

# ERISA May Hinder States As They Attempt Healthcare Reform

BY JANE H. WHITE

**A**lthough members of Congress spent this past year talking a lot but taking little action on healthcare reform, a number of state legislatures have offered the brightest hope of movement forward on reform.

This month's column provides an update on some states' healthcare reform activities and lessons states can offer national reformers. Although several states are making headway in their reform efforts, they are being hindered by the Employment Retirement Income Security Act (ERISA), which prevents states from regulating health insurance plans of large employers that self-insure. States would like to see the act amended.

## STATE ACTIONS

All states have considered aspects of health reform, but fewer than a dozen have passed comprehensive legislation that aims for universal coverage and cost control. These states include Florida, Hawaii, Maryland, Massachusetts, Minnesota, Oregon, Vermont, and Washington. At the close of states' 1994 legislative sessions, Connecticut and Kentucky also passed comprehensive reform laws. Kentucky, however, backed off on its universal access and rate-setting goals.

Of these states, only Hawaii's program is fully implemented. Still, Hawaii continues to reform its healthcare system and has not achieved "universal" coverage for its citizens nearly two decades since it first passed its comprehensive reform law, the Hawaii Prepaid Health Care Act of 1974.

**Vermont** In April 1992 Vermont passed the Vermont Health Care Act of 1992 to ensure universal coverage for state citizens, control healthcare costs via a global budget, implement insurance community rating, reform medical malpractice laws, and place the state's healthcare under one state authority. The legislation did not specify how the state would pay for and achieve universal coverage. This led to development of two



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state proposals—one backed by a group of 55 legislators for a single-payer plan and one pushed by the governor for an employer mandate.

Although the single-payer plan was not brought to the floor for a vote during the current 1994 session, many predicted it would have been defeated. Additionally, Gov. Howard Dean, MD, had promised to veto it if passed. Dean, the nation's only physician governor, allied with the state's medical community in pushing for reform that was not government run. As Linfield College political scientist Howard M. Leichter describes it: "When Governor Dean speaks, the views of Dr. Dean are never entirely obscured. Dean, for example, shares the distaste of his colleagues for federal micromanagement of medical practices, especially through the much-hated Medicare program."<sup>1</sup>

Dean's employer mandate bill was killed (7-0) in Vermont's Republican-dominated Senate Finance Committee in May 1994. Earlier in March, the House passed a bill without an explicit financing mechanism. This essentially puts the state's universal coverage effort at square one. Some Vermont legislators are predicting action in future sessions on an individual mandate; and the single-payer advocates have not yet given up hope.

Even though universal coverage is currently derailed in Vermont, other aspects of the reform law are still on track—"most notably a unified health budget that includes binding caps on hospital spending and the development of a health care database," reports *State Health Notes*, a publication of George Washington University's Intergovernmental Health Policy Project.<sup>2</sup>

**Florida** In Florida, too, the move toward universal coverage appears jeopardized. Florida's Health Security Act, the first state-managed, competition-style law, was passed in April 1993, with the goal of universal coverage by the end of 1994. However, the Florida legislature remains deadlocked on how many low-income workers it is willing to cover. Gov. Lawton Chiles wanted to cover 1.1 million low-income workers at up to 250 percent of the poverty level. The Senate



wanted to hold the line at 150 percent of the poverty level. Despite special sessions in April and June, state lawmakers were unable to pass the insurance plan for Florida's low-income residents. Further action is unlikely until after the November elections.

**Minnesota** In April 1992 Minnesota passed the HealthRight Act to ensure universal coverage for the state's uninsured citizens and to control costs. Children and their parents were initially targeted for coverage. By summer 1994, more than 70,000 Minnesotans (mostly children) were covered by the program of subsidized health insurance. The goal of universal coverage for all uninsured Minnesotans was to have been achieved by July 1, 1994. That deadline has now been delayed until July 1, 1997. A key issue for the state in next year's legislative session will be how to pay for such coverage.

Minnesota's reform effort has been characterized by an initial commitment to broad reform but with sketchy details. Legislation in subsequent years has provided additional details and slowed the reform timetable. The 1993 MinnesotaCare Act was passed with bipartisan support to adopt state healthcare expenditure limits to control rising costs. The 1994 MinnesotaCare Act instituted the delays and added refinements to the cost-containment plan.

To control costs, Minnesota plans to encourage competition on price and quality among integrated service networks (ISNs). Providers and payers would be encouraged to form and join such networks. On the regulatory side, the plan includes provider rate setting—the “regulated all-payer option”—for those payers and providers not participating in the ISN system. The 1994 act delayed implementation of the all-payer system until January 1996, with an 18-month phase-in. The ISNs would not start until July 1, 1997. The state wants to encourage smaller community ISNs (with 50,000 or fewer members) to form by January 1995, however. Finally, Minnesota has instituted statewide expenditure limits to reduce the projected rate of growth in healthcare spending by 10 percent per year for five years (1994-98).

Despite the delays, Minnesota's reforms remain on track. A lesson that the state can offer national reformers is that “reform is an iterative process,” according to Lynn A. Blewett of Minnesota's Department of Health.<sup>3</sup> “During each legislative session, more details are added and adjustments made to previous approaches. Even with the progress that Minnesota has made, the final outcome of health care reform in the state is still unclear. It will take many years of hard work and a commitment from both sides of the aisle to stick it out and

keep the process going,” Blewett concludes.

**Oregon and Washington** In March 1993 Oregon received a Medicaid waiver to allow it to expand Medicaid benefits to more Oregonians through funds saved by prioritizing types of healthcare treatments. The Oregon Health Plan officially began on February 1, 1994, expanding Medicaid to 120,000 low-income, uninsured Oregonians. However, *State Health Notes* reports that “the fate of an employer mandate to cover the rest of the uninsured population remains up in the air.”<sup>4</sup>

Washington State passed its version of managed competition in late April 1993. The state is taking steps toward its goal of near-universal coverage by 1999, including passing a bill in spring 1994 to include seasonal migrant workers under the state plan. Said Bill Hagens, senior research analyst in the state's House of Representatives, “We are very much on track with our reforms. The only problem is ERISA.”

#### **ERISA: REFORM ROADBLOCK**

ERISA, the federal law passed in 1974 primarily to protect employees from pension fund fraud, prevents states from regulating health insurance plans of large employers that self-insure. Any health reform law a state passes may not have an intended or direct impact on these self-funded plans, but state reform activities in the categories of financing, expenditure controls, insurance reform, and administration may all butt against the wall of ERISA.

A sizable portion of a state's citizens may come under ERISA's jurisdiction. Minnesota, for instance, estimates that more than a third of its citizens are covered through self-insured employer plans. Nationally, the National Governors' Association (NGA) estimates that nearly two-thirds of the people insured through their employer are in self-insured plans.

Lawyers Mary Ann Chirba-Martin of Boston College and Troyen A. Brennan of Harvard University explain the difficulty ERISA has caused for state reform efforts:

ERISA preemption has been used to eviscerate state attempts to regulate both health care financing and health care delivery. Preemption had undercut efforts to implement employer mandates and to cross-subsidize uncompensated care and high-risk pools. It is now being invoked to deny the state any meaningful role in regulating HMOs [health maintenance organizations], PPOs [preferred provider organizations], and insurer/provider relations. All of this is occurring despite the absence of any countervailing federal substantive

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regulation of such entities and their activities.<sup>5</sup>

Although Washington, Oregon, and Minnesota appear on track with their reforms, ERISA looms on the horizon as a critical roadblock. ERISA is likely to derail key reform components in all three states unless they receive waivers from the federal government or the law is changed. The threatened components include Oregon's "play-or-pay" option to require employers to help pay for a minimum healthcare benefit plan for employees or else pay a tax; Washington's employer mandate to move toward universal coverage and to help subsidize its coverage of low-income families; and Minnesota's plan to finance its subsidization of low-income residents' insurance.

### APPROACHES TO ERISA

On July 21, 1994, the NGA urged Congress to modify ERISA so that the act does not "stifle state innovation."<sup>6</sup> Only through amendment or judicial interpretation can Congress or the federal courts, respectively, resolve the state healthcare reform dilemmas ERISA poses.

According to NGA, the judicial route is unsatisfactory because "the different levels of federal courts invite differing interpretations that are inconsistent or even conflicting." Judicial decisions also typically lack principles to guide state policymakers, and "the rulings by federal courts have generally narrowed the scope of state authority with respect to state oversight of health plans and the health care delivery system."

NGA poses three approaches Congress could take on ERISA. First, it could "identify categories of activities that states could undertake without a formal waiver." Such activities could include taxing self-funded plans at the same level as all insurance plans, requiring participation in state purchasing pools, requiring participation in state health data collection and uniform billing, and requiring compliance with state cost-control efforts. Second, and more narrowly, Congress could "authorize a federal administrative agency to evaluate individual state requests for preemption waivers." Third, and most restrictive, Congress could provide waivers to only those states with existing programs, such as Hawaii (which is already exempt). NGA does not favor this last option.

### STATES' MESSAGE TO WASHINGTON

As states watch the unfolding reform debate in Washington, many are taking a "wait and see" approach to their own reforms. They want to be certain that any federal reforms will not wipe out their own efforts. They also want to see what

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foundation national reforms will set for them to build on at the state level.

Some state leaders have expressed frustration that national policymakers have not learned more from those states which have already moved forward with comprehensive reforms. Many of the same political debates were already fought at the state level.

"It's very frustrating that Washington doesn't pay attention to what's happening in the states," said Trish Riley, executive director of the National Academy for State Health Policy (NASHP), in a conversation. "From the vantage point of right now [late August], the strategy Washington is taking is a strategy states have found doesn't work. You can't do insurance reform alone and expect it to be comprehensive. If that's all Congress does, it could hurt more than help. Some 30-40 states have already passed insurance reform. However, if Congress does insurance reform *and* ERISA reform and Medicaid reform, states would see it as a positive step forward," she added.

Vermont's Dean, who is also the current chair of the NGA, offered some additional lessons based on his state's experience. "People are going to suffer if we don't compromise. We have to be practical; we have to compromise," Dean told state leaders at NASHP's mid-August meeting in Burlington, VT. Health reform "isn't going to happen overnight," he added. "We have to do it piece by piece . . . and we have to have a bipartisan bill."

National reformers would do well to look beyond the Beltway to the reform lessons offered by the states. And if, as seems likely, action at the national level ends up in a much scaled-back version of healthcare reform, the least Congress could do is to allow more flexibility in ERISA so that some of these state experiments can move forward and provide useful insight into how healthcare reform does and does not work around the nation. □

### NOTES

1. Howard M. Leichter, "Health Care in Vermont: A Work in Progress," *Health Affairs*, Summer 1993, pp. 71-81.
2. "Vermont: Hitting the Wall," *State Health Notes*, June 13, 1994.
3. Lynn A. Blewett, "Issues in Setting and Enforcing State Expenditure Limits," *Health Affairs*, Fall 1994.
4. "Oregon Plan in Place," *State Health Notes*, February 21, 1994.
5. Mary Ann Chirba-Martin and Troyen A. Brennan, "The Critical Role of ERISA in State Health Reform," *Health Affairs*, Spring II 1994, pp. 142-156.
6. National Governors' Association, "ERISA: Roadblock to State Health Care Reform," *Issue Brief*, July 21, 1994.