee benefit plans of churches.⁸³ ERISA contains an exception for state qualified domestic orders.⁸⁴ These exceptions recognize fundamental state interests that are traditional functions in which states exercise police and other powers. In essence, ERISA preempts many state exercises of power, and only gives way to the most fundamental of state interests.⁸⁵

C. State Law and Preemption

ERISA has preempted much state common law and public policy. Specifically, ERISA has preempted a state wrongful dis-

76. 29 U.S.C. § 1144(b)(2)(B) (1988 & Supp. III 1991).

77. *Id.* at § 1144(b)(4) (Subsection (a) shall not apply to any generally applicable criminal law of a State).

78. *Id.* at 1144(b)(2)(5). This section provides:

(5)(A) Except as provided in subparagraph (B), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a)—

(i) any state tax law relating to employee benefit plans, or,

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

Id. See *infra* note 109 and accompanying text.

79. Hofmann, *supra* note 43, at 1.

80. 29 U.S.C. § 1003(b)(1).

81. *Id.* § 1003(b)(3).

82. *Id.*

83. *Id.* § 1003(b)(2).

84. *Id.* § 1144(b)(7).

85. See David L. Gregory, *ERISA Law in the Rehnquist Court*, 42 SYRACUSE L. REV. 945, 957-64 (1991).

charge claim,⁸⁶ an anti-subrogation law,⁸⁷ a tort and contract law claim,⁸⁸ a common law insurance claim,⁸⁹ and specific provisions of workers' compensation acts.⁹⁰ The Court has held that ERISA preempts state common law and statutory claims that "relate to" employee benefit plans. Inductively, from the Court's holdings, federal courts have concluded that preemption of state law occurs where the state law provides claims that establish "an alternative cause of action to employees to collect benefits protected by ERISA, refers specifically to ERISA plans and applies solely to them, or interferes with the calculation of benefits owed to an employee."⁹¹ More succinctly, ERISA does not permit states to directly or indirectly regulate employee benefit plans, except when ERISA expressly grants exception to or exemption from preemption.

Notwithstanding its expansive construction, the preemption clause is neither absolute nor indiscriminate.⁹² Under the Court's interpretation of section 1144(a), it has held that ERISA does not preempt state-mandated benefit regulation,⁹³ criminal law,⁹⁴ severance pay at plant closings,⁹⁵ and garnishment of ERISA welfare benefit plans.⁹⁶ State common law and public policy which are not preempted by ERISA are traditional areas in which states routinely exercise police and other powers,⁹⁷ and thus have only "incidental effects" on ERISA regulated plans.⁹⁸ In conclusion, the express exceptions and exemptions, along with the "incidental effects" of traditional state power, do not save state health care

86. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990).

87. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

88. *Pilot-Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

89. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

90. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981); *District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580 (1992); *See infra* notes 124-57 and accompanying text.

91. *AETNA Life Ins. Co. v. Borges*, 869 F.2d 142, 146 (2d Cir. 1989), *cert. denied*, 493 U.S. 811 (1989).

92. *Gregory*, *supra* note 85, at 958.

93. *Metropolitan Life*, 471 U.S. 724 (1985).

94. *Massachusetts v. Morash*, 490 U.S. 107 (1989); *See also* 29 U.S.C. § 1144(b)(4) (1988 & Supp. 1991).

95. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987).

96. *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825 (1988).

97. *See Metropolitan Life*, 471 U.S. at 727-30.

98. *See Mackey*, 486 U.S. at 830-38; *See infra* note 140 and accompanying text.

law and public policy from preemption under section 1144(a) of ERISA.

III. PREEMPTION AND STATE HEALTH CARE POLICY

Currently, states are recognizing that many of their citizens do not have access to adequate health care. In addition, states are feeling pressure to address deep concerns over the plight of uninsured and underinsured citizens. In attempting to respond to these concerns, states are realizing that their ability to develop a public policy with respect to health care is severely restrained by ERISA. They are also finding that ERISA makes the state public policy issue of health care more difficult to address. States are finding that the broad interpretation of the ERISA preemption clause, and the narrow interpretation of the exemption provisions, stymie efforts to provide access to and pay for health care.⁹⁹ In attempting to overcome these barriers, the reform of state health care law and public policy has been achieved by several regulatory means.

One of the means used by states is mandated-benefit regulation. Under mandated-benefits regulation, states require insurance companies to provide coverage for certain types of illness, such as mental illness and substance abuse.¹⁰⁰ Because ERISA neither directly mandates nor permits states to require employer-sponsored health care obligations, states are forced to indirectly mandate health care benefits by imposing benefit-related obligations on insurance companies which, in turn, means that employers will provide these health care benefits if they voluntarily choose to purchase group health care insurance.¹⁰¹

Mandated-benefit regulation, however, does not resolve the states' concerns over health care since it does not provide benefits for the unemployed, indigent, and uninsurable. Because access to health care is still needed, and voluntarily mandated-benefits regulation has proven inadequate,¹⁰² states have continued to try more ingenious, indirect means of providing health care. For

99. See *supra* notes 1 and 7 and accompanying text.

100. *Metropolitan Life*, 471 U.S. at 728-29.

101. See *id.* at 747-48.

102. Employees have no right to employee welfare benefits that are gratuitously provided by their employers. *Metropolitan Life*, 471 U.S. at 732; *McGann v. H.H. Music Co.*, 946 F.2d 401 (5th Cir. 1991), *cert. denied*, 113 S. Ct. 482 (1992); *Hamilton v. Travelers Ins. Co.*, 752 F.2d 1350 (8th Cir. 1985).

example, states have enacted hospital surcharges and fees,¹⁰³ health care continuation coverage,¹⁰⁴ employee benefit-related taxes,¹⁰⁵ and hospital cost containment regulations.¹⁰⁶ Few of these means, however, have survived preemption challenges under the ERISA preemption clause.

To overcome the preemptive effects of ERISA, states have asked Congress to amend the ERISA preemption clause. They seek to obtain either a blanket exemption from preemption for state health care law or a specific exemption for each state's health care law.¹⁰⁷ In spite of the ERISA preemption clause, states have enacted comprehensive health care programs that

The Health Security Proposal, *supra* note 5, would impose fiduciary obligations on employers participating in regional and corporate health alliances. *President's Health Plan*, *supra* note 5, at 78.

103. *See infra* notes 112-24 and accompanying text.

104. *See infra* note 105 and accompanying text.

105. *National Carriers' Conference Comm. v. Heffernan*, 454 F. Supp. 914 (D. Conn. 1978) (preempts state tax that is levied on benefits paid by employee benefit plan); *Morgan Guaranty Trust Co. v. Tax Appeals Tribunal of New York State Dept. of Taxation & Fin.*, 569 N.Y.S.2d 502 (N.Y. App. Div. 1991) (preempts state taxes on plan earnings). *But see Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987) (does not preempt municipal income tax that is assessed on employees). For a comment on the preemption of state tax law by ERISA, see Kevin Matz, Note, *ERISA's Preemption of State Tax Laws*, 61 *FORDHAM L. REV.* 401 (1992).

For cases on the taxation of insurers, *see generally* *General Motors Corp. v. California State Bd.*, 815 F.2d 1305 (9th Cir. 1987), *reh'g denied*, 824 F.2d 816 (9th Cir. 1987), *cert. denied*, 485 U.S. 941 (1988) (does not preempt state tax that is assessed against insurers and calculated with reference to ERISA plans because such state taxes are exempted under the savings clause); *Mutual Life Ins. Co. v. Insurance Bureau*, 399 N.W.2d 466 (Mich. Ct. App. 1986) (does not preempt state tax on gross revenues from insurance premiums).

106. *See, e.g., Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985) (ERISA does not preempt state law that prohibits benefit plans from negotiating a discount with hospitals); *but see infra* notes 112-24 and accompanying text. Later, *Rebaldo* was accorded limited weight in *United Wire Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp.*, 793 F. Supp. 524, 537 (D.N.J. 1992). However, its demise was premature. *United Wire Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179, 1194 (3d Cir. 1993). In *United Wire*, the court of appeals found that "a portion of the *Rebaldo* court's analysis remains persuasive," though other portions did not survive *Ingersoll-Rand Co. v. McClendon*, 489 U.S. 133 (1990). In distinguishing the two cases, the court of appeals stated that "it was the absence of a direct nexus to ERISA plans and limited nature of the statute's impact on such plans that put the pricing regulation in *Rebaldo* beyond the scope of § 514 preemption." *Id.* at 1195.

107. *See supra* note 79 and accompanying text.

consist of state-sponsored health care insurance as well as federal and state subsidized medical assistance. An example of a comprehensive state health care program is the Oregon Basic Health Service Plan.¹⁰⁸

The comprehensive programs do not mandate employer-sponsored health care benefits which would be preempted by ERISA. However, there is one exception to the preemption of employer sponsored programs. The Hawaii Prepaid Health Care Act mandates employer-sponsored health care benefits.¹⁰⁹ The Hawaii health care program is given a statutory exemption from preemption under section 1144(b).¹¹⁰ Notwithstanding ingenious and innovative means, most state health care law does not successfully survive preemption challenges. In many instances states have been, and continue to be, plainly denied the right to "experi-

108. See generally, Eric Lamond Robinson, Note, *The Oregon Basic Health Care Services Act: A Model for State Reform*, 45 VAND. L. REV. 977 (1992); Kenneth K. Schmitt, *Waiver quest: Oregon's Attempt to Re-Ration Health Care*, 36 ST. LOUIS U. L.J. 947 (1992); Note, *The Oregon Health Care Proposal and the Americans with Disabilities Act*, 106 HARV. L. REV. 1296 (1993); W. John Thomas, *The Oregon Medicaid Proposal: Ethical Paralysis, Tragic Democracy, and the Fate of a Utilitarian Health Care Program*, 72 OR. L. REV. 47 (1993). In March 1993, the Clinton Administration approved the Oregon Plan by granting Oregon the necessary Medicaid waiver. C. Connel, *White House OKs Oregon Health Plan*, DAILY REFLECTOR, March 20, 1993, at A1.

109. HAW. REV. STAT. §§ 393-1 to 393-51 (1974). Upon the enactment of ERISA, Hawaii's health care program was preempted by ERISA. *Standard Oil Co. v. Agsalud*, 442 F. Supp. 695 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981). Later, Congress granted the Hawaii Prepaid Health Care Act of 1974 an exemption from preemption under section 1144. 29 U.S.C. § 1144(b)(5)(A)-(b)(5)(C) (1988 & Supp. III 1991); see *ERISA: Exemption from Preemption for Hawaii Prepaid Health Care Act: Hearing on H.R. 4046 Before the Subcomm. on Labor-Management Relations of the Comm. on Education and Labor*, 97th Cong., 2d Sess. 3 (1982).

However, Congress did not exempt future amendments other than those amendments to provide "for . . . effective administration." 29 U.S.C. § 1144(b)(5)(B)(ii); see *Council of Hawaii Hotels v. Agsalud*, 594 F. Supp. 449 (D. Haw. 1984). The district court found that ERISA preempted the 1978 Amendment to the Hawaii Prepaid Health Care Act that required collectively bargained health care plans to provide state mandated health care benefits. The district court concluded that the 1978 amendment was exempted from preemption under 29 U.S.C. § 1144(b)(5)(B)(ii) in that the 1978 amendment provided for "more than the effective administration" of the Hawaii Prepaid Health Care Act that was in effect before September 2, 1974. *Agسالud*, 594 F. Supp. at 453. For the pertinent language of 29 U.S.C. § 1144(b)(5), see *supra* note 78.

110. 29 U.S.C. § 1144(b)(5)(A)-(b)(5)(C) (1988 & Supp. III 1991).

ment with novel legislation" to further their own public interests.¹¹¹ Hospital surcharges and fees are two such examples.

A. *Hospital Surcharges and Fees: Preempted and Not Preempted*

A few states, either as part of a comprehensive health care plan or as an effort to increase access to health care services, have enacted statutes imposing hospital surcharges and fees on patients' bills paid by commercial insurers or on services provided by Health Maintenance Organizations (HMOs).¹¹² These surcharges and fees allow states to shift costs to ERISA regulated employee benefit plans for both the insured and uninsured, the costs resulting from increasing accessibility to health care for both indigents and those who are employed but uninsured.¹¹³

Several states have enacted hospital surcharges and fees. State and federal courts have not agreed on whether or not ERISA preempts all hospital surcharges and fees. First, New Jersey enacted a state hospital reimbursement system that required self-insured plans to pay in excess of actual charges, but this regulatory scheme was eventually held not to be preempted by ERISA.¹¹⁴ Second, Minnesota enacted the MinnesotaCare Pro-

111. See Ackerman, *supra* note 7, at 829.

112. Woolsey, *supra* note 38, at 74. As of 1987, six states financed charity care through a special add-on rate to hospital charges: Connecticut, Maine, Maryland, Massachusetts, New Jersey, and New York. Boblinski, *supra* note 1, at 334 n.279, citing, EMPLOYEE BENEFIT RESEARCH INSTITUTE, *Employer-Provided Health Benefits: Legislative Initiatives*, 62 EBRI ISSUE BRIEF 10 (1987)).

113. Sarah Lyall, *Billing System For Hospitals Is Overturned: U.S. Ruling Threatens Subsidies in New York*, N.Y. TIMES, Feb. 4, 1993, at B.1; *ERISA Does Not Preempt Hospital Surcharge*, EMPLOYEE BENEFIT PLAN REV., August 1993, at 75-76 (comment on *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 793 F. Supp. 524 (D.N.J. 1992), *modified* 995 F.2d 1179 (3d Cir. 1993)).

114. *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 793 F. Supp. 524, 537 (D.N.J. 1992), *modified*, 995 F.2d 1179 (3d Cir. 1993). New Jersey hospital rate setting scheme force self-insured plans to pay in excess of actual charges. These plans had to pay: "costs of care for the indigent, charges to pay a hospital's bad debts, subsidies for the medicare program, and funds to reimburse hospitals for discounts given by the hospitals to other types of benefit plans." *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 793 F. Supp. 524, 537 (D.N.J. 1992), *modified*, 995 F.2d 1179 (3d Cir. 1993). The district court found that the New Jersey statute would undermine the uniform and consistent regulation of the administration of employee benefit plans. *Id.* at 537. Moreover, the court

gram that "requires hospitals to pay a 2% tax on gross revenues to help cover the state's uninsured . . ." ¹¹⁵ The MinnesotaCare Program has been challenged by a self-insured plan as violating the preemption clause of ERISA. ¹¹⁶ Third, New York enacted a state health care provision that imposed a surcharge on hospital bills of patients covered by commercial health insurers and HMOs. ¹¹⁷

concluded that the New Jersey statute forces the benefit plans to "structure themselves in a certain manner, and to pay hospital costs that accrue to non-beneficiaries." *Id.*; see also, *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Assoc.*, 771 F. Supp. 771 (E.D. La. 1991). But the court of appeals did not agree. It held that the New Jersey statute was not preempted by ERISA. *United Wire*, 995 F.2d at 1196. The court of appeals stated that:

More importantly, there are many forms of state regulation under the police power which result in increases in the cost of doing business and corresponding increases in prices where the beneficiaries of the regulation are not those who are paying the increased prices. . . . We are confident, however, that ERISA was not intended to foreclose a state regulation of this kind.

Id. Although New Jersey shifted the cost of health care to hospital by imposing an added cost onto employee benefit plans, the court of appeals found this exercise of police power, imposing a surcharge, to result only in an increase in the cost of doing business. In turn, hospitals can pass health care cost forward to employee benefit plans as an increase in the prices of health care services.

In *United Wire*, the court of appeals held that the New Jersey statute "do[es] not constitute an unlawful taking of property without just compensation." *Id.* at 1190-91. See also, *Morristown Memorial Hosp.*, 793 F. Supp. at 540-42 (district court holding that statute did not constitute an unlawful taking). However, that holding may not be the last word on whether the regulation of health care costs through controlling doctor's fees constitutes a regulatory taking, an interference with property and economic rights. See Edward Felsenthal, *AMA to Fight Limits on Doctor's Fees*, WALL ST. J., Sept. 9, 1993, at B7 (AMA report believes that limits on doctor's fees could violate the Takings Clause of the Fifth Amendment to the United States Constitution).

115. *Id.*

116. MinnesotaCare's first phase, which was passed in 1992, "provides state-subsidized health insurance." MinnesotaCare is expected to cost \$320 million by 1997 and to cover 320,000 uninsured citizens. M. Jordan, *MinnesotaCare Health Reform* (Associated Press), DAILY REFLECTOR, May 24, 1993, at A4. MinnesotaCare is funded by a "2% percent tax on gross receipts of health care providers." *Id.* MinnesotaCare is not Minnesota's first effort to enact a comprehensive health care program. An earlier Minnesota health care program was also preempted by ERISA. See *St. Paul Elec. Workers Welfare Fund v. Markman*, 490 F. Supp. 931 (D. Minn. 1980).

117. See N.Y. PUB. HEALTH LAW § 2807-c(1)(b) (McKinney 1992) amended 1993; See also *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996, 999-1000 (S.D.N.Y. 1993); Woolsey, *supra* note 38, at 1.

In *Travelers Ins. Co.*, New York established a comprehensive scheme for the regulation of inpatient hospital rates. These rates are "determined by the

The New York surcharge was held by a federal district court to be preempted by ERISA.¹¹⁸ The insurers challenged the surcharge, and the federal district court found that the 24% (combined 11% and 13%) for commercial insurers, and 9% for HMOs, shifted the costs of health care to employee benefit plans and thus increased plan costs.¹¹⁹ Additionally, the district court did not believe that employee benefit plans should be forced to participate in a statutory scheme that "spread[s] the risk of high risk individuals among a larger pool."¹²⁰ Federal courts are mixed on whether state health care policy can impose fees or surcharges, either directly or indirectly, on employee welfare benefit plans that even-

patient's diagnosis." *Travelers Ins. Co.*, 813 F. Supp. at 999. The diagnosis governed the category or Diagnosis Related Group (DRG) the case is assigned. New York Public Health law increased the DRG for inpatient services by 13% *Id.* It imposed a surcharge on inpatient services for all patients covered by commercial insurers. *Id.* It exempted Blue Cross and Blue Shield, health maintenance organizations (HMO), and government plans. *Id.* Thus, patients covered by commercial insurers would pay 113% of the DRG rate. On April 2, 1992, New York added another 11% surcharge on the DRG rate, which was already 13%, for inpatient services covered by commercial insurers. *Id.* at 999-1000. At the same time, it added a 9% surcharge on HMOs which previously had been exempted from the surcharge. *Id.* at 1000. The Travelers Insurance Company, and the New York State Health Maintenance Organization Conference as an intervenor, challenged the New York Public Health Law as preempted by ERISA. *Id.* at 999.

The district court found that the surcharge was not exempted from preemption by the saving clause, 29 U.S.C. § 1144(b)(2)(A) (1988 & Supp. III 1991), and thus was preempted by ERISA. *Travelers Ins. Co.*, 813 F. Supp. at 1002. The surcharge was also not regulating "the business of insurance" under the McCarran-Ferguson Act., 15 U.S.C. § 1001 (1988 & Supp. III 1991). *Travelers Ins. Co.*, 813 F. Supp. at 1007. In addition, the court noted that the statute imposing the surcharge referred to HMOs and self-insured benefit plans, entities which the court stated "are not directly involved with the issuance of insurance." *Id.* at 1008. For a discussion of the application of the McCarran-Ferguson Act, see *infra* note 161 and accompanying text.

118. *Travelers Ins. Co.*, 813 F. Supp. at 1003. See also, Lyall, *supra* note 113, at B1. Lyall reported that: "[h]ealth-care experts say that yesterday's ruling could put New York on the same path as New Jersey, which lost a similar lawsuit last year and hastily had to patch together a new way of paying for indigent care and setting hospital rates." *Id.* See also *United Health Serv., Inc. v. Upstate Admin. Serv., Inc.*, 573 N.Y.S.2d 851 (N.Y. Sup. Ct. 1991) (state court found that a similar New York hospital cost containment statute was preempted by ERISA).

119. *Travelers Ins. Co.*, 813 F. Supp. at 1003; see also Lyall, *supra* note 113, at B1.

120. *Travelers Inc. Co.*, 813 F. Supp. at 1008; see also Lyall, *supra* note 113, at B7.

tually require insured and uninsured (self-funded) plans to "pay for uncompensated health care or to expand health-care coverage."¹²¹

In conclusion, states have sought to shift health care cost to commercial insurers and HMOs that insure and provide services for employees under employee benefit plans.¹²² The surcharges and fees are more intrusive than mandated-benefits in that they are mandatory and cover self-funded plans.¹²³ The preemption of surcharges and other fees that "relate to" ERISA regulated plans, restricts a "state's flexibility to devise ways to pay for care and subsidize health care without insurance."¹²⁴

B. Continuation of Health Care Coverage: Preempted

A few states mandate that employers who provide health care coverage must continue to provide this coverage upon an occurrence that would cause a break in or termination of employment, such as becoming eligible for family leave or receiving worker's compensation benefits. This legislation, which is called health care continuation coverage,¹²⁵ has been challenged as being preempted by section 1144(a) of ERISA. An example of one such challenge is *District of Columbia v. Greater Washington Board of Trade*.¹²⁶

121. Woolsey, *supra* note 35, at 1; Lyall, *supra* note 113, at B1. However, the situation could even get worse, according to Lyall, in that:

The ruling [in *Travelers Ins. Co.*] does not in itself pull down the state's hospital financing system, but it begins to chip away at it. In a similar case pending in Federal Court in Brooklyn, a group of unions have challenged a different state surcharge using the same ERISA argument. In that case, the 5.5 percent is tacked on most hospital bills and raises \$1.1 billion a year that is used to subsidize health care for people without insurance.

Lyall, *supra* note 113, at B7.

122. *Id.* at B1-B7.

123. *Id.*

124. *Id.* at B7.

125. See *infra* notes 126-38 and accompanying text.

126. 113 S. Ct. 580 (1992) (preempting District of Columbia regulation requiring continuation of health care coverage); see also *R.R. Donnelly & Son Co. v. Prevost*, 915 F.2d 787 (2d Cir. 1990), *cert. denied*, 111 S. Ct. 1415 (1991) (does not preempt Connecticut statute requiring continuation of health care coverage in which statute was an exception to ERISA coverage under 29 U.S.C. § 1003(b)(3) (1988 & Supp. III 1991)); *New Jersey Business & Indus. Ass'n v. New Jersey*, 592 A.2d 660 (N.J. Super. 1991) (preempting New Jersey Family Leave Act that requires employers to continue health benefit plan for absent employees during authorized period of family leave); but see *Stone & Webster*

1. Greater Washington

In *Greater Washington*, the Court addressed an amendment to the District of Columbia's Workers' Compensation Act which provided for continuing health care benefits for employees eligible for workers' compensation benefits. This amendment was called the Workers' Compensation Equity Amendment Act (Equity Amendment Act) of 1990.¹²⁷ In section 2(c)(2), the Equity Amendment Act imposes the following requirement:

Any employer who provides health insurance coverage for an employee shall provide health insurance coverage equivalent to the exiting health insurance coverage of the employee while the employee receives or is eligible to receive workers' compensation benefits under this chapter.¹²⁸

Section 2(c)(2) also mandated that employers provide health insurance coverage for up to 52 weeks. Furthermore, this section required employers to provide coverage "at the same benefit level that the employee had at the time the employee received or was eligible to receive workers' compensation benefits."¹²⁹ In *Greater Washington*, the Board of Trade sought to enjoin the enforcement

Eng'g Corp. v. Ilsly, 690 F.2d 323 (2d Cir. 1982), *aff'd mem.*, 463 U.S. 1220 (1983) (preempting a similar Connecticut statute requiring continuation coverage in that statute did not relate to an exception under 29 U.S.C. § 1003(b)(3)).

The preemption of state law requiring continuation of health care coverage has resulted in much professional commentary on the status of the law. *See, e.g.*, Dean M. Werner, *Group Health Coverage Continuation Requirement under Federal and State Law*, 64 WIS. LAW. 15 (1991); Rosalind Z. Wiggins & Thomas Z. Reicher, *ERISA Preemption of Connecticut Statutes Providing for Continuation of Health Care Coverage*, 64 CONN. B.J. 191 (1990); Theresa A. Orlaske, *Law Changes Affecting Employers' Health Care Continuation Obligations*, 69 MICH. B.J. 1158 (1990).

Federal health care continuation coverage law is provided in Title X of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), 29 U.S.C. § 1161-1168 (1988 & Supp. 1993). COBRA does not require employers to provide health care insurance; however, if they do provide this insurance, employers must allow employees and/or their dependents to continue participation in the employer's group health insurance plan upon termination of employment under certain circumstances. 29 U.S.C. § 1161(a) (1988 & Supp. 1993); *see* M.S. Lapidus & L.A. Erbs, *Recent COBRA Developments in the Courts*, EMPLOYEE BENEFITS J., June 1992, at 1-13; 1992 Business Publications Research, *COBRA Court Cases Alert Employers to Compliance Pitfalls*, MANAGEMENT POLICIES AND PERSONNEL LAW, July 1, 1992, at 1-2; Werner, *supra*.

127. D.C. CODE ANN. § 36-307 (Supp. 1992).

128. D.C. CODE ANN. § 36-307(a-1)(1) (Supp. 1992); *see Greater Washington*, 113 S. Ct. at 582.

129. D.C. CODE ANN. § 36-307(a-1)(3) (Supp. 1992).

of section 2(c)(2) by arguing that it was preempted by section 1144(a) of ERISA. The parties agreed that section 2(c)(2) "relate[s] to" an ERISA-covered plan in the sense that the benefits required under the challenged law "are set by reference to covered employee benefit plans."¹³⁰ "However, the United States District Court for the District of Columbia held that [section] 2(c)(2) was not preempted because it also related to respondent's workers' compensation plan, which is exempt from ERISA coverage"¹³¹ Furthermore, in faulty reliance on *Shaw v. Delta Air Lines, Inc.*,¹³² the district court also found that section 2(c)(2) was not

130. *Greater Washington*, 113 S. Ct. at 582-83.

131. *Id.* at 583. State workers' compensation acts are exempted from ERISA coverage. 29 U.S.C. § 1003(b)(3) (1988 & Supp. III 1991).

132. 463 U.S. 85 (1983). In *Shaw*, the New York Human Rights law, N.Y. Exec. Law §§ 290-301 (McKinney 1982 & Supp. 1982-83), prohibited discrimination on the basis of sex. It also prohibited discrimination in employee benefit plans, including discrimination on the basis of pregnancy. *Shaw*, 463 U.S. at 88. The New York Court of Appeals has held that a private employer whose benefit plan treated pregnancy different from any other nonoccupational disabilities engaged in sex discrimination. *Id.* (citing *Brooklyn Union Gas Co. v. New York State Human Rights Appeal Board*, 359 N.E.2d 393 (1976)). In contrast, the U.S. Supreme Court had recently held that discrimination based upon pregnancy was not sex discrimination under Title VII of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000e et seq. (hereinafter Title VII). *Shaw*, 463 U.S. at 88 (citing *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976)). In 1978, Congress amended Title VII to prohibit sex discrimination based upon pregnancy. Pregnancy Discrimination Act of 1978, 42 U.S.C. § 2000(e)k (hereinafter PDA). Prior to the PDA, the New York Human Rights law had a broader coverage than Title VII. *Shaw*, 463 U.S. at 88-89.

The New York Disability Benefits Law, N.Y. WORK COMP. LAW §§ 200-242 (McKinney 1965 and Supp. 1982-83), "require[d] employers to pay certain benefits to employees unable to work because of nonoccupational injuries or illness." *Shaw*, 463 U.S. at 89. The N.Y. Disability Benefits Law was amended in August 1977, requiring employers to pay eight weeks of benefits for pregnancy-related disabilities. *Id.* In 1981, the eight week pregnancy payment provision was repealed, and the new provision requires employers to treat pregnancy as any other disability. *Id.* at 90.

In *Shaw*, plaintiff-appellee Delta Air Lines and others provided medical and disability benefits for their employees. Prior to the PDA, appellee's benefits plan did not provide benefits to employees disabled by pregnancy as required by N.Y. laws. Appellee filed the action alleging that the N.Y. Disability Benefits Law and Human Rights Law were preempted by section 1144(a) of ERISA, 29 U.S.C. § 1144(a). *Shaw*, 463 U.S. at 92.

The district court "held that Human Rights Law was preempted, insofar as it required the provision of pregnancy benefits prior to the effective date of the PDA." *Shaw*, 463 U.S. at 92-93. With respect to the Disability Benefits Law, the district court concluded that these benefits were exempted under section

preempted by ERISA "because [the Board of Trade] could comply with § 2(c)(2) 'by creating a separate administrative unit to administer the required benefit.'"¹³³

The United States Court of Appeals for the District of Columbia reversed the district court judgment and held that section 2(c)(2) was preempted by ERISA.¹³⁴ In reaching this decision, the court of appeals held "[b]y tying the benefit levels of the workers' compensation plan to those provided in an ERISA-covered plan, that the Equity Amendment Act could have a serious impact on the administration and content of the ERISA-covered plan."¹³⁵ On review under a writ of certiorari, the U.S. Supreme Court affirmed the court of appeals' decision.¹³⁶ The Court granted certiorari because the decision of the District of Columbia Court of Appeals conflicted with the United States Court of Appeals for the

1003(b)(3) of ERISA, 29 U.S.C. § 1003(b)(3), which exempts state disability law from ERISA's coverage. *Shaw*, 463 U.S. at 93.

The court of appeals affirmed as to the Human Rights Law, but it remanded the district court's finding on the preemption of Disability Benefits Law. It concluded that the Disability Benefits Law was exempted from preemption so long as the disability benefit plan, "as an integral unit," was maintained solely to comply with a disability law. *Shaw*, 463 U.S. at 94-95 (citing *Delta Air Lines, Inc. v. Kramarshy*, 650 F.2d 1287, 1304 (1981)). The court of appeals concluded that if, on remand, the district court found that the disability was not a separate administrative unit, it would be preempted by ERISA. *Shaw*, 463 U.S. at 95.

On review, the Court held "that the Human Rights Law and the Disability Benefits Law 'relate to any employee benefit plans' within the meaning of" section 1144(a) of ERISA. *Id.* at 100. In construing the "relate to" language of section 1144(a), the Court gave the language its ordinary meaning, "connection with or reference to." *Id.* at 97. In its construction, the Court reviewed the legislative history of section 1144(a), further justifying its broad interpretation. With respect to whether section 1144(a) preempted state disability law, the Court held that it did not. The Court held "that the Disability Benefits Law is not preempted by ERISA," although the state permits employers to comply with its disability law by including disability benefits in their employee benefit plans. *Id.* at 109. However, the Court stated New York can enforce its disability benefit plan, although it is part of a multibenefit ERISA plan. *Id.* at 108. The Court stated that to enforce its disability benefit plan, New York could not regulate the contents of ERISA covered plans. *Id.* at 109.

The Court also held "that New York's Human Rights Law is not preempted with respect to ERISA benefit plans only insofar as it prohibits practices that were lawful under federal law . . ." *Id.* at 108.

133. *Greater Washington*, 113 S. Ct. at 583 (quoting *Shaw*, 463 U.S. at 108).

134. *Greater Washington Bd. of Trade v. District of Columbia*, 948 F.2d 1317 (D.C. Cir. 1991).

135. *Greater Washington*, 113 S. Ct. at 583.

136. *Greater Washington*, 113 S. Ct. at 580.

Second Circuit's decision in *R.R. Donnelly & Sons Co. v. Prevost*.¹³⁷ In *R.R. Donnelly*, the Second Circuit "upheld against a preemption challenge a Connecticut law substantially similar to [section] 2(c)(2)."¹³⁸

2. "Relate[s] to" an ERISA Plan: Exempted from Preemption

In the *Greater Washington*, the United States Supreme Court restated an earlier conclusion that a law "related to" an ERISA covered employee benefit plan for purposes of section 1144(a), "if it has a connection with or reference to such a plan."¹³⁹ The Court also noted that such a law is preempted by ERISA if it is not exempted by section 1003(b)(3). Finally, the Court stated the law is still preempted even if the effect was not intended, was indirect, or was consistent with ERISA requirements.¹⁴⁰ The Court then held that "section 2(c)(2) of the Equity Amendment Act specifically

137. 915 F.2d 787 (2d Cir. 1990), cert. denied, 499 U.S. 947 (1991).

138. *Greater Washington*, 113 S. Ct. at 583.

139. *Id.* (citing *Shaw*, 463 U.S. at 97; *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988)).

140. *Id.* at 583. The court stated specifically that:

Under [Section] 514(a), ERISA preempts any state law that refers to or has a connection with covered benefit plans (and that does not fall within a § 514(b) exception) "even if the law is not specifically designed to affect such plans, or the affect is only indirect," *Ingersoll-Rand*, [] 498 U.S. at 139, . . . and even if the law is "consistent with ERISA's substantive requirements."

Id. (citing *Metropolitan Life*, 471 U.S. at 739). In a footnote, the Court observed that [p]reemption does not occur, however, if state law has only a "tenuous, remote, peripheral" connection with covered plans, as is the case with many laws of general applicability. *Id.* at 583 n.1 (quoting *Shaw*, 463 U.S. at 100 n. 21).

Other lower federal courts have noted that the exercise of traditional state authority is among the criteria to be considered by courts in deciding whether a state law is "remote, tenuous, and peripheral." *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 553 (6th Cir. 1987); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146 (2nd Cir. 1989). In *Neusser*, the Sixth Circuit provided a list of factors to be considered in deciding whether state law falls within the "remote and tenuous" exception to section 1144. *Neusser*, 810 F.2d at 555. These factors include: (1) whether the state law represents a traditional exercise of state authority; (2) whether the benefit plan affects relations among employer, plan, fiduciaries and beneficiaries rather than relations between one of these entities and an outside party or between two outside parties, and (3) whether law's effect on ERISA plan is incidental. *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d at 555-56. In *Borges*, the court of appeals noted that indirect economic impact did constitute incidental impact and that any effect on structure, administration, and contents of these plans is not incidental. *Aetna Life Ins. Co. v. Borges*, 869

refers to welfare benefit plans regulated by ERISA and, on that basis alone, is preempted."¹⁴¹ The Court reasoned that health care coverage required by section 2(c)(2) "is measured by reference to 'existing health insurance coverage' provided by the employer and "shall be at the same benefit level."¹⁴² The Court found that an "employee's existing health care coverage"¹⁴³ . . . is a welfare benefit plan . . .," that "employer-sponsored health insurance programs are subject to ERISA regulation," and that "any state law imposing requirements by reference to covered plans must yield to ERISA."

Section 2(c)(2) of the Equity Amendment Act was not saved from preemption by the exception granted under section 1003(b)(3)¹⁴⁴ of ERISA for state worker's compensation.¹⁴⁵ The Court stated that this statutory exception did not restrict section 1144(a) once it is found that state regulation "relate[s] to" an ERISA covered plan.¹⁴⁶ The Court also stated that section 2(c)(2) did not relate directly to a statutorily exempted welfare benefit plan, *i.e.*, workers' compensation, and was not "maintained solely for the purpose of complying with" state law exempted by section 1003(b)(3) of ERISA.¹⁴⁷

In holding that section 2(c)(2) of the Equity Amendment Act was exempted from preemption, the District Court relied on *Shaw v. Delta Air Lines, Inc.*¹⁴⁸ The Supreme Court did not find the District Court's reasoning persuasive. In *Shaw*, the Court held that a New York disability insurance law was exempted under section 1003(b)(3) and thus was not preempted by ERISA.¹⁴⁹ Furthermore, the Court found that the disability law did not "relate to" an ERISA covered plan because it was administered through a

F.2d at 146; *see also*, *Rebaldo v. Cuomo*, 749 F.2d 133, 138 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985).

141. *Greater Washington*, 113 S. Ct. at 583.

142. *Id.* at 583-84 (quoting D.C. CODE ANN. §§ 36-307(a-1)(1) & (3) (Supp. 1992)).

143. *Id.* at 584.

144. 29 U.S.C. § 1003(b)(3) (1988 & Supp. III 1991).

145. *Greater Washington*, at 584-85.

146. *Id.* at 584 (citing *Alessi v. Raybestos-Mahattan, Inc.*, 451 U.S. 504, 525 (1981) ("it is of no moment that New Jersey intrudes indirectly through a workers' compensation law, rather than directly, through a statute called 'pension regulation.'")).

147. *Greater Washington*, 113 S. Ct. at 584.

148. 436 U.S. 85, 94-95 (1983).

149. *Shaw*, 463 U.S. at 108.

multibenefit ERISA plan.¹⁵⁰ Based on this holding, the *Greater Washington* Court concluded that *Shaw* could not support the District Court's argument that section 2(c)(2) was exempted by section 1003(b)(3) of ERISA.¹⁵¹ The Court emphatically stated that once state law "relate[s] to" an ERISA covered plan, it is not automatically saved by exemption under section 1003(b)(3), even though it could be administered as a separate, non-ERISA plan under section 1003(b)(3).¹⁵² *Greater Washington* is most explicit: if state continuation of health care coverage regulations "relate[s] to" an ERISA covered plan, it is not saved by exemption from preemption under section 1003(b)(3) of ERISA because it is administered under a workers' compensation plan. Thus any state health care law which would extend coverage to an uninsured who would be gainfully employed but for an accident in the course of employment, would be invalidated by an expansive interpretation of ERISA's preemption clause.

C. Mandated-Benefits Regulation: Not Preempted

Although the interpretation of ERISA's preemption clause has been expansive, the clause does not preempt all health care policy that "relate[s] to" ERISA-covered plans. For example, states establish and implement health care policy through insurance regulations which mandate health care benefits, such as mental health, drug and alcohol abuse, and disability, under group health care insurance contracts.¹⁵³ The Court permitted states to indirectly regulate employee benefit plans in *Metropolitan Life Insurance Co. v. Massachusetts*.¹⁵⁴

1. Metropolitan Life

In *Metropolitan Life*, the Court addressed Massachusetts General Statute chapter 175, section 47B,¹⁵⁵ which "requires that specified minimum mental-health-care benefits be provided [to] a

150. *Shaw*, 463 U.S. at 107; see *supra* note 80-85.

151. *Greater Washington*, 113 S. Ct. at 584.

152. *Id.*

153. *Metropolitan Life*, 471 U.S. at 746-47.

154. 471 U.S. 724 (1985).

155. MASS. GEN. LAWS ANN. ch. 175, § 47B (West Supp. 1985) (hereinafter Section 47B). The commonwealth required that,
any general health-insurance policy that provides hospital and surgical coverage, or any benefit plan that has such coverage, to provide as well a certain minimum of mental health protection.

Id.

Massachusetts resident who is insured under a general insurance policy, an accident or sickness insurance policy, or an employee health-care plan that covers hospital and surgical expenses.”¹⁵⁶ The purpose of section 47B was to address “problems encountered in treating mental illness” by providing more effective treatment in the private community.¹⁵⁷

In *Metropolitan Life*, the Court concluded that Section 47B was a mandated-benefit statute “that regulate[s] the substantive contents of health-insurance policies to further state health care policy.”¹⁵⁸ The Court observed that mandated-benefit statutes, regulating the terms of insurance contracts, were quite common among the states.¹⁵⁹ Moreover, the Court observed that states had long regulated insurance contracts.¹⁶⁰ In addition, the Court observed “that the McCarran-Ferguson Act,¹⁶¹ also strongly supports the conclusion that regulation regarding the substantive

156. *Metropolitan Life*, 471 U.S. at 727.

157. *Id.* at 730-31.

158. *Id.* at 729.

159. *Id.* at 728-29.

160. *Id.* at 727-30 n.2-10, 742 n.18-19.

161. 15 U.S.C. §§ 1011-1015 (1988 & Supp. III 1991). The McCarran-Ferguson Act was a legislative response to *United States v. South-Eastern Underwriters Assn.*, 322 U.S. 533 (1944), in which the Court held that insurance was interstate commerce and subject to antitrust law. See *United States Dep't of Treasury v. Fabe*, 113 S. Ct. 2202, 2207 (1993) (Ohio law to liquidate insurance is, in part, “regulating the business of insurance.”).

In *Metropolitan Life*, the Court stated that “federal law should not be construed to supersede state laws ‘regulating the business of insurance.’” *Metropolitan Life*, 471 U.S. at 736. (quoting 15 U.S.C. § 1012(b)). The Court also observed that the McCarran-Ferguson Act “ensure[s] that the States would continue to have the ability to tax and regulate the business of insurance.” *Id.* at 744 (citing *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 217-18 (1979)b. See also *Union Labor Life Ins. Co. v. Pierno*, 458 U.S. 119 (1982) (three prong test to determine what constitutes the business of insurance); *SEC v. National Sec. Inc.*, 393 U.S. 453 (1969) (emphasis on the relationship between insurers and insured). Based upon the similarity in the language of McCarran-Ferguson Act and the saving clause, the Court concluded that the saving clause was designed to preserve the McCarran-Ferguson Act. *Metropolitan Life*, 471 U.S. at 744.

The Court also noted that McCarran-Ferguson Act had been interpreted in other cases to mean that the regulation of the substantive terms of insurance contracts is “regulating the business of insurance.” *Id.* at 742-43. These cases have established three criteria to determine whether a practice or activity falls within the “business of insurance.” The Court stated that:

[F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk, second, whether the practice is an integral part of

terms of insurance contracts falls squarely within the saving clause (exempted from preemption) as laws "which regulate insurance."¹⁶² The Court found that even though mandated-benefit statutes required insured employers to provide minimum level and kinds of benefits, they were nevertheless regulation of the business of insurance.¹⁶³ The Court then found that Section 47B was a mandated-benefit law and thus a regulation of the business of insurance.¹⁶⁴ However, it agreed with the Massachusetts Judicial Court that the Massachusetts statute "as applied relates to ERISA plans and thus is covered by ERISA's broad preemption provision set forth in [section] 1144(a)."¹⁶⁵

2. "Relate[s] to" an ERISA Plan: Exempted from Preemption

In *Metropolitan Life*, the Court noted that the preemption clause in section 1144(a) is limited by the insurance saving clause,

the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities with the insurance industry.

Id. at 743 (citing *Union Labor Life Ins. Co. v. Pierno*, 458 U.S. 119, 129 (1982)). The Court then applied the three criteria to section 47B and concluded that mandated-benefit laws are state regulation of the "business of insurance." *Id.* at 757.

162. *Metropolitan Life*, 417 U.S. at 742-43.

163. *Id.* at 743. In *Metropolitan Life*, defendants-appellants Metropolitan Life Insurance Co. and Travelers Insurance Company (Travelers) issued group health policies to employers who employed Massachusetts residents. Under section 47B appellants were required to provide mental health benefits under policies issued to cover Massachusetts residents. However, believing they were not bound by section 47B, the appellants did not provide such benefits. The Attorney General sought enforcement of Section 47B by declaratory and injunctive relief. In granting the injunction, the superior court stated that the appellants refused to provide the benefits because they believed that section 47B was preempted by ERISA. *Id.* at 734-35.

On appeal, the Supreme Judicial Court of Massachusetts affirmed. *Attorney General v. Travelers Ins. Co.*, 433 N.E.2d 1223 (Mass. 1982). The Court agreed that section 47B relates to an ERISA covered employee benefit plan. *Metropolitan Life*, 471 U.S. at 739. It then considered whether the insurance exemption under section 1144(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), would exempt section 47B from preemption. The Court concluded that section 47B is saved from preemption by section 1144(b)(2)(A) which exempts insurance contracts from preemption. *Id.* at 745-46. The Court held that "Massachusetts' mandated-benefit law is a 'law which regulates insurance' and so is not preempted by ERISA as it applies to insurance contracts purchased for plans subject to ERISA." *Id.* at 758.

164. *Metropolitan Life*, 417 U.S. at 742-43.

165. *Id.* at 739.

section 1144(b)(2)(A),¹⁶⁶ which "preserves any state law which regulates insurance."¹⁶⁷ The Court concluded that the Massachusetts statute, requiring mandated-mental health benefits, was exempted from pre-emption by the insurance saving clause.¹⁶⁸ The Court reached its conclusion based on its interpretation of the language of the saving clause.¹⁶⁹ The Court found that the language of section 1144(a) was inconsistent with the language of section 1144(b)(2)(A) in that section 1144(a) preempts state law, but section 1144(b)(2)(A) permits states to make insurance law. It then accepted the assumption "that the ordinary meaning of that language accurately expresses the legislative purpose."¹⁷⁰ The Court then concluded that the "plain language of the saving clause, its relationship to the other ERISA pre-emption provisions, and the traditional understanding of insurance regulation" lead to one conclusion: section 1144(b)(2)(B), the deemer clause, exempts from the saving clause state insurance law that indirectly regulates welfare benefit plans.¹⁷¹ Stated another way, the Court concluded that Congress intended to exempt insurance law that did not directly regulate employee benefit plans.¹⁷² Thus, the saving clause exempts traditional state regulation of insurance

166. 29 U.S.C. § 1144(b)(2)(A) (1988 & Supp. III 1991).

167. *Metropolitan Life*, 471 U.S. at 742-43.

168. *Id.* at 746.

169. *Id.* at 744.

170. *Id.* at 740.

171. *Id.* at 744-45.

172. *Id.* at 741; see also *Michigan United Food & Commercial Workers Union v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985) (does not preempt state insurance regulation requiring substance abuse treatment); *Maryland v. Metropolitan Life Ins. Co.*, 463 A.2d 793 (Md. 1983) (does not preempt state insurance regulation that requires reimbursement of social worker services); *Blue Cross Hosp. Serv., Inc. v. Frappier*, 698 S.W.2d 326 (Mo. 1985) (does not preempt state insurance regulation that mandates chiropractic and psychological services). *But see, e.g.*, *Insurance Bd. Under Social Ins. Plan of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987) (preempts state laws that regulate contents of employee health care benefit plans); *Blue Cross & Blue Shield v. Peacock's Apothecary, Inc.*, 567 F. Supp. 1258 (N.D. Ala. 1983) (preempts state law that regulates reimbursement for prescription drugs); *Council of Hawaii Hotels v. Agsalud*, 594 F. Supp. 449 (D. Haw. 1984) (preempts 1978 amendments to Hawaii Prepaid Health Care Act of 1974 that regulates collectively bargained employee health care benefit plans); *Wayne Chem. Inc. v. Columbus Agency Serv. Corp.*, 426 F. Supp. 316 (N.D. Ind. 1977), *modified on other grounds*, 567 F.2d 692 (7th Cir. 1978) (preempts state insurance law that prohibits the termination of dependent coverage under employee benefit plan); *General Split Corp. v. Mitchell*, 523 F. Supp. 427 (W.D. Wis. 1981) (preempts state law that mandates conversion

that does not regulate employee benefit plans, though it "relate[s] to" ERISA-covered plans.¹⁷³

The Court noted that its decision did not apply to uninsured or self-funded welfare benefit plans.¹⁷⁴ As a result, the Massachusetts statute affects only employee benefit plans that are covered or insured by commercial insurance contracts. ERISA does not, under section 1144(a) and its exemptions, permit direct regulation of employee benefit plans by states.¹⁷⁵ However it allows indirect regulation when it is imposed under an insurance regulation that does not mandate the contents of employee benefit plans.¹⁷⁶ Mandated-benefit regulation is actually voluntary in that employers are not required to purchase group health insurance. In sum, after *Greater Washington* and *Metropolitan Life*, it is well settled that ERISA invalidates much state health care policy that "relate[s] to any employee benefit plans," and leaves few regulatory means for states to implement effective health care policy.¹⁷⁷

IV. ERISA, FEDERALISM, AND HEALTH CARE POLICY

Section 1144(a) is highly restrictive of state health care law and public policy, except for narrowly drawn exemptions provided in sections 1144(b) and 1003(b)(3). *Greater Washington*, *Metropolitan Life* and *Shaw* clearly show that ERISA implements federal employment and labor policies mostly for administrative purposes. Ironically, these policies preempt much state health care law and public policy, and thus constitutionally affect the exercise of state powers under the federal system.¹⁷⁸ However, the worst may be yet to come.

benefits and establishes risk-sharing plans). Ford, *supra* note 37, discusses mandated-benefit statutes enacted by the states after the enactment of ERISA.

173. *Metropolitan Life*, 471 U.S. at 745-46. The Court found that Congress intended for the states to regulate the business of insurance. *Id.* at 736-37; *supra* note 158-165 and accompanying text.

174. *Metropolitan Life*, 471 U.S. at 747. See generally Jonathan Goldstein, Note, *ERISA's Deemer Clause and the Question of Self-Insureds: What's a State To Do?* 67 WASH. U. L.Q. 291, 291-303 (1989).

175. *Metropolitan Life*, 471 U.S. at 747.

176. *Id.*

177. See generally *supra* notes 109, 172, and accompanying text (discussing the statutory exemption that Congress granted the Hawaii Prepaid Health Care Program (hereinafter Hawaii Prepaid Program)). The Hawaii Prepaid Program had been preempted by the section 1144(a) of ERISA.

178. ERISA preemption frustrates the financing of state health care reforms in that states cannot shift the cost of health care to employers unless they decide to purchase group health care insurance. Still states can only affect those

ERISA is a legislative scheme that demonstrates the need for uniformity and consistency in implementing a comprehensive, federal regulatory framework for certain fields of law, namely employment and labor, that were once governed by state common law and public policy. Eventually, federal health care policy could be as comprehensive. Such a policy could require uniformity and consistency in implementing it among the fifty states and thus require the preemption of much state health care law and public policy.¹⁷⁹ Although it furthers a significant public interest, federal health care regulation still raises substantial concerns that are worth considering in regard to its ultimate effect on the scope of federalism.

A. *ERISA and Its Impact on State Health Care Policy*

Section 1144(a) of ERISA limits state health care policy even though sections 1003(b)(3) and 1144(b)(2)(A) grant exemptions from preemption. Those exemptions do not give states the flexibility to broadly formulate health care policy for their citizens, unless Congress grants an explicit exemption for each state's program.¹⁸⁰ For example, states cannot mandate the continuation of health care coverage in conjunction with employee absences created by their receiving workers' compensation, disability benefits, or family leave.¹⁸¹ Therefore, states are severely restricted in designing health care regulation to increase access to and pay for health care for unemployed, uninsured individuals.

employers who can afford to and do purchase groups health insurance. The self-funded employers are out of reach. Under the Court's holding in *Metropolitan Life*, mandated-benefit statutes do not apply to self-funded or uninsured employers. *Metropolitan Life Ins. Co.*, 471 U.S. at 747. As previously stated, section 1144(a) preempts taxes on employee benefit plans, *supra* note 105, and surcharges and fees on commercial insurers, *supra* notes 112-24. Furthermore, section 1144(a) flatly prohibits employer-sponsored benefits and thus states must rely on incentives to induce employer participation in state health care plans. Boblinski, *supra* note 1, at 335. It is believed that voluntary health care programs are not effective. *Id.* at 337.

The financing of any state reforms could be totally preempted if the federal government mandates new taxes or fees to finance a national health care program. Therefore, any state health care reform must be closely coordinated with, governed by federal guidelines, and financed by the federal government or exceptions it grants. *Infra* notes 212, 222, and accompanying text.

179. See Boblinski, *supra* note 1, at 345.

180. *Supra* notes 99-111 and accompanying text.

181. See *Greater Washington*, 113 S. Ct. at 584-85.

1. *Expansive Interpretations Impose Severe Limits on State Health Care Policy*

In *Greater Washington*, the Court made it quite clear that if state law "relate[s] to" ERISA-covered welfare benefit plans, it is preempted, even though it is exempted under section 1003(b)(3).¹⁸² The Court found that the continuation of health care coverage is a too-direct regulation of ERISA-covered plans, even though this coverage made sure that health care coverage was accessible to workers who may not easily qualify for or immediately find employment with health care coverage.¹⁸³ Although the continuation of health care coverage maintains access to health care insurance, the Court was not compelled to create an exception to ERISA.

Earlier, in *Metropolitan Life*, the Court permitted indirect regulation of employee benefit plans through mandated-benefits imposed under group health care insurance contracts.¹⁸⁴ The Court did not allow the states to affect the contents of or mandate employee benefit plans.¹⁸⁵ Even mandated-benefits regulation must stay within the limits of the saving clause, section 1144(b)(2)(A), and if this regulation is found to be an ERISA-covered plan, it is preempted under the deemer clause of section 1144(b)(2)(B).¹⁸⁶ Furthermore, mandated-benefit regulation does

182. *Greater Washington*, 113 S. Ct. at 584-85.

183. *Id.* at 587-88 (Stevens, J., dissenting). In arguing that the Court ignored the purpose of District of Columbia's continuation coverage and over-interpreted the "relate to" language, the dissent maintained:

The statute at issue in this case does not regulate any ERISA plan or require any ERISA plan administrator to make any changes in the administration of such a plan Moreover, by requiring an injured worker's compensation to reflect his entire pay package, the statute attempts to replace fully the lost earning power of every injured employee.

Id. at 587 (Stevens, J., dissenting). The dissent believed that the Court applied a mechanical test and never really considered the disfavor of preempting state law and the specific concerns of Congress. *Id.* at 588.

184. *Metropolitan Life*, 471 U.S. at 747.

185. *Id.*

186. See, e.g., *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978) (state law cannot subject employee benefit plan to state insurance regulation or make this plan insurance); *St. Paul Elec. Workers Welfare Fund v. Markman*, 490 F. Supp. 931 (D. Minn. 1980) (state comprehensive health care act "relates to" employee welfare benefit plans).

The interpretation of the deemer clause by federal courts has resulted in much praise and criticism. See, e.g., J.K. Swedback, Note, *The Deemer Clause: A*

not apply to self-funded insurance plans.¹⁸⁷ However, even though the Court permitted states to enact insurance regulation to implement health care policy, it held such regulation shall not regulate the contents of employee benefit plans or apply to self-

Legislative Savior for Self-Funded Health Insurance Plans Under the Employee Retirement Income Security Act of 1974, 18 WM. MITCHELL L. REV. 757 (1992); Goldstein, *supra* note 174 (analyzing *Reilly v. Blue Cross and Blue Shield United of Wis.*, 846 F.2d 416 (7th Cir. 1988), in which the court of appeals held that "the deemer clause of ERISA preempts state law claims against self-insured employee benefit plans.").

187. Federal courts have held that 29 U.S.C. § 1144(a) preempts state common law and insurance regulation that applies to self-funded plans. *See, e.g.*, *Metropolitan Life Ins. Co.*, 471 U.S. at 738 (decision does not apply to self-funded plans); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (preempts state insurance law that regulates self-insured welfare benefit plan); *Reilly v. Blue Cross & Blue Shield United of Wis.*, 846 F.2d 416 (7th Cir. 1988) (preempts state law that allow claims against self-funded plans); *United Food & Commercial Workers & Employers Ariz. Health & Welfare Trust v. Paeyza*, 801 F.2d 1157 (9th Cir. 1986) (preempts state insurance law that establishes reimbursement requirements for self-funded plan); *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir. 1977), *cert. denied*, 439 U.S. 831 (1978) (preempts state comprehensive health plan that relates to employee benefit plans); *Cuttle v. Federal Employees Metal Trades Council*, 623 F. Supp. 1154 (D. Me. 1985) (preempts state insurance conversion law that might apply to self funded plans).

The protection that ERISA gives to self-funded plans may be short lived. The Health Security Proposal, *supra* note 5, imposes stringent requirements on self-funded health care benefit plans. President's Health Plan, *supra* note 5, at 79-80. The Health Security Proposal sets "financial reserve requirements for self-funded health benefit plans." President's Health Plan, *supra* note 5, at 79. These requirements are as follows:

New requirements for financial reserves apply to self-funded health plans. Self-funded health plans establish a trust fund that is maintained at a level equal to estimated amount that the plan owes providers at any given time. The plan pays claims from the trust fund. Trust funds are protected by special status in bankruptcy proceedings if the sponsoring employer fails.

Reserve requirements may be met through letters of credit, bonds or other appropriate security rather than establishing the trust fund.

A new national guaranty fund for self-funded health plans provides financial protection for health providers in case of financial failure of a plan. The Department of Labor oversees the national guaranty fund; it operates in a manner similar to state insurance guaranty funds.

The Department of Labor may inspect the books and records of self-funded health plans and assume control over plans if they fail to meet reserve requirements. Health benefit plans notify the Department of Labor if they fail to meet requirements.

President's Health Plan, *supra* note 5, at 79-80.

funded employee benefit plans.¹⁸⁸ Under the Court's holdings in *Greater Washington* and *Metropolitan Life*, not much state health care law and public policy will actually survive challenges under section 1144(a).

B. ERISA and a Reduction in States' Rights

Preemption is compelled when it is explicit in the language of the statute.¹⁸⁹ As ERISA expressly preempts state law, state health care policy must give way to federal employment and labor regulation. But labor and employment regulation have not traditionally governed medical care and assistance. As a part of this regulation, ERISA establishes a uniform and consistent regulatory framework for the administration of employee benefit plans, not for the regulation of medical care. The employment purpose is valid, but its effect on medical care is either too political or too legal.

1. States' Dependency on Federal and Private Interests

Permitting ERISA to affect uniformity in health care policy among the states exceeds the bounds of cooperative government relations. Rather than permitting the interaction of the labor market and state public policy to set a minimum standard of health care benefits, ERISA retains an employer's common law discretion to withhold health care benefits. ERISA decreases the influence that state public policy has on local employees and

188. *Metropolitan Life*, 471 U.S. at 738.

189. *Id.* at 738. The Court has made it abundantly clear that:

In deciding whether a federal law pre-empts a state statute, our task is to ascertain Congress' intent in enacting the federal statute at issue. "Pre-emption may be either expressed or implied, and is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose. . . ."

Id. In addition, the Court has other more settled principles that should be considered in deciding whether state law and public policy is preempted:

Consideration of issues arising under the Supremacy Clause "start[s] with the assumption that the historic police powers of the States [are] not to be superseded by . . . Federal Act unless that [is] the clear and manifest purpose of Congress. Accordingly, "[t]he purpose of Congress is the ultimate touchstone" of pre-emption analysis.

Greater Washington, 113 S. Ct. at 587 n.4 (Stevens, J., dissenting) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947); *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978); *Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103 (1963)). Nevertheless, ERISA invalidates much state public policy, legislation, and common law.

employee-related decisions. Consequently, the labor market that is influenced by global competition is the primary, or at least the most significant, determinant of local health care needs and services. Under the Court's interpretation of ERISA, local communities are more likely, when compared with the past, to lose health care benefits first and jobs second as the result of the diminished influence of local public policy. According to this interpretation, ERISA severely restricts the implementation of a flexible, comprehensive state health care policy. Matters are made worse by federal legislative reticence on health care reform.

Unlike the federal government, states have reformed health care. For example, state health care reform consists of federally subsidized Medicaid,¹⁹⁰ state-sponsored health insurance,¹⁹¹ and mandated-benefits of insurance contracts.¹⁹² Still, many states find themselves in a precarious position when they implement their programs. Existing state health care policy that furthers legitimate health care needs depends mostly on voluntary gratuities by employers and federal subsidies.¹⁹³ State health care reform depends on the following factors: (1) whether employers will voluntarily grant health care benefits under self-funded plans;¹⁹⁴ (2) whether employers will voluntarily purchase commercial insurance subject to mandated-benefits regulation;¹⁹⁵ (3) whether the federal government will grant an exemption from or exception to section 1144(a);¹⁹⁶ and (4) whether the federal government will continue to subsidize medical care and assistance

190. See generally Robinson, *supra* note 108, at 977-1013 (extending health care to Oregon citizens under federally subsidized Medicaid, voluntarily granted employer mandated-benefits, and state-sponsored insurance); *supra* notes 28-32, 108, and accompanying text.

191. Robinson, *supra* note 108, at 977-1013.

192. *Metropolitan Life*, 471 U.S. at 729-31.

193. See *Metropolitan Life*, 471 U.S. at 729-31; 29 U.S.C. § 1003(b)(3) (exceptions for worker's compensation and disability benefit laws). In *Metropolitan Life*, the Court noted Massachusetts' rationale and purposes for implementing a mandated-benefit statute requiring that mental health benefits be given in group health insurance policies. *Id.*

194. See *Metropolitan Life*, 471 U.S. at 747; *supra* notes 109, 172, and accompanying text.

195. See *Metropolitan Life*, 471 U.S. at 746-47; *supra* note 178 and accompanying text.

196. See *Metropolitan Life*, 471 U.S. at 742-47; *supra* note 14 and accompanying text.

programs.¹⁹⁷ Employers' gratuities and federal subsidies do not fall within the "reserved powers" of the states and thus states lack the power to enforce most health care regulation. State financing must be taken from already recession-weakened and deficit-laden coffers. Therefore, state health care policy is precariously dependent on the whims of deficit-ridden federal and cost-conscious private interests that are not within the control of the states' public policy mechanisms.

2. Raising More Fundamental Constitution Concerns

The ERISA preemption clause raises other more fundamental issues, namely the existing scope of federalism under the United States Constitution. Much debate has been raised regarding the preemptive effects of ERISA on state law (other than insurance regulation) that mandates the contents of employee welfare benefit plans.¹⁹⁸ ERISA eliminates substantive protection for employees who were once protected under state common law and public policy.¹⁹⁹ The lack of protection for employee interests is exacerbated by the states' inability to intervene in employer decisions to unilaterally terminate or modify health care and other benefits. In enacting ERISA, Congress, relying on the Commerce²⁰⁰ and

197. See Robinson, *supra* note 108, at 977-1013 (extending health care to Oregon citizens under federally subsidized Medicaid); *supra* notes 28-32, 108, and accompanying text.

198. See, e.g., Laura J. Bond, Note, *ERISA-Preemption—Pilot Life Insurance Co. v. Dedeaux: Congress's Cue to Reassess ERISA's Preemptive Effect*, 36 KAN. L. REV. 611 (1988); Robert I. Lorio, Note, *Ingersoll-Rand Co. v. McClendon: State Actions for Wrongful Employment Discharge Subject to ERISA Preemption*, 37 LOY. L. REV. 375 (1991); Boblinski, *supra* note 1; David L. Gregory, *The Scope of ERISA Preemption of State Law: A Study on Effective Federalism*, 48 U. PITT. L. REV. 427 (1987); James D. Hutchinson & David M. Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 U. CHI. L. REV. 23 (1978); Peter H. Turza & Lorraine Hollaway, *Preemption of State Laws Under the Employee Retirement Income Act of 1974*, 28 CATH. U. L. REV. 163, 169-74 (1974); Ackerman, *supra* note 7, at 825.

199. See 29 U.S.C. § 1144(a) (1988 & Supp. 1991); *supra* notes 48-57 and accompanying text. ERISA also requires federal courts to develop federal common law contract and trust to construe employee benefit plans. *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 110-12 (1989) (citing, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987)); see also, *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n.26 (1983). "A body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." *Id.* at 24 n.26 (quoting, 129 Cong. Rec. 29942 (1974) (remarks of Sen. Javits)).

200. U.S. CONST. art. I, § 8, cl. 3.

Supremacy Clauses,²⁰¹ sought and established uniformity and consistency in employee benefit policies. Congress did not intend to affect States' abilities to formulate local public policy or to strengthen states' rights for employee benefits, notwithstanding the explicit reservation of power under the Tenth Amendment of the Constitution.²⁰²

V. LESSER FEDERALISM OR MORE FEDERAL MEDICAL CARE

To lessen the preemption of state health care policy and to preserve states' rights to affect public policy, amending the ERISA preemption clause is not the answer. Amending the preemption clause will not entirely eliminate federal-state conflict regarding the preemption of state health care law and public policy. This is because federal policy-makers may preempt even more state health care and other law and public policy by establishing a comprehensive national health care program.²⁰³ A comprehensive national health care policy would have to deal with interrelated social, economic, and political issues in order to address essential health care and health care related standards. Namely, such a policy would need to accomplish several or all of the following goals: (1) make health care more accessible; (2) reduce or limit health care costs; (3) provide medical malpractice reform; (4) eliminate duplicate state health care and health-care related programs; and (5) pay for the increased use of health care services.²⁰⁴ A comprehensive federal health care legislation that establishes a

201. U.S. CONST. art. VI, cl. 2.

202. U.S. CONST. art. VI; see generally Gregory, *supra* note 34, at 429; Boblinski, *supra* note 1, at 258 (discussing ERISA's impact on federalism under the labor preemption doctrine). In *Standard Oil Co. of Cal. v. Agsalud*, 442 F. Supp. 695 (1977), the district court stated that: "By preempting state health insurance laws, Congress did not violate the limits placed by the Tenth Amendment on its authority under the Commerce Clause." *Id.* at 710. Relying on the *National League of Cities v. Usery*, 426 U.S. 833 (1976), the district court concluded that ERISA regulates business affairs, namely employment relationships and "does not impair any essential attribute of state sovereignty." *Agsalud*, 442 F. Supp. at 710. For comments on whether federalism has political or legal substance under the Constitution, see generally H. Jefferson Powell, *The Oldest Question of Constitutional Law*, 79 VA. L. REV. 633 (1993) (discussing the prudential grounds for a rule of law protecting federalism under the U.S. Constitution).

203. See Boblinski, *supra* note 1, at 344-45.

204. See, e.g., Boblinski, *supra* note 1, at 260-68, Ackerman, *supra* note 7, at 826-830; President's Health Plan, *supra* note 5, at 3-4.

uniform and consistent policy would potentially preempt more state law than ERISA.

A. *Impact of National Health Care Policy*

Why would such a federal law need to be so Draconian? To further legitimate federal interests among the states, a comprehensive federal health care regulation would eventually preempt parts or all of state law and public policy in the following fields: (1) hospital and health care institution regulation;²⁰⁵ (2) insur-

205. Health care providers and others have challenged state hospital surcharges, fees, and other regulations under section 1144(a) of ERISA. *Supra* notes 112-24 and accompanying text. In not preempting hospital surcharges, ERISA permits states to shift health care cost to commercial insurers and employers. *Supra* notes 114-26. A federally provided and financed health care program would make it difficult for states' citizens, who are required to pay a health care tax, to finance additional local and state health care needs. *See* President's Health Plan, *supra* note 5, at 52. Under the Health Security Proposal, "[s]tates can not regulate premium rates changed by health plans, except when necessary to meet budget requirements or to ensure plan solvency." *Id.* at 55-56. Although states may provide benefits beyond those required by the Health Security Proposal, they can not use revenues from the Health Security Proposal to provide additional benefits. *Id.* at 56. In addition, they cannot "rely on a payroll mandate on employers or another revenue source applicable solely to corporations or payroll." *Id.*

Finally, a comprehensive federal comprehensive health care proposal, such as the Health Security Proposal, would more likely eliminate state hospital surcharges and fees that are imposed on patients' bills as these bills would then be paid by funds collected and distributed under a national health care program. And remaining state fees could be so burdensome that hospital and other organizations may not be able to pay them. Furthermore, comprehensive federal health care would eventually subject hospitals and other health care institutions to more federal regulation, either directly or indirectly. *See* Ron Winslow, *Medical Industry Scrambles To Keep Up With Changes*, WALL ST. J., Sept. 13, 1993, at A7.

Under the Health Security Proposal, *supra* note 5, the federal government will regulate health care institutions in streamlining regulations. For example, the Health Security Proposal states that:

Minimum Standards for Health Care Institutions. The National Quality management Program develops uniform standards for licensing of health care institutions that focus on essential performance requirements related to patient care. As those standards are developed, those standards replace current standards . . .

Id. at 118-19. Thus, the Health Security Proposal and similar proposals would make existing state regulation and public policy invalid as the federal government creates a uniform and consistent health care institution standards.

ance regulation;²⁰⁶ (3) common law tort, contract, and employment;²⁰⁷ (4) worker's compensation acts;²⁰⁸ (5) disability benefits

206. The federal regulation of insurance contracts to increase accessibility to health care would necessarily preempt much state insurance statutes and common law as insurance is regulated by the state. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727-29 (1985). Such preemption could also undermine much health care-related benefits that are provided under mandated-benefit statutes of insurance regulation. *See Hofmann & Fletcher, supra* note 3, at 1 & 45; Fletcher, *supra* note 3, at 24.

The Health Security Proposal would drastically change state health insurance regulation. Many health insurers would be affected by the Health Security Proposal as health insurance as we know it today would be drastically scaled back. Winslow, *supra* note 205, at A7. Health plans, insurers, or any other persons may not offer a supplemental insurance policy that duplicates the benefits of the comprehensive package. President's Health Plan, *supra* note 5, at 89-90. Supplemental insurance can be used to cover both cost sharing and additional health benefits. It can cover all or some of benefits not included in the comprehensive package. *Id.* at 88. Not all supplemental policies must abide by the rules for insurance; e.g., medigap insurance and insurance against accidents. *Id.* The specifics of the Health Security Proposal provide:

The National Health Board develops two standard, supplemental cost-sharing policies. One model provides standard coverage; the other maximum coverage.

SUPPLEMENTAL INSURANCE

Supplemental insurance to cover both cost sharing and additional health benefits is allowed.

A supplemental benefit policy may cover all or some portion of benefits not included in the comprehensive package, such as long-term rehabilitation services and cosmetic surgery. A policy covering cost sharing might pay a portion of co-payments and co-insurance required by a health plan.

Any entity that offers supplemental policies must abide by the rules for supplemental insurance. However, the following types of insurance policies are not subject to these rules:

- * Long-term care insurance
- * Insurance against specific diseases
- * Hospital or nursing home indemnity insurance
- * Medigap insurance
- * Insurance against accidents.

Id. at 88. In addition, the Health Security Proposal would repeal the antitrust exemption given to health insurance companies. This would eliminate the ability of the health plan, as insurers, to "collectively determine the rates they charge . . ." *Id.* at 195. In short, there will be a smaller health insurance industry and less state authority to regulate it.

207. As a comprehensive regulatory scheme, ERISA has had, and is still having, a broad impact on employer-employee relations, as well as other state common law and public policy. In comparison, a comprehensive national health care program could have similar effects on the employment and other contractual

relationships that arise between the health care delivery system and the public. Thus, a comprehensive health care system may be equally as intrusive as ERISA. It is reasonable to infer that national health care will affect parts of contract (doctor-patient), tort (medical malpractice), and employment (employer-employee). See Hofmann & Fletcher, *supra* note 3, at 1 & 45; Fletcher, *supra* note 3, at 24.

ERISA has preempted much state common law and related public policy to maintain a uniform and consistent regulatory scheme for the administration of employee benefit plans. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (preempts state wrongful discharge claim); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (preempts state common law fraud in the inducement); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (preempts state common law insurance claim). The Court's expansive interpretation of ERISA does not permit state tort, contract, or insurance laws "that provide an alternative cause of action to employees to collect benefits protected by ERISA . . ." *AETNA Life Ins. Co. v. Borges*, 869 F.2d 142, 146 (2d Cir. 1989), *cert. denied*, 493 U.S. 811 (1990); *supra* notes 90-91 and accompanying text. ERISA's preemption of much state common law has generated much scholarly commentary. See *supra* note 198 and accompanying text. The Health Security Proposal, *supra* note 5, shows how a comprehensive health care plan could eventually affect state common law and public policy. For example, the Health Security Proposal increases employer responsibility for employee welfare benefits. It requires the employer to share health care costs with the employee. President's Health Plan, *supra* note 5, at 17-18. It also requires "[e]mployers whose primary occupation is employee leasing . . . to participate in regional Health alliances regardless of the number of employees." *Id.* at 21. "The term employer is defined as it is under the ERISA statute." *Id.* Finally, "The Department of Labor regulates employers . . ." in corporate alliances. *Id.* at 72. It is entirely unreasonable to expect a comprehensive federal health care plan to have a lesser effect on state common law and public policy of employment and other fields of law.

208. Hofmann & Fletcher, *supra* note 3, at 1-45; Fletcher, *supra* note 3, at 24. Section 1003(b)(3) of ERISA exempts state worker's compensation acts from preemption, but it may not be the same under a comprehensive federal health care program. Commentators, policy analysts, and others are worried about the impact of a national health care program on state worker's compensation. Hofmann & Fletcher, *supra* note 3, at 45; Fletcher, *supra* note 3, at 24. It is urged that "coverage for injured workers' medical care," be shifted to a national health care program. *Id.* Some believe that the shift is a foregone conclusion, while others have cautioned the current Federal Administration not to forget the purpose of workers' compensation: "overall workplace disability management system that focuses on maximum medical improvement and prompt return to work." *Id.* Implementing worker's compensation under a comprehensive federal health care program requires coordinating—probably through creating uniform and consistent workers' compensation laws—federal and state laws. Hofmann & Fletcher, *supra* note 3, at 45. This would required the preemption of state workers' compensation law. Fletcher, *supra* note 3, at 24.

Commentators and others were not entirely wrong. In actuality, the Health Security Proposal, *supra* note 5, would preempt state workers' compensation law regulating the choice of health care "provider for workers' compensation cases of

law;²⁰⁹ (6) automobile liability insurance law;²¹⁰ (7) medical malpractice law;²¹¹ and (8) special exemption from preemption under Section 1144.²¹² Such expansive and massive preemption, whether immediate or gradual, means that preemption under a

individuals covered through health alliances." President Health Plan, *supra* note 5, at 98. However, the Health Security Proposal presently does not preempt other workers' compensation regulation. *Id.* at 99. "Health benefits for work-related injuries and illness continue to be defined by states." *Id.* But recognizing the existing federal dominance in the field of health care, federal preemption of state law and public policy tends to be even more expansive. Federal preemption may give the States healthy citizens but perhaps a sick government, preemption that causes morbid federalism.

209. *See supra* note 208.

210. *See supra* note 208; Hofmann & Fletcher, *supra* note 3, at 1. The Health Security Proposal, *supra* note 5, requires automobile insurers to "reimburse . . . the health plan for services provided." President's Health Plan, *supra* note 5, at 101. The Health Security Proposal does not preempt the much state liability insurance other than that insurance law covering the choice of providers. *Id.*

211. A federal health care program could become as preemptive as ERISA. To maintain uniform and consistent access to health care, many state common law claims will be preempted by federal health care regulation, or the federal program will become a patch work of uncoordinated state schemes that lack the consistency and uniformity intended by the federal scheme. *See Boblinski, supra* note 1, at 345.

For that reason and others, many health care reformers see a reform of medical malpractice law as a part of a national health care program. *See Woolsey, supra* note 1, at 20-25. It is strongly believed that the current Federal Administration's proposal includes provisions for reforming medical malpractice laws. These provisions "will discourage frivolous suits and encourage greater use of alternative dispute resolution mechanisms." J. Geisel, *Employer Mandate Key to Financing*, Bus. Ins., May 17, 1993, at 144.

That thinking is correct. The Health Security Proposal, *supra* note 5, does attempt to reform medical malpractice. The Health Security Proposal reforms medical malpractice law by proposing changes in tort and alternative dispute resolution mechanisms. President's Health Plan, *supra* note 5, at 189. Its proposed changes are as follows: (1) creation of alternative dispute resolution mechanisms, (2) requirement for certificate of merit, (3) limits on attorney fees, (4) repeat offenders, (5) collateral services, (6) periodic payment of awards, (7) enterprise liability demonstration project, and (8) standards based on practice guidelines. *Id.* at 189-91. Unless states are exempted from the requirements of a comprehensive federal health care program, much state common law will be preempted as the federal program seeks to maintain uniformity and consistency in the exclusive federal scheme.

212. *Supra* note 205 and accompanying text. The Health Security Proposal, *supra* note 5, modifies the preemption provision of ERISA. It states that:

The ERISA preemption provision is modified to:

* Apply the preemption only with respect to employers and health benefit plans in corporate alliances.

comprehensive federal health care regulation would only start where ERISA left off. This may explain Congress' reservation in not amending ERISA. By not giving the states exemptions from and exceptions to preemption for local health care plans,²¹³ Congress avoids repealing ERISA amendments that would be inconsistent with highly comprehensive federal health care.²¹⁴

1. Broad Preemptive Effects of Comprehensive Health Care

Comprehensive federal health care would have some broad preemptive effects in many fields of regulation. For example, a regulation governing the health care insurance industry could impliedly, if not expressly, preempt states from using the mandated-benefit statute as a voluntary means of establishing access to health care benefits for employed, retired, and disabled workers. Obviously, state mandated-benefits that are imposed under insurance contracts would either be preempted or incorporated into the national health care program. In any event, states lose some of their authority over the insurance industry by not having the power to make broad based mandated-benefit statutes. Moreover, strengthening the ERISA prohibition against employer-sponsored health care benefits would continue to deny all states, except Hawaii,²¹⁵ an alternative means to affect local and state public policy. But permitting the federal government to impose employer-based health care taxes that are not designed specifically to support health care needs of the local population requires local employers to support health care for the general population

* Permit taxes and assessments on employers or health benefit plans in corporate alliances if the assessments are nondiscriminatory in nature.

* Permit states to develop all-payer hospital rates or all-payer rate setting.

* States also may require all payers, including health benefit plans in corporate alliances, to reimburse essential community providers.

President's Health Plan, *supra* note 5, at 80. Note that the Health Security Proposal permits "taxes and assessments employers or health benefit plans in corporate alliances." *Id.* at 80. States can also develop all-payer hospital rates or all-payer rate setting. *Id.* The Health Security Proposal would provide some relief for states, but they would still be subject to new federal regulations.

213. *Infra* notes 217-20 and accompanying text.

214. It is believed that a national health care program should make it easier for states to enact new and maintain health care reforms. See Geisel, *supra* note 211, at 44.

215. See *supra* note 109 and accompanying text.

rather than for local employees and their families.²¹⁶ As a result, states are denied the ability to redistribute wealth to support local economic growth and social progress. Under such a program, states will lose the power to affect local public policy.

A comprehensive national health care policy will be more preemptive than ERISA because in providing a minimum standard and some uniformity, it will have to control health care and health care-related interests which are intertwined with numerous fields of state law and public policy. This will result in the undermining of federalism.

B. *Comprehensive Health Care in the Spirit of Federalism*

The time has passed for Congress to relieve states of the preemptive effects of federal labor and employment law on state health care policy. At this time, amending ERISA would only confuse sincere federal efforts to design a national health care program.²¹⁷ Furthermore, any federal health care policy must preempt considerable state law or exempt from preemption state health care policy that complies with or exceeds minimum federal health care standards. The latter alternative considerably preserves federalism by giving the states responsibility for their own welfare²¹⁸ and not enlarging federal health care powers where exclusive federal power may not necessarily exist.²¹⁹ A coordinated state-federal health care policy is the preferred long-term

216. *But see* President's Health Plan, *supra* note 5, at 52-53; *supra* note 5 and accompanying text. To avoid the full scale redistribution of wealth across the nation, the Health Security Proposal, *supra* note 5, establishes a local-national arrangement through creating corporate and regional health alliances. States establish and govern the regional health alliances. President's Health Plan, *supra* note 5, at 60-80.

217. Boblinski, *supra* note 1, at 343-46.

218. *Infra* notes 220-22 and accompanying text. States do not necessarily give first priority to legitimate social interests when they are unpopular with the states' citizens. *See* Boblinski, *supra* note 1, at 344-45.

219. Parmet, *supra* note 22, at 319-30; Thompson, *supra* note 22, at 647-48; Rivkin, *supra* note 22, at A19. Expansive preemptive provisions that control employer-employee relations, personal injury law, insurance suits, and work-related claims threaten to create a uniform system of federal common law which would supplant much state common law and public policy. This expands the interpretive powers of federal courts but leaves them without much state public policy. In regard to the making of federal common law, many health care issues are broad based social questions that federal courts should not decide, such as the duration, frequency, amount, and quality of health care for specific illnesses. National health care is a complex, state and federal public policy problem. *See*

strategy. In the short-term, as a stop gap measure, a limited exemption from preemption under ERISA of federally recognized comprehensive state health care programs is suitable.²²⁰

1. *Maintaining "Cooperative Federalism" In Comprehensive Health Care*

Notwithstanding long-running state reluctance to redistribute wealth and pursue broad social welfare interests,²²¹ if states are constantly subjected to federal authority that provides essential human needs for their citizens, they may lose their faith in democracy.²²² Whether Hamiltonian or Jeffersonian federalism,²²³ state interests that economically encourage employment in communities that permit unhealthy labor do not invest in their human resources. These state interests are characteristic of the dawn of the industrial age, not the dawn of the information age. For that reason, a national health care policy should start with an adamant stand by the federal government that the nation will

Boblinski, *supra* note 1, at 345-48. It is not precedent for federal courts to tread where fools dare not to go.

220. Boblinski, *supra* note 1, finds that a comprehensive national health care program is the better alternative. *Id.* at 346. She finds that an ERISA waiver would not be entirely effective in that some states may feel that employer-mandated health care benefits make them less attractive. Furthermore, Congress may be reluctant to grant such a waiver. *Id.* at 344-45.

221. See Boblinski, *supra* note 1, at 270-71; Thompson, *supra* note 22, at 648.

222. See Boblinski, *supra* note 1, at 270-71. Many commentators, policy analysts, and others argue that "poorer, less industrialized states" may not be able to formulate effective health care programs. Kenny & Sullivan, *supra* note 1, at 44. They argue that this reason justifies exclusive federal control of health care. But it should not. It justifies federal policy and financial assistance. If the United States does not reduce the cost of health care, it could be a poor, deficit ridden, service state and thus, it could not establish health care for anyone.

223. Gregory, *supra* note 34, at 429. Gregory describes the thinking on the federal-state relationship during the framing of the Constitution:

Alexander Hamilton advocated a strong federal government. He feared that the forum of national government originally proposed at the Convention was not sufficiently powerful and lobbied to broaden its authority

Thomas Jefferson and the anti-Federalist Republicans, on the other hand, believed that a powerful national government would inevitably lead to an irresponsible, corrupt and expensive bureaucratic government.

Id. at 439.

have coordinated local-national health care and that states shall administer and pay for much of it.²²⁴

2. *Governmental Participation In Comprehensive Health Care*

Under local-national health care sharing responsibility, the federal government should participate with authority, as opposed to exclusive control, in establishing minimum health care needs and reasonable cost controls for health care services.²²⁵ Federal participation should not greatly exceed federal-state relations that were created in establishing medical services, controlling costs, and insuring quality under Medicaid and Medicare. Moreover, Medicaid should be fully integrated into a coordinated local-national health care program. Small and large businesses should not be permitted to externalize (to Medicaid and other programs) the costs of health care for uninsured, employed, low-income workers, and nonworkers if these businesses are subject to employer-sponsored health care programs. Most significantly, the federal government must provide some funds to provide health care for the insurable and uninsured persons. The federal role should be to facilitate and coordinate but not exclusively govern the health care systems of the states.

3. *The Quintessential Constitutional Concerns*

In local-national health care regulation, states must accept and impose greater health care responsibilities on their businesses, local governments, and citizens. Unfortunately, states

224. Kenny & Sullivan, *supra* note 1, at 41 & 44; Keefe, *supra* note 7, at 40; Thompson, *supra* note 22, at 647-48. Under the Health Security Proposal, it is intended that governmental responsibility for the administration of the health care system be shared by the federal and state governments. President's Health Plan, *supra* note 5, at 52-53. The Health Security Proposal states that:

States assume primary responsibility for ensuring that all eligible individuals have access to a health plan that delivers the nationally guaranteed comprehensive benefit package.

Id. at 52-53. However, the states are generally permitted in limited circumstances to levy taxes or assess fees to pay for health care needs of their citizens, though the ERISA preemption will be modified. *Id.* at 80.

225. Kenny & Sullivan, *supra* note 1, at 43. Similar components of major health care proposals are as follows: "[(1)] [a] uniform benefit packages, [(2)] [a]ccountable health care plans that compete at the local level[, and (3)] public sponsorships of individuals and small employers. *Id.* at 43. The Health Security Proposal contains similar components. See President's Health Plan, *supra* note 5, at 3-4.

have been reluctant to do this.²²⁶ As a starting point, states need to make equitable social welfare regulation. Next, they need to establish medical services that are equal to or consistent with federally proposed benefit packages. Finally, they need to establish and maintain access to and control of local health care costs.

Several reasons support states' acceptance of greater health care responsibilities. First, states already regulate doctors, nurses, hospitals, and insurers.²²⁷ Second, states know local social and economic conditions and thus can design health care plans to fit local communities, such as municipalities and counties.²²⁸ Third, states have gained considerable fiscal knowledge and experience in regulating health care costs under Medicare and Medicaid.²²⁹ They have also attempted to implement comprehensive health care programs. Finally, since states provide much of the health care and medical education, they can use their education systems to educate their citizens and businesses. In preserving federalism by insuring greater participation and authority for states in making health care law and public policy, the quintessential questions are: (1) whether the states are willing to accept more responsibility for health care; and (2) whether the federal government is willing to give up some of its health care authority.²³⁰ Presently, neither appears willing to share this responsibility and thus federalism falters.

VI. CONCLUSION

ERISA has a negative impact on state health care law and public policy. Its exceptions to coverage and exemptions from preemption do not give the states enough flexibility to design and implement state health care reform unless the federal government grants prior approval for employer-sponsored benefits or grants funds for medical assistance programs. The federal-state relationship regarding state health care policy reflects the almost total dependence of the states on federal regulation. This dependence signals a decline in federalism. This decline could be accelerated by the formulation and eventual implementation of a comprehensive federal health care policy that, when compared with the com-

226. Thompson, *supra* note 22, at 647-48.

227. *Supra* notes 112-24 and accompanying text.

228. *But see* Thompson, *supra* note 22, at 647-48.

229. *See supra* notes 113-14 and accompanying text.

230. *See* Thompson, *supra* note 22, at 647-48.

prehensive regulation of employee benefit plans, could preempt more state law and public policy than ERISA.²³¹

Despite this decline, federalism can still be strengthened. First, the federal government needs to establish a minimum standard of health care. Second, federal employee benefit policy needs to exempt from preemption state health care law and policy under certain conditions. When a state comprehensive health care program complies with federal cost, access and quality requirements, and insures an equitable distribution of medical care among a state's citizens, it should be recognized and supported by the federal government.²³² However, in the long-term, state-federal coordination and the sharing of health care responsibilities through a local-national health care plan is the ultimate solution.²³³ Federal regulation that preempts (i.e. ignores) local and state public policy furthers the decline of coordinated government needed for "cooperative federalism"²³⁴ in a complex, maturing society. Such inept constitutional wisdom leads to complex policy problems that eventually mature into strategic failures.

231. *Supra* notes 217-20 and accompanying text; see Rivkin, *supra* note 22, at A19.

232. *Supra* note 7 and accompanying text.

233. Keefe, *supra* note 7, at 44.

234. *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985) (ERISA does not preempt state law that regulates hospital fees.); *supra* note 106 and accompanying text.