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A QUICK FIX, BUT NO REAL SOLUTION: WHY ERISA PREEMPTION SHOULD NOT BE EXPANDED TO ASSOCIATION HEALTH PLANS

*Meghan M. McAllister**

I. INTRODUCTION

American small business owners and employees are finding it increasingly difficult to afford health insurance.¹ Health insurance premiums for employer sponsored health plans rose 7.7 percent in 2006, a percentage increase twice the rate of inflation.² A family of four that is insured through an employer-sponsored plan spends on average approximately \$11,000 a year in health care premiums, and a single person pays nearly \$4,000 a year.³ Perhaps one of the most telling statistics highlighting this trend of increasingly expensive health care coverage is the fact that health insurance premiums for family coverage has increased 87 percent since 2000.⁴

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¹ Ann Hilton Fisher, *Small Employers and the Health Insurance Needs of Employees with High Health Care Costs: A Need for Better Models*, 8 EMP. RTS. & EMP. POL'Y J. 53, 56 (2004) (“The combination of rising health insurance premiums and declining revenues may force small businesses to severely reduce health benefits, sometimes dropping them altogether.”); see also CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & CHERYL HILL LEE, U. S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2005 21 (2006), available at <http://www.census.gov/prod/2006pubs/p60-231.pdf>. [hereinafter U. S. CENSUS BUREAU]. The percentage of people covered by employment-based health insurance decreased between 2004 and 2005, from 59.8 percent to 59.5 percent. *Id.*

² THE KAISER FAMILY FOUNDATION—AND—HEALTH RESEARCH AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS: 2006 SUMMARY OF FINDINGS 1 (2006), available at <http://www.kff.org/insurance/7527/upload/7528.pdf> [hereinafter THE KAISER FAMILY FOUNDATION].

³ Nat'l Coalition on Health Care, Facts on Health Care Costs 1 (2006), available at <http://www.nchc.org/facts/2006%20Fact%20Sheets/Cost%20-%202006.pdf> [hereinafter Nat'l Coalition on Health Care].

⁴ THE KAISER FAMILY FOUNDATION, *supra* note 2.

This rise in cost has come with casualties. As of the 2005 Census reports, 15.9 percent of the United States population reported to be without health insurance coverage.⁵ This percentage translates into roughly 46.6 million citizens who are uninsured. Most, if not all, are uninsured because coverage is too expensive – either to them individually or for their employer to provide.⁶

Affordability of health care coverage is a topic of great debate. We know the statistical figures on how expensive health care is, and we can estimate how many people are burdened by this financial strain.⁷ We also know what the major contributing factors are to rising health care costs.⁸

What is unknown is a solution to this serious problem. Some solutions advocated for are nothing more than quick-fixes, which aim to enable more Americans to afford health insurance coverage by simply lowering prices. However the potential benefits these proposed “solutions” promise for some segments of the population must be weighed against the possible reverberating effects they would have across the entire health care system. This comment will address one such quick-fix solution, and explain why the potential negative ramifications far outweigh the possible beneficial effects.

This quick-fix proposal expands ERISA preemption to Association Health Plans (AHPs). While devised with good intentions, there is strong evidence that illustrates that the broadening of federal preemption to Association Health Plans is short-sighted. Most importantly, the potential benefits of expansion of federal regulatory preemption, while possibly good for a small portion of the population, has the potential to cause negative repercussions that would far outweigh any potential benefits.⁹

⁵ U. S. CENSUS BUREAU, *supra* note 1, at 21.

⁶ See generally Catherine Hoffman, Diane Rowland, Alicia L. Carbaugh, *Holes in the Health Insurance System – Who Lacks Coverage and Why*, 32 J.L. MED. & ETHICS 390 (2004).

⁷ THE KAISER FAMILY FOUNDATION, *supra* note 2, at 4 (“Sixty-one percent of firms offer health benefits to at least some of their employees . . . [s]ince 2000, the percentage of firms offering health benefits has fallen from 69 percent.”).

⁸ Nat’l Coalition on Health Care, *supra* note 3. “Experts agree that our health care system is riddled with inefficiencies, excessive administrative expenses, inflated prices, poor management, inappropriate care, waste and fraud. These problems significantly increase the cost of medical care and health insurance for employers and workers.” *Id.*

⁹ BETH FRITCHEN & KAREN BENDER, THE NAT’L SMALL BUSINESS ASS’N, IMPACT OF ASSOCIATION HEALTH PLAN LEGISLATION ON PREMIUMS AND COVERAGE FOR SMALL

Part I of this comment will discuss the background of AHPs and introduce the proposition of expansion of ERISA preemption to AHPs. Part II will discuss the two chief reasons why further expansion of federal preemption into state regulatory control through AHPs is an unwise decision. The first argument against federal preemption of state regulation of AHPs focuses on the importance of state control in the area of health insurance regulation, as this is an important avenue for the testing of potential solutions to the myriad of health insurance affordability and coverage problems in this nation. Secondly, state regulations are an important way that states maintain control over the coverage and overall health of their citizens. Important state regulations also include protection against ‘cherry-picking,’ or discrimination protection for all citizens regardless of health status, as well as protection for groups most dependent on comprehensive regulations.¹⁰ Finally, states are more concerned and invested in the overall health of their citizens than the Department of Labor (DOL), and, thus, control over insurance regulation should remain within state control.

Part II of this comment will focus on the practical problems that will result with expansion of ERISA preemption to AHPs. First, studies show that the growth of AHPs will make health insurance potentially more affordable for only a small fraction of Americans.¹¹ Secondly, expansion of federal control over more state health insurance customers will be costly for both the federal and state governments, and, additionally, expansion of ERISA preemption to AHPs has the potential to un-insure even more Americans because of the reverberating effects across the state health insurance markets.¹² Finally, as history shows, ERISA preemption has left many health care consumers and plans susceptible to fraud and abuse, and further expansion of ERISA to AHPs could likely leave even more Americans vulnerable. This is especially relevant because the federal government

EMPLOYERS 1 (2003), available at http://www.nsbadvocate.com/docs/mercer_ahp_report.pdf.

¹⁰ Mark A. Hall, *The Geography of Health Insurance Regulation: A Guide to Identifying, Exploiting, and Policing Market Boundaries*, 19 HEALTH AFFAIRS 2, at 179–80 (2000); Nat’l Partnership for Women & Families, Association Health Plan (AHP) Legislation: Myths & Facts, <http://paysickdays.nationalpartnership.org/site/DocServer/AHPMythsandFacts.pdf?docID=1094> (last visited Feb. 22, 2007) [hereinafter Nat’l Partnership for Women & Families].

¹¹ FRITCHEN & BENDER, *supra* note 9, at 1.

¹² *Id.*

is unprepared to take up the increased regulatory responsibilities that the expansion of preemption to AHPs would necessitate.¹³

Finally, this comment will summarize how federal preemption of state regulations through expansion of ERISA to AHPs is a short-sighted and potentially dangerous solution to America's health insurance affordability problems. The potential reverberating effects this expansion will have on the vast majority of Americans who will not take part or do not qualify for an AHP have the potential to be more harmful than any possible benefit that could be had for the small percentage of Americans projected to take part or qualify for an AHP.¹⁴

II. THE HISTORY OF THE AHP PROPOSAL AND ERISA PREEMPTION

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted as a federal safeguard for America's employee benefit and pension plans.¹⁵ This legislation effectively preempts state regulatory control of employee benefit plans, placing the job of regulation at the federal level with the United States DOL.¹⁶ ERISA relates to the regulation of health insurance when it comes to the issue of self-funded health insurance plans.

A self-funded health plan is one type of employer-sponsored health benefit plan. It is important to note that employers are not required to offer health plans to employees; however, 59.5 percent of Americans receive their health insurance through their employer as part of their compensation package.¹⁷ Of those employers that offer health

¹³ Roderick A. DeArment, *The Department of Labor Lacks the Staffing, Experience, and Regulatory Authority to Effectively Regulate Association Health Plans*, 1 AM. U. BUS. L. BRIEF 5, Spring 2004, at 5.

¹⁴ FRITCHEN & BENDER, *supra* note 9, at 1.

¹⁵ Employee Retirement Income Security Act of 1974, Pub. L. 93-406, 88 Stat. 829 (1974), (codified in scattered sections of 29 U.S.C.);

¹⁶ U.S. Dep't of Labor, Compliance Assistance, http://www.dol.gov/ebsa/compliance_assistance.html (last visited Aug. 22, 2006).

¹⁷ U. S. CENSUS BUREAU, *supra* note 5, at 21. Employers that offer health plans will usually do so as part of an employment contract, generally as an incentive to employees who view this more or less as a non-taxed portion of their overall compensation. An employer who self-insures will pay operating costs themselves out of assets usually accumulated through a trust. Smaller employers cannot afford to assume that cost out of company assets, and therefore if they choose to offer a company health plan to employees will contract with an outside managed care organization. Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the*

plans, some choose to self-fund, while others choose to purchase the employee health plan through a separate private health benefit provider. An employer who self-funds does not purchase employee health insurance from an outside company, rather the employer contracts with an insurance company to run the plan administration and network, while the business itself bears the financial risk, often with some type of stop-loss insurance to prevent large-scale losses.¹⁸ Typically, only large employers (those with around 100 to 500 employees) can afford to self-fund employee health insurance plans.¹⁹

One aspect that contributes to the costs of non-self-funded health plans is the added expenses that come with the myriad of state regulations that these plans must conform with. States have historically had control over the regulation of the insurance industries run within their borders.²⁰ When Congress passed ERISA in 1974, it made it clear that the preemption power of this statute was limited to the regulation of employee pension and benefit plans and not insurance plans. This intention is clearly evident from the text of the statute itself. Section 1144(b)(2)(a) is called ERISA's "savings clause" and has had the effect to exempt from federal preemption any state regulations dealing with insurance, banking, or securities.²¹

However, self-funded health plans are the exception to the rule that all health plans that run within a state's borders are subject to that state's health insurance regulations. Section 1144(b)(2)(b) of ERISA is called the "deemer clause." This clause sets out that employer-sponsored benefit plans should not be "deemed" to be insurance companies, thus are subject to ERISA's regulatory powers and thus preempt state laws.²² Here is where self-funded health plans come into

Supreme Court Allow States to Regulate Managed Care?, 74 TUL. L. REV. 951, 1004 (2000).

¹⁸ U. S. Dep't of Labor, Definitions of Health Insurance Terms, <http://stats.bls.gov/ncs/ebs/sp/healthterms.pdf> (last visited Nov. 15, 2006).

¹⁹ Hall, *supra* note 10, at 173-174.

²⁰ See *infra* note 23 and accompanying text.

²¹ 29 U.S.C. § 1144(b)(2)(A) (2006) ("Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.").

²² 29 U. S. C. §1144(b)(2)(B) (2006);

Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, *shall be deemed to be an insurance company* or other insurer, bank, trust company, or

play. The Supreme Court has held that self-funded health plans are considered employee benefit plans. As such self-funded plans are exempted out of the health insurance regulations saved through the savings clause. This is because the plans fit under the definition of a benefit plan governed under ERISA's deemer clause, and are therefore not deemed an insurance plan.²³ State health insurance laws and regulations are therefore not "saved" as they apply to self-funded plans, and the self-funded plans are effectively preempted by ERISA. These self-funded plans are instead subject to the much more limited federal regulations on health benefit plans enforced by the DOL.²⁴ It is

investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Id. (emphasis added).

²³ *FMC Corp. v. Holliday*, 498 U.S. 52 (1990)

We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulat[e] insurance" within the meaning of the saving clause. By forbidding States to deem employee benefit plans "to be an insurance company or other insurer . . . or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are preempted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation.

Id. at 61.

²⁴ ERISA preemption of self-funded employee health plans has itself been a hotly debated topic. As Donald T. Bogan illustrates,

State insurance regulations have historically protected consumers from abuses by overreaching insurance companies. Self-funded plans, however, receive near absolute immunity from state regulation under current ERISA preemption doctrine because self-funded plans cannot be deemed to be insurance companies. Consequently, self-funded health care plans may disregard state mandated benefits and mandated provider laws, state notice-of-cancellation and conversion rights laws, and state laws that require health care plans to provide participants the right to choose their own doctors. . . . [S]ince ERISA prevents the states

interesting to note that while ERISA has such great control over large parts of the health care industry, it is widely believed that Congress had neither intended nor expected the scope of ERISA's preemption power to extend into this arena of state regulatory control.²⁵

Because of this preemption treatment, one advantage of self-funding is that the health plan escapes state regulations, which tends to make health plans more expensive overall.²⁶ While health premiums rose on average 7.7 percent in 2006, there is a clear discrepancy in rising premiums for those taking part in self-funded plans and those not able to. This is exemplified by the fact that health premiums for those taking part in self-funded health plans rose 6.8 percent, whereas they rose 8.7 percent for those not part of self-funded plans.²⁷ While the economic benefits seem obvious, it is important to note that not all businesses are large enough to bear the financial risk necessary to self-fund.²⁸

An employer who wishes to offer a company health plan, but is not large enough to self-fund, must contract with an outside managed care organization that offers different types of health care plans.²⁹ With rising costs in the insurance industry, more of the burden is placed on employers who offer these plans, who in turn pass that burden on to the employees through higher costs for the plan and higher premiums within the plan.³⁰ Many believe that the increasing cost of health insurance coverage is pricing small businesses out of offering company

from regulating self-funded plans, self-funded health care plans receive no regulatory oversight over financial practices, leaving plan participants extremely vulnerable to plan insolvency.

Bogan, *supra* note 17, at 1004–05.

²⁵ “. . . Congress apparently gave very little thought to the effects ERISA might have on health care, and in particular how ERISA's preemption clause, added as a last minute conference committee compromise, would dramatically change the nature of health care financing regulation in the United States.” BARRY R. FURROW ET AL., *HEALTH LAW* 418–19 (2d ed. 2000).

²⁶ Hall, *supra* note 10, at 173–74.

²⁷ THE KAISER FAMILY FOUNDATION, *supra* note 2, at 1.

²⁸ *Id.*

²⁹ Examples include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and traditional indemnity insurance. Peter K. Kongstvedt, *Essentials of Managed Care* 18 (4th ed. 2003).

³⁰ Fisher, *supra* note 1, at 54–58.

health programs, and ultimately pricing employees out of health insurance coverage altogether.³¹

This inequality between large and small businesses highlights the sentiment behind the proposal examined in this comment. Namely, small business owners and their employees are rightfully upset about the gap in health care affordability between themselves and larger companies, a disparity exasperated by the fact that large businesses that self-fund are exempt from state regulations and taxes. There is not a clear answer as to exactly why there is such a great disparity between the ability of large employers to afford health coverage for their employees and the fact that small employers increasingly cannot. One theory is that large employers who contract out are on a more equal footing with the large insurance companies and can therefore bargain more efficiently for more competitive prices.³² Large employers who self-fund are able to avoid state regulations and certain taxes that inevitably raise the price of health care coverage.³³ Additionally, health plans sponsored by small-businesses are more susceptible to market changes than larger businesses, which can spread costs out amongst a larger group due in large part to the small numbers of participants in small business health plans.³⁴

The AHP proposal is just one potential “solution” advanced to try to close the gap between self-funded health plans and privately run ones. Although at first glance it looks like an easy solution to the inequality problem plaguing this area of regulation, upon deeper

³¹ DONALD L. WESTERFIELD, NAT’L CTR. FOR POLICY ANALYSIS, *INSURING THE UNINSURED THROUGH ASSOCIATION HEALTH PLANS*, 8 (2003), *available at* <http://www.ncpa.org/pub/st/st259/st259.pdf>.

³² *Id.*

³³ Hall, *supra* note 10, at 173-74.

³⁴ Fisher, *supra* note 1, at 55-57.

[J]ust when more employees with high cost health conditions are looking for insurance coverage through their employers, their employers are facing a segmented health insurance market that directly ties the cost of their insurance premiums to the health of their workforce. Although this may not create a crises for the largest employers, where the group is large enough to allow for averaging of costs within the group, it creates acute problems for small employers. These small employers...may find themselves subject to sudden swings in health insurance costs simply because one employee has a costly injury or illness.

analysis it is clear that this is nothing more than a shortsighted solution that could potentially do more harm than good for the overall population.

A. Association Health Plans

In an effort to put small business employees who are unable to self-fund on the same financial-footing as employees who can take part in self-funded plans, some are pushing for the creation of another exception to ERISA's current regulatory scheme. They advocate that groups of these small business employees should be allowed to join together, regardless of their individual employers, through Associations.³⁵ These Associations would then offer their members health plans that self-fund, and it is these AHPs that some advocate should be viewed the same as employer-sponsored self-funded plans that are federally preempted through ERISA's deemer clause.

AHPs would allow members of bona-fide Associations to come together to form health care plans such as those traditionally sponsored by an employer.³⁶ Examples of bona-fide Associations are trade and professional groups such as AARP, the National Restaurant Association, and the National Rifle Association..³⁷ One estimate is that there are nearly 15,000 bona-fide associations that would qualify to offer AHPs.³⁸

Expansion of federal preemption to AHPs through ERISA is a unique idea advanced by proponents of federal preemption who hope to use the AHP designation as an avenue to usher more consumers into the arena of federally deregulated health insurance.³⁹ Legislation which would authorize federal regulatory preemption of AHPs is currently in the U.S. Senate Committee on Health, Education, Labor and Pensions.⁴⁰ In theory, an AHP acts just like an employer-sponsored self-insured health plan. However, instead of running the self-funded

³⁵ See *AHPs Will Improve Access*, *infra* note 44.

³⁶ Current legislation would allow for Associations with at least 1,000 members to apply with the Secretary of Labor for status as a self-funded health plan. See FRITCHEN & BENDER, *supra* note 9, at 4.

³⁷ WESTERFIELD, *supra* note 31, at 7.

³⁸ *Id.*

³⁹ David Leavitt, *What Ails ERISA Health Plans?* 34 THE BRIEF, Spring 2005, at 46. "This proposed Act would federalize the regulation of these plans and remove the power of the states to regulate association-sponsored health plans under ERISA." *Id.*

⁴⁰ Small Business Health Fairness Act of 2005, S. 406, 109th Cong. (2005).

health plan through an employer, it would be run through an Association.

The idea of expansion of federal preemption of regulatory control through AHPs has floated around Congress for more or less the past 5 years.⁴¹ No AHP bill has yet to make it out of committee in the U.S. Senate, where the current version, the *Small Business Health Fairness Act of 2005*, has been since summer 2005.⁴² The bill was introduced by Maine Republican Senator Olympia Snowe. It has 15 co-sponsors, 14 of whom are Republican. Senator Robert Byrd of West Virginia is the lone Democrat co-sponsor.⁴³ Regardless of whether or not this current legislation makes it out of committee and onto the Senate floor for a full vote, it appears that the issue of AHPs is unlikely to go away anytime soon. The theory underlying AHPs has a strong following with good numbers of Associations, consumer advocates, and politicians.⁴⁴ However, just as there are strong proponents of

⁴¹ The current version's synopsis is as follows:

Small Business Health Fairness Act of 2005 - Amends the Employee Retirement Income Security Act of 1974 (ERISA) to provide for establishment and governance of association health plans (AHPs), which are group health plans whose sponsors are trade, industry, professional, chamber of commerce, or similar business associations, and which meet certain ERISA certification requirements. (Thus, through ERISA preemption of State laws, certified AHPs are exempted from State regulation of health insurance providers, including State consumer protection laws and State requirements for health care benefits to be offered by such entities, with certain exceptions.).

The Library of Congress (Thomas), <http://thomas.loc.gov/cgi-bin/bdquery/z?d109:SN00406:@@D&summ2=m&> (last visited Feb. 6, 2007).

⁴² After passing in the House in early 2005, S. 406 (The Small Business Health Fairness Act of 2005) is still in the Health, Education, Labor and Pensions Committee in the United States Senate as of February 2007. *Id.*

⁴³ The Bill is co-sponsored by Senators Christopher Bond (R-Mo), Robert Byrd (D-WV), Sam Brownback (R-KS), Norm Coleman (R-MN), Elizabeth Dole (R-NC), Chuck Hagel (R-NE), Kay Bailey Hutchison (R-TX), Johnny Isakson (R-GA), Mel Martinez (R-FL), John McCain (R-AZ), Rick Santorum (R-PA), Arlen Specter (R-PA), Jim Talent (R-MO), John Thune (R-SD), and David Vitter (R-LA). The Library of Congress (Thomas), <http://thomas.loc.gov/cgi-bin/bdquery/z?d109:SN00406:@@P> (last visited Feb. 6, 2007).

⁴⁴ See Small Business Law Firms, *AHPs Will Improve Access to Affordable Health Insurance for Small Business Owners and Their Employees, Witnesses Say*, <http://www.smallbusinesslawfirms.com/national-content.cfm/Article/6466/AHPs-Will-Improve-Access-to-Affordable.html> (last visited Feb. 21, 2007) [hereinafter *AHPs Will Improve Access*]; *Senator Snowe Cites SBA Study as Further Evidence of*

expansion of ERISA preemption, there are very strong opponents AHP-type proposals, and these opponents assert strong policy and practicality arguments in support of their resistance to ERISA expansion.⁴⁵

In short, the data collected regarding this issue illustrates that not only is the expansion of ERISA preemption to AHPs a bad idea because it further encroaches onto an area of shrinking state control and frustrates state attempts at health policy goals, but data also shows that this supposed “solution” to health care affordability will help only a handful of Americans and has the potential to do much more harm than good.

B. Examples of Important State Health Insurance Regulations

Non-self-funded health insurance plans are subject to several different types of state regulations, including mandated benefits, regulations on financial practices, certain taxes, consumer protection laws, anti-discrimination laws, and licensing requirements.⁴⁶ It is these regulations and mandates that proponents of the expansion of federal preemption argue have “unfairly” contributed to the rise in health care costs.⁴⁷ However, many cite regulations such as mandated benefits and anti-discrimination laws as necessary to provide consumer safeguards.⁴⁸ Regulatory power is also seen as a necessary tool that

Need for Association Health Plans, U.S. FED. NEWS, Aug. 19, 2003, available at 2005 WLNR 13120603; *Act on AHPs*, ROLL CALL (USA), Aug. 1, 2005, available at 2005 WLNR 12074141.

⁴⁵ Joe Gardyas, *Association Health Plans: Good or Bad Rx for Iowa Companies?*, DES MOINES BUSINESS RECORD, Aug. 14, 2005, available at <http://www.businessrecord.com/print.asp?ArticleID=2097&SectionID=8&SubSectionID=9>; Jossey-Bass, *Advocates oppose federal legislation that would affect MH parity laws*, MENTAL HEALTH WKLY., Aug. 8, 2005, available at 2005 WLNR 13270476; Nat'l Partnership for Women & Families, *supra*, note 10.

⁴⁶ Other regulatory functions include “market conduct reviews, premium/rate reviews/timely and detailed financial reporting, financial solvency protections, guaranty funds.” DeArment, *supra* note 13, at 6.

⁴⁷ Fisher, *supra* note 1, at 57–58. “Small business and insurance groups argue for an end to state mandates so that insurers would be free to offer lower cost products to businesses.” *Id.*

⁴⁸ Nat'l Partnership for Women & Families, *supra* note 10.

[M]any states now require insurers to cover maternity benefits, preventive screenings for breast and cervical cancer, mental health services, and contraceptive drugs and devices. Most of these state benefit mandates would be preempted under the proposed AHP bills,

states utilize to implement and maintain comprehensive health policy standards and goals for their citizens.⁴⁹

Some advocate for if not a return to total state control then at least a continuation of the current level of state control over health insurance plans with minor adjustments to improve efficiencies across state boarders.⁵⁰ Others argue that federal preemption of state regulations is a good way to make health care more affordable for American employers and employees.⁵¹ This debate has made its way from the intellectual arena to the political one in the form of AHPs and is currently being fought both within the chambers of the U.S. Congress and with health care professionals, managed care experts, and consumer advocates.⁵² Beginning with ERISA's preemption of self-funded insurance plans and their subsequent growth, state control over the regulation of health coverage has been continuously eroding.⁵³ The issue is one that raises serious federalism concerns because the regulation of insurance companies and plans has been a historical province of state control.⁵⁴

and AHPs would have a strong incentive to offer narrower benefits to trim costs. In the end, women would lose . . .

Id.

⁴⁹ Scott D. Linmann, *Health Care Reform for the Twenty-First Century: The Need for A Federal and State Partnership*, 7 CORNELL J.L. & PUB. POL'Y 871, 879–82 (1998).

⁵⁰ Danielle F. Waterfield, *Insurers Jump on Train for Federal Insurance Regulation: Is It Really What They Want or Need?*, 9 CONN. INS. L.J. 283, 333 (2002). "The objective goal for reform should be to remove the unnecessary and burdensome requirements and apply principles of consistency and efficiency to insurance regulation." *Id.*

⁵¹ *AHPs Will Improve Access*, *supra* note 44. "(AHP legislation) would increase small businesses' bargaining power with health care providers, give them freedom from costly state-mandated benefit packages, and lower their overhead costs by as much as 30 percent . . ." *Id.*

⁵² Gardyasz, *supra* note 45; Jossey-Bass, *supra* note 45, Nat'l Partnership for Women & Families, *supra* note 10.

⁵³ Waterfield, *supra* note 50, at 302–03.

[S]tate streamlining efforts gained steam again with the renewed threat of federal preemption . . . This real threat of federal preemption sparked a renewed interest among the states in creating more uniformity within the state regulatory system. It also indicated a new sentiment in Congress representing a threat the states had thought was gone, or at least greatly diminished, after the 1994 elections.

Id.

⁵⁴ Bogan, *supra* note 17, at 951. ("Prior to Congress's enactment of [ERISA], the states regulated the health care and health insurance industries.")

III. EXPANSION OF ERISA PREEMPTION TO AHPS IS A SHORTSIGHTED SOLUTION THAT WILL DO MORE HARM THAN GOOD

There are serious federalism concerns at issue here. Expanding federal control through ERISA preemption of state power to regulate the health care coverage of their citizens translates into contracting state control over an area that has long been a state stronghold. Additionally, federal regulatory takeover encroaches upon states' abilities to implement and regulate individualized health policies for their communities. Expansion of ERISA to AHPs would do little more than deregulate an even larger portion of the insured population than is already subject to ERISA preemption because there are not comprehensive federal safeguards intact to pick up where state control has been preempted.⁵⁵ It would be irresponsible for the federal government to take more power away from the states at this point in the debate, especially when the potential benefits are so low and the potential risks so high.

Further, AHPs will help only a small number of Americans and will undoubtedly come with their own costs to both the federal and state governments.⁵⁶ Expansion of ERISA preemption to AHPs proposes to insure a very small percentage of the 15.9 percent of uninsured Americans.⁵⁷ Federal preemption of these plans would cost both state governments and the federal government money in lost tax revenues. In addition, the DOL, already in charge of regulating the ERISA qualified self-funded health plans, would undertake the task of regulating these additional plans. This expansion of the DOL's duties translates into greater administrative costs⁵⁸ and studies show that the DOL is unprepared for this greater regulatory responsibility, which would leave consumers open to fraud and other industry abuses.⁵⁹ The purported positive impact that expanding ERISA would have on

⁵⁵ *Id.* "The combined effect of ERISA's failure to regulate nonpension employee benefits and court opinions that declare state regulations that relate to nonpension employee benefit plans preempted is that the managed care health benefits industry remains virtually unregulated, leaving consumers hopelessly unprotected from industry abuses." *Id.*

⁵⁶ See CONGRESSIONAL BUDGET OFFICE COST ESTIMATE, H.R. 525: SMALL BUSINESS HEALTH FAIRNESS ACT OF 2005 (Apr. 8, 2005), available at <http://www.cbo.gov/ftpdocs/62xx/doc6265/hr525.pdf> [hereinafter CONGRESSIONAL BUDGET OFFICE].

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ DeArment, *supra* note 13, at 5.

insuring more small business workers is far outweighed by the potential negative effects expansion would have on the states' ability to implement cohesive health policies and improve access to health care and health insurance coverage.

A. State Regulatory Control Over Health Insurance Should not be Further Diminished.

States have regulated the insurance companies that operate within their borders since the early 1850s.⁶⁰ During this time, there were some insurance companies that resisted state regulations and instead advocated for federal standards, primarily to ease cross-border problems companies faced when trying to adhere to each state's unique regulatory scheme.⁶¹ The issue of which governmental body (the federal government or the states) should regulate insurance was first settled by the Supreme Court in *Paul v. Virginia* in 1868.⁶² This case held that state insurance regulations were not in violation of the U.S. Constitution's commerce clause.⁶³ However, nearly 80 years later, the Supreme Court reversed this position in *United States v. South-Eastern Underwriters Association*, holding that insurance plans were to be interpreted as interstate commerce, and, thus, state regulations were invalid because they were in violation of the commerce clause.⁶⁴

The federal government responded to the *South-Eastern Underwriters* decision by enacting the McCarran-Ferguson Act one year later in 1945.⁶⁵ This law effectively reinstated the *Paul v. Virginia* precedent and declared that states have the power to regulate insurance companies that operate within their state.⁶⁶ This law is the foundation for today's state-controlled insurance regulations.

⁶⁰ Waterfield, *supra* note 50, at 286.

⁶¹ *Id.* at 286-90.

⁶² *Paul v. Virginia*, 75 U.S. 168 (1868).

⁶³ *Id.* The Court held that insurance policies were "simple contracts of indemnity" which "are not articles of commerce in any proper meaning of the word." *Id.* at 183.

⁶⁴ *United States v. S.-E. Underwriters Ass'n*, 322 U.S. 533 (1944).

⁶⁵ McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15 (2000).

⁶⁶ As currently amended, this policy section of the McCarran-Ferguson Act states that:

[C]ongress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

With the power to regulate health insurance plans and companies, the states have enacted a multitude of different regulatory schemes, which all, for the most part, share the same elements.⁶⁷ These common elements of health insurance regulation include taxation, financial regulations, anti-discrimination policies, rate regulation, mandated benefits, licensing, consumer protections, and other basic regulatory functions.⁶⁸ Insurance regulation is one way that states advance health policy goals for their citizens, and state governments are frequently tweaking these regulations in the pursuit of finding the right health policy fit.⁶⁹

i. The States Use Their Regulatory Power to Effectuate Unique and Individualized Health Policy Goals

When looking at the many different health policy goals the fifty states pursue, it is clear that there is not one solution to any of the multitude of health care problems facing America.

For example, in 2005, Iowa's governor Thomas Vilsack expressed his desire for the state of Iowa to provide parity coverage for substance abuse and mental health conditions.⁷⁰ This type of state regulated mandatory benefit is currently law in sixteen states with an additional three (including Iowa) passing bills on the issue in 2005.⁷¹ Parity is achieved when insurers are required to offer coverage for substance abuse and/or mental health treatment at the same rate as other medical coverage.⁷² This type of regulation is just one example of how differently the states use their ability to regulate health insurance coverage to effectuate health policy goals.

Another example of a state taking the initiative and attempting a new solution to health care problems comes from Kansas, where in 2005 Governor Kathleen Sebelius expressed her desire for Kansas to

15 U.S.C. § 1011 (2000).

⁶⁷ Hall, *supra* note 10, at 173-84.

⁶⁸ *Id.* Other regulatory functions include "market conduct reviews, premium/rate reviews/timely and detailed financial reporting, financial solvency protections, guaranty funds." DeArment, *supra* note 13, at 5-6.

⁶⁹ Health Policy Tracking Service, *State of the States: Summary of Governors' Addresses*, Health Policy Tracking Service publication 05229.1 (2005).

⁷⁰ *Id.* at 3.

⁷¹ *Id.*; Chris Bandoli, *Mandated Benefits: Overview of 2005 Legislative Activity*, Health Policy Issue Brief publication 050718.2 (2005).

⁷² Michele Garvin et. al., *Mental Health Parity: The Massachusetts Experience in Context*, 47 B. B.J. 18 (2003).

work towards improving the technology used to implement their health delivery system. These improvements, Governor Sebelius argued, would help cut administrative costs and could hopefully make health care more affordable for Kansas citizens.⁷³

New Hampshire Governor John Lynch proposed a new regulation on insurance plans within that state, and urged state legislators to follow his lead in 2005. He recommended that a law which “allows insurance providers to set rates for businesses with fewer than 50 employees based on risk factors” be repealed in hopes to make coverage for these small businesses more affordable.⁷⁴

One of the most newsworthy recent examples comes out of Maryland, where the state legislature passed “fair share” legislation in January 2006,⁷⁵ which is commonly referred to as the “Wal-Mart Law.”⁷⁶ This law requires large employers (those who have more than 10,000 employees) operating within the state to spend at least eight percent of the company payroll on health benefits. If the company does not spend that much on employee health benefits, it is required to pay the balance into the state’s Medicaid fund.⁷⁷ When the law was passed, the only large company in Maryland that did not already contribute to this extent was Wal-Mart, which at the time employed about 15,000

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ Maryland’s Fair Share Health Care Act, MD. CODE ANN. HEALTH-GEN § 15-142 (LexisNexis 2006). The bill had previously been passed by the state legislature in 2005, which Governor Ehrlich vetoed. On January 12, 2006 the state legislature overrode the Governor’s veto of the bill. *See* Veto Overrides – 2006 Legislative Session, <http://mlis.state.md.us/2006rs/Signings/2006overrides.htm> (last visited Feb. 21, 2007); *see also* Senate Bill 790, <http://mlis.state.md.us/2005rs/billfile/SB0790.htm> (last visited Feb. 21, 2007). The Bill’s synopsis is stated as:

Establishing the Fair Share Health Care Fund; establishing the purpose of the Fund; providing that the Fund consists of specified payments made by employers in connection with a specified health care payroll assessment; providing that the Fund is a special, nonlapsing fund; requiring the State Treasurer to hold the Fund and the Comptroller to account for the Fund; requiring that investment earnings of the Fund be retained in the Fund; requiring the interest on and other income from the Fund be separately accounted for; etc.

Id.

⁷⁶ Ross Runkel, *Maryland Wal-Mart Law, and ERISA Preemption*, LAWMEMO.COM, Feb. 12, 2006, http://www.lawmemo.com/blog/2006/02/maryland_walmart.html.

⁷⁷ MD. CODE ANN. HEALTH-GEN § 15-142.

Maryland citizens.⁷⁸ The debate over this bill sparked nation-wide attention, and there are a number of states that have followed Maryland's lead and are attempting to pass similar bills.⁷⁹

This debate represents on a smaller scale what has become a nation-wide debate over the level of contribution and responsibilities Americans expect employers to assume as health care costs continue to rise, particularly larger and very profitable employers (such as Wal-Mart) whom many claim to be passing the health costs of their employees onto the general public and small business owners, instead of assuming it themselves.⁸⁰

Wal-Mart has turned into a target for state health care reforms primarily because it is the nation's largest private employer, employing nearly 1.2 million Americans.⁸¹ This issue reflects how states have assumed a role in testing how large-employer mandates would affect the larger problem of health care financing. Perhaps this theory will fail, or perhaps it will succeed, but it simply shows the initiative of state attempts to fix health financing problems in this nation – initiatives which might not be as easy to test out at the federal level. These unique initiatives are increasingly threatened as federal regulatory preemption expands further into states' ability to use regulatory tools to effectuate these health policy goals.

⁷⁸ Walmart Watch – Wal-Mart vs. Maryland – On Background, http://walmartwatch.com/home/pages/wal_mart_vs_maryland_background_to_the_fight_ahead (last visited Nov. 20, 2006).

⁷⁹ *NewsHour with Jim Lehrer: Online Focus: Health Debate*, (PBS television broadcast, Feb. 13, 2006) available at http://www.pbs.org/newshour/bb/health/jan-june06/debate_2-13.html. "...Maryland health care advocate Vincent DeMarco led the drive to pass the law. He's among many activists now trying to get similar laws enacted in about 30 states, including Washington, Kentucky, Idaho and West Virginia." *Id.*

⁸⁰ *Id.* Quoting Maryland Healthcare advocate Vincent DeMarco: "Fair share health care is sweeping the nation because average citizens and small businesses are tired of subsidizing large companies who don't do their fair share on health care. That's why we succeeded in Maryland and that's why I think many other states are going to succeed also." *Id.*

⁸¹ *Wal-Mart's Unhealthy Care: Inadequate Coverage Leaves Taxpayers Paying the Bill*, Walmart Watch, available at: <http://walmartwatch.com/img/downloads/healthcare.pdf>; Bonnie Throckmorton, *Who Should Be Responsible for Your Health Care?*, THE DAILY NEWS – JACKSONVILLE, N.C., Mar. 4, 2006, available at: <http://www.retail-leaders.org/new/resources/Daily%20News%20editorial.pdf>, (last visited Mar. 5, 2007).

ii. Mandated Benefits Are an Important Tool States Use to Implement Health Policy Goals

One specific way states use insurance regulations as an avenue for effectuating health policy goals is through mandated benefits. A mandated benefit is a law that requires all insurance plans, subject to state regulation (all non-ERISA preempted plans), to cover specific benefits, such as certain cancer screenings, diabetes treatments, and coverage for certain prescriptions, to name just a few.⁸² Different states have different attitudes about the importance of mandated benefits. Critics cite mandated benefits as one area of regulation that contributes to high health costs, whereas advocates point to mandated benefits as an important tool states use to achieve a healthier public.⁸³

⁸² THE COUNCIL FOR AFFORDABLE HEALTH INSURANCE, TRENDS & ENDS: TRENDS IN STATE MANDATED BENEFITS, Dec. 2005, *available at*: http://www.cahi.org/cahi_contents_resources/pdf/trendsEndsDec2005.pdf.

⁸³ TEXAS DEPARTMENT OF INSURANCE, HEALTH INSURANCE REGULATION IN TEXAS: THE IMPACT OF HEALTH MANDATED BENEFITS 15 (Dec. 1998), *available at*: <http://www.tdi.state.tx.us/reports/documents/benefit.pdf>.

While some have argued that mandates restrict the ability of insurers to respond to changing needs in the marketplace, others argue that it is because of insurers' failure to address these needs that mandated benefits are sometimes necessary. Fifteen years ago, the concept of "preventative health care" was fairly new and there was originally no widespread expectation that insurers would pay such expenses. Over time, however, the benefits of certain screening and diagnoses interventions were widely recognized by both medical providers and public health agencies as an effective way of detecting potential medical problems in early stages when treatment is less expensive and medical outcomes are more favorable. Many insurers also recognized the financial and physical benefits of good health and a few began to actively promote "healthy lifestyles" among their insureds. However, most insurers were not initially receptive to some aspects of the preventative screening health care movement, and resisted providing coverage for such services as mammography screening, PAP tests, immunizations for children, and annual physicals. Facing pressure from both consumers and physicians, lawmakers in many states responded by mandating coverage for these benefits. Thus, whereas ten years ago few insurance policies covered these medical treatments that were not "medically necessary" by insurers' definitions, these benefits are widely available today as a result of legislative intervention in the form of mandated benefit requirements.

States enact mandated benefits to ensure that their citizens receive coverage for the procedures, treatments, and pharmaceuticals that the legislature deems necessary to protect the insurance consumers that cannot bargain individually for these comprehensive health plans.⁸⁴ These benefits are all part of each state's individual health policies. Some states, like Illinois, require a large number of mandated benefits, while other states, such as Utah, do not.⁸⁵ Illinois mandates that all health insurance plans cover members for cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, clinical trials, offering of contraceptives, diabetes treatment, infertility treatment, breast reconstructive surgery, and osteoporosis screening.⁸⁶ In contrast, Utah has none of the aforementioned mandates passed in Illinois, except a mandate for breast reconstructive surgery.⁸⁷

One goal of mandated benefits is to ensure that coverage of specific procedures and treatments are available to all state citizens who purchase a health insurance plan or are part of government-sponsored insurance plans.⁸⁸ One of the fears spurring on this type of legislation is that less affluent citizens will not be able to receive as complete coverage as those who are better able to afford more comprehensive coverage plans.⁸⁹ In addition, state mandated benefits are a way for state governments to encourage certain procedures they deem important to creating and maintaining a healthy public.⁹⁰ For

⁸⁴ Nat'l Partnership for Women & Families, *supra* note 10.

⁸⁵ See generally Kaiser Family Foundation: StateHealthFacts.org, Managed Care and Health Insurance, <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&welcome=1&category=Managed+Care+%26+Health+Insurance>, (last visited Jan. 21, 2007).

⁸⁶ Bandoli, *supra* note 71.

⁸⁷ *Id.*

⁸⁸ David Hyman, *Mandated Benefits: A behavioral economics / comparative institutional perspective*. FTC Hearings on Healthcare, at <http://www.ftc.gov/og/healthcarehearings/docs/030625hyman.pdf> (last visited Aug. 15, 2006).

⁸⁹ Bandoli, *supra* note 71.

⁹⁰ TEXAS DEPARTMENT OF INSURANCE, *supra* note 83, at 15.

Despite insurers' arguments against the use of mandated benefits to achieve public policy goals, both state and federal lawmakers have insisted that health insurance is distinctly different from other types of insurance and is, therefore, subject to somewhat different standards of regulation. In discussing state policy on health insurance, the New York State Council on Health Care Financing noted, '*Health insurance is not simply insurance in the conventional sense. It is fundamentally different from other types of insurance because it forms the base for*

example, nearly every state mandates coverage for breast cancer screenings.⁹¹ This mandated benefit is in place to ensure that all citizens, regardless of their financial abilities, will have this coverage, and, secondly, to encourage more women to undergo annual mammograms.

The American Cancer Society (ACS) is a strong advocate for mandated benefits.⁹² The ACS believes that screenings will increase early detection of cancer and advocates that early detection is an incredibly important factor in a successful cancer treatment.⁹³

Mandated benefits are by no means a popular regulatory tool in all states.⁹⁴ Just as those who advocate for federal deregulation through the expansion of ERISA to AHPs believe that state mandates are unjustifiably driving up the costs of health coverage for the average American, many state lawmakers have pushed to scale back or

allocating an essential social good and because its existence has a profound effect on the availability, costs, and use of medical services. Health insurance today is a form of social budgeting and State policy must recognize it as such in order to better guide the medical care system and to ensure an equitable health insurance system.

Id. at 16–17 (emphasis added).

⁹¹ Bandoli, *supra* note 71. Utah does not mandate coverage for mammograms and does not mandate it as an offering. Mammograms are a mandated offering in Arkansas, Mississippi, and Michigan. All other states require mammograms as a mandated benefit. *Id.*

⁹² American Cancer Society – Breast Cancer – Early Detection, http://www.cancer.org/docroot/CRI/content/CRI_2_6x_Breast_Cancer_Early_Detection.asp (last visited Aug. 15, 2006). “Many states ensure that private insurance companies, Medicaid, and public employee health plans provide coverage and reimbursement for specific health services and procedures. The ACS supports these kinds of patient protections, particularly when it comes to evidence-based cancer prevention, early detection, and treatment services.” *Id.*

⁹³ American Cancer Society – Early Detection, http://www.cancer.org/docroot/PED/ped_2.asp?sitearea=PED (last visited Aug. 15, 2006). “If you can’t prevent cancer, the next best thing you can do to protect your health is to detect it early.” *Id.*

⁹⁴ Richard B. McKenzie, *The Mandated Benefit Mirage – Effects of Requiring Employers to Provide Certain Employee Benefits*, BUSINESS HORIZONS, May-June 19993; National Association of Health Underwriters, Mandated Health Insurance Benefits – Legislative Advocacy, <http://www.nahu.org/legislative/mandated/index.cfm> (last visited Aug. 22, 2006).

eliminate mandated benefits for the same reason.⁹⁵ In 2004, Illinois state representative Frank Mautino (D) advocated in the Illinois General Assembly for House Bill 5925, which would have effectively eliminated Illinois' mandated benefit requirements on insurance plans within the state.⁹⁶ Mautino's goal was to make insurance plans less expensive by eliminating the requirement of mandated benefits. This bill was adamantly opposed during House debate by Rep. Mary Flowers (D).

The following debate over HB 5925 occurred between Flowers and Mautino during the 2004 Legislative session.⁹⁷

Flowers: Well, then I have to ask this question. If the . . . employee is going to choose something lesser that's going to fit his or her needs, will they have full coverage? And then, what part of their body will be excluded under this Bill, in regards to coverage? ...And let me just ask you about the family. Let's say I want to have my daughter who might have asthma, I want to include her in this particular policy that don't have the mandates. Will the insurance company....will he discriminate against my daughter because she has a preexisting condition? And will my policy go higher?

Mautino: All policies include the existing requirements for children and adopted children, both. And in your case, Mary, you would choose the option of full mandated coverage. You would not be the person that . . . would choose a different program that fit their needs. The choice is yours.

Flowers: Well, it's easy for you to say the choice is mine, because the choice is what I can afford. Am I correct? And it appears to me, Representatives, what we're doing here is

⁹⁵ Memorandum from the Council for Affordable Health Insurance, Trends & Ends: Trends in State Mandated Benefits, December 2005, *available at* http://www.cahi.org/cahi_contents/resources/pdf/TrendsEndsDec2005.pdf.

⁹⁶ Illinois General Assembly – Bill Status of HB5925, <http://ilga.gov/legislation/BillStatus.asp?DocNum=5925&GAID=3&DocTypeID=HB&LegID=11026&SessionID=3&SpecSess=&Session=&GA=93> (last visited Aug. 22, 2006).

⁹⁷ IL. H.R. TRAN. 2004 REG. SESS. NO. 112, 20-21 (2004), *available at* <http://www.ilga.gov/house/transcripts/htrans93/09300112.pdf>.

setting up a situation that could cause havoc in the workplace.⁹⁸

Representative Flowers summed up her position later in the debate as such:

Flowers: It appears to me that what we're doing here is advocating on the behalf of the insurance company as opposed to on behalf of the people who... the consumers who really need the service. And what we're doing is we're cherry picking, we want the young and the healthy to pay a premium and hopefully, they won't need it. And then for the sick it may be they don't know what they're gonna have because you're asking them to choose the insurance policy that they don't know what's going to happen to them once they have this policy. They don't know what part of their body is going to be covered because you've eliminated the mandates. They don't know if they will have the emergency room opportunity.⁹⁹

Representative Flowers was advocating that Illinois maintain their mandated benefits, as these mandates both help the citizens who require such coverage and enable a level of consistency for workplace health plans.¹⁰⁰ The Bill was last read in July of 2004 and has yet to resurface in the General Assembly.¹⁰¹

iii. State Regulations Such as Mandated Benefits Prevent Discrimination and Help the Most Vulnerable Citizens Receive Comprehensive Health Care Coverage

During the debate with Rep. Mautino, representative Flowers mentioned her concern that citizens would be victims of "cherry-picking." Cherry-picking is a term used to describe how insurance companies can pick and choose their customers, with the obvious

⁹⁸ *Id.*

⁹⁹ *Id.* at 23.

¹⁰⁰ *Id.* at 18–23.

¹⁰¹ Illinois General Assembly, *available at*: <http://ilga.gov/legislation/BillStatus.asp?DocNum=5925&GAID=3&DocTypeID=HB&LegID=11026&SessionID=3&SpecSess=&Session=&GA=93> (last visited Aug. 22, 2006).

preference being the healthiest available.¹⁰² Mandated benefits are one way states seek to combat this practice. For instance, 46 states mandate coverage for diabetes treatment.¹⁰³ By ensuring that coverage for this treatment is included in every plan sold within the state, the goal is that the greater numbers of individuals without diabetes will compensate for the small numbers who require diabetes treatment, thus allowing the treatment to be available to those who need it. Without the mandate, insurance companies would not have to offer the treatment, and people who require it would be forced to pay even more for coverage or not be able to afford coverage at all and pay out of pocket. By spreading out the costs amongst the entire healthy population, states hope to help the most vulnerable citizens get the coverage they absolutely require without insurance discrimination.¹⁰⁴

This is yet another example of why expansion of ERISA preemption to AHPs could have possible negative effects on a state's population. Taking the segment of the population that qualifies for AHP coverage out of the entire state's insurance market would shrink the number of contributors to state insurance plans, causing costs to rise for those left behind.¹⁰⁵ Expansion of ERISA preemption to AHPs

¹⁰² Health Care Reform Education Institute – Important Words in Health Care Insurance, <http://www.healthcarereform.com/commonterms/> (last visited Feb. 22, 2007). “Cherry-picking refers to health insurance companies that try to insure only healthy people. Sicker patients are turned down and forced to look elsewhere. This is designed to result in a bigger profit for the insurance company that does “cherry-picking.” *Id.*

¹⁰³ Bandoli, *supra* note 71.

¹⁰⁴ TEXAS DEPARTMENT OF INSURANCE, *supra* note 83, at 15.

Employers who are opposed to mandated benefits argue such requirements restrict their freedom of choice to decide which benefits they desire to provide for their employees, and impose unfair obligations on employers when they are not even required to provide insurance at all. However, some employers have welcomed government mandates as a way of guaranteeing benefits that would otherwise be unavailable or unaffordable. This is particularly true of small employers who have historically encountered serious problems obtaining comprehensive health care at prices competitive with larger employers.

Id.

¹⁰⁵ FRITCHEN & BENDER, *supra* note 9, at 1.

As AHPs attract small employers whose perceived health status is good, firms with greater expected health care utilization would remain in the state-regulated market, where they have the protection of

would enable more “cherry-picking.” It may make health insurance somewhat cheaper for the small number of citizens who would take part, but the economic consequences to the whole state has the frightening potential to be much worse.¹⁰⁶

iv. States Use Health Insurance Regulations to Achieve Health Policy Goals, and Further Federal Preemption will Frustrate States’ Ability to Implement Such Policy Initiatives.

Proponents of AHPs point to state insurance regulations as the enemy, that it is these regulations that are the root cause of the high price of health care today.¹⁰⁷ However, it seems counterintuitive that states would continue to pursue a health policy that is detrimental to their overall population. Surely, state governments see value for the greater good in their regulations; if they did not, it would not make economic sense to continue with regulations. It is a hard argument to swallow that states have some interest in “pricing” their citizens out of the health insurance market by burdensome and unnecessary regulations. Since the beginning of the insurance industry in this country, regulation has been a matter of state control.¹⁰⁸ It makes sense to continue to let states control their own health policies. There is no clear “right” answer to the health insurance problems in this country, and, by federalizing the problem without a true federal health plan to supplant state regulations, we would do nothing but destabilize the industry and leave consumers unprotected from abuses.¹⁰⁹ Fifty different voices pursuing their own

mandated benefits and other requirements. The resulting outflow of low-cost groups from the state-regulated market and the remaining concentration of high-cost groups would start an adverse selection spiral that would accelerate premium increases for employers in the state-regulated market.

Id.

¹⁰⁶ *Id.*

¹⁰⁷ WESTERFIELD, *supra* note 31, at 22. “Unnecessary state regulations add costs to employer health plans, and they may add legal fees and administration costs...AHPs would have state regulation preemption, thus resulting in saving significant enough to make the difference between affording and not affording a health plan.” *Id.*

¹⁰⁸ See generally FURROW ET AL., *supra* note 25; Paul v. Virginia, 75 U.S. 168, 170 (1868); McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (2006).

¹⁰⁹ Bogan, *supra* note 17, at 951. “The combined effect of ERISA’s failure to regulate nonpension employee benefits and court opinions that declare state regulations that relate to nonpension employee benefit plans preempted is that the managed care health benefits industry remains virtually unregulated, leaving consumers hopelessly unprotected from industry abuses.” *Id.*

individualized health policies seems preferable to one voice trying to fill the gaps left wide open for abuses by ERISA preemption and deregulation.¹¹⁰

A prime example is the modern emphasis on ‘preventative’ treatment.¹¹¹ Twenty years ago, the concept of preventative care was a new concept, and as such health insurers were reluctant to cover such procedures as cancer screenings because they were not “medically necessary.”¹¹² Through mandated benefit trends moving across state borders, state governments were able to speed along the acceptance and promote the importance of such procedures as cancer screenings. Death rates for breast cancer have dropped continuously over the past decade,¹¹³ a fact mirrored by colon-cancer death rates and prostate

¹¹⁰ Scott D. Litman, *Health Care Reform for the Twenty-First Century: The Need for a Federal and State Partnership*, 7 CORNELL J.L. & PUB. POL’Y 871, 879-87 (1998).

¹¹¹ TEXAS DEPARTMENT OF INSURANCE, *supra* note 83, at 15.

¹¹² *Id.*

Fifteen years ago, the concept of “preventive health care” was fairly new and there was originally no widespread expectation that insurers would pay such expenses. Over time, however, the benefits of certain screening and diagnoses interventions were widely recognized by both medical providers and public health agencies as an effective way of detecting potential medical problems in early stages when treatment is less expensive and medical outcomes are more favorable. Many insurers also recognized the financial and physical benefits of good health and a few began to actively promote “healthy lifestyles” among their insureds. However, most insurers were not initially receptive to some aspects of the preventive health care movement, and resisted providing coverage for such services as mammography screening, PAP tests, immunizations for children, and annual physicals. Facing pressure from both consumers and physicians, lawmakers in many states responded by mandating coverage for these benefits. Thus, whereas ten years ago few insurance policies covered these medical treatments that were not “medically necessary” by insurers’ definitions, these benefits are widely available today as a result of legislative intervention in the form of mandated benefit requirements.

Id.

¹¹³ AMERICAN CANCER SOCIETY, *CANCER FACTS & FIGURES: 2005* 11 (2005), available at: <http://www.cancer.org/downloads/STT/CAFF2005f4PWSecured.pdf>.

An estimated 40,870 breast cancer deaths (40,410 women, 460 men) are anticipated in 2005. Breast cancer ranks second among cancer deaths in women (after lung cancer). According to the most recent data, mortality rates declined by 2.3% per year from 1990 to 2001 in all women, with larger decreases in younger (<50 years) women. These

cancer death rates.¹¹⁴ No one can know for sure whether or not the trend of cancer screening mandated benefit legislation is to thank for this drop, but the coincidence is worth noting. Who knows which other procedure deemed not “medically necessary” could be hastened along by the state regulatory power of mandated benefits, much to the advantage of all Americans? Further federal erosion of states’ ability to enact regulations, such as mandated benefits, has the potential to stifle advances and acceptance of what could end up being the next big life-saving procedure. State control over the health care policies of its citizens, limited as it is right now, should remain protected.

v. Expansion of ERISA Preemption to AHPs Would Disproportionately Harm Women

State regulations, such as mandated benefits, are often in place to protect sections of the population that require more health coverage than others, and women are a good example. Women have traditionally been the biggest health care consumers, and some argue that the elimination of mandated benefits will disproportionately harm women.¹¹⁵ It is argued that women are more likely to qualify for AHPs (because many work for smaller employers), and, in turn, an ERISA-regulated AHP would not have to offer mandated benefits such as mammograms, cervical cancer screenings, contraceptives, and pre-natal care.¹¹⁶ There is no guarantee that an AHP would not cover these types of procedures and treatments; however, the assumption is that AHPs would be stripped down because of the emphasis on cutting costs. In addition, AHPs may harm women who are not participants in the AHPs because their rates would increase when the number of individuals who were once part of their overall risk pool switch to AHP deregulated coverage.¹¹⁷ In sum, many state regulations are in place to protect

decreases are due to *increased awareness, earlier detection through screening, and improved treatment.*

Id. at 9(emphasis added).

¹¹⁴ *Id.* at 14, 17.

¹¹⁵ The Male Health Center – Men & Checkups, http://www.malehealthcenter.com/p_check.html (last visited Feb. 4, 2007). “Each year, men make 150 million fewer trips to doctors than women (the disparity occurs in every age group, not just the years some women have prenatal checkups.” *Id.*; Nat’l Partnership for Women & Families, *supra* note 10.

¹¹⁶ Nat’l Partnership for Women & Families, *supra* note 10.

¹¹⁷ *Id.*

specific vulnerable groups such as women, and the elimination of the power to enact these regulations would hit these vulnerable groups the hardest.

B. Expansion of ERISA Preemption to AHPs is an Impractical Solution to the Health Care Affordability Problems in this Nation, and the Federal Government is Unprepared to Accept the Regulatory Duties this Expansion Would Require

Advocates of AHPs argue that it is unfair for large employers to enjoy the “benefits” of ERISA preemption and state deregulation while other Americans are forced to purchase health plans that are subject to more costly state regulations.¹¹⁸ The disparity in treatment of these two groups of health insurance consumers is apparent, and it is feasible to see how this is viewed as unfair. It is true that something needs to be done to ease the burden of small business employers and employees; however, expansion of ERISA preemption is a proposal that has far too many potential negative consequences and far too few potential benefits to be implemented as a true “solution” to this major problem.

The expansion of ERISA preemption to AHPs will amount to not much more than a drop in the bucket toward solving the real problem: enabling more Americans to obtain health insurance coverage.¹¹⁹ Additionally, studies show that eliminating this small population of the most likely healthiest individuals from the state-wide pool of insurance consumers will have adverse consequences for the most vulnerable citizens who will be left behind or exempt because of their health problems.¹²⁰ When these two concerns are coupled with the

In the end, women would lose: women covered by AHPs would likely pay more out-of-pocket for needed services, and women left out of AHPs could see their premiums increase as they are left to get coverage from a state-regulated pool along with others who need access to more comprehensive coverage. Low-income and low-wage working women, many of whom are single mothers, would be at particular risk, since many lack the resources to purchase additional coverage or pay high out-of-pocket costs.

Id.

¹¹⁸ *AHPs Will Improve Access*, *supra* note 44.

¹¹⁹ CONGRESSIONAL BUDGET OFFICE, *supra* note 56, at 4–5.

¹²⁰ Press Release, National Small Business Association, Uninsured Would Increase by Over 1 Million Under Association Health Plan Legislation, (June 10, 2003), *available at*: <http://nsbaonline.org/content/55.shtml>: “According to the study, AHPs are expected to reduce premiums by an average of 10 percent for their participants, but the state-regulated market would incur price increases of an average of 26 percent,

major policy and federalism considerations of taking more control away from states and placing it with the federal government, especially the issue of further federal encroachment into states' abilities to create and maintain their individualized health policies, AHPs just do not seem worth it. The potential benefits are outweighed by the obvious drawbacks and potential negative ramifications.

The practical effects of self-insured AHPs are all estimates. No one knows for sure what actual effect broadening ERISA preemption will actually have on the insurance market or the American population. However, the evidence so far seems to point to two widely accepted conclusions. First, AHPs would help qualifying small business employees and employers by allowing them to pool their populations together and self-insure their groups, thus saving between 9 percent and 25 percent on health insurance costs.¹²¹ And second, the amount of people who were previously uninsured and who will now become insured as a result of AHPs is estimated to be less than one percent of the 45.8 million uninsured Americans.¹²²

In April 2005, the Congressional Budget Office (CBO) published estimates of the financial effects of the most recently proposed AHP legislation.¹²³ The CBO estimated that within five years of enactment of AHP legislation, 620,000 Americans who were previously uninsured would be able to be insured through small business employers taking part in an AHP.¹²⁴ The CBO also estimated that 8.5 million people would be eligible and likely to take part in an AHP health plan. However, not all estimates were positive, as the CBO estimated that 10,000 people would lose insurance coverage as a result of rising premiums due to the flight of people within their current risk pool to deregulated AHP coverage.¹²⁵ Still, others estimate this number to be much greater.¹²⁶

Another study of the potential risks and benefits of AHP legislation was conducted by Beth Fritchen and Karen Bender of the

resulting in an overall average increase of 6 percent for the small-business market.”
Id. (citing FRITCHEN & BENDER, *supra* note 9).

¹²¹ WESTERFIELD, *supra* note 31, at 3.

¹²² Press Release, U.S. Census Bureau, Income Stable, Poverty up, Numbers of Americans with and Without Health Insurance Rises, Census Bureau Reports (Aug. 26, 2004), available at http://www.census.gov/Press-Release/www/releases/archives/income_wealth/002484.html.

¹²³ CONGRESSIONAL BUDGET OFFICE, *supra* note 56, at 4–5.

¹²⁴ *Id.* at 4.

¹²⁵ *Id.* at 4–5.

¹²⁶ See generally FRITCHEN & BENDER, *supra* note 9.

private consulting firm Mercer Risk, Finance & Insurance Consulting for the National Small Business Association in June 2003.¹²⁷ The study, titled “Impact of Association Health Plan Legislation on Premiums and Coverage for Small Employers,” painted an even bleaker picture than the CBO financial estimates of the problems that would accompany an expansion of federal deregulation to AHPs.¹²⁸ The study estimated that 1 million previously insured Americans would lose their health insurance coverage as a result of higher premiums caused by the flight of the healthiest consumers to AHPs and that premiums would actually increase for most small business employers.¹²⁹

The Mercer study contained five major conclusions. First, it concluded that “health insurance costs would increase significantly for small businesses in the state-regulated insurance market.” Secondly, it found that “AHP legislation would increase, not decrease, the number of uninsured.” Third, the study concluded that “federal AHPs would gain a pricing advantage through risk-selection, not greater administrative efficiency.” Fourth, it found that “federal AHPs would insure the healthiest small employers,” and, finally, that “small employers would face higher premiums overall.”¹³⁰

The study noted:

Average small employer premiums (considering both cost increases for the state-regulated market and premium reductions for AHPs) would increase by 6%. Average premiums would increase because the size of the average premium increase for the population remaining in the state-regulated market (23%) would outweigh the smaller average premium decrease for those covered by AHPs (10%).¹³¹

These results indicate that AHP legislation is not a solution to rising health care costs for small employers. While some firms obtaining coverage through AHPs may see lower premiums, firms with higher-cost employees would see their premiums increase. Overall, small employers would

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.* at 1.

¹³⁰ *Id.* at 2.

¹³¹ *Id.*

pay higher premiums and the uninsured population would increase if this legislation were enacted.¹³²

IV. EXPANSION OF THE FEDERAL GOVERNMENT'S REGULATORY RESPONSIBILITIES WILL BE COSTLY AND WILL STRAIN AN ALREADY OVERWHELMED AND UNPREPARED DEPARTMENT OF LABOR

Expanding the reach of federal authority will also come with administrative costs and lost revenues. The CBO estimates that passage of AHP legislation would result in decreases in total federal revenues of around \$261 million for the first ten years.¹³³ It is also estimated to cost the U.S. DOL around \$136 million to implement the additional regulatory functions for the first ten years.¹³⁴

In addition to expenses and limited improvement on overall access, federal preemption of state regulations has the potential to leave consumers unprotected in the insurance market.¹³⁵ While the federal government is quick to usurp state regulatory authority, they have not implemented their own comprehensive federal regulatory scheme.¹³⁶

¹³² FRITCHEN & BENDER, *supra* note 9.

¹³³ CONGRESSIONAL BUDGET OFFICE, *supra* note 56, at 5, 7.

The bill would reduce federal tax revenues because the share of employee compensation paid in the form of taxable wages and salaries would decrease as employers and employees spent more on tax-excluded health benefits. That increase in net spending on health benefits is the result of several factors that move in different directions. In general, spending on health benefits would decline for firms that switched from coverage purchased in the traditional, state-regulated market to AHP coverage due to savings from the exemption from requiring certain benefits, and from administrative savings. Eligible firms could attain additional premium savings by joining an AHP whose members had lower average costs than those of the insurance pools existing in the state-regulated market.

Id. at 5.

¹³⁴ *Id.* at 2. "CBO estimates that DOL would hire 150 workers over the next three years to regulate the AHP market and certify AHPs." *Id.*

¹³⁵ Leavitt, *supra* note 39, at 47–49.

¹³⁶ Hall, *supra* note 10, at 180.

Citizens are far more protected from industry abuses in a state regulated system than in the federal realm.¹³⁷

A. Federal Regulation of Health Plans Will Not Protect Citizens from Discrimination to the Extent that State Health Insurance Regulation Can

As mentioned previously, one of the fears of expansion of federal preemption to entities like AHPs is that it will open the gate for cherry-picking.¹³⁸ The aforementioned *Mercer* study estimated that the reason AHPs will be cheaper for individual small businesses that are able to utilize their preemptive benefits is because they will be more free to select their plan participants.¹³⁹ This means that these plans will select the healthiest individuals in the pursuit of keeping premiums as low as possible for all of the healthiest plan members. In addition, preempted plans will not have to comply with state mandates, and this too will have a detrimental discriminatory effect on individuals who depend on these mandates for their health coverage.¹⁴⁰

This set-up is a good scenario for the healthy individual who is able to get a small decrease in health costs, however it will have detrimental effects for those left behind. For example, imagine an Illinois resident who has diabetes. His employer is switching the entire shop to an ERISA-qualified AHP in an attempt to lower costs. This AHP would not have to conform to Illinois' mandated benefit of diabetes treatment, and the AHP may not offer coverage because including it would raise overall plan costs. This resident would be forced to pay out of pocket for diabetes treatment, or try to get on some other state regulated plan or plan that will cover his diabetes treatment. Here the AHPs are effectively allowed to cherry-pick by deterring less healthy individuals from being members of the health plan. This may save the other members of the AHP a little money in health care premiums, but for those who survive off of mandated benefits the downside is much too great.¹⁴¹ In addition, Illinois' ability to implement a health policy goal of assuring proper diabetes treatment

¹³⁷ See DeArment, *supra* note 13, at 5–6. “The states have more than 125 years of experience in regulating the insurance industry....This state insurance-regulatory work is conducted by highly skilled and trained employees, many of whom have specialized education and certification.” *Id.* at 5.

¹³⁸ Nat'l Partnership for Women & Families, *supra* note 10.

¹³⁹ FRITCHEN & BENDER, *supra* note 9, at 3.

¹⁴⁰ Nat'l Partnership for Women & Families, *supra* note 10.

¹⁴¹ *Id.*

for their citizens, illustrated by their passage of mandated benefits, is frustrated by further federal deregulation.

While a small number will be able to remove themselves from the overall state-regulated market and pay around 10% less for their health coverage, those left behind will incur expenses, both financially and in costs to their health, that far outweigh such a small overall benefit.

B. The Department of Labor is Not Prepared to Increase its Regulatory Responsibilities, Leaving These New Plans Susceptible to Fraud

While proponents of federal preemption would argue otherwise, the truth is that ERISA preemption of self-funded health plans has caused serious problems for unprotected consumers.¹⁴² Self-funded ERISA qualified plans have had major problems with fraud and insolvency over the past 20 years.¹⁴³ Without state safeguards or solvency regulations, fraudulent health plans have sprung up and have gone undetected until the point where consumers are left personally liable for the bulk of the fraudulent plan's bills.¹⁴⁴

Critics of AHP legislation such as the Small Business Health Fairness Act, point out that expansion of ERISA's deregulation will only increase the already growing number of fraudulent health plans in this nation.¹⁴⁵ The major loser in this situation is the consumer, who, when left without the benefit of state regulatory control and the lack of

¹⁴² Leavitt, *supra* note 39, at 47.

For the first nine years of ERISA's existence, the courts relied on ERISA's explicit statement that it preempted any state laws that conflicted with ERISA's mandates. This ERISA preemption enabled shady plan operators to sponsor health benefit plans that they could market free from state regulation. Because the federal government committed so few resources to health plan enforcement, fraudulent schemes flourished.

Id.

¹⁴³ *Id.*

¹⁴⁴ *Id.* at 50–51.

¹⁴⁵ *Id.* at 51: "In light of the government's experiences with fraudulent plans operating under ERISA and the SBHFA's (Small Business Health Fairness Act) effort to eliminate 'burdensome' regulatory oversight, there is considerable risk that corrupt or inexperienced operators and promoters would abuse the proposed new AHP scheme." *Id.*

a supplanting comprehensive federal scheme, can often be held personally liable for the insolvency of a health plan, potentially leading to personal bankruptcy.¹⁴⁶ Health care consumers are better protected under state regulatory schemes than they are under the DOL's limited regulations, which is yet another example of how further expansion of ERISA's preemption growth would require much more serious consideration and large improvements to the ineffective federal regulatory scheme currently in place.¹⁴⁷

As previously noted, federal preemption of AHPs does not truly supplant a comprehensive regulatory system in place of the now deregulated health plans.¹⁴⁸ These plans once enjoyed a myriad of state regulations, but with federal deregulation not only are there serious federalism concerns over the rights of states to control and regulate what has historically been their province, but there is also a concern that the federal government is unable regulate this volatile industry with any type of consumer-focused success. A study conducted by Roderick A. DeArment asserts that the DOL is unprepared for the type of expansion of regulatory duties that would be necessary should

¹⁴⁶ *Id.*

For example, under the SBHFA, if an AHP set its expected claim level at \$2 million but ended up with \$3 million in claims, the plan would be required to pay \$2.5 million in claims, leaving members with \$500,000 in unplanned claims that the stop-loss insurance would not cover. This assumes that the stop-loss insurers would even provide coverage. Because the federal legislation would not regulate the stop-loss insurers, there is a significant risk that fraudulent insurers will refuse to pay, be unable to pay, or fail to pay in a timely fashion. Once again, association members could find themselves liable for the unpaid claims.

Id. at 50–51.

¹⁴⁷ Leavitt, *supra* note 39, at 46. Critics of expanding ERISA deregulation point out that state control is better at protecting consumers than the current limited federal regulatory scheme.

In light of the government's experiences with fraudulent plans operating under ERISA and the SBHFA's [Small Business Health Fairness Act] effort to eliminate "burdensome" regulatory oversight, there is considerable risk that corrupt or inexperienced operators and promoters would abuse the proposed new AHP scheme. In fact, the SBHFA would remove oversight of AHPs from the very people with the most skill and experience dealing with them: the states.

Id.

¹⁴⁸ Hall, *supra* note 10, at 179-80.

federal preemption be expanded.¹⁴⁹ This study concludes that AHP regulation would be minimal at best given the current conditions of the DOL.¹⁵⁰ It notes:

Without the funding, staff experience, or regulatory tools currently available to state regulators, the DOL would be unable to extend the protection that consumers have come to expect from state regulated insurance. Instead, consumers would be forced to rely on an insufficient number of inexperienced federal regulators who would be unable to ensure that AHPs comply with federal requirements, charge fair rates for coverage, market coverage appropriately, or detect potential solvency problems in time to protect consumers from plan failure and resulting unpaid medical bills. Nor would DOL have the ability to protect consumers from the results of "cherry picking" by AHPs. In sum, DOL regulation of association health plans would fall far below the standards state regulators have set to ensure access to fairly priced and financially sound health coverage.¹⁵¹

V. CONCLUSION

Expanding ERSIA preemption of state health insurance regulations would allow AHPs to offer cheaper health insurance to some Americans. That would be the quick fix. The 8.5 million Americans who would qualify and possibly take part in AHPs would likely pay around 10 percent less for health insurance premiums than they currently do under state regulated plans.¹⁵² However, when the issue is analyzed with more depth this limited "solution" does not seem quite as attractive.

The expansion of federal preemption further into a state stronghold of sovereign control poses serious federalism concerns. States should have the right not only to regulate an industry that Congress granted them statutory control over, but the federal government should not frustrate state attempts to implement public

¹⁴⁹ DeArment, *supra* note 13, at 5.

¹⁵⁰ *Id.*

¹⁵¹ *Id.* at 13.

¹⁵² FRITCHEN & BENDER, *supra* note 9, at 4, 17; CONGRESSIONAL BUDGET OFFICE, *supra* note 56, at 4-5.

policy goals unless there is a comprehensive federal plan to supplant the deregulation.¹⁵³ There is no such federal health policy behind AHP legislation – the one goal is to make insurance coverage cheaper for one small segment of the population.

Further, it is estimated that expansion of ERISA preemption to AHPs will only apply directly to just under three percent of the U.S. population.¹⁵⁴ Of that three percent who may take part, only around one percent of the over 45 million uninsured Americans would become insured as a result of cheaper AHP health coverage.¹⁵⁵ Most Americans would already be taking part in an employer-sponsored health plans without AHP legislation – these plans would simply become around ten percent less expensive for those who qualify because of deregulation.¹⁵⁶

While it may make insurance a little less expensive, deregulation has serious costs. Financially, the federal government would lose around \$261 million over ten years in lost revenues. Additionally, the DOL would incur \$136 million in administrative costs for the first ten years of administration.¹⁵⁷ The DOL is also extremely unprepared for this type of expansion of its regulatory duties,¹⁵⁸ which is a scary fact considering that fraudulent health plans have become a major threat to insurance consumers across the country.¹⁵⁹ The federal government currently does not have the regulatory scheme to supplant what it is taking away when these plans move out of the realm of state control and, this fact, coupled with the stretched authority and staffing abilities of the DOL, leaves consumers unprotected from industry abuses.¹⁶⁰ Health coverage may be cheaper, but a health plan may also be fraudulent, and it is the consumer who will be left personally liable for the health care costs, which many times results in the consumer's personal bankruptcy.¹⁶¹

¹⁵³ Bogan, *supra* note 17, at 951.

¹⁵⁴ See U.S. Census Bureau Population Clock, <http://www.census.gov/population/www/popclockus.html> (last visited Aug. 22, 2006).

¹⁵⁵ CONGRESSIONAL BUDGET OFFICE, *supra* note 56, at 2.

¹⁵⁶ FRITCHEN & BENDER, *supra* note 9, at 17.

¹⁵⁷ CONGRESSIONAL BUDGET OFFICE, *supra* note 56, at 2.

¹⁵⁸ DeArment, *supra* note 13, at 5.

¹⁵⁹ See *gen.* United States General Accounting Office *Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus entities Selling Coverage*, Feb. 2004, at: www.gao.gov/cgi-bin/getrpt?GAO-04-312. (last visited Mar. 5, 2007).

¹⁶⁰ Bogan, *supra* note 17, at 951.

¹⁶¹ Leavitt, *supra* note 147, at 49.

Perhaps the most striking reason not to expand ERISA preemption to AHPs is the effect it will have on those left behind. The individuals who do not qualify for AHP health plans will pay six percent more in health care premiums,¹⁶² and costs for small businesses that would still utilize state-regulated health care plans would increase by approximately 23 percent.¹⁶³ The effect of this rise in premiums has the potential to be catastrophic. One study estimates that approximately one million previously insured Americans will lose their health insurance as a result of rising premiums due to the flight of the healthiest individuals to AHPs.¹⁶⁴

In addition, those who do qualify for an ERISA preempted AHP may find themselves under-insured and the subject of discrimination because of their individual medical condition.¹⁶⁵ Individuals in states with comprehensive mandated benefits who depend on those mandates to cover such important benefits as diabetes treatment, asthma treatment, and many others, will have to make a difficult choice. They will be forced to choose to be part of an AHP plan that will not cover their necessary treatments, choose to pay a much higher premium for state-regulated plan that likely mandates these essential benefits, or not be insured at all. This “choice” is no real solution to any of America’s health care problems, in fact, it makes the situation even worse because it shifts more of the burden onto our most vulnerable citizens at a minimal gain for the more fortunate. AHPs will decrease premiums for a small portion of the population, but the effects they will have on the outlying population is much too great to make up for this small benefit.

Congress has yet to pass legislation that would authorize expansion of ERISA preemption to entities such as AHPs, and this is a good thing. This type of legislation is very attractive on the surface, but when analyzed in depth, it is clear that this quick-fix has far too many downsides to be considered a true solution to America’s growing health

¹⁶² FRITCHEN & BENDER, *supra* note 9, at 19.

¹⁶³ *Id.* at 16.

Health insurance premiums would increase by 23% for small employers that continued to purchase state-regulated coverage. This increase is directly attributable to AHPs’ ability to attract healthier-than-average firms from the insured market. AHPs’ exemption from mandated benefits, rating limitations and marketing standards would allow them to tailor products attractive to healthier populations.

Id.

¹⁶⁴ *Id.* at 1.

¹⁶⁵ See TEXAS DEPARTMENT OF INSURANCE, *supra* note 83, at 15.

care affordability problem. It is clear that any potential “solution” that the federal and state governments chose to enact in the future must look at the big picture. The positive effects to some citizens must be weighed against the reverberating effects on others – especially society’s most vulnerable.

