

Fall 2019

10th Annual Pegalis Law Group Health Law Colloquium

New York Law School

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Recommended Citation

New York Law School, "10th Annual Pegalis Law Group Health Law Colloquium" (2019). *Health Law Society Publications*. 3.

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10th Annual Pegalis Law Group Health Law Colloquium

**FEDERALISM, ERISA, AND STATE
SINGLE-PAYER HEALTH CARE:**

**How to Make Sense of Future Legislation and
the Impact on Population Health**

DATE

Thursday
October 24, 2019

TIME

6:00 p.m.—8:00 p.m.

6:00 p.m.—6:30 p.m.:
Registration and Networking

6:30 p.m.—8:00 p.m.: Panel

LOCATION

New York Law School
Auditorium

185 West Broadway
New York, NY 10013

COST

Free

CLE

1.5 credits in Areas of
Professional Practice
(NY transitional and
nontransitional)

MODERATOR

Adam Herbst, Senior Vice President/Chief Legal and
Strategic Planning Officer, Blythedale Children's Hospital;
Adjunct Professor, New York Law School; Assistant Adjunct
Professor at Columbia's Mailman School of Public Health

PANELISTS

Niyum Gandhi, Executive Vice President and Chief
Population Health Officer, Mount Sinai Health System;
Assistant Professor of Health System Design, Icahn
School of Medicine at Mount Sinai

Hon. Richard N. Gottfried, New York State Assembly
(District 75); Chair of the Assembly's Committee on Health
and Sponsor of the New York Health Act

Hon. Gustavo Rivera, New York State Senate
(District 33); Chair of the Senate's Committee on
Health and Sponsor of the New York Health Act

Michael S. Sparer, J.D., Ph.D., Professor and Chair
of the Department of Health Policy and Management,
Mailman School of Public Health at Columbia University

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10th Annual Pegalis Law Group Health Law Colloquium

Federalism, ERISA, and State Single-Payer Health Care. How to Make Sense of Future Legislation and the Impact on Population Health

Timed Agenda

6:00pm - 6:30pm	Networking Reception and Registration
6:30pm – 6:35pm	Welcome Remarks by Steven E. Pegalis '65 Founder, The Pegalis Law Group and Anthony W. Crowell, Dean and President of New York Law School
6:35pm – 7:25pm (1 Professional Practice CLE Credit, NY Transitional and Non-Transition)	Panel Discussion with introduction of Federalism, ERISA and an overview on single payer legislation by Adam Herbst
7:25pm – 7:50pm (0.5 Professional Practice CLE Credit, NY Transitional and Non-Transition)	Substantive Question & Answer with the Panelists and Audience
7:50pm – 8:15pm	Closing Reception and CLE Sign-Out

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Erin C. Fuse Brown & Elizabeth Y. McCuskey

* All page numbers listed above correspond with numbering system in bottom left corner.

Oct. 24th – Presenter Bios

Moderator

Adam S. Herbst, Esq.

Senior Vice President, Chief Legal and Strategic Planning Officer of Blythedale's Children Hospital; Adjunct Professor at New York Law School teaching Health Law and Policy; Co-director of the NYLS Health Law and Patient Safety Project; Lecturer, Mailman School of Public Health at Columbia University

Adam S. Herbst, Esq., is Senior Vice President, Chief Legal, Compliance, Planning, and Government Relations Officer for Blythedale Children's Hospital. In this role, Mr. Herbst has legal and compliance oversight for the Hospital and is responsible for developing corporate planning strategies and administering government relations. In addition, he oversees human resources, advocacy and community relations.

Mr. Herbst has devoted a considerable portion of his career specializing at the intersection of where health care law meets with communications, technology and employment issues. He has extensive experience structuring agreements on behalf of the Hospital while advising on risk mitigation and offering solutions on operations, board governance, and regulatory matters.

Mr. Herbst has worked on issues related to housing, education, public health, economic development and has trial experience in both federal and state courts, as well as arbitrations throughout the country. He is a frequent speaker on health care access and is an adjunct law professor focusing on health policy and advocacy.

Mr. Herbst received his Juris Doctor cum laude from Albany Law School, Masters in Business Administration from Union College and his Bachelor of Arts cum laude from American University. Mr. Herbst is admitted to practice law in New York and New Jersey.

Distinguished Panelists

Honorable Richard N. Gottfried

New York State Assembly (District 75) & Chairman of the Assembly's Committee on Health and Sponsor of the New York Health Act

Richard N. Gottfried has chaired the New York State Assembly Committee on Health since 1987. He is a Democrat representing a Manhattan district including Chelsea, Hell's Kitchen, Midtown, and part of the Upper West Side.

He sponsors the N.Y. Health Act to create a universal “improved Medicare for all” single-payer health plan for New York. He is a leading proponent of patient autonomy and reproductive freedom. He was the sponsor of the law to allow medical use of marijuana in New York and the HIV Testing and Confidentiality Law.

He works to protect funding for Medicaid, community health centers, school health clinics, HIV/AIDS services, and other health concerns, and creating and expanding public health insurance programs in New York, including Child Health Plus.

His legislative work includes: promoting primary and preventive care; the Health Care Proxy Law (which allows people to designate an agent to make health care decisions for them if they lose decision-making capacity); the Family Health Care Decisions Act (which enables family members to make health care decisions for incapacitated patients who have not signed a health care proxy); managed care reforms; giving patients access to information about a doctor's background and malpractice record; licensing of midwives; and insurance coverage for midwife services.

He is a graduate of Cornell University (1968) and Columbia Law School (1973). He is licensed to practice law in New York, but does not maintain a private practice; his only occupation is Assembly Member. He is a member of the New York Academy of Medicine, the National Academy for State Health Policy, the Public Health Association of New York City, and the New York Civil Liberties Union. He was first elected to the Assembly in 1970 while in law school.

Niyum Gandhi

Executive Vice President and Chief Population Health Officer, Mount Sinai Health System

Niyum Gandhi is the Executive Vice President and Chief Population Health Officer of the Mount Sinai Health System. In this role, he oversees Mount Sinai's transition from a primarily fee-for-service model of care to one that is focused on value and risk-based population health.

Niyum leads Mount Sinai Health Partners and helps align the Health System's clinical and economic transformations in support of Mount Sinai's vision to be the leading population health manager in the competitive New York market, as well as the best possible partner to plan sponsors, health insurers, and other population health managers who are responsible for total cost of care of patient groups. This includes fostering care management and clinical model redesign to ensure that high-value care is delivered by the Health System and its partners, and working with payers and employers to establish the new economic models that support the delivery of value-based care.

Prior to his position at Mount Sinai, Niyum served as a Partner in the Health and Life Sciences consulting practice of Oliver Wyman in Chicago, where he focused on value-based health care strategy and transformation for physician groups, hospitals, and health plans. At Oliver Wyman,

Niyum also worked with a variety of Accountable Care Organizations (ACOs) and other population health management companies, helping them design and implement value-based clinical models, develop value-based contracts and integrated product distribution strategies, align physician incentives toward value, and establish the appropriate infrastructure to support population health management.

Niyum holds an A.B. in economics and finance from Harvard University. He has authored several articles on ACOs, payer/provider partnerships, and physician engagement, and served as a conference speaker on a variety of issues related to population health and value-based care. He also serves as an Assistant Professor in the Department of Health System Design and Global Health at the Icahn School of Medicine at Mount Sinai.

Honorable Gustavo Rivera

New York State Senate (33rd District), and Chairman of the Senate's Committee on Health and Sponsor of the New York Health Act

State Senator Gustavo Rivera represents the 33rd Senate District in the Bronx, which includes the neighborhoods of Kingsbridge Heights, Belmont, Fordham, University Heights, Van Nest, East Tremont, Crotona and Mount Hope.

Since taking office, Senator Rivera has focused his efforts on addressing issues of health inequity both legislatively and on the ground.

In 2018, his passion to improve the health of New Yorkers led Majority Leader Andrea Stewart-Cousins to appoint Senator Rivera as the Chair of the New York State Senate's Health Committee. As the Chair, Senator Rivera's goal is to collaborate with his colleagues, stakeholders, and constituents to improve health outcomes, increase access to health coverage, and ensure a financially viable system for the 20 million New Yorkers he proudly serves.

Prior to his appointment as Chair, Senator Rivera served as the ranking member of the Senate Health Committee for six years. As a sitting member of the committee, Senator Rivera passed three laws to ban smoking around schools, after schools, and libraries, and has been a champion of public health and harm reduction policies.

In March 2017, he became the main sponsor of the "New York Health Act," an innovative bill to create a single payer health system in New York State. In 2011, Senator Rivera launched the Bronx CAN (Changing Attitudes Now) Health Initiative. The goal of this community oriented health initiative is not only to encourage Bronx residents to develop healthy behaviors, but to shape policies that will help tear down some of the institutional barriers that stand in the way of Bronxites having a healthier lifestyle.

Senator Rivera also worked as a community organizer on New York State campaigns, as well as on President Barack Obama's 2008 campaign. He has worked as a college professor and briefly was a staff member for U.S. Senator Kirsten Gillibrand.

Michael S. Sparer, J.D., Ph.D.

Professor and Chair in the Department of Health Policy and Management at the Mailman School of Public Health at Columbia University

Michael S. Sparer, J.D., Ph.D. is Professor and Chair in the Department of Health Policy and Management at the Mailman School of Public Health at Columbia University. Professor Sparer studies and writes about the politics of health care, with a particular emphasis on the health insurance and health delivery systems for low-and-middle income populations, both in the United States and globally. His current projects include a study of efforts to enact "public option" insurance programs, the impact of federalism on the implementation of the Affordable Care Act, and the rise (and demise) of non-profit insurance "cooperatives." He is a two-time winner of the Mailman School's Student Government Association Teacher of the Year Award, the recipient of a 2010 Columbia University Presidential Award for Outstanding Teaching, and a two-time winner of the Core Curriculum Teaching Excellence Award. Professor Sparer spent seven years as a litigator for the New York City Law Department, specializing in inter-governmental social welfare litigation. After leaving the practice of law, Sparer obtained a Ph.D. in Political Science from Brandeis University. Sparer is the former editor of the *Journal of Health Politics, Policy and Law*, and the author of *Medicaid and the Limits of State Health Reform*, as well as numerous articles and book chapters.

New York Health Act
A.5248 (Gottfried); S.3577 (Rivera)

Underlined text is new law to be added. Text in brackets [] is existing law being repealed.
Footnotes are only for explanation and are not part of the actual bill.

AN ACT to amend the public health law and the state finance law, in relation to enacting the
"New York health act" and to establishing New York Health

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Short title. This act shall be known and may be cited as the "New York health act".

§ 2. Legislative findings and intent. 1. The state constitution states: "The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine." (Article XVII, §3.) The legislature finds and declares that all residents of the state have the right to health care. While the federal Affordable Care Act brought many improvements in health care and health coverage, it still leaves many New Yorkers without coverage or with inadequate coverage. Millions of New Yorkers do not get the health care they need or face financial obstacles and hardships to get it. That is not acceptable. There is no plan other than the New York health act that will enable New York state to meet that need. New Yorkers - as individuals, employers, and taxpayers - have experienced a rise in the cost of health care and coverage in recent years, including rising premiums, deductibles and co-pays, restricted provider networks and high out-of-network charges. Many New Yorkers go without health care because they cannot afford it or suffer financial hardship to get it. Businesses have also experienced increases in the costs of health care benefits for their employees, and many employers are shifting a larger share of the cost of coverage to their employees or dropping coverage entirely. Including long-term services and supports (LTSS) in New York Health is a major step forward for older adults, people with disabilities, and their families. Older adults and people with disabilities often cannot receive the services necessary to stay in the

community or other LTSS. Even when older adults and people with disabilities receive LTSS, especially services in the community, it is often at the cost of unreasonable demands on unpaid family caregivers, depleting their own or family resources, or impoverishing themselves to qualify for public coverage. Health care providers are also affected by inadequate health coverage in New York state. A large portion of hospitals, health centers and other providers now experience substantial losses due to the provision of care that is uncompensated. Individuals often find that they are deprived of affordable care and choice because of decisions by health plans guided by the plan's economic interests rather than the individual's health care needs. To address the fiscal crisis facing the health care system and the state and to assure New Yorkers can exercise their right to health care, affordable and comprehensive health coverage must be provided. Pursuant to the state constitution's charge to the legislature to provide for the health of New Yorkers, this legislation is an enactment of state concern for the purpose of establishing a comprehensive universal guaranteed health care coverage program and a health care cost control system for the benefit of all residents of the state of New York.¹

2. (a) It is the intent of the Legislature to create the New York Health program to provide a universal single payer health plan for every New Yorker, funded by broad-based revenue based on ability to pay. The legislature intends that federal waivers and approvals be sought where they will improve the administration of the New York Health program, but the legislature intends that the program be implemented even in the absence of such waivers or approvals. The state shall work to obtain waivers and other approvals relating to Medicaid, Child Health Plus, Medicare, the Affordable Care Act, and any other appropriate federal programs, under which federal funds and other subsidies that would otherwise be paid to New York State, New Yorkers, and health care providers for health coverage that will be equaled or exceeded by New York Health will be paid by the federal government to New York State and deposited in the New York Health trust fund, or paid to health care providers and individuals in combination with New York Health trust fund payments, and for other program modifications (including elimination of cost sharing and insurance premiums).

¹ This subdivision is meant to lay a constitutional foundation.

Under such waivers and approvals, health coverage under those programs will, to the maximum extent possible, be replaced and merged into New York Health, which will operate as a true single-payer program.

(b) If any necessary waiver or approval is not obtained, the state shall use state plan amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of federally-matched health programs and federal health programs in New York Health. Thus, even where other programs such as Medicaid or Medicare may contribute to paying for care, it is the goal of this legislation that the coverage will be delivered by New York Health and, as much as possible, the multiple sources of funding will be pooled with other New York Health funds and not be apparent to New York Health members or participating providers.

(c) This program will promote movement away from fee-for-service payment, which tends to reward quantity and requires excessive administrative expense, and towards alternate payment methodologies, such as global or capitated payments to providers or health care organizations, that promote quality, efficiency, investment in primary and preventive care, and innovation and integration in the organizing of health care.

(d) The program shall promote the use of clinical data to improve the quality of health care and public health, consistent with protection of patient confidentiality. The program shall maximize patient autonomy in choice of health care providers and health care decision making. Care coordination within the program shall ensure management and coordination among a patient's health care services, consistent with patient autonomy and person-centered service planning, rather than acting as a gatekeeper to needed services.

3. This act does not create any employment benefit, nor does it require, prohibit, or limit the providing of any employment benefit.²

4. In order to promote improved quality of, and access to, health care services and promote improved clinical outcomes, it is the policy of the state to encourage cooperative, collaborative and integrative arrangements among health care providers who might otherwise be competitors, under the active supervision of the commissioner of health. It is the intent of

² This subdivision is meant to make clear that this does not violate ERISA.

the state to supplant competition with such arrangements and regulation only to the extent necessary to accomplish the purposes of this act, and to provide state action immunity under the state and federal antitrust laws to health care providers, particularly with respect to their relations with the single-payer New York Health plan created by this act.³

§ 3. Article 50 and sections 5000, 5001, 5002 and 5003 of the public health law are renumbered article 80 and sections 8000, 8001, 8002 and 8003, respectively, and a new article 51 is added to read as follows:

ARTICLE 51

NEW YORK HEALTH Section 5100. Definitions.

5101. Program created.

5102. Board of trustees.

5103. Eligibility and enrollment.

5104. Benefits.

5105. Health care providers; care coordination; payment methodologies.

5106. Health care organizations.

5107. Program standards.

5108. Regulations.

5109. Provisions relating to federal health programs.

5110. Additional provisions.

5111. Regional advisory councils.

§ 5100. Definitions. As used in this article, the following terms shall have the following meanings, unless the context clearly requires otherwise:

1. "Board" means the board of trustees of the New York Health program created by section fifty-one hundred two of this article, and "trustee" means a trustee of the board.

2. "Care coordination" means, but is not limited to, managing, referring to, locating, coordinating, and monitoring health care services for the member to assure that all medically necessary health care services are made available to and are effectively used by the member

³ This language, and similar language in the body of the bill, lays the foundation for a "state-action" exemption from anti-trust laws.

in a timely manner, consistent with patient autonomy. Care coordination does not include a requirement for prior authorization for health care services or for referral for a member to receive a health care service.

3. "Care coordinator" means an individual or entity approved to provide care coordination under subdivision two of section fifty-one hundred five of this article.

4. "Federally-matched public health program" means the medical assistance program under title eleven of article five of the social services law, the basic health program under section three hundred sixty-nine-gg of the social services law,⁴ and the child health plus program under title one-A of article twenty-five of this chapter.⁵

5. "Health care organization" means an entity that is approved by the commissioner⁶ under section fifty-one hundred six of this article to provide health care services to members under the program.

6. "Health care provider" means any individual or entity legally authorized to provide a health care service under Medicaid or Medicare or this article. "Health care professional" means a health care provider that is an individual licensed, certified, registered or otherwise authorized to practice under title eight of the education law to provide such health care service, acting within his or her lawful scope of practice.

7. "Health care service" means any health care service, including care coordination, included as a benefit under the program.

8. "Implementation period" means the period under subdivision three of section fifty-one hundred one of this article during which the program will be subject to special eligibility and financing provisions until it is fully implemented under that section.

10. "Medicaid" or "medical assistance" means title eleven of article five of the social services law and the program thereunder. "Child health plus" means title one-A of article twenty-five of this chapter and the program thereunder. "Medicare" means title XVIII of the

⁴ The basic health program is authorized by the federal Affordable Care Act. It operates under the name "Essential Plan" in New York.

⁵ New York's Child Health Insurance Program.

⁶ In the Public Health Law, "commissioner" means the Commissioner of Health.

federal social security act and the programs thereunder. "Affordable care act" means the federal patient protection and affordable care act, public law 111-148, as amended by the health care and education reconciliation act of 2010, public law 111-152, and as otherwise amended and any regulations or guidance issued thereunder. "Basic health program" means section three hundred sixty-nine-gg of the social services law and the program thereunder.

11. "Member" means an individual who is enrolled in the program.

12. "New York Health", "New York Health program", and "program" mean the New York Health program created by section fifty-one hundred one of this article.

13. "New York Health trust fund" means the New York Health trust fund established under section eighty-nine-j of the state finance law.⁷

14. "Out-of-state health care service" means a health care service provided to a member while the member is temporarily out of the state and (a) it is medically necessary that the health care service be provided while the member is out of the state, or (b) it is clinically appropriate that the health care service be provided by a particular health care provider located out of the state rather than in the state. However, any health care service provided to a New York Health enrollee by a health care provider qualified under paragraph (a) of subdivision three of section fifty-one hundred five of this article that is located outside the state shall not be considered an out-of-state service and shall be covered as otherwise provided in this article.

15. "Participating provider" means any individual or entity that is a health care provider qualified under subdivision three of section fifty-one hundred five of this article that provides health care services to members under the program, or a health care organization.

16. "Person" means any individual or natural person, trust, partnership, association, unincorporated association, corporation, company, limited liability company, proprietorship, joint venture, firm, joint stock association, department, agency, authority, or other legal entity, whether for-profit, not-for-profit or governmental.

17. "Prescription and non-prescription drugs" means prescription drugs as defined in section two hundred seventy of this chapter, and non-prescription smoking cessation

⁷ See below in the bill.

products or devices.

18. "Resident" means an individual whose primary place of abode is in the state, without regard to the individual's immigration status, as determined according to regulations of the commissioner.

§ 5101. Program created. 1. The New York Health program is hereby created in the department. The commissioner shall establish and implement the program under this article. The program shall provide comprehensive health coverage to every resident who enrolls in the program.

2. The commissioner shall, to the maximum extent possible, organize, administer and market the program and services as a single program under the name "New York Health" or such other name as the commissioner shall determine, regardless of under which law or source the definition of a benefit is found including (on a voluntary basis) retiree health benefits.⁸ In implementing this article, the commissioner shall avoid jeopardizing federal financial participation in these programs and shall take care to promote public understanding and awareness of available benefits and programs.

3. The commissioner shall determine when individuals may begin enrolling in the program. There shall be an implementation period, which shall begin on the date that individuals may begin enrolling in the program and shall end as determined by the commissioner.

4. An insurer authorized to provide coverage pursuant to the insurance law or a health maintenance organization certified under this chapter may, if otherwise authorized, offer benefits that do not cover any service for which coverage is offered to individuals under the program, but may not offer benefits that cover any service for which coverage is offered to individuals under the program. Provided, however, that this subdivision shall not prohibit (a) the offering of any benefits to or for individuals, including their families, who are employed or self-employed in the state but who are not residents of the state, or (b) the offering of benefits during the implementation period to individuals who enrolled or may enroll as members of the program, or (c) the offering of retiree health benefits.

⁸ Retiree health benefits are covered by contracts and ERISA. §5102(8)(b) requires the board to develop further proposals for dealing with retiree benefits.

5. A college, university or other institution of higher education in the state may purchase coverage under the program for any student, or student's dependent, who is not a resident of the state.

6. To the extent any provision of this chapter, the social services law, the insurance law or the elder law:

(a) is inconsistent with any provision of this article or the legislative intent of the New York Health Act, this article shall apply and prevail, except where explicitly provided otherwise by this article; and

(b) is consistent with the provisions of this article and the legislative intent of the New York Health Act, the provision of that law shall apply.

7. The program shall be deemed to be a health care plan for purposes of utilization review and external appeal under article forty-nine of this chapter. An enrollee may designate a person or entity, including, but not limited to, a representative of the enrollee's care coordinator, a health care organization providing the service under review or appeal, or a labor union or Taft-Hartley fund of which such enrollee or enrollee's family member is a member to serve as the enrollee's designee for purposes of that article, if the person or entity agrees to be the designee.

8. (a) No member shall be required to receive any health care service through any entity organized, certified or operating under guidelines under article forty-four of this chapter, or specified under section three hundred sixty-four-j of the social services law, the insurance law or the elder law. No such entity shall receive payment for health care services (other than care coordination) from the program.

(b) However, this subdivision shall not preclude the use of a Medicare managed care ("Medicare advantage") entity or other entity created by or under the direction of the program where reasonably necessary to maximize federal financial participation or other federal financial support under any federally-matched public health program, Medicare or the Affordable Care Act. Any entity under this paragraph shall, to the maximum extent feasible, operate in the background, without burden on or interference with the member and health care provider, without depriving the member or health care provider of any right or benefit

under the program and otherwise consistent with this article.⁹

9. The program shall include provisions for an appropriate reserve fund.

10. (a) This subdivision applies to every person who is a retiree of a public employer, as defined in section two hundred one of the civil service law, and any person who is a beneficiary of the retiree's public employee retiree health benefit. Any reference to the retiree shall mean and include any beneficiary of the retiree. This subdivision does not create or increase any eligibility for any public employee retiree health benefit that would not otherwise exist and does not diminish any public employee retiree health benefit.

(b) This paragraph applies to the retiree while he or she is a resident of New York state. The retiree shall enroll in the program. If, by the implementation date, the retiree has not enrolled in the program, the appropriate public employee retirement system and the commissioner shall enroll the retiree in the New York Health program. If the retiree's public employee retiree health benefit includes any service for which coverage is not offered under the New York Health program, the retiree shall continue to receive that benefit from the public employee retirement program.

(c) For every retiree, while he or she is not a resident of New York state, the appropriate public employee retirement system shall maintain the retiree's public employee retiree health benefit as if this article had not been enacted.

§ 5102. Board of trustees. 1. The New York Health board of trustees is hereby created in the department. The board of trustees shall, at the request of the commissioner, consider any matter to effectuate the provisions and purposes of this article, and may advise the commissioner thereon; and it may, from time to time, submit to the commissioner any recommendations to effectuate the provisions and purposes of this article. The commissioner may propose regulations under this article and amendments thereto for consideration by the board. The board of trustees shall have no executive, administrative or appointive duties except as otherwise provided by law. The board of trustees shall have power to establish, and

⁹ This enables the program to use insurance- or managed care-like entities so the program can fit into some requirements of Medicaid or the ACA to continue to draw federal support. The entities would operate "in the background," so patients and health care providers would see no difference from the ordinary operation of New York Health.

from time to time, amend regulations to effectuate the provisions and purposes of this article, subject to approval by the commissioner.¹⁰

2. The board shall be composed of:

(a) the commissioner, the superintendent of financial services, and the director of the budget, or their designees, as ex officio members;

(b) twenty-six trustees appointed by the governor;

(i) six of whom shall be representatives of health care consumer advocacy organizations which have a statewide or regional constituency, who have been involved in issues of interest to low- and moderate-income individuals, older adults, and people with disabilities; at least three of whom shall represent organizations led by consumers in those groups;

(ii) two of whom shall be representatives of professional organizations representing physicians;

(iii) two of whom shall be representatives of professional organizations representing licensed or registered health care professionals other than physicians;

(iv) three of whom shall be representatives of general hospitals, one of whom shall be a representative of public general hospitals;

(v) one of whom shall be a representative of community health centers;

(vi) two of whom shall be representatives of rehabilitation or home care providers;

(vii) two of whom shall be representatives of behavioral or mental health or disability service providers;

(viii) two of whom shall be representatives of health care organizations;

(ix) two of whom shall be representatives of organized labor;

(x) two of whom shall have demonstrated expertise in health care finance; and

(xi) two of whom shall be employers or representatives of employers who pay the payroll tax under this article, or, prior to the tax becoming effective, will pay the tax;

(c) fourteen trustees appointed by the governor; five of whom to be appointed on the recommendation of the speaker of the assembly; five of whom to be appointed on the recommendation of the temporary president of the senate; two of whom to be appointed on

¹⁰ This subdivision is modeled largely on the Public Health and Health Planning Council.

the recommendation of the minority leader of the assembly; and two of whom to be appointed on the recommendation of the minority leader of the senate.

3. After the end of the implementation period, no person shall be a trustee unless he or she is a member of the program, except the ex officio trustees. Each trustee shall serve at the pleasure of the appointing officer, except the ex officio trustees.

4. The chair of the board shall be appointed, and may be removed as chair, by the governor from among the trustees. The board shall meet at least four times each calendar year. Meetings shall be held upon the call of the chair and as provided by the board. A majority of the appointed trustees shall be a quorum of the board, and the affirmative vote of a majority of the trustees voting, but not less than ten, shall be necessary for any action to be taken by the board. The board may establish an executive committee to exercise any powers or duties of the board as it may provide, and other committees to assist the board or the executive committee. The chair of the board shall chair the executive committee and shall appoint the chair and members of all other committees. The board of trustees may appoint one or more advisory committees. Members of advisory committees need not be members of the board of trustees.

5. Trustees shall serve without compensation but shall be reimbursed for their necessary and actual expenses incurred while engaged in the business of the board.

6. Notwithstanding any provision of law to the contrary, no officer or employee of the state or any local government shall forfeit or be deemed to have forfeited his or her office or employment by reason of being a trustee.

7. The board and its committees and advisory committees may request and receive the assistance of the department and any other state or local governmental entity in exercising its powers and duties.

8. No later than two years after the effective date of this article:

(a) The board shall develop proposals for: (i) incorporating retiree health benefits into New York Health; (ii) accommodating employer retiree health benefits for people who have been members of New York Health but live as retirees out of the state; and (iii) accommodating employer retiree health benefits for people who earned or accrued such benefits while residing in the state prior to the implementation of New York Health and live

as retirees out of the state. The board shall present its proposals to the governor and the legislature.

(b) The board shall develop a proposal for New York Health coverage of health care services covered under the workers' compensation law, including whether and how to continue funding for those services under that law and whether and how to incorporate an element of experience rating.

§ 5103. Eligibility and enrollment. 1. Every resident of the state shall be eligible and entitled to enroll as a member under the program.

2. No individual shall be required to pay any premium or other charge for enrolling in or being a member under the program.

3. A newborn child shall be enrolled as of the date of the child's birth if enrollment is done prior to the child's birth or within sixty days after the child's birth.

§ 5104. Benefits. 1. The program shall provide comprehensive health coverage to every member, which shall include all health care services required to be covered under any of the following, without regard to whether the member would otherwise be eligible for or covered by the program or source referred to:

(a) child health plus;

(b) Medicaid;

(c) Medicare;

(d) article forty-four of this chapter or article thirty-two or forty-three of the insurance law;

(e) article eleven of the civil service law, as of the date one year before the beginning of the implementation period;

(f) any cost incurred defined in paragraph one of subsection (a) of section fifty-one hundred two of the insurance law, provided that this coverage shall not replace coverage under article fifty-one of the insurance law;

(g) any additional health care service authorized to be added to the program's benefits by the program; and

(h) provided that where any state law or regulation related to any federally-matched public health program states that a benefit is contingent on federal financial participation, or words to that effect, the benefit shall be included under the New York Health program without

regard to federal financial participation.¹¹

2. No member shall be required to pay any premium, deductible, co-payment or co-insurance under the program.

3. The program shall provide for payment under the program for:

(a) emergency and temporary health care services provided to a member or individual entitled to become a member who has not had a reasonable opportunity to become a member or to enroll with a care coordinator; and

(b) health care services provided in an emergency to an individual who is entitled to become a member or enrolled with a care coordinator, regardless of having had an opportunity to do so.

§ 5105. Health care providers; care coordination; payment methodologies. 1. Choice of health care provider. (a) Any health care provider qualified to participate under this section may provide health care services under the program, provided that the health care provider is otherwise legally authorized to perform the health care service for the individual and under the circumstances involved.

(b) A member may choose to receive health care services under the program from any participating provider, consistent with provisions of this article relating to care coordination and health care organizations, the willingness or availability of the provider (subject to provisions of this article relating to discrimination), and the appropriate clinically-relevant circumstances.

2. Care coordination. (a) A care coordinator may be an individual or entity that is approved by the program that is:

(i) a health care practitioner who is: (A) the member's primary care practitioner; (B) at the option of a female member, the member's provider of primary gynecological care; or (C) at the option of a member who has a chronic condition that requires specialty care, a specialist health care practitioner who regularly and continually provides treatment for that condition to

¹¹ Many provisions of NY's Medicaid and other laws say they only apply if there is "federal financial participation" (i.e., if it would qualify for federal matching funds). But under NY Health, services covered by Medicaid would be covered for all New Yorkers, even though they might not be federally Medicaid eligible. This language makes sure these benefits would be fully available.

the member;

(ii) an entity licensed under article twenty-eight of this chapter or certified under article thirty-six of this chapter, or, with respect to a member who receives chronic mental health care services, an entity licensed under article thirty-one of the mental hygiene law or other entity approved by the commissioner in consultation with the commissioner of mental health;

(iii) a health care organization;

(iv) a Taft-Hartley fund or labor union, with respect to its members and their family members; provided that this provision shall not preclude a Taft-Hartley fund or labor union from becoming a care coordinator under subparagraph (v) of this paragraph or a health care organization under section fifty-one hundred six of this article; or

(v) any not-for-profit or governmental entity approved by the program.

(b)(i) Every member shall enroll with a care coordinator that agrees to provide care coordination to the member prior to receiving health care services to be paid for under the program. Health care services provided to a member shall not be subject to payment under the program unless the member is enrolled with a care coordinator at the time the health care service is provided.

(ii) This paragraph shall not apply to health care services provided under subdivision three of section fifty-one hundred four of this article.

(iii) The member shall remain enrolled with that care coordinator until the member becomes enrolled with a different care coordinator or ceases to be a member. Members have the right to change their care coordinator on terms at least as permissive as the provisions of section three hundred sixty-four-j of the social services law relating to an individual changing his or her primary care provider or managed care provider.

(c) Care coordination shall be provided to the member by the member's care coordinator. A care coordinator may employ or utilize the services of other individuals or entities to assist in providing care coordination for the member, consistent with regulations of the commissioner.

(d) A health care organization may establish rules relating to care coordination for members in the health care organization, different from this subdivision but otherwise consistent with this article and other applicable laws.

(e) The commissioner shall develop and implement procedures and standards for an individual or entity to be approved to be a care coordinator in the program, including but not limited to procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the individual or entity is not competent to be a care coordinator or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety. Such procedures and standards shall not limit approval to be a care coordinator in the program for economic purposes and shall be consistent with good professional practice. In developing the procedures and standards, the commissioner shall: (i) consider existing standards developed by national accrediting and professional organizations; and (ii) consult with national and local organizations working on care coordination or similar models, including health care practitioners, hospitals, clinics, and consumers and their representatives. When developing and implementing standards of approval of care coordinators for individuals receiving chronic mental health care services, the commissioner shall consult with the commissioner of mental health. An individual or entity may not be a care coordinator unless the services included in care coordination are within the individual's professional scope of practice or the entity's legal authority.

(f) To maintain approval under the program, a care coordinator must: (i) renew its status at a frequency determined by the commissioner; and (ii) provide data to the department as required by the commissioner to enable the commissioner to evaluate the impact of care coordinators on quality, outcomes and cost.

(g) Nothing in this subdivision shall authorize any individual to engage in any act in violation of title eight of the education law.

3. Health care providers. (a) The commissioner shall establish and maintain procedures and standards for health care providers to be qualified to participate in the program, including but not limited to procedures and standards relating to the revocation, suspension, limitation, or annulment of qualification to participate on a determination that the health care provider is not competent to be a provider of specific health care services or has exhibited a course of conduct which is either inconsistent with program standards and regulations or

which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety. Such procedures and standards shall not limit health care provider participation in the program for economic purposes and shall be consistent with good professional practice. Such procedures and standards may be different for different types of health care providers and health care professionals. Any health care provider who is qualified to participate under Medicaid, child health plus or Medicare shall be deemed to be qualified to participate in the program, and any health care provider's revocation, suspension, limitation, or annulment of qualification to participate in any of those programs shall apply to the health care provider's qualification to participate in the program; provided that a health care provider qualified under this sentence shall follow the procedures to become qualified under the program by the end of the implementation period.

(b) The commissioner shall establish and maintain procedures and standards for recognizing health care providers located out of the state for purposes of providing coverage under the program for out-of-state health care services.

(c) Procedures and standards under this subdivision shall include provisions for expedited temporary qualification to participate in the program for health care professionals who are (i) temporarily authorized to practice in the state or (ii) are recently arrived in the state or recently authorized to practice in the state.

4. Payment for health care services. (a) The commissioner may establish by regulation payment methodologies for health care services and care coordination provided to members under the program by participating providers, care coordinators, and health care organizations. There may be a variety of different payment methodologies, including those established on a demonstration basis. All payment rates under the program shall be reasonable and reasonably related to the cost of efficiently providing the health care service and assuring an adequate and accessible supply of the health care service. Until and unless another payment methodology is established, health care services provided to members under the program shall be paid for on a fee-for-service basis, except for care coordination.

(b) The program shall engage in good faith negotiations with health care providers' representatives under title III of article forty-nine of this chapter, including, but not limited to, in relation to rates of payment and payment methodologies.

(c) Notwithstanding any provision of law to the contrary, payment for drugs provided by pharmacies under the program shall be made pursuant to title one of article two-A of this chapter. However, the program shall provide for payment for prescription drugs under section 340B of the federal public service act where applicable. Payment for prescription drugs provided by health care providers other than pharmacies shall be pursuant to other provisions of this article.

(d) Payment for health care services established under this article shall be considered payment in full. A participating provider shall not charge any rate in excess of the payment established under this article for any health care service provided under the program and shall not solicit or accept payment from any member or third party for any such service except as provided under section fifty-one hundred nine of this article. However, this paragraph shall not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payer where permitted under section fifty-one hundred nine of this article.

(e) The program may provide in payment methodologies for payment for capital related expenses for specifically identified capital expenditures incurred by not-for-profit or governmental entities certified under article twenty-eight of this chapter. Any capital related expense generated by a capital expenditure that requires or required approval under article twenty-eight of this chapter must have received that approval for the capital related expense to be paid for under the program.

(f) Payment methodologies and rates shall include a distinct component of reimbursement for direct and indirect graduate medical education as defined, calculated and implemented pursuant to section twenty-eight hundred seven-c of this chapter.

(g) The commissioner shall provide by regulation for payment methodologies and procedures for paying for out-of-state health care services.

5. Prior authorization. The program shall not require prior authorization for any health care service in any manner more restrictive of access to or payment for the service than would be required for the service under Medicare Part A or Part B. Prior authorization for prescription drugs provided by pharmacies under the program shall be under title one of article two-A of this chapter.

§ 5106. Health care organizations. 1. A member may choose to enroll with and receive health care services under the program from a health care organization.

2. A health care organization shall be a not-for-profit or governmental entity that is approved by the commissioner that is:

(a) an accountable care organization under article twenty-nine-E of this chapter; or
(b) a Taft-Hartley fund (i) with respect to its members and their family members, and (ii) if allowed by applicable law and approved by the commissioner, for other members of the program.

3. A health care organization may be responsible for providing all or part of the health care services to which its members are entitled under the program, consistent with the terms of its approval by the commissioner.

4. (a) The commissioner shall develop and implement procedures and standards for an entity to be approved to be a health care organization in the program, including but not limited to procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the entity is not competent to be a health care organization or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety. Such procedures and standards shall not limit approval to be a health care organization in the program for economic purposes and shall be consistent with good professional practice. In developing the procedures and standards, the commissioner shall: (i) consider existing standards developed by national accrediting and professional organizations; and (ii) consult with national and local organizations working in the field of health care organizations, including health care practitioners, hospitals, clinics, long-term supports and service providers, consumers and their representatives and labor organizations representing health care workers. When developing and implementing standards of approval of health care organizations, the commissioner shall consult with the commissioner of mental health, the commissioner of developmental disabilities, the director of the state office for the aging and the commissioner of the office of alcoholism and substance abuse services.

(b) To maintain approval under the program, a health care organization must: (i) renew its

status at a frequency determined by the commissioner; and (ii) provide data to the department as required by the commissioner to enable the commissioner to evaluate the health care organization in relation to quality of health care services, health care outcomes, and cost.

5. The commissioner shall make regulations relating to health care organizations consistent with and to ensure compliance with this article.

6. The provision of health care services directly or indirectly by a health care organization through health care providers shall not be considered the practice of a profession under title eight of the education law by the health care organization.

§ 5107. Program standards. 1. The commissioner shall establish requirements and standards for the program and for health care organizations, care coordinators, and health care providers, consistent with this article, including requirements and standards for, as applicable:

(a) the scope, quality and accessibility of health care services;
(b) relations between health care organizations or health care providers and members; and
(c) relations between health care organizations and health care providers, including (i) credentialing and participation in the health care organization; and (ii) terms, methods and rates of payment.

2. Requirements and standards under the program shall include, but not be limited to, provisions to promote the following:

(a) simplification, transparency, uniformity, and fairness in health care provider credentialing and participation in health care organization networks, referrals, payment procedures and rates, claims processing, and approval of health care services, as applicable;

(b) primary and preventive care, care coordination, efficient and effective health care services, quality assurance, coordination and integration of health care services, including use of appropriate technology, and promotion of public, environmental and occupational health;

(c) elimination of health care disparities;

(d) non-discrimination with respect to members and health care providers on the basis of race, ethnicity, national origin, religion, disability, age, sex, sexual orientation, gender identity or expression, or economic circumstances; provided that health care services

provided under the program shall be appropriate to the patient's clinically-relevant circumstances;

(e) accessibility of care coordination, health care organization services and health care services, including accessibility for people with disabilities and people with limited ability to speak or understand English, and the providing of care coordination, health care organization services and health care services in a culturally competent manner; and

(f) especially in relation to long-term supports and services, the maximization and prioritization of the most integrated community-based supports and services.

3. Any participating provider or care coordinator that is organized as a for-profit entity (other than a professional practice of one or more health care professionals) shall be required to meet the same requirements and standards as entities organized as not-for-profit entities, and payments under the program paid to such entities shall not be calculated to accommodate the generation of profit or revenue for dividends or other return on investment or the payment of taxes that would not be paid by a not-for-profit entity.

4. Every participating provider shall furnish to the program such information to, and permit examination of its records by, the program, as may be reasonably required for purposes of reviewing accessibility and utilization of health care services, quality assurance, promoting improved patient outcomes and cost containment, the making of payments, and statistical or other studies of the operation of the program or for protection and promotion of public, environmental and occupational health.

5. In developing requirements and standards and making other policy determinations under this article, the commissioner shall consult with representatives of members, health care providers, care coordinators, health care organizations employers, organized labor including representatives of health care workers, and other interested parties.

6. The program shall maintain the security and confidentiality of all data and other information collected under the program when such data would be normally considered confidential patient data. Aggregate data of the program which is derived from confidential data but does not violate patient confidentiality shall be public information including for purposes of article six of the public officers law.

§ 5108. Regulations. The commissioner may make regulations under this article by

approving regulations and amendments thereto, under subdivision one of section fifty-one hundred two of this article. The commissioner may make regulations or amendments thereto under this article on an emergency basis under section two hundred two of the state administrative procedure act, provided that such regulations or amendments shall not become permanent unless adopted under subdivision one of section fifty-one hundred two of this article.

§ 5109. Provisions relating to federal health programs. 1. The commissioner shall seek all federal waivers and other federal approvals and arrangements and submit state plan amendments necessary to operate the program consistent with this article to the maximum extent possible.

2. (a) The commissioner shall apply to the secretary of health and human services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally-matched public health program, the affordable care act, and any other federal programs that provide federal funds for payment for health care services, that are necessary to enable all New York Health members to receive all benefits under the program through the program to enable the state to implement this article and to receive and deposit all federal payments under those programs (including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits) in the state treasury to the credit of the New York Health trust fund and to use those funds for the New York Health program and other provisions under this article. To the extent possible, the commissioner shall negotiate arrangements with the federal government in which bulk or lump-sum federal payments are paid to New York Health in place of federal spending or tax benefits for federally-matched health programs or federal health programs. The commissioner shall take actions under paragraph (b) of subdivision eight of section fifty-one hundred one of this article as reasonably necessary.

(b) The commissioner may require members or applicants to be members to provide information necessary for the program to comply with any waiver or arrangement under this subdivision.

3. (a) The commissioner may take actions consistent with this article to enable New York Health to administer Medicare in New York state, to create a Medicare managed care plan

("Medicare Advantage") that would operate consistent with this article, and to be a provider of drug coverage under Medicare part D for eligible members of New York Health.

(b) The commissioner may waive or modify the applicability of provisions of this section relating to any federally-matched public health program or Medicare as necessary to implement any waiver or arrangement under this section or to maximize the benefit to the New York Health program under this section, provided that the commissioner, in consultation with the director of the budget, shall determine that such waiver or modification is in the best interests of the members affected by the action and the state.

(c) The commissioner may apply for coverage under any federally-matched public health program on behalf of any member and enroll the member in the federally-matched public health program or Medicare if the member is eligible for it. Enrollment in a federally-matched public health program or Medicare shall not cause any member to lose any health care service provided by the program or diminish any right the member would otherwise have.

(d) The commissioner shall by regulation increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally-matched public health program, and for any program to reduce or eliminate an individual's coinsurance, cost-sharing or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the affordable care act notwithstanding any law or regulation to the contrary. The commissioner may act under this paragraph upon a finding, approved by the director of the budget, that the action (i) will help to increase the number of members who are eligible for and enrolled in federally-matched public health programs, or for any program to reduce or eliminate an individual's coinsurance, cost-sharing or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the affordable care act; (ii) will not diminish any individual's access to any health care service, benefit or right the individual would otherwise have; (iii) is in the interest of the program; and (iv) does not require or has received any necessary federal waivers or approvals to ensure federal financial participation.

(e) To enable the commissioner to apply for coverage or financial support under any

federally-matched public health program, the Affordable Care Act, or Medicare on behalf of any member and enroll the member in any such program, including an entity under paragraph (b) of subdivision eight of section fifty-one hundred one of this article if the member is eligible for it, the commissioner may require that every member or applicant to be a member shall provide information to enable the commissioner to determine whether the applicant is eligible for such program. The program shall make a reasonable effort to notify members of their obligations under this paragraph. After a reasonable effort has been made to contact the member, the member shall be notified in writing that he or she has sixty days to provide such required information. If such information is not provided within the sixty day period, the member's coverage under the program may be terminated.

(f) To the extent necessary for purposes of this section, as a condition of continued eligibility for health care services under the program, a member who is eligible for benefits under Medicare shall enroll in Medicare, including parts A, B and D.

(g) The program shall provide premium assistance for all members enrolling in a Medicare part D drug coverage under section 1860D of Title XVIII of the federal social security act limited to the low-income benchmark premium amount established by the federal centers for Medicare and Medicaid services and any other amount which such agency establishes under its de minimis premium policy, except that such payments made on behalf of members enrolled in a Medicare advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to the program.

(h) If the commissioner has reasonable grounds to believe that a member could be eligible for an income-related subsidy under section 1860D-14 of Title XVIII of the federal social security act, the member shall provide, and authorize the program to obtain, any information or documentation required to establish the member's eligibility for such subsidy, provided that the commissioner shall attempt to obtain as much of the information and documentation as possible from records that are available to him or her.

(i) The program shall make a reasonable effort to notify members of their obligations under this subdivision. After a reasonable effort has been made to contact the member, the member shall be notified in writing that he or she has sixty days to provide such required information. If such information is not provided within the sixty day period, the member's

coverage under the program may be terminated.

§ 5110. Additional provisions. 1. The commissioner shall contract with not-for-profit organizations to provide:

(a) consumer assistance to individuals with respect to selection and changing selection of a care coordinator or health care organization, enrolling, obtaining health care services, and other matters relating to the program;

(b) health care provider assistance to health care providers providing and seeking or considering whether to provide, health care services under the program, with respect to participating in a health care organization and dealing with a health care organization; and

(c) care coordinator assistance to individuals and entities providing and seeking or considering whether to provide, care coordination to members.

2. The commissioner shall provide grants from funds in the New York Health trust fund or otherwise appropriated for this purpose, to health systems agencies under section twenty-nine hundred four-b of this chapter to support the operation of such health systems agencies.

3. Retraining and re-employment of impacted employees. (a) As used in this subdivision:

(i) "Third party payer" means an insurer authorized to provide health coverage under the insurance law, a health maintenance organization under article forty-four of this chapter, a self-insured plan providing health coverage, or any other third party payer for health care services.

(ii) "Health care provider administrative employee" means an employee of a health care provider primarily engaged in relations or dealings with third party payers or seeking payment or reimbursement for health care services from third party payers.

(iii) "Impacted employee" means an individual who, at any time from the date this section becomes a law until two years after the end of the implementation period, is employed by a third party payer or is a health care provider administrative employee, and whose employment ends as a result of the implementation of the New York Health program.

(b) Within ninety days after this section shall become a law, the commissioner of labor shall convene a retraining and re-employment task force including but not limited to: representatives of potential impacted employees, human resource departments of third party payers and health care providers, individuals with experience and expertise in retraining and

re-employment programs relevant to the circumstances of impacted employees, and representatives of the commissioner of labor. The commissioner of labor and the task force shall review and provide:

(i) analysis of potential impacted employees by job title and geography;

(ii) competency mapping and labor market analysis of impacted employee occupations with job openings; and

(iii) establishment of regional retraining and re-employment systems, including but not limited to job boards, outplacement services, job search services, career advisement services, and retraining advisement, to be coordinated with the regional advisory councils established under section fifty-one hundred eleven of this article.

(c) (i) Three or more impacted employees, a recognized union of workers including impacted employees, or an employer of impacted employees may file a petition with the commissioner of labor to certify such employees as being impacted employees.

(ii) Impacted employees shall be eligible for:

(A) up to two years of retraining at any training provider approved by the commissioner of labor; and

(B) up to two years of unemployment benefits, provided that the impacted employee is enrolled in a department of labor approved training program, is actively seeking employment, and is not currently employed full time; provided, however, that such impacted employee may maintain unemployment benefits for up to two years even if he or she does not meet the criteria set forth in this clause but is sixty-three years of age or older at the time of loss of employment as an impacted employee.

(d) The commissioner shall provide funds from the New York Health trust fund or otherwise appropriated for this purpose to the commissioner of labor for retraining and re-employment programs for impacted employees under this subdivision.

(e) The commissioner of labor shall make regulations and take other actions reasonably necessary to implement this subdivision. This subdivision shall be implemented consistent with applicable law and regulations.

4. The commissioner shall, directly and through grants to not-for-profit entities, conduct programs using data collected through the New York Health program, to promote and protect

the quality of health care services, patient outcomes, and public, environmental and occupational health, including cooperation with other data collection and research programs of the department, consistent with this article, the protection of the security and confidentiality of individually identifiable patient information, and otherwise applicable law.

§ 5111. Regional advisory councils. 1. The New York Health regional advisory councils (each referred to in this article as a "regional advisory council") are hereby created in the department.

2. There shall be a regional advisory council established in each of the following regions:

(a) Long Island, consisting of Nassau and Suffolk counties;

(b) New York City;

(c) Hudson Valley, consisting of Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester counties;

(d) Northern, consisting of Albany, Clinton, Columbia, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, St. Lawrence, Warren, Washington counties;

(e) Central, consisting of Broome, Cayuga, Chemung, Chenango, Cortland, Livingston, Madison, Monroe, Oneida, Onondaga, Ontario, Oswego, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Yates counties; and

(f) Western, consisting of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming counties.

3. Each regional advisory council shall be composed of not fewer than twenty-seven members, as determined by the commissioner and the board, as necessary to appropriately represent the diverse needs and concerns of the region. Members of a regional advisory council shall be residents of or have their principal place of business in the region served by the regional advisory council.

4. Appointment of members of the regional advisory councils.

(a) The twenty-seven members shall be appointed as follows:

(i) nine members shall be appointed by the governor;

(ii) six members shall be appointed by the governor on the recommendation of the speaker of the assembly;

(iii) six members shall be appointed by the governor on the recommendation of the temporary president of the senate;

(iv) three members shall be appointed by the governor on the recommendation of the minority leader of the assembly; and

(v) three members shall be appointed by the governor on the recommendation of the minority leader of the senate.

Where a regional advisory council has more than twenty-seven members, additional members shall be appointed and recommended by these officials in the same proportion as the twenty-seven members.

(b) Regional advisory council membership shall include but not be limited to:

(i) representatives of organizations with a regional constituency that advocate for health care consumers, older adults, and people with disabilities including organizations led by members of those groups, who shall constitute at least one third of the membership of each regional council;

(ii) representatives of professional organizations representing physicians;

(iii) representatives of professional organizations representing health care professionals other than physicians;

(iv) representatives of general hospitals, including public hospitals;

(v) representatives of community health centers;

(vi) representatives of mental health, behavioral health (including substance use), physical disability, developmental disability, rehabilitation, home care and other service providers;

(vii) representatives of women's health service providers;

(viii) representatives of health care organizations;

(ix) representatives of organized labor including representatives of health care workers;

(x) representatives of employers; and

(xi) representatives of municipal and county government.

5. Members of a regional advisory council shall be appointed for terms of three years provided, however, that of the members first appointed, one-third shall be appointed for one year terms and one-third shall be appointed for two year terms. Vacancies shall be filled in the same manner as original appointments for the remainder of any unexpired term. No

person shall be a member of a regional advisory council for more than six years in any period of twelve consecutive years.

6. Members of the regional advisory councils shall serve without compensation but shall be reimbursed for their necessary and actual expenses incurred while engaged in the business of the advisory councils. The program shall provide financial support for such expenses and other expenses of the regional advisory councils.

7. Each regional advisory council shall meet at least quarterly. Each regional advisory council may form committees to assist it in its work. Members of a committee need not be members of the regional advisory council. The New York City regional advisory council shall form a committee for each borough of New York City, to assist the regional advisory council in its work as it relates particularly to that borough.

8. Each regional advisory council shall advise the commissioner, the board, the governor and the legislature on all matters relating to the development and implementation of the New York Health program.

9. Each regional advisory council shall adopt, and from time to time revise, a community health improvement plan for its region for the purpose of:

(a) promoting the delivery of health care services in the region, improving the quality and accessibility of care, including cultural competency, clinical integration of care between service providers including but not limited to physical, mental, and behavioral health, physical and developmental disability services, and long-term supports and services;

(b) facility and health services planning in the region;

(c) identifying gaps in regional health care services;

(d) promoting increased public knowledge and responsibility regarding the availability and appropriate utilization of health care services. Each community health improvement plan shall be submitted to the commissioner and the board and shall be posted on the department's website;

(e) identifying needs in professional and service personnel required to deliver health care services; and

(f) coordinating regional implementation of retraining and re-employment programs for impacted employees under subdivision three of section fifty-one hundred ten of this article.

10. Each regional advisory council shall hold at least four public hearings annually on matters relating to the New York Health program and the development and implementation of the community health improvement plan.

11. Each regional advisory council shall publish an annual report to the commissioner and the board on the progress of the community health improvement plan. These reports shall be posted on the department's website.

12. All meetings of the regional advisory councils and committees shall be subject to article six of the public officers law.

§ 4. Financing of New York Health. 1. The governor shall submit to the legislature a revenue plan and legislative bills to implement the plan (referred to collectively in this section as the "revenue proposal") to provide the revenue necessary to finance the New York Health program, as created by article 51 of the public health law and all provisions of that article (referred to in this section as the "program"), taking into consideration anticipated federal revenue available for the program. The revenue proposal shall be submitted to the legislature as part of the executive budget under article VII of the state constitution, for the fiscal year commencing on the first day of April in the calendar year after this act shall become a law. In developing the revenue proposal, the governor shall consult with appropriate officials of the executive branch; the temporary president of the senate; the speaker of the assembly; the chairs of the fiscal and health committees of the senate and assembly; and representatives of business, labor, consumers and local government.

2. (a) Basic structure. The basic structure of the revenue proposal shall be as follows: Revenue for the program shall come from two taxes (referred to collectively in this section as the "taxes"). First, there shall be a progressively graduated tax on all payroll and self-employed income (referred to in this section as the "payroll tax"), paid by employers, employees and self-employed individuals. Second, there shall be a progressively graduated tax on taxable income (such as interest, dividends, and capital gains) not subject to the payroll tax (referred to in this section as the "non-payroll tax"). Income in the bracket below twenty-five thousand dollars per year shall be exempt from the taxes. Higher brackets of income subject to the taxes shall be assessed at a higher marginal rate than lower brackets. The taxes shall be set at levels anticipated to produce sufficient revenue to finance the

program, to be scaled up as enrollment grows, taking into consideration anticipated federal revenue available for the program. Provision shall be made for state residents (who are eligible for the program) who are employed out-of-state, and non-residents (who are not eligible for the program) who are employed in the state.

(b) Payroll tax. The income to be subject to the payroll tax shall be all income subject to the Medicare Part A tax. The tax shall be set at a percentage of that income, which shall be progressively graduated, so the percentage is higher on higher brackets of income. For employed individuals, the employer shall pay eighty percent of the tax and the employee shall pay twenty percent of the tax, except that an employer may agree to pay all or part of the employee's share. A self-employed individual shall pay the full tax.

(c) Non-payroll income tax. There shall be a tax on income that is subject to the personal income tax under article 22 of the tax law and is not subject to the payroll tax. It shall be set at a percentage of that income, which shall be progressively graduated, so the percentage is higher on higher brackets of income.

(d) Phased-in rates. Early in the program, when enrollment is growing, the amount of the taxes shall be at an appropriate level, and shall be changed as anticipated enrollment grows, to cover the actual cost of the program. The revenue proposal shall include a mechanism for determining the rates of the taxes.

(e) Cross-border employees. (i) State residents employed out-of-state. If an individual is employed out-of-state by an employer that is subject to New York state law, the employer and employee shall be required to pay the payroll tax as to that employee as if the employment were in the state. If an individual is employed out-of-state by an employer that is not subject to New York state law, either (A) the employer and employee shall voluntarily comply with the tax or (B) the employee shall pay the tax as if he or she were self-employed.

(ii) Out-of-state residents employed in the state. (A) The payroll tax shall apply to any out-of-state resident who is employed or self-employed in the state. (B) In the case of an out-of-state resident who is employed or self-employed in the state, such individual and individual's employer shall be able to take a credit against the payroll taxes each would otherwise pay as to that individual for amounts they spend respectively on health benefits for the individual that would otherwise be covered by the program if the individual were a member of the

program. For the employer, the credit shall be available regardless of the form of the health benefit (e.g., health insurance, a self-insured plan, direct services, or reimbursement for services), to make sure that the revenue proposal does not relate to employment benefits in violation of the federal ERISA. For non-employment-based spending by the individual, the credit shall be available for and limited to spending for health coverage (not out-of-pocket health spending). The credit shall be available without regard to how little is spent or how sparse the benefit. The credit may only be taken against the payroll tax. Any excess amount may not be applied to other tax liability. The credit shall be distributed between the employer and employee in the same proportion as the spending by each for the benefit and may be applied to their respective portion of the tax. (C) If any provision of this subparagraph or any application of it shall be ruled to violate federal ERISA, the provision or the application of it shall be null and void and the ruling shall not affect any other provision or application of this section or the act that enacted it.

3. (a) The revenue proposal shall include a plan and legislative provisions for ending the requirement for local social services districts to pay part of the cost of Medicaid and replacing those payments with revenue from the taxes under the revenue proposal.

(b) The taxes under this section shall not supplant the spending of other state revenue to pay for the Medicaid program as it exists as of the enactment of the revenue proposal as amended, unless the revenue proposal as amended provides otherwise.

4. To the extent that the revenue proposal differs from the terms of subdivision two or paragraph (b) of subdivision three of this section, the revenue proposal shall state how it differs from those terms and reasons for and the effects of the differences.

5. All revenue from the taxes shall be deposited in the New York Health trust fund account under section 89-j of the state finance law.

§ 5. Article 49 of the public health law is amended by adding a new title 3 to read as follows:

TITLE III

COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH

NEW YORK HEALTH

Section 4920. Definitions.

4921. Collective negotiation authorized.

4922. Collective negotiation requirements.

4923. Requirements for health care providers' representative.

4924. Mediation.

4925. Certain collective action prohibited.

4926. Fees.

4927. Confidentiality.

4928. Severability and construction.

§ 4920. Definitions. For purposes of this title:

1. "New York Health" means the program under article fifty-one of this chapter.

2. "Person" means an individual, association, corporation, or any other legal entity.

3. "Health care providers' representative" means a third party that is authorized by health care providers to negotiate on their behalf with New York Health over terms and conditions affecting those health care providers.

4. "Strike" means a work stoppage in part or in whole, direct or indirect, by a body of workers to gain compliance with demands made on an employer.

5. "Health care provider" means a health care provider under article fifty-one of this chapter. A health care professional as defined in article fifty-one of this chapter who practices as an employee or independent contractor of another health care provider shall not be deemed a health care provider for purposes of this title.

§ 4921. Collective negotiation authorized. 1. Health care providers may meet and communicate for the purpose of collectively negotiating with New York Health on any matter relating to New York Health, including but not limited to rates of payment and payment methodologies.

2. Nothing in this section shall be construed to allow or authorize an alteration of the terms of the internal and external review procedures set forth in law.

3. Nothing in this section shall be construed to allow a strike of New York Health by health care providers.

4. Nothing in this section shall be construed to allow or authorize terms or conditions which would impede the ability of New York Health to obtain or retain accreditation by the

national committee for quality assurance or a similar body or to comply with applicable state or federal law.

§ 4922. Collective negotiation requirements. 1. Collective negotiation rights granted by this title must conform to the following requirements:

(a) health care providers may communicate with other health care providers regarding the terms and conditions to be negotiated with New York Health;

(b) health care providers may communicate with health care providers' representatives;

(c) a health care providers' representative is the only party authorized to negotiate with New York Health on behalf of the health care providers as a group;

(d) a health care provider can be bound by the terms and conditions negotiated by the health care providers' representatives; and

(e) in communicating or negotiating with the health care providers' representative, New York Health is entitled to offer and provide different terms and conditions to individual competing health care providers.

2. Nothing in this title shall affect or limit the right of a health care provider or group of health care providers to collectively petition a government entity for a change in a law, rule, or regulation.

3. Nothing in this title shall affect or limit collective action or collective bargaining on the part of any health care provider with his or her employer or any other lawful collective action or collective bargaining.

§ 4923. Requirements for health care providers' representative. Before engaging in collective negotiations with New York Health on behalf of health care providers, a health care providers' representative shall file with the commissioner, in the manner prescribed by the commissioner, information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance with this title.

§ 4924. Mediation. 1. In the event the commissioner determines that an impasse exists in the negotiations, the commissioner shall render assistance as follows:

(a) to assist the parties to effect a voluntary resolution of the negotiations, the commissioner shall appoint a mediator who is mutually acceptable to both the health care providers' representative and the representative of New York Health. If the mediator is

successful in resolving the impasse, then the health care providers' representative shall proceed as set forth in this article;

(b) if an impasse continues, the commissioner shall appoint a fact-finding board of not more than three members, who are mutually acceptable to both the health care providers' representative and the representative of New York Health. The fact-finding board shall have, in addition to the powers delegated to it by the board, the power to make recommendations for the resolution of the dispute;

(c) the fact-finding board, acting by a majority of its members, shall transmit its findings of fact and recommendations for resolution of the dispute to the commissioner, and may thereafter assist the parties to effect a voluntary resolution of the dispute. The fact-finding board shall also share its findings of fact and recommendations with the health care providers' representative and the representative of New York Health. If within twenty days after the submission of the findings of fact and recommendations, the impasse continues, the commissioner shall order a resolution to the negotiations based upon the findings of fact and recommendations submitted by the fact-finding board.

§ 4925. Certain collective action prohibited. 1. This title is not intended to authorize competing health care providers to act in concert in response to a health care providers' representative's discussions or negotiations with New York Health except as authorized by other law.

2. No health care providers' representative shall negotiate any agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care provider or group of health care providers with respect to the performance of services that are within the health care provider's lawful scope or terms of practice, license, registration, or certificate.

§ 4926. Fees. Each person who acts as the representative of negotiating parties under this title shall pay to the department a fee to act as a representative. The commissioner, by regulation, shall set fees in amounts deemed reasonable and necessary to cover the costs incurred by the department in administering this title.

§ 4927. Confidentiality. All reports and other information required to be reported to the department under this title shall not be subject to disclosure under article six of the public

officers law.

§ 4928. Severability and construction. If any provision or application of this title shall be held to be invalid, or to violate or be inconsistent with any applicable federal law or regulation, that shall not affect other provisions or applications of this title which can be given effect without that provision or application; and to that end, the provisions and applications of this title are severable. The provisions of this title shall be liberally construed to give effect to the purposes thereof.

§ 6. Subdivision 11 of section 270 of the public health law, as amended by section 2-a of part C of chapter 58 of the laws of 2008, is amended to read as follows:

11. "State public health plan" means the medical assistance program established by title eleven of article five of the social services law (referred to in this article as "Medicaid"), the elderly pharmaceutical insurance coverage program established by title three of article two of the elder law (referred to in this article as "EPIC"), and the ~~[family health plus program established by section three hundred sixty-nine-ee of the social services law to the extent that section provides that the program shall be subject to this article]~~ New York Health program established by article fifty-one of this chapter.

§ 7. The state finance law is amended by adding a new section 89-j to read as follows:

§ 89-j. New York Health trust fund. 1. There is hereby established in the joint custody of the state comptroller and the commissioner of taxation and finance a special revenue fund to be known as the "New York Health trust fund", referred to in this section as "the fund". The definitions in section fifty-one hundred of the public health law shall apply to this section.

2. The fund shall consist of:

(a) all monies obtained from taxes pursuant to legislation enacted as proposed under section three of the New York Health act;

(b) federal payments received as a result of any waiver or other arrangements agreed to by the United States secretary of health and human services or other appropriate federal officials for health care programs established under Medicare, any federally-matched public health program, or the affordable care act;

(c) the amounts paid by the department of health that are equivalent to those amounts that are paid on behalf of residents of this state under Medicare, any federally-matched public

health program, or the affordable care act for health benefits which are equivalent to health benefits covered under New York Health;

(d) federal and state funds for purposes of the provision of services authorized under title XX of the federal social security act that would otherwise be covered under article fifty-one of the public health law; and

(e) state monies that would otherwise be appropriated to any governmental agency, office, program, instrumentality or institution which provides health services, for services and benefits covered under New York Health. Payments to the fund pursuant to this paragraph shall be in an amount equal to the money appropriated for such purposes in the fiscal year beginning immediately preceding the effective date of the New York Health act.

3. Monies in the fund shall only be used for purposes established under article fifty-one of the public health law.

§ 8. Temporary commission on implementation. 1. There is hereby established a temporary commission on implementation of the New York Health program, referred to in this section as the commission, consisting of fifteen members: five members, including the chair, shall be appointed by the governor; four members shall be appointed by the temporary president of the senate, one member shall be appointed by the senate minority leader; four members shall be appointed by the speaker of the assembly, and one member shall be appointed by the assembly minority leader. The commissioner of health, the superintendent of financial services, and the commissioner of taxation and finance, or their designees shall serve as non-voting ex-officio members of the commission.

2. Members of the commission shall receive such assistance as may be necessary from other state agencies and entities, and shall receive reasonable and necessary expenses incurred in the performance of their duties. The commission may employ staff as needed, prescribe their duties, and fix their compensation within amounts appropriated for the commission.

3. The commission shall examine the laws and regulations of the state and make such recommendations as are necessary to conform the laws and regulations of the state and article 51 of the public health law establishing the New York Health program and other provisions of law relating to the New York Health program, and to improve and implement

the program. The commission shall report its recommendations to the governor and the legislature. The commission shall immediately begin development of proposals consistent with the principles of article 51 of the public health law for provision of health care services covered under the workers' compensation law; and incorporation of retiree health benefits, as described in paragraphs (a), (b) and (c) of subdivision 8 of section 5102 of the public health law. The commission shall provide its work product and assistance to the board established pursuant to section 5102 of the public health law upon completion of the appointment of the board.

§ 9. Severability. If any provision or application of this act shall be held to be invalid, or to violate or be inconsistent with any applicable federal law or regulation, that shall not affect other provisions or applications of this act which can be given effect without that provision or application; and to that end, the provisions and applications of this act are severable.

§ 10. This act shall take effect immediately.



What makes the NY Health Act work.

And why no other plan does.

1. End the burdens and obstacles to health care.

Every year, millions of New Yorkers with health insurance go without health care because they can't afford it. Deductibles, copays, out-of-network charges and unfair denials of coverage get in the way. People choose between health care and other basic necessities. And most New Yorkers say they have fears about the affordability of health care.

Insurance companies don't care if you're a multi-millionaire CEO or a receptionist. They impose the same financial obstacles regardless of your ability to pay.

If someone in a family needs home health care or nursing home care, the cost can wipe out a lifetime of savings or force family members to give up a career to care for a loved one. Instead, the NY Health Act covers the long-term care people need, in the setting of their choice.

The NY Health Act has no premiums, deductibles, copays, restricted provider networks or out-of-network charges. It lowers costs for seniors by picking up Medicare Part B premiums and eliminating Medicare "cost-sharing." It brings local tax relief by eliminating the "local share" of Medicaid.

NY Health would save billions that New Yorkers now spend for coverage and out-of-pocket costs – and is paid for by a broad-based progressively-graduated tax based on ability to pay.

The tax would apply to payroll income (i.e., subject to the Medicare Part A tax) paid at least 80% by the employer, and "unearned" income (e.g., capital gains, dividends, etc.) that is currently subject to the NY state personal income tax.

Income in lower brackets would be taxed at lower rates or exempt from the tax, and income in higher brackets would be taxed at a higher rate. That's just fair.

2. Stop wasting money.

Getting insurance companies off our backs will save billions of dollars to pay for health care and to put money back into New Yorkers' pockets. Getting rid of insurance company bureaucracy and profits saves us over \$20 billion. We save over \$16 billion we now pay to doctors, hospitals and other providers for the administrative cost of fighting with insurance companies. We'll cut drug prices over \$18 billion with the bargaining power of 20 million consumers. That's \$55 billion a year.

These savings are what frees up the money to pay for ending deductibles, co-pays, restricted provider networks, and out-of-network charges, and covering long-term care. The fragmentation of the current system is the enemy of affordability, quality and real reform.

3. All in the same boat.

Covering all of us in the same plan isn't just a matter of fairness. Making the plan universal and publicly accountable also guarantees that NY Health will be top quality.

How? Legislators, governors and other officials, their families, friends will be covered by the same plan as all their constituents. They'll have a personal stake in making sure the plan treats them and their doctors, hospitals and other providers as best as can be. All 20 million New Yorkers will

benefit by being in the same plan with them.

We all want to hold down costs and the taxes that pay for the plan. But we'll also have a stake in keeping NY Health top quality. That balance of pressures is key.

Insurance companies have to deliver as much of our money to their stockholders as possible. That means cutting what they spend on our health care any way they can.

The NY Health Act explicitly requires that payments to health care providers must be "reasonably related to the cost of efficiently providing the health care service and assuring an adequate and accessible supply of the health care service." No insurance company promises or delivers that.



No other plan can do the job.

Some argue that we should just try to get health insurance for the 5% of New Yorkers who are still uninsured.

But plans that keep our fractured insurance company system can't remove the burdens and financial obstacles to health care and don't give us the savings that will pay for health care and put money back in New Yorkers' pockets. They won't relieve the administrative burdens on doctors, hospitals and other providers.

Millions of New Yorkers go without needed health care or face financial obstacles and burdens to get it. No one says that's acceptable. And the NY Health Act is the only plan that meets that need.

**NEW YORK STATE ASSEMBLY
MEMORANDUM IN SUPPORT OF LEGISLATION
submitted in accordance with Assembly Rule III, Sec 1(f)**

BILL NUMBER: A5248

SPONSOR: Gottfried (MS)

TITLE OF BILL:

An act to amend the public health law and the state finance law, in relation to enacting the "New York health act" and to establishing New York Health

PURPOSE OR GENERAL IDEA OF BILL:

This bill would create a universal single payer health plan - New York Health - to provide comprehensive health coverage for all New Yorkers.

SUMMARY OF SPECIFIC PROVISIONS:

Every New York resident would be eligible to enroll, regardless of age, income, wealth, employment, or other status.

There would be no network restrictions, deductibles, or co-pays. Coverage would be publicly funded. The benefits will include comprehensive outpatient and inpatient medical care, long-term care, primary and preventive care, prescription drugs, laboratory tests, rehabilitative, dental, vision, hearing, etc. - all benefits required by current state insurance law or provided by the state public employee package, Family Health Plus, Child Health Plus, Medicare, or Medicaid, and others added by the plan.

Everyone would choose a primary care practitioner or other provider to provide care coordination - helping to get the care and follow-up the patient needs, referrals, and navigating the system. But there would be no "gatekeeper" obstacles to care.

As with most health coverage, New York Health covers health care services when a member is out of state, either because health care is needed while the member is traveling or because there is a clinical reason for going to a particular out-of-state provider.

A broadly representative Board of Trustees will advise the Commissioner of Health. The Board shall develop proposals relating to retiree health benefits and coverage of health care services covered under the workers' compensation law.

In addition to the Board, there will be six regional advisory councils to represent the diverse needs and concerns of the region. The councils shall include but not be limited to representatives of health care consumers, providers, municipal and county government, and organized labor. The councils shall advise the Board, Commissioner, Governor, and

Legislature on matters relating to the NY Health program and shall adopt community health improvement plans to promote health care access and quality in their regions.

Health care providers, including those providing care coordination, would be paid in full by New York Health, with no co-pays or other charges to patients. The plan would develop alternative payment methods to replace old-style fee-for-service (which rewards volume but not quality), and would negotiate rates with health care provider organizations. (Fee-for-service would continue until new methods are phased in.) The bill would authorize health care providers to form organizations to collectively negotiate with New York Health. Health care would no longer be paid for by insurance companies charging a regressive "tax" insurance premiums, deductibles and co-pays imposed regardless of ability to pay. Instead, New York Health would be paid for based on ability to pay, through a progressively-graduated payroll-based tax (paid at least 80% by employers and not more than 20% by employees, and 100% by self-employed) and a progressively-graduated tax based on other taxable income, such as capital gains, interest and dividends. A specific revenue plan, following guidelines in the bill, would be submitted to the Legislature by the Governor.

Federal funds now received for Medicare, Medicaid, Family Health and Child Health Plus would be combined with the state revenue in a New York Health Trust Fund. New York would seek federal waivers that will allow New York to completely fold those programs into New York Health. The "local share" of Medicaid funding - a major burden on local property taxes - would be ended.

Private insurance that duplicates benefits offered under New York Health could not be offered to New York residents. (Existing retiree coverage could be phased out and replaced with New York Health.)

JUSTIFICATION:

The state constitution states: "The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine." (Article XVII, § 3.) All residents of the state have the right to health care.

New Yorkers - as individuals, employers, and taxpayers - have experienced a rapid rise in the cost of health care and coverage in recent years. This increase has resulted in a large number of people without health coverage. Businesses have also experienced extraordinary increases in the costs of health care benefits for their employees. An unacceptable number of New Yorkers have no health coverage, and many more are severely underinsured.

Health care providers are also affected by inadequate health coverage in New York State. A large portion of voluntary and public hospitals, health centers and other providers now experience substantial losses due to the provision of care that is uncompensated. Individuals often find that they are deprived of affordable care and choice because of decisions by health plans guided by the plan's economic needs rather than

their health care needs.

To address the fiscal crisis facing the health care system and the state and to assure New Yorkers can exercise their right to health care, this legislation would establish a comprehensive universal single-payer health care coverage program, funded by broad-based revenue based on ability to pay, for the benefit of all residents of the state of New York.

The state will work to obtain waivers relating to Medicaid, Family Health Plus, Child Health Plus, Medicare, the Patient Protection and Affordable Care Act, and any other appropriate federal programs, under which federal funds and other subsidies that would otherwise be paid to New York State will be paid by the federal government to New York State and deposited in the New York Health trust fund. Under such a waiver, health coverage under those programs will be replaced and merged into New York Health, which will operate as a true single-payer program. If such a waiver is not obtained, the state shall use state plan amendments and seek waivers to maximize, and make as seamless as possible, the use of federally-matched health programs and federal health programs in New York Health. The goal of this legislation is that coverage be delivered by New York Health and, as much as possible, the multiple sources of funding will be pooled with other New York Health funds and not be apparent to New York Health members or participating providers. This program will promote movement away from fee-for-service payment, which tends to reward quantity and requires excessive administrative expense, and towards alternate payment methodologies, such as a global or capitated payments to providers or health care organizations, that promote quality, efficiency, investment in primary and preventive care, and innovation and integration in the organizing of health care.

This act does not create any employment benefit, nor does it require, prohibit, or limit the providing of any employment benefit. In order to promote improved quality of, and access to, health care services and promote improved clinical outcomes, it is the policy of the state to encourage cooperative, collaborative and integrative arrangements among health care providers who might otherwise be competitors, under the active supervision of the commissioner. It is the intent of the state to supplant competition with such arrangements and regulation only to the extent necessary to accomplish the purposes of this act, and to provide state action immunity under the state and federal antitrust laws to health care providers, particularly with respect to their relations with the single-payer New York Health plan created by this act.

PRIOR LEGISLATIVE HISTORY:

1992: A.8912-A passed Assembly
1993: A.5900 reported to Ways and Means
1994: A.5900 referred to Health Committee
1995-96: A.6801 reported to Ways and Means
1997-98: A.6172 reported to Ways and Means
1999-00: A.3571 reported to Ways and Means
2001-02: A.6779 reported to Ways and Means
2003-04: A.6952 reported to Ways and Means
2005: A.6576 reported to Ways and Means
2006: A.6576 referred to Health Committee

2007-08: A.7354 - reported to Ways and Means
2009-10: A.2356 - referred to Health Committee
2011-12: A.7860-A - referred to Ways and Means
2013: A5389 referred to Health Committee
2014: A5389 - reported to Ways and Means
2015: A5062 - Passed Assembly
2016: A5062 - passed Assembly
2017: A4738 - passed Assembly
2018: A4738 - passed Assembly

FISCAL IMPLICATIONS:

Full funding for New York Health would come from the revenue measures to be proposed by the Governor under guidelines in the bill, plus available federal funds. The revenue package would also replace: local share of Medicaid, the state share of Medicaid, state and local payments for public employee health coverage, and various other health care spending. Numerous analyses document that a single-payer system would be most effective for reducing and controlling costs, for taxpayers, employers and individuals.

EFFECTIVE DATE:

Immediately. The program will actually begin functioning when the Commissioner of Health declares the beginning of the implementation period.

States as Policy Laboratories: The Politics of State-Based Single-Payer Proposals

Although the focus for most single-payer advocates is in Washington, DC, and on proposals for Medicare for all, there are also efforts in a handful of states to enact a state-based single-payer program. Moreover, the odds of legislative passage are better in a state like New York than at the federal level.

Even if enacted, however, state-based single-payer proposals face a distinct set of obstacles, including (1) the need to obtain federal permission (via waivers) to repurpose federal dollars, (2) the federal Employee Retirement Income and Security Act, and (3) the burden of state-only action in an interconnected 50-state economy.

The most likely result of the energized single-payer movement will be incremental public insurance expansions at the federal and state levels, including state programs to permit the uninsured to buy into the Medicaid program. Such an outcome is consistent with the most plausible path (incrementalism) to a US version of universal coverage. (*Am J Public Health*. 2019;109:1511–1514. doi:10.2105/AJPH.2019.305294)

Michael S. Sparer, JD, PhD



See also Donnelly et al., p. 1482.

Despite the gains generated by the Affordable Care Act (ACA), more than 30 million Americans remain uninsured, and millions more delay or defer needed medical care because of high deductibles and other out-of-pocket costs. This ongoing policy challenge prompts an increasing cadre of progressive Democrats to call for a comprehensive overhaul of the nation's health care system, dramatically reducing (or perhaps completely eliminating) the multipayer private insurance health insurance industry and replacing it with comprehensive publicly funded coverage for all, referred to generally as a "single-payer" insurance model.¹ Although the focus for most single-payer advocates is Washington, DC, where the rhetorical movement for Medicare for all animates the presidential campaigns of numerous Democratic candidates, there are also efforts in a handful of states to enact a state-based single-payer program that could become a model for federal policymakers.²

The political obstacles to the single-payer movement are obvious.³ First, the interest group opposition is fierce, wealthy, and influential. Opponents include private insurers worried about being forced into bankruptcy, providers worried about lower reimbursement, employers worried about higher taxes and lost control over employee benefits, unions worried about losing dollars generated by their health

benefit programs, and of course a variety of conservative and Republican advocacy groups. Interest group support for single payer is far weaker, more fragmented, and less wealthy.

Single-payer proposals also raise concerns about the appropriate role of government and the division of labor between the public and private sectors. These concerns are especially powerful here in the United States, where an antigovernment ethos resonates strongly with much of the population and where the view that government is less competent than the private sector is deeply engrained. This context makes any effort to dramatically raise taxes to fund a single-payer system even more difficult, even when economists point to administrative efficiencies, long-term system savings, and the elimination of insurance premiums.

The odds of overcoming these obstacles are better at the state level than in Washington, DC.

Although single-payer proposals at the national level have only recently received their first congressional committee hearing, there are several states in which single-payer proposals have received serious consideration.

Vermont, for example, enacted legislation in 2011 that put them on the path to single payer (although that effort was eventually dropped in 2014). Colorado voters considered (but defeated) a single-payer referendum in 2016, as did voters in Oregon in 2002. More recently, the California state senate passed a single-payer bill in 2017 that garnered the support (at least during the campaign) of that state's newly elected governor, Gavin Newsom. And in New York, single-payer supporters saw a window of opportunity after the November 2018 election results in which the Democrats took control of the state senate, following several years in which a Republican senate had blocked an assembly passed single-payer bill.

There may indeed be a small window of opportunity for policymakers in a couple of states to enact legislation that would put their state on a path to a single-payer system—it is not likely, but it is possible. Even if enacted, however, state-based single-payer proposals face a distinct set of obstacles on the path to implementation. These barriers include (1) the need to obtain federal permission (via waivers) to repurpose the vast amounts of

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This article was accepted July 15, 2019.

doi: 10.2105/AJPH.2019.305294

federal dollars that now underpin the nation's health system; (2) the federal Employee Retirement Income and Security Act (ERISA), which significantly limits state jurisdiction over the employers' role in health insurance; and (3) the burden of state-only action in an interconnected 50-state economy.

Perhaps ironically, the most likely result of an energized single-payer movement is a series of incremental public insurance expansions at both the federal and state levels. Instead of Medicare for all, Congress may enact Medicare for more. Instead of the New York Health Act, New York may permit the uninsured to buy into the state's Medicaid program. Such an outcome would be consistent with the most plausible path to an American version of universal coverage, one that emerges step by step through incremental expansions that build on the current system, as opposed to proposals to fundamentally change the way the system works. More on this later. First, however, I review the limits on state efforts to enact their own version of a single-payer program.

THE NEED FOR FEDERAL WAIVERS

The federal government is the largest single funder of health care services, and state-based single-payer proposals seek to use federal dollars as a core fiscal component of the new state program. To do so, however, requires federal permission to redirect funds from Medicare, Medicaid, the ACA, the Federal Employees Health Benefit Program, the Veteran's Health Administration, and perhaps other federal programs as well. Federal officials in the Trump administration have

already made clear that they will oppose any such waiver requests.⁴ Even assuming an eventual friendly Democratic administration, the details of such waiver requests would be complicated and controversial.

For more than 50 years, for example, Medicare has served as a single national program, with federal rules governing eligibility, benefits, and provider reimbursement. There are, of course, some exceptions to the uniformity requirements, including the all-payer hospital reimbursement program, which allows Maryland (and previously a few other states) to set the allowable hospital charges for all payers, including Medicare. Similarly, Medicare Advantage plans have some flexibility to add benefits and set reimbursement rates. These exceptions pale, however, in comparison with a proposal that the program (and all its dollars) be turned over to state officials, an idea that will raise concerns not only among federal policymakers but among politically influential Medicare beneficiaries and advocates on their behalf as well. (The effort to redirect Veteran's Health Administration funds to a state will likely also generate fierce resistance from an even more potent political group, the nation's military veterans!)

State officials have a somewhat easier path to redirecting Medicaid and ACA funds. Medicaid, for example, already delegates broad authority to determine eligibility, benefits, and reimbursement rates to the states, and there is a long history of granting waivers from the federal rules designed to limit such state discretion. Moreover, conservatives have long proposed that federal officials give states a fixed amount of federal Medicaid funding, and the block grant

concept is very close to what state-based single-payer advocates seek. The ACA also contains explicit authority (in section 1332 of the law) for state-based experimentation along the lines proposed by single-payer advocates. Here again, however, despite its rhetorical support for state experimentation, the Trump administration is unlikely to be receptive to comprehensive Medicaid or ACA waivers designed to create a path to a single-payer system. Nor would the waiver process be simple and straightforward even in a Democratic administration.

The single-payer proposal now under consideration in New York (the New York Health Act) contains a backup plan in case the state is unable to obtain the desired federal waivers, under which the state would provide supplemental wraparound coverage for Medicaid and Medicare beneficiaries. In other words, those programs would continue as is, but the state would ensure that those beneficiaries also receive the additional benefits covered by the new single-payer program. Such a system would be quite administratively complex, undermining one of the guiding principles of the reform. At the same time, the cost of such supplemental coverage would be significant, thereby making it even more difficult to generate political support for the initiative.

EMPLOYEE RETIREMENT INCOME AND SECURITY ACT

ERISA, enacted by Congress in 1974, is concerned primarily with employer pension programs (requiring that such programs be adequately capitalized, avoid inequitable vesting requirements,

and provide clear disclosure about terms and conditions). But ERISA also has two provisions likely to generate court challenges to state-based single-payer programs. First, the law prohibits states from regulating, taxing or otherwise interfering with companies that have self-insured health plans in which the firm itself holds the financial risk of employee medical costs.⁵ More than 60% of the 173 million Americans with group coverage receive coverage through one of these self-insured ERISA plans. State legislation that imposed a significant payroll tax to fund a single-payer plan would almost certainly be challenged in court as unlawful under ERISA. Second, ERISA also prevents states from enacting a so-called employer mandate, or a requirement that firms provide health coverage (or pay for such coverage) for their employees. Here again, any state legislation that imposed a significant payroll tax to fund a single-payer plan would likely be challenged as an unlawful employer mandate, a claim that could have special resonance with small businesses that currently are exempt from the federal employer mandate contained in the ACA.

Richard Gottfried, the legislative sponsor of the single-payer proposal in New York, dismisses the ERISA challenge as unlikely to succeed, noting that (1) the state has clear authority to impose payroll taxes; (2) the proposed law does not require any firm to provide coverage but, in fact, does just the opposite, relieving firms of any such obligation; and (3) firms could still maintain their employer-based coverage, although it would be irrational for them to do so because they also would be contributing to the cost of the single-payer program.⁶ There is no clear precedent

suggesting how the courts would rule in the inevitable ERISA challenge to a state-based single-payer initiative. It is quite likely, however, that the litigation would drag on for years, complicating at a minimum any effort to implement such a program.

AN INTERCONNECTED 50-STATE ECONOMY

The implementation of a state-based single-payer program is complicated by the nation's interconnected 50-state economy. States need to decide, for example, whether the new program will cover nonresidents (and, if not, how businesses can provide coverage to that population). Former Vermont governor Peter Shumlin, the guiding force behind that state's single-payer proposal, decided to include the out-of-state commuters, but that decision both raised the overall cost and added to the potential implementation challenge.⁷ There also are a host of potential unintended consequences that are hard to predict or plan for. Will businesses and high-income individuals exit the state to avoid paying the new taxes needed to finance the system? Will physicians and other health care providers exit the state to maintain income generated from commercial insurers? Will severely ill individuals move to the state to receive comprehensive coverage, and, if so, what would be the fiscal result of such a "health care magnet" effect? What will be the impact on large companies that operate in multiple states?

It is plausible that these concerns are overstated. For example, despite the longstanding differences in state-based health and welfare programs, there is

little evidence of a significant health care magnet effect. Nor is there evidence of a major exodus of high-income individuals following the imposition of new state income taxes or of a large-scale physician exit because of cuts in reimbursement. This is especially true in New York City and other destinations of choice among the nation's most wealthy individuals. Nevertheless, in its analysis of the proposed New York Health Act, the RAND Corporation projected that if roughly 50 000 high-income taxpayers changed their domicile, the state would lose more than \$30 billion in revenue, or more than 20% of the estimated \$139 billion needed to fund the first year of the new single-payer program.⁸

The fiscal (and political) capacity of a single state to generate sufficient tax revenue to finance a single-payer system is also questionable. For example, when Vermont's Governor Shumlin pulled the plug on that state's single-payer initiative, he cited the "economic shock" of having to impose dramatic tax increases (11.5% on employers and 9.5% on individuals) that would increase the state's budget by almost 50%.⁷ New York assemblyman Richard Gottfried argues that the progressive tax scheme contained in the New York Health Act enables the state to more easily withstand the economic shock of the massive tax, but the potential exit of at least some of the state's wealthiest citizens would undermine that assumption.

Finally, single-payer advocates can also face unexpected resistance from presumed political allies based on the idiosyncratic provisions in state constitutions. For example, both Planned Parenthood and NARAL Pro-Choice America opposed the 2016 single-payer referendum in

Colorado because the state's constitution banned public funding for abortions, and reproductive rights advocates feared the initiative would eliminate access to abortions for women now covered by private health plans. The referendum's supporters challenged that assumption, arguing that the new law would lead to the repeal of the constitutional ban. But the uncertainty about this issue undoubtedly contributed to the overwhelming rejection of the proposal.⁹

ADVANTAGES OF INCREMENTALISM

Those who propose Medicare for all and who tout the economic and moral virtues of a single payer argue persuasively that such an approach would dramatically reduce the inequities and disparities deeply rooted in the nation's complicated, fragmented, and decentralized system. Medicare is a national program with uniform rules; it is viewed by most Americans as an "earned right," and although it now has a relatively limited benefit package, Senator Bernie Sanders and other advocates promise vastly expanded coverage. But the notion that the United States (or any of its political subdivisions) is going to replace (nearly overnight) the longstanding system of employer-sponsored coverage runs contrary to both US history and US politics. The interest group opposition is too strong, the cultural concerns about government are too deep, and the opportunities for opponents to stymie the policy process are too plentiful. Moreover, state officials who hope to create the policy laboratory that enacts and

implements a single-payer program must overcome additional obstacles, including ERISA, the need for federal waivers, and the complications generated by an interconnected 50-state economy.

In this context, the most likely reform scenarios are incremental rather than comprehensive. One idea generating significant momentum is to expand Medicare enrollment (either by lowering the eligibility age or by permitting additional populations to buy into the program). But Medicare for more is politically plausible only if the Democrats control both the White House and Congress, a scenario that cannot happen before 2021. States, however, can act more quickly, aiding their remaining uninsured (and underinsured) and providing a model for national reform (much as the 2006 coverage expansions in Massachusetts provided a model for the ACA). Washington state, for example, recently passed the nation's first so-called public option, Cascade Care, under which buyers on the state's insurance exchange will soon be able to purchase a lower-cost plan in which premiums (and deductibles) are kept low because of state-mandated caps on provider reimbursement. The private carrier that operates this plan will need to meet a host of additional requirements not imposed on the other plans in the insurance market.¹⁰

Similarly, several states are currently considering different versions of a Medicaid buy-in, which could lead to a policy menu for future reformers. Such buy-in programs could differ on

1. whether to offer the buy-in product on or off the ACA insurance exchange,
2. the benefit package,

3. out-of-pocket costs,
4. provider reimbursement, and
5. how to finance the initiative.¹¹

Under the proposal now under consideration in New Mexico, for example, the state would establish a buy-in plan available to all those not otherwise eligible for public or private coverage, with out-of-pocket costs based on household income and benefits delivered by plans currently operating in the state's Medicaid managed care market.¹²

The argument for relying on Medicaid as a path to universal coverage is strengthened as well by the program's 30-year history of incremental expansion, under both Democratic and Republican administrations. Medicaid now has more than 70 million enrollees, its cost is shared by the federal government and the states, and its political resilience was an important factor in the failure of the Republicans to repeal and replace the ACA. The program has surprisingly strong interest group support, it is administered by the states (thus shielding it from claims that it is a big government monolith), and it provides an insurance safety net for public health crises (from AIDS to the Flint, MI, water crisis). Finally, Medicaid buy-in strategies are not precluded by ERISA, can proceed without federal waivers (although such waivers could help), and can proceed without raising concerns about nonresidents or neighboring states.

At the same time, Medicaid politics also shows the potential risk of relying on states to provide a path to universal coverage. After all, there are still more than a dozen "red" states that have not adopted the ACA Medicaid expansion. There is increased pressure in many red states to expand coverage, as illustrated by the recent voter referendums in

Idaho, Nebraska, and Utah requiring state officials to expand Medicaid.¹³ But the political pressure in these states to expand coverage competes with equally strong (if not stronger) pressure to cut back, suggesting that universal coverage in the United States will not happen without federal legislation. The question, however, is whether the best path to universal coverage is through a single-payer path or through incremental expansions of current programs.

There is no doubt that many progressive Democrats will continue to advocate the more ambitious single-payer approach, and in some states there clearly are going to be windows of opportunity for legislative success. But single payer even in the most liberal of states is still a political long shot. In New York, for example, Richard Gottfried and his colleagues could not round up the votes to pass the New York Health Act in the most recent legislative session, even with the current Democratic control of both the state legislative and executive branches. And legislative enactment even if achieved would lead to further battles over waivers, ERISA, and nonresidents.

The argument here is that the single-payer debate at both the national and state levels will ultimately generate consensus on a more incremental proposal, one that looks much more like a Medicare or Medicaid expansion or buy-in. Such an outcome would be consistent with longstanding trends in US health policy. It also would be a welcome step on the path toward a US version of affordable universal coverage. **AJPH**

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CONFLICTS OF INTEREST

The author has no conflicts of interest to declare.

FEDERALISM, ERISA, AND STATE SINGLE-PAYER HEALTH CARE

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ABSTRACT

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

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

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ERISA's preemption provisions, the addition of a statutory waiver, and/or a reinterpretation of ERISA preemption consistent with Congressional intent and the presumption against preemption.

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INTRODUCTION

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

Rather than wait idly by for federal progress, states have picked up the momentum on health reform, spurred both by necessity and an appetite for policy innovation. Of necessity, states have turned to their own reforms in response to federal governmental attempts to undermine the ACA’s coverage and cost-containment policies since the Trump Administration took power in 2017.³ States also are testing different models and serving as laboratories for

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

² See, e.g., John A. Graves, Sayeh S. Nikpay, *The Changing Dynamics of US Health Insurance And Implications for The Future of The Affordable Care Act*, 36 HEALTH AFF. 297 (2017); Jonathan Oberlander, *The End of Obamacare*, 376 N. ENGL. J. MED. 1 (2017); Sara Rosenbaum, *The (Almost) Great Unraveling*, 43 J. HEALTH POLITICS POL’Y & L. 679580 (2018); Elizabeth Y. McCuskey, *Big Waiver under Statutory Sabotage*, 45 OH. N. L. REV. 213_ (forthcoming 2019).

³ See Andrew M. Bindman et al., *Beyond the ACA: Paths to Universal Coverage in California*, 37 HEALTH AFF. 1367, 1367 (2018) (“The passage of the ACA temporarily relieved states of the need to take the lead in expanding health care coverage. However, many states have returned to the issue in the wake of the threat by the administration of President

alternative ways to pay for health care, including some ambitious proposed experiments in single-payer plans. While federal single-payer reform under “Medicare-for-All”⁴ gains support and attention,⁵ state legislators quietly have drafted and introduced dozens of single-payer bills.

This project surveys state efforts from 2010 through 2019 to establish single-payer health care, which we define as legislative attempts to achieve universal health care coverage for all residents in a state by combining financing for all health care services into a single, state-administered payer.⁶ State legislative proposals to establish single-payer plans have been surprisingly robust both in volume and variation, with sixty-six unique single-payer bills introduced across twenty-one states since 2010.⁷ Though state single-payer proposals also face steep political, practical, legal, and financial challenges,⁸ the volume and detail of state bills suggest many of

Donald Trump to repeal the ACA.”).

⁴ See Bernie Sanders, Healthcare for All, <https://berniesanders.com/topics/health-care-for-all/> [https://perma.cc/Q396-VD66]. See also Nicole Gaudiano & Maureen Groppe, “Democrats back Medicare for all in about half of House races they’re contesting,” USA TODAY (Oct. 23, 2018), <https://www.usatoday.com/story/news/politics/elections/2018/10/23/democrats-back-medicare-all-half-contested-house-races/1732966002/> [https://perma.cc/K6EM-FRAB].

⁵ Cf. Kaiser Family Foundation, *Public Opinion on Single Payer, National Health Plans, and Expanding Access to Medicare Coverage*, (2018), <https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/> [https://perma.cc/M4PT-ZDQX]; Liz Hamel, Bryan Wu, Mollyann Brodie, *Data Note: Modestly Strong but Malleable Support for Single-Payer Health Care* (Jul 5, 2017), <https://www.kff.org/health-reform/poll-finding/data-note-modestly-strong-but-malleable-support-for-single-payer-health-care/> [https://perma.cc/3AT8-WYHP].

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

⁷ See Part I.A., *infra*.

⁸ A full discussion of these other challenges is beyond the scope of this Article. The most significant of these include: (a) the difficulty and necessity of securing waivers from the federal government to include Medicare, Medicaid, and Affordable Care Act marketplaces in the single payer plan; (b) the need for states to raise taxes significantly to make up for the massive federal subsidy of employer-based health plans through the preferred tax treatment of these plans, which would be lost if these plans are shifted to the state single-payer plan;

these are serious, non-symbolic efforts. Our research particularly focuses on how these states seek to capture the employer-sponsored health insurance that currently covers 49% of Americans—a critical market for the solvency and viability of any single-payer plan.⁹

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

This indeterminately broad preemption language in ERISA, combined with an obscure “savings” clause for state regulation of insurers and an equally obscure “deemer” clause interpreted to prohibit states from regulating employer benefit arrangements that mimic insurance has spawned voluminous litigation and derailed state health reforms for decades.¹³ States, for example, may not impose their own “employer mandate” to provide health benefits due to ERISA preemption and therefore mostly had to wait for federal legislation (the ACA) to impose one. As another example, state

and (c) the fact that states, unlike the federal government, cannot deficit-spend and thus would struggle to finance single-payer programs in a recession when revenues decline. *See, e.g.,* Lindsay Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 79 OHIO ST. L. J. 843 (2018); Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L. J. F. 1 (2017).

⁹ Kaiser Family Foundation, Health Insurance Coverage of the Total Population, (2017), <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

¹⁰ 29 U.S.C. § 1001 *et seq.*

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

¹² 29 U.S.C. § 1144(a) (2012) (included as § 514 in the Act).

¹³ *See, e.g.,* Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J. L. MED. & ETHICS 86, 89-90 (2009).

laws establishing mandatory minimum health benefits “relate to” employer-provided health benefits; the “savings” clause avoids preemption when states enforce these minimum benefits laws against insurance companies selling insurance to employers, yet the “deemer” clause preempts their application to employers who self-insure their own health benefits.¹⁴ ERISA preemption thus raises a daunting legal challenge and uncertainty for states trying to capture critical employer-based health spending and draw those with employer-based coverage into the single-payer system.

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

This article comprehensively catalogues state single-payer proposals and analyzes whether ERISA would preempt state efforts to capture the employer expenditures. There are strong arguments why each of these three types of

¹⁴ *E.g., id.* at 90.

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

¹⁶ *See* Part I.B.1., *infra*.

¹⁷ *See* Part I.B.2., *infra*.

¹⁸ *See* Part I.B.3., *infra*.

provisions (A–Funding Plan; B–Provider Restriction; or C–Assignment/Subrogation/Secondary Payer) should survive ERISA preemption. But courts’ unpredictable, tortured, and at times, contradictory application of ERISA casts a pall of uncertainty over their durability and invites litigation.¹⁹ Legal uncertainty amplifies the political challenges of establishing a state single-payer system because policymakers may struggle to pass such a sweeping legislative reform if key parts may be preempted.²⁰ ERISA preemption targets the primary funding provisions in these bills, further threatening the economic modeling and revenue stream upon which single-payer plans depend. Legal uncertainty over ERISA preemption thus narrows the eye of the political and economic needle a state must thread to establish single-payer health care.

ERISA is also an interloper in federal health insurance regulation – an employee-benefits statute not originally intended to govern health care, but which now exerts a powerful influence over it. Unlike most major federal health care statutes including Medicare, Medicaid, and the ACA, ERISA does not provide for waiver, state experimentation, or federal funding.²¹ The Department of Labor, which administers ERISA, lacks the statutory authority to waive its preemption, even if the Department finds it would be beneficial.²²

¹⁹ See Part II.A.2., *infra*.

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

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

²² See Part III.B.2. and text accompanying notes 338-342, *infra*. See also Manatt Health, “Understanding the Rules: Federal Legal Considerations for State-Based Approaches to Expand Coverage in California,” 5, 10 (Feb. 2018) (noting that ERISA’s “provisions are

Nor will the agency's enforcement discretion save a state's single-payer provision from preemption because employers or third-party administrators can raise ERISA preemption through litigation, enforced by courts.

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

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

In this article, we do not argue that any state *ought* to establish single-payer health care or that state-based single payer is preferable to a national effort or to other more incremental reforms toward universal coverage and

not waivable by administrative action" and that suspension of the statutory preemption "would likely need federal legislation to receive an exemption".

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

²⁴ 29 U.S.C. § 1185d; 26 U.S.C. § 9815 (applying many of the ACA's health insurance requirements, codified at 42 U.S.C. § 300gg et seq., to group health plans governed by ERISA); 26 U.S.C. § 45R (containing the employer mandate).

²⁵ Mallory Jensen, *Is ERISA Preemption Superfluous in the New Age of Health Care Reform?*, 2011 COLUM. BUS. L. REV. 464, 516 (2011).

cost-control.²⁶ Instead, our research reveals that even if a state’s citizens *want* single payer, the state faces a nearly insurmountable structural challenge from ERISA. Because ERISA thwarts state experimentation with single-payer models, it also denies an opportunity to gather evidence on *whether* single-payer systems have advantages or disadvantages over other reforms. State single-payer legislation provides a stark illustration of the federalism trap created by ERISA that has stymied states’ health reform efforts—big and small—for decades.

We propose four solutions to clear the way for state health reforms and reduce ERISA’s obstruction – three legislative and one jurisprudential. First, Congress could amend ERISA’s preemption provisions with respect to health benefit plans, replacing its broad “any and all” preemption with “floor preemption,” used in other federal health care statutes. Floor preemption, which displaces only those state laws that are less stringent than the federal standard (the “floor”), preserves uniformity in federal baseline regulations, balanced with state flexibility to enact laws consistent with and no less protective than the federal floor. Second, Congress could eliminate ERISA’s “deemer clause”²⁷ for health benefits to correct Supreme Court interpretation that has built an impenetrable barrier of preemption around self-funded employer-based plans. Third, Congress could instead add a statutory waiver provision to ERISA, which would allow states to ask the federal government to suspend ERISA preemption for their proposed health reforms. As seen in other federal health care statutes, an ERISA waiver would allow the federal government to manage the degrees of uniformity and variation, while still permitting state experimentation in health policy. Floor preemption and

²⁶ See, e.g., Katie Gudiksen, *Single-Payer vs. Public Option: Can Either System Address Rising Health Care Prices?* THE SOURCE BLOG (Mar. 29, 2018), <http://sourceonhealthcare.org/single-payer-vs-public-option-can-either-system-address-rising-health-care-prices/> [https://perma.cc/N8RZ-EATX].

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

deemer clause revisions to ERISA would produce the most direct and enduring reforms, but a waiver provision might offer the most politically expedient option, though far more limited in its effect.

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

This Article proceeds in three parts. Part I presents the findings of a survey of state-single payer bills introduced from 2010 through 2019 and their key features, identifying three types of provisions that state single-payer proposals use to capture employer health expenditures and the 49% of Americans covered by employer plans: Type A (Funding Plan), Type B (Provider Restrictions), and Type C (Assignment / Subrogation / Secondary Payer) provisions. Part II details the application of ERISA preemption analysis to each of these provisions and the degree to which each should survive ERISA preemption. Part III then situates ERISA in the broader context of federal health insurance statutes. Although Congress did not intend ERISA to be a health care statute, ERISA’s extraordinarily broad preemption, scant federal regulation, and lack of waiver flexibility create a federalism trap, obstructing state experimentation and autonomy in ways that undermine the health care federalism infrastructure of the ACA, Medicaid, and Medicare statutes. We offer four proposals to remove ERISA’s obstructions to state health reform, infusing the federal regulatory scheme with greater flexibility and recalibrating its role in health care federalism.

Ultimately, we urge that the time has come to amend ERISA preemption

²⁸ See Part III.B., *infra*.

²⁹ See Part II.C., *infra*.

in order to unshackle meaningful state health reforms from its outdated prohibitions.

I. STATE SINGLE-PAYER PLANS

State health reform momentum has only picked up steam after the ACA. State reform efforts range from patches for the individual market,³⁰ laws targeting surprise medical bills³¹ and prescription drug prices,³² proposals to allow any state resident to buy a public plan, such as Medicaid,³³ all the way to full transformation of the health care finance system in state single-payer proposals. This Part takes a deep dive into the ambitious end of state health reforms: state single-payer plans.

A. The Recent Proliferation of State Single-Payer Proposals

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

³⁰ See Kaiser Family Found., “Tracking Section 1332 State Innovation Waivers,” (Aug 23, 2018) <https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/> [<https://perma.cc/EQ99-FHWZ>].

³¹ See Christina Cousart, “State Legislators Take Action to Protect Consumers from Surprise Billing,” NASHP.org (Sept. 18, 2018), <https://nashp.org/state-legislators-take-action-to-protect-consumers-from-surprise-billing/> [<https://perma.cc/8MWM-UJL5>].

³² See Robert Pear, “States Rush to Rein In Prescription Costs, and Drug Companies Fight Back,” NY Times (Aug. 18, 2018), <https://nyti.ms/2OMyV0T> [<https://perma.cc/8E2W-4WXY>].

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

³⁴ See [Appendix A](#) for a table listing all the bills by state and year and [Appendix B](#) for search terms and methodology for identifying state single-payer proposals.

numbers as they move through the legislative process) resulted in sixty- six bills. Although many bills explicitly stated that their purpose was to establish a single-payer health system, not all did.³⁵ We characterized bills as state single-payer proposals if they sought to establish universal health care coverage for all residents in a state by combining financing for all health care services into a single, state-administered payer. We excluded bills that did not meet this definition and thus did not purport to establish a single-payer plan, such as those that called for a study of single-payer, expressed support for a national single-payer plan, or attempted less-than comprehensive health reforms (e.g., universal primary care).³⁶ None except Vermont’s ill-fated single-payer plan³⁷ was passed, and no state has implemented a single-payer system.

The defining characteristics of state single-payer proposals are the combination of universal eligibility for state residents³⁸ and reliance on statutory waivers from Medicare, Medicaid, and the ACA to consolidate these sources of federal funding and their covered populations into the state single-payer plan.³⁹ Other common elements include: expansive provider

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

³⁶ See Appendix B for search terms and exclusion criteria.

³⁷ Act of May 26, 2011, 2011 Vt. Acts & Resolves 48 (enacting H.B. 202, providing for universal coverage in Vermont); see also, John E. McDonough, *The Demise of Vermont’s Single-Payer Plan*, 372 N. ENGL. J. MED. 1584, 1584 (2015).

³⁸ See, e.g., S.B. 562, 2017-2018 Reg. Sess. (Cal. 2017), § 100620(a) (“Every resident of the state shall be eligible and entitled to enroll as a member under the program”); H.B. 440, 132nd Gen. Assemb., 2017-2018 Sess. (Ohio 2017) § 3920.07(A), “All Ohio residents and individuals employed in Ohio, including the homeless and migrant workers, are eligible for coverage under the Ohio health care plan.”). Cf. *id.* at §§ 3920.07(F), (G) (extending eligibility to nonresidents who work in the state or college students who attend university in the state).

³⁹ Waiver reliance to include federal payers is nearly universal among the single-payer plans. See, e.g., S.B. 2237, 2018 Leg. Session (R.I. 2018), § 23-95-12(d) (providing, “The

eligibility;⁴⁰ administratively set or negotiated rates for providers and health care goods, such as prescription drugs;⁴¹ low or no cost-sharing for patients;⁴² comprehensive coverage of services;⁴³ and mechanisms for care-coordination.⁴⁴

The volume, variation, and detail of these state single-payer proposals is surprising. Although many of the states with single-payer proposals are controlled by Democrats, the single-payer bills are not exclusively from “blue” states. Most of the states with single payer proposals expanded Medicaid under the ACA, reducing the percentage so only a small fraction of the population that remains uninsured. So, there seems to be something else beyond universal coverage driving many of these single-payer bills. That something else appears to be an effort to control health care costs through expansive rate-setting authority for health care services and prescription

director shall seek and obtain waivers and other approvals relating to Medicaid, the Children's Health Insurance Program, Medicare, the ACA, and any other relevant federal programs” to preserve and maximize federal funds available, while moving them into the state single-payer fund). Further, most state single-payer proposals would require a waiver from the U.S. Department of Health & Human Services of the Affordable Care Act’s employer mandate, pursuant to the ACA’s Section 1332 waiver provision. *See Wiley, supra* note 8.

⁴⁰ *See, e.g.,* S.B. 1872, 120th Leg., Reg. Sess. (Fla. 2018) (“Any health care provider who is licensed to practice in this state and is otherwise in good standing is qualified to participate in the program as long as the health care provider's services are performed within this state.”).

⁴¹ *See, e.g.,* A. 4738-A, 2017 Leg., 240th Sess. (N.Y. 2018), § 4. Provider rates are commonly set through negotiation representatives of providers and the single-payer plan, along with formularies and negotiated prices for prescription drugs.

⁴² *See, e.g.,* S.B. 1014, 202nd Gen. Assemb., 2017-2018 Sess. (Pa. 2018), § 503(c) (“Participants are not subject to copayments, deductibles, point-of-service charges or any other fee or charge for a service within the package and shall not be directly billed nor balance billed by participating providers for covered benefits provided to the participant.”)

⁴³ *See, e.g.,* S.B. 5957, 65th Leg., 2017 2d Spec. Sess. (Wash. 2017), § 16. The bills include, and go beyond, the ACA’s essential health benefits, and typically include services covered by Medicare and Medicaid.

⁴⁴ *See, e.g.,* H.F. 2352, 87th Gen. Assemb., 2017-2019 Sess. § 16 (Iowa 2018). Some require eligible beneficiaries to enroll in a care coordinator, which can be their primary care physician, a “medical home,” or an organization, such as an ACO or HMO.

drugs,⁴⁵ a reduction of administrative costs for the state and the health care industry by streamlining the multi-payer system into one,⁴⁶ and relieving citizens of their growing cost-sharing burdens from high deductibles, out-of-network bills, and co-insurance rates.⁴⁷ Figure 1 depicts the twenty-one states with at least one single-payer bill proposed between 2010 and 2019.

⁴⁵ *See, e.g.*, A. 5248, 2019 Leg., 2019-2020 Reg. Sess. (N.Y. 2019) § 2, (“To address the fiscal crisis facing the health care system and the state and to assure New Yorkers can exercise their right to health care, affordable and comprehensive health coverage must be provided. . . [T]his legislation is an enactment of state concern for the purpose of establishing a comprehensive universal guaranteed health care coverage program and a health care cost control system for the benefit of all residents of the state of New York.”); S.B. 786, 2015 Leg., 121st Sess. (S.C. 2015), §§ 44-18-910 to -930 (providing for the authority to establish rates for both health care providers that participate in the state program and those that do not).

⁴⁶ *See, e.g.*, H.B. 2987, 190th Gen. Ct., 2017-2018 Sess. (Mass. 2017), § 1(b) (“Today’s numerous private and public health insurance plans, with differing benefits and patient payment requirements, impose massive administrative burdens on doctors, hospitals, other health care organizations, as well as on patients, employers and other payers. Purchasing power is fragmented.”).

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

[illegible]

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

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totality is that there is a nontrivial possibility that some state or states could thread the political, administrative, financial, and legal needles necessary to pass a single-payer plan in the coming years.

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

The billion-dollar question, both in terms of dollars-at-stake and legal hurdles from ERISA, is how the state single-payer plan addresses employer-sponsored health coverage.⁵⁰ In the U.S., 49% of the population is covered by employer-sponsored coverage, which amounts to 20% of our total national health care expenditures.⁵¹ Once the single-payer system starts covering this population, it must capture the vast employer and employee expenditures that pays for such coverage.⁵² State legislation faces a big obstacle in achieving this critical task: ERISA preempts state law that “relates to” employer-

THE LEWIN GROUP, COST AND ECONOMIC IMPACT ANALYSIS OF A SINGLE-PAYER PLAN IN MINNESOTA (2012), https://growthandjustice.org/images/uploads/LEWIN.Final_Report_FINAL_DRAFT.pdf.

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

⁵¹ Kaiser Family Foundation, “Health Insurance Coverage of the Total Population,” (timeframe: 2017), <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> GARY CLAXTON ET AL., KAISER FAMILY FOUNDATION, 2018 EMPLOYER HEALTH BENEFITS SURVEY, Section 10: Plan Funding, <https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/>; Centers for Medicare and Medicaid Services, National Health Expenditures 2016 Highlights 2, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>.

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

sponsored benefits, as detailed in Part II below. Additionally, the population covered by employer-sponsored health benefits tends to be healthier than those covered by public programs, which is critical to balancing the risk pool for the single-payer plan.⁵³ Of those with employer-based coverage, more than 60% are covered by self-funded plans (also called self-insured plans), where the employer pays for the health benefits with its own funds, retaining financial or insurance risk.⁵⁴ As discussed in Part II, ERISA’s “deemer” clause has placed self-funded plans entirely beyond the reach of state regulation.⁵⁵

To assess the distorting effect of ERISA preemption on states’ health reform efforts, this project focuses on the analyzing how states can capture employers’ expenditures and transition the 49% of the population covered by employer-sponsored health plans into the state single-payer program.⁵⁶ We reviewed the sixty-six single-payer bills to identify their methods of capturing employer expenditures, as discussed below.⁵⁷ Eight of the sixty-six proposals purported to establish a single-payer program for the state, but did not contain an explicit mechanism to capture employer expenditures or move those with employer coverage into the single payer, for example by creating a state-based “Medicare-for-All” program, enrolling everyone in the state in an

⁵³ See Victor R. Fuchs, *How to Make US Health Care More Equitable and Less Costly: Begin By Replacing Employment-Based Insurance*, 320 JAMA 2071, 2071 (2018); Brief for the Harvard Law School Center for Health Law & Policy et al., as Amici Curiae in support of Petitioner, *Gobeille v. Liberty Mutual Ins. Co.*, 577 U.S. ____; 136 S. Ct. 936 (2016) (No. 14-181), at 19-20.

⁵⁴ GARY CLAXTON ET AL., Kaiser Family Foundation, 2018 Employer Health Benefits Survey, Section 10: Plan Funding, at 167, <https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/>*supra* note , at Section 10 167. See, e.g., *Advantages and Myths of Self-Funding for Employers with Fewer than 250 Employees*, Cigna Health & Life Ins. Co. (Feb. 2014), http://www.cigna.com/assets/docs/business/small-employers/841956_b_self_funding_whitepaper_v8.pdf (“Traditional self-funding is defined as when an employer pays for their own medical claims directly, while a third-party administrator administers the health plan by processing the claims, issuing ID cards, handling customer questions and performing other tasks.”).

⁵⁵ See Part II.A., *infra*.

⁵⁶ GARY CLAXTON ET AL. Kaiser Family Foundation, *supra* note 51, at Section 10.

⁵⁷ See Part I.B., *infra*.

expanded version of Medicare.⁵⁸ Thus, we focused our analysis on the remaining fifty-eight state single-payer proposals for their methods of capturing employer expenditures and moving those covered by employee health plans into the single-payer program.

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

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

In addition, most proposals contain nonduplication provisions prohibiting insurers from offering health benefits that duplicate those covered by the single-payer plan.⁵⁹ The idea behind nonduplication is that if insurers cannot sell plans that cover any of the services or benefits covered by the single-payer plan, then there are no competing private plans to choose from. Insurers may only sell so-called wraparound services that supplement the single-payer coverage. On its face, a nonduplication provision appears to do much of the work of shifting those with employer-based coverage to the single-payer plan, because employers would not have any health plan options to offer their employees in the single-payer state. However, as discussed in Part II, ERISA

⁵⁸ *See, e.g.*, S.B. 2598, 218th Leg., Reg. Sess. (N.J. 2018).

⁵⁹ *See, e.g.*, H.F. 2352, 87th Gen. Assemb., 2018 Sess. (Iowa 2017), § 7(3) (“An insurer, carrier, or health maintenance organization that is issued a certificate of authority by the commissioner of insurance may offer only the following: . . . Benefits that do not duplicate the health care services covered by the healthy Iowa program.”).

preemption likely would make the nonduplication provisions unenforceable against self-funded employer-based health plans.⁶⁰ Thus, state single-payer proposals must use other provisions to draw the self-funded employers' expenditures and their enrollees into the single-payer plan.

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

1. Type A—Funding Plan

The Type A—Funding Plan model captures employer expenditures and participation through a payroll tax and/or an individual income tax. Payroll taxes are levied on employers and are calculated as a percentage of the wages that the employer pays its employees.⁶¹ The fact that the payroll tax is based on wages and not the employer's spending on employee health benefits is significant for the ERISA preemption analysis below.⁶² As tallied in Figure 3, forty-five bills across sixteen states contain a Type-A funding plan.⁶³ State proposals may impose a flat⁶⁴ or graduated payroll tax rate,⁶⁵ which also may apply to self-employed income.⁶⁶ Some states divide the payroll tax among employers and employees, with the employer paying a larger proportion of the tax, similar to the current division of premiums for employer-based

⁶⁰ See Part II.B.4, *infra*.

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

⁶² See Part II.B.1, *infra*.

⁶³ See Fig. 2, *infra*.

⁶⁴ See, e.g., Pa. S.B. 1014, § 904 ("[A] tax of 10% is imposed on payroll amounts generated as a result of an employer conducting business activity within this Commonwealth."). Vermont's plan would have imposed a flat 11.5% payroll tax as well as a graduated income tax. See PETER SHUMLIN, GOVERNOR OF THE STATE OF VERMONT, GREEN MOUNTAIN CARE: A COMPREHENSIVE MODEL FOR BUILDING VERMONT'S UNIVERSAL HEALTH CARE SYSTEM 5 (2014), <http://hcr.vermont.gov/sites/hcr/files/pdfs/GMC%20FINAL%20REPORT%20123014.pdf>.

⁶⁵ See NY A. 4738-A, § 4-2a; LIU ET AL., *supra* note 49, at 2.

⁶⁶ See R.I. S.B. 2237, § 23-95-12(i).

coverage.⁶⁷ Other states would impose an income tax on employees to capture the employee-share of spending on health coverage.⁶⁸ Income taxes may apply to unearned income to capture non-wage earnings, such as interest, capital gains, or dividends,⁶⁹ and can be progressively scaled to income levels. Sales and excise taxes are possible, but potentially more regressive than taxes scaled to individual income.

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

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

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

⁶⁹ See R.I. S.B. 2237, § 23-95-12(ji) (“There shall be a progressive contribution based on unearned income, i.e., capital gains, dividends, interest, profits, and rents. Initially, the unearned income RICHIP contributions shall be equal to ten percent (10%) of such unearned income. The ten percent (10%) initial rate may be adjusted by the director to allow for a graduated progressive exemption or credit for individuals with lower unearned income levels.”) See also, LIU ET AL., *supra* note 49, at 2 (“Individuals would not pay premiums for NYHA. Instead, the program would be financed by new graduated state taxes on payroll and nonpayroll income (such as interest, dividends, and capital gains) and redirected federal funding through waivers and state funding for current health care programs.”).

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

⁷¹ As discussed in Part II, a funding plan based on a payroll tax should avoid preemption by ERISA, but it is far from certain whether courts will agree. Income taxes generally would

The simplest form of Type A plan would rely solely on a payroll tax and/or income tax to capture employer expenditures and move enrollees to drop their employer coverage. These “Funding Only” proposals capture employers’ health care expenditures directly via a payroll tax and assume that few employers would continue to offer their own coverage for employees subject to the payroll tax assessment, and even if they do, few employees will continue to take up employer coverage once they are covered by the state single-payer plan. An example of a Funding Only model is Washington’s 2017 single-payer bill, which would fund its single-payer plan using a payroll tax for employers, with no exceptions.⁷² Most of the state single-payer bills that contain a funding plan combine the financing mechanism with other tools, discussed below, to entice individuals into the single-payer plan and capture employer health expenditures.

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

2. Type B—Provider Restriction

A second variation, the Type B—the Provider Restriction model, uses a form of provider regulation to draw individuals away from employer-based plans into the single-payer plan. Thirty-four of the single-payer bills across fourteen states contain a Type-B provider restriction.⁷⁴ Because provider regulation tends to fall beyond the reach of ERISA preemption,⁷⁵ state single-payer proposals use provider regulation to move individuals to drop their

not implicate ERISA. *See* Part II.A.2, *infra*.

⁷² S.B. 5747, 65th Leg., 2017 Reg. Sess. (Wash. 2017).

⁷³ *See* SHUMLIN, *supra* note 64, at 11 (explaining the analogous relationship between public school financing and Green Mountain Care).

⁷⁴ *See* [Figure 3](#), *infra*.

⁷⁵ *See* Part II.A, *infra*.

employer coverage. These provisions restrict the ability of participating providers from billing anyone other than the single-payer plan, whether the patient or any third-party payer, for services rendered to a patient with single-payer coverage. In addition, the provisions limit providers' payment rates to the single-payer rates. For example, California's S.B. 562 says that participating providers may not "charge any rate in excess of the payment established under this title for any health care service provided to a member under the program and *shall not solicit or accept payment from any member or third party for any health care service*, except as provided under a federal program."⁷⁶ The proposals may automatically enroll all residents in the state single-payer plan, or they may deem all residents presumptively eligible, but require an affirmative step to enroll.⁷⁷ Under either model, most plans assume all residents would be covered by the single-payer plan.

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

⁷⁶ Cal. S.B. 562, § 100639(e) (emphasis added). The proposed statute further states that "[t]his section does not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program." *Id.* In other words, for programs like TRICARE and the federal employee health benefits programs, which do not provide waivers, presumably the provider would be permitted to bill these federal programs directly, and the state single payer could be the secondary payer.

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

employer-based coverage is all but worthless to employees. Employees will drop employer coverage if it lacks a functioning provider network.

In some instances, we characterized single-payer proposals as a Type B model even when they lacked an explicit limit on providers' ability to be paid from non-single payer sources. For example, Provider Restrictions could exist where the plan contained strong incentives for providers to participate exclusively in the program short of a mandate to do so, such as requirements that providers participate on an all-or-nothing basis⁷⁸ or onerous notification requirements.⁷⁹ Another example is South Carolina's bill, which would pay providers a higher rate if they participate in the single-payer plan's network than if they do not.⁸⁰

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

3. Type C—Assignment, Subrogation, Secondary Payer

A third variation, the Type C model, includes an explicit subrogation, assignment, or secondary payer provision to facilitate the single-payer plan's ability to recover paid claims from collateral sources of coverage, including

⁷⁸ See, e.g., H.B. 2436, 100th Gen. Assemb., 1st Reg. Sess. (Ill. 2017), § 40(g) ("Providers who accept payment from the Program for services rendered may not bill any patient for covered services. Providers may elect either to participate fully, or not at all, in the Program."). See also, R.I. S.B. 2237, § 23-95-9(d), § 23-95-7(a)(2) (using nearly identical language).

⁷⁹ See, e.g., Pa. S.B. 1014, § 507 (requiring nonparticipating providers to notify patients of their provider's nonparticipation and to have the patient sign a form acknowledging he or she is solely responsible for amounts charged in excess of the approved single-payer rates, or else face penalties for noncompliance up to 200% of the amount they billed the patient).

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

employer-based plans.⁸¹ Twenty-five bills across nine states employed a Type-C subrogation, assignment or secondary payer provision.⁸²

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

(2) The Oregon Health Authority is subrogated to the rights of any participant that has a claim against an insurer, tortfeasor, *employer, third party administrator*, pension manager, public or private corporation, government entity or any other person that may be liable for the cost of health services provided to the participant and paid for by the Health Care for All Oregon Plan. (3) The authority may enter into an agreement with any person for the prepayment of claims anticipated to arise under subsection (2) of this section during a biennium. At the end of each biennium, the authority shall appropriately charge or refund to the payer the difference between the amount prepaid and the amount due.⁸⁴

An assignment of benefits is a legal agreement where the individual agrees to transfer the right to reimbursement for his or her health care services

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

⁸² See [Figure 3](#), *infra*.

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

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

to another party, typically to a provider.⁸⁵ In the single-payer context, an assignment provision would transfer to the single-payer plan the individual's right to reimbursement from another third-party payer, such as a health plan.⁸⁶

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

To illustrate the mechanics of these provisions, assume an employee gets an MRI and a bill for \$800 for the service. Her employer's plan agrees to pay up to \$1,000 for an MRI. Under a subrogation provision, the state single-payer plan would pay the provider's bill of \$800, then charge the employer \$800.⁸⁹ Under an assignment provision, similarly, the state single-

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

⁸⁶ *See, e.g.*, R.I. S.B. 2237, § 23-95-12(g), providing:

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

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

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

⁸⁹ *E.g.* S.B. 631, 78th Leg. Assemb., 2015 Reg. Sess (Or. 2015), § 15(3) (providing that

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

In proposals using a Type C—Assignment/Subrogation/Secondary Payer model, if a patient has dual coverage in both the single-payer plan and another plan, such as employer-sponsored coverage, the single payer plan is able to seek reimbursement from the other plan (the collateral source of coverage) for any services provided. In states where the providers are permitted to bill collateral sources, the single-payer plan would just be responsible for patient cost-sharing and services not covered by the collateral source. Using the MRI example from above, the MRI provider could bill the patient's employer plan \$800 for the MRI. If the patient had a \$500 deductible under her employer plan, the patient would ordinarily owe \$500 to the MRI provider. However, the state single-payer plan, which does not permit patient cost-sharing, would then function as supplemental coverage and pay the patient's \$500 cost-sharing, and the employer would pay \$300.⁹² Thus, the assignment, subrogation, or secondary payer provision saves the single-payer plan money by turning first to collateral sources of coverage,⁹³ which may reduce the amount of payroll or other taxes required to fund the single-payer program.

these charges shall be amassed each "biennium").

⁹⁰ *E.g.*, R.I. S.B. 2237 § 23-95-12(g) (authorizing the state single-payer plan's director to take "any action necessary" to recover these funds).

⁹¹ *E.g.*, H.P. 887, 128th Leg., 1st Reg. Sess. (Me. 2017), § 7506 (providing that if the employer plan should have paid and did not, the state single-payer plan can pay and recoup the bill from the employer plan).

⁹² *E.g.*, P.A. S.B. 1014, §§ 503(c) (prohibiting patient cost sharing), 505 (subrogation), 507 (provider participation) (providing that the state plan is subrogated to and deemed an assignee of a participant's duplicate coverage, prohibiting the provider from charging participants cost-sharing, and not prohibiting the provider from billing a participant's duplicate coverage).

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

It also contains an implied acknowledgement that employers may continue to offer coverage if they so choose. The circuitous inefficiency of these Type C pay-and-recoup provisions illustrate the contortions that ERISA forces states into. These provisions would be unnecessary if the state could simply mandate that employers offer coverage to employees through the state single-payer plan or cease providing employer-based coverage altogether because the possibility of dual coverage would be eliminated.

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

A few states—Ohio, Rhode Island, and Maine—combine Types B and C.⁹⁴ Ohio's single payer bills contain provisions that require providers to seek payment only from the state single-payer plan, a provision subrogating the rights of the single-payer plan to all rights of a participant against a collateral source of payment, and a provision assigning from the participant to the single payer plan any rights to receive payment for services from any other source.⁹⁵ Combining Types B and C creates a mechanism to pull both employees and the employer expenditures into the single-payer plan: (1) require participating providers to seek payment only from the single payer; (2) all services provided to state residents will be paid by the single payer at the established rates; and (3) if the patient is dually covered by an employer plan or other coverage, then the single-payer entity will seek reimbursement from the collateral source. In this way, the single-payer system can capture some of the employer expenditures on claims paid. For patients with dual coverage, it effectively transforms the single-payer plan into the billing agent of the provider. The employer can still pay claims to the single-payer plan if

⁹⁴ See, e.g., Ohio H.B. 440; H. 5611, 2019 Gen. Assemb., Jan. Sess. (R.I. 2019); H.P. 962, 126th Leg., 1st Reg. Sess. (Me. 2013).

⁹⁵ Ohio H.B. 440 § 3920.09(C)-(D), § 3920.13, § 3920.04(B)(15)(g).

it elects to keep its private plan, but it may be easier and cheaper to simply stop covering the employees in that state and pay a payroll tax per employee instead. This model still relies upon a payroll tax or other way to capture the employer funds saved if it stops providing coverage to its employees, but it allows the single-payer to capture health expenditures from third-party payers that continue to exist outside the single-payer system.⁹⁶

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

A summary of the different types of mechanisms that state single-payer bills use to capture employer expenditures is listed in [Figure 2](#). The number of state proposals that contain each of the features, A, B, and C, are listed in [Figure 3](#). Note that proposals that feature more than one type of provision are

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

⁹⁷ H.P. 887, 127th Leg., 1st Reg. Sess. (Me. 2017); H.P. 316, 129th Leg., 1st Reg. Sess. (Me. 2019); H.B. 6285, (Mich. 2018); Or. S.B. 631; S.B. 5222, 66th Leg., Reg. Sess. (Wa. 2019).

⁹⁸ For example Wash. S.B. 5222 (2019) would allow employers that provide minimum essential coverage to employees to apply for an exemption from the payroll taxes to pay for the state plan. [See](#) § 114(3). Moreover, the bill does not contain a nonduplication provision and allows providers to continue to bill other payers. Mich. H.B. 6285 (2018) creates a state plan that would be secondary to other coverage. Providers remain free to contract with and bill third-party payers, but only at rates less than the state plan's rates. Employers may participate voluntarily.

counted more than once.

Figure 2. Types of State Single-Payer Provisions

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

Figure 3. Number of State Single Payer Proposals by Type

TYPE	PROPOSALS	# PROPOSALS	# STATES
A (Funding Plan)	CA SB810, DE HB392, DE HB74, IA HF2352, IA HF96, IL HB207, IL HB311, IL HB942, IL HF2436, IL SB2177, MA HB1026, MA HB2987, MA SB501, MA SB515, MD HB1087, ME HP1026, MN SF18, MN SF912, MN SF2163, MN SF219, MN SF1125, NJ AB4945, NY AB5062, NYAB5248, NY AB5389, NY AB7860, NY SB4840, OH HB440, OH SB104, OHSB137, OH HB292, PA HB1688, PA HB2551, PA SB1014, PA SB400, RI HB5611, RI SB2237, RI SB 2824, SC SB786, VT HB202, WA HB1104, WA SB5224, WA, SB5609, WA SB5741, WA SB5747	45	16
B (Provider Restriction)	CA SB562, FL SB1486, FL SB1872, IA HF2352, IA HF96, IL HB207, IL HB311, IL HB942, IL HF2436, IL SB2177, MA HB1026, MA HB2987, MA SB501, MA SB515, MD HB1087, MD HB1516, ME HP1026, ME HP962, NJ AB4945, NY AB5062, NY AB5248, NY AB5389, NY SB4840, OH HB287, OH HB440, OH SB104, OH SB137, OH HB292, RI HB5611, RI SB2237, RI SB2824, SC SB786, VT HB80, WA SB5957	34	14
C (Assignment, Subrogation, Secondary Payer)	ME HP1026, ME HP316, ME HP887, ME HP962, MI HB6285, MN SF18, MN SF912, MN SF2163, MN SF219, MN SF1125, OH HB287, OH HB440, OH SB104, OH SB137, OH HB292, OR SB631, PA HB1688, PA HB2551, PA SB1014, PA SB400, RI HB5611, RI SB2237, VT HB202, WA HB1104, WA SB5222	25	9

4. Summarizing the Models to Capture Employer Spending

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

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

In response to ERISA, the emerging models for state single-payer plans use a combination of nudges and incentives operating on all the various actors in the health care transaction. Employers are encouraged, but not required, by the payroll tax to drop their employee coverage in the single-payer state. Providers are given incentives to participate in the single-payer plan and thus relinquish the ability to charge any other party for their services, including

⁹⁹ See e.g., N.Y. A. 4738-A (combining a payroll tax, unearned income tax, and a provider restriction); Penn. S.B. 1014 § 904, § 905, § 505 (combining a payroll tax, income tax, and subrogation and assignment provisions). See also, [Appendix A](#).

¹⁰⁰ See, e.g., H.B. 1516, 438th Sess. Gen. Assemb., (Md. 2018) (providing for the revenue plan to be developed and a provider restriction); Or. S.B. 631 (providing for a revenue plan to be developed and a subrogation provision).

the individual patient or employer plans. Employees likely will choose the state-single payer plan and drop their employer plan, because the single-payer plan's broad provider network, lower cost-sharing, and comprehensive coverage will make it more attractive. Even if employees keep their employer-sponsored plan, the state single-payer plan may pay the providers and seek reimbursement from this collateral source. The legal question we turn to in the next Part is whether ERISA preempts these nudges and incentives designed to pull employees and employer health spending through the state's single-payer plan.

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

States' powers to regulate their health care systems are historic and expansive, but bounded by federal laws that limit state regulatory power through preemption. One federal law has erected a notorious obstacle to state regulation of health insurance: ERISA.¹⁰¹ Congress enacted ERISA in 1974 to regulate pensions (hence the "Retirement Income Security" in its title),¹⁰² but the statute's broad preemption language has wrought unintended consequences, blocking numerous state health reform laws over the past 40 years as impermissibly "relat[ing] to" employer-sponsored health insurance. ERISA's formidable preemption barrier is not, however, impassible. The ERISA preemption scheme allows states to regulate some aspects of the insurance industry, provider payments, and general revenues. State laws that manage to wriggle through the narrow space between permitted targets of regulation and impermissible burdens on employer-sponsored plans may survive preemption.

Whether state-based single-payer plans survive ERISA preemption is the billion-dollar question posed in Part I. The logical answer is that ERISA preemption poses a substantial obstacle to these state efforts, but the plans should survive if carefully drafted. The practical answer is that ERISA

¹⁰¹ Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001–1461 (2012))

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

preemption doctrine and precedent have become so harsh and unstable that they cast a pall of uncertainty, jurisdiction by jurisdiction, and invite litigation challenging these state efforts no matter where they arise.

A. The ERISA Preemption Labyrinth

Preemption generally describes the displacement of one legal authority by another legal authority in an established hierarchy.¹⁰³ The U.S. Constitution's Supremacy Clause makes duly enacted federal law the "supreme law of the land," and subordinates state laws "to the contrary."¹⁰⁴ Preemption doctrine thus plays a crucial role in maintaining order in a federal system and policing the boundaries of authority.¹⁰⁵

These boundaries, however, are porous, poorly defined, and disorderly at many important junctures.¹⁰⁶ Preemption doctrine has evolved a taxonomy of forms to determine which conflicts of authority have preemptive effect.¹⁰⁷ The taxonomy relies on divination of Congressional intent behind the federal law,¹⁰⁸ identification of its points of friction with state laws, and selection of

¹⁰³ See generally Caleb Nelson, *Preemption*, 86 VA. L. REV. 225, 225 n.3 (2000) (defining "preemption" as "the displacement of state law by federal statutes (or by courts seeking to fill gaps in federal statutes)"); *Preemption*, BLACK'S LAW DICTIONARY 1368–69 (10th ed. 2014) ("The principle (derived from the Supremacy Clause) that a federal law can supersede or supplant any inconsistent state law or regulation.").

¹⁰⁴ U.S. CONST. art. VI, cl. 2. See also, e.g., Lauren E. Phillips, Note, *Impeding Innovation: State Preemption of Progressive Local Regulations*, 117 COLUM. L. REV. 2225 (2018).

¹⁰⁵ See generally WILLIAM W. BUZBEE ED., PREEMPTION CHOICE (2009); RICHARD A. EPSTEIN & MICHAEL S. GREVE, EDS., FEDERAL PREEMPTION: STATES' POWERS, NATIONAL INTERESTS 309 (2007).

¹⁰⁶ See Elizabeth Y. McCuskey, *Body of Preemption: Health Law Traditions and the Presumption against Preemption*, 89 TEMPLE L. REV. 89, 95-97 (2016).

¹⁰⁷ See generally David S. Rubenstein, *Delegating Supremacy?*, 65 VAND. L. REV. 1125, 1136-37 (2012) (explaining the Supreme Court's preemption taxonomy).

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

the degree to which they may coexist.¹⁰⁹ Congress may explicitly express its intention to preempt state law, or that intent may be implied.¹¹⁰ Even when Congress expresses its wishes for preemption, those provisions invite plenty of ambiguity and room for interpretation.¹¹¹

ERISA exemplifies the phenomenon of expressed but ambiguous preemption provisions because the statute's preemption is both forcefully-worded and inscrutable. Although passed primarily with pension benefits in mind,¹¹² ERISA applies to all employer-sponsored benefits, and expressly extends to plans that provide "medical, surgical, or hospital care or benefits . . . through the purchase of insurance or otherwise."¹¹³ ERISA's original purposes were to safeguard employees' pensions and to encourage employers' provision of pension benefits by establishing a uniform system of federal regulation and limiting employees' remedies.¹¹⁴ ERISA, however,

¹⁰⁹ See McCuskey, *Body of Preemption*, *supra* note 106, at 95-97.

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

¹¹¹ See, e.g., *Geier v. Am. Honda*, 529 U.S. 861, 866, 873 (2000) (holding that implied preemption may apply even when the statute has express preemption provisions); Jamelle C. Sharpe, *Legislating Preemption*, 53 WM. & MARY L. REV. 163, 179, 216 (2011) ("Although an express preemption or saving clause can be *clear* evidence of Congress's preemptive intent, it may not be *definitive* evidence."); Meltzer, *supra* note 110, at 30-31 (noting the variety of interpretive methods applied to express preemption provisions). See also Brendan S. Maher, *The Affordable Care Act, Remedy, and Litigation Reform*, 63 AM. U. L. REV. 649, 702 (2014) (observing that, "[t]he doctrine of preemption—and obstacle preemption in particular—is quite muddled")

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

¹¹³ 29 U.S.C. § 1002(1) (originally § 3(1)). See, e.g., *Travelers*, 514 U.S. at 650-51. But cf. PATASHNIK, *supra* note 112, at 83 (noting scholarly disagreement about how far Congress intended ERISA to intrude on health insurance regulation, but agreement on "the importance of the preemption provision for health politics and policy").

¹¹⁴ See, e.g., 29 § 1001 (2012) (declaring ERISA's policy as, "to protect interstate

“does not go about protecting plan participants . . . by requiring employers to provide any given set of minimum benefits, but instead controls the administration of benefit plans”¹¹⁵ if employers choose to provide them.

To promote uniformity¹¹⁶ and encourage multi-state employers to provide benefits, Congress wrote into ERISA a “terse but comprehensive”¹¹⁷ provision expressly preempting “any and all” state laws¹¹⁸ that “relate to” any “benefit plan[s]”¹¹⁹ covered by the Act.¹²⁰ Even state laws friendly to ERISA’s goals have run afoul of its preemption.¹²¹

The “relates to” provision “may be the most expansive express pre-emption provision in any federal statute.”¹²² But ERISA contains a “savings

commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.”); 29 § 1001a (declaring “multiemployer pension” plans to be targets of ERISA’s policies); 29 § 1001b (declaring “single-employer defined benefit pension plans” to be targets of ERISA’s policies).

¹¹⁵ *Travelers*, 514 U.S. at 651.

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

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

¹¹⁸ ERISA defines state “laws” as “all laws, decisions, rules, regulations, or other state actions having the effect of law,” §514(c)(1), and includes both states and “any political subdivision thereof, or any agency or instrumentality of either which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by ERISA,” § 514(c)(2).

¹¹⁹ 29 U.S.C. § 1144(a) (2012) (included as § 514 in the Act).

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

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

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

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

The Court’s ERISA preemption jurisprudence has, over the past four decades, attempted to navigate a workable course between the “broad scope Congress intended” and the “susceptibility to limitless application” its chosen words engender.¹²⁷ The quest for workable standards in light of the clause’s “indeterminacy” has resulted in an ERISA preemption doctrine that rejects

litigated”).

¹²³ Noting in ERISA “shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities.” § 514(b)(2)(A) This clause preserves states’ ability to directly regulate the “business of insurance.” *See, e.g., Ky. Ass’n of Health Plans v. Miller*, 538 U.S. 329, 339, 341-42 (2003) (holding that “any willing provider” laws were not preempted); *Pharm. Care Mgm’t. Ass’n v. Rowe*, 429 F.3d 294, 301 (1st Cir. 2005) (holding that pharmacy benefit manager legislation was saved from preemption). *But see PCMA v. Gerhart*, 852 F.3d 722, 732 (8th Cir. 2018) (holding that ERISA preempted Iowa’s regulation of PBMs that provided services to ERISA plans). ERISA also contains a provision that expressly preserves other *federal* laws, stating that they are not preempted if ERISA’s application would “alter, amend, modify, invalidate, impair, or supersede” them. 29 U.S.C. § 1144(d); *see Shaw v. Delta Airlines*, 463 U.S. 85, 96-97 (1983).

¹²⁴ 29 U.S.C. § 1144(b)(2)(B).

¹²⁵ *See* Part II.A.2.b., *infra*.

¹²⁶ *See also* Mary Ann Chirba-Martin & Troyen A. Brennan, *The critical role of ERISA in state health reform*, 13 HEALTH AFF. 142, 142-156 (1994) (explaining the “intricate three-step dance of the ‘relate to,’ ‘savings,’ and ‘deemer’ clauses”).

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

“uncritical literalism,”¹²⁸ but replaces it with a complex analytical framework whose outcomes can be difficult to predict. It is a mess.

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

State laws also may “relate to” ERISA plans by having too strong a “connection with” them, such as when a state law “governs the payment of benefits, a central matter of plan administration,” or “interferes with nationally uniform plan administration,”¹³² or indirectly produces “economic effects” which would “force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers.”¹³³ Thus, ERISA would preempt state laws that require employers to offer health benefits or impose requirements on the benefits offered as impermissibly relating to an employee benefit plan.¹³⁴ The concept of a forced choice or

¹²⁸ *NY State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656. *See also* *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 336 (Scalia, J., concurring) (opining that the preemption clause’s furthest literal interpretations produce infinite preemption that “no sensible person could have intended”).

¹²⁹ *Travelers*, 514 U.S. at 655-56 (calling the preemption language “unhelpful” and rejecting a literal reading of the phrase). *Accord* *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (“not a model of legislative drafting”).

¹³⁰ *Travelers*, 514 U.S. at 656.

¹³¹ *Dillingham*, 519 U.S. at 325.

¹³² *Egelhoff*, 532 U.S. at 148.

¹³³ *Travelers*, 514 U.S. at 668. *See Gobeille*, 136 S.Ct. at 943 (collecting cases). *See also Egelhoff*, 532 U.S. at 146-47; *Shaw v. Delta Air Lines*, 463 U.S. 85, 97-100 (1983) (finding that laws effectively requiring employers to “pay employees specific benefits” are preempted).

¹³⁴ *E.g.*, *Travelers*, 514 U.S. at 664 (noting that a “substantive mandate” on health benefits would be preempted); Mary Anne Bobinski, *Unhealthy Federalism: Barriers to*

“Hobson’s choice” plays an important role in distinguishing preempted state laws from permitted ones.¹³⁵ State laws that nudge too hard may leave employers with only the illusion of choice in whether to offer benefits and what to cover.¹³⁶ Those laws are preempted as impermissibly relating to ERISA plans.¹³⁷ But state laws that merely make certain choices more attractive than others may survive;¹³⁸ their connection is “too tenuous, remote, or peripheral” for preemption.¹³⁹

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

In a health reform landscape already fraught with uncertainty and

Increasing Health Care Access for the Uninsured, 24 U.C. DAVIS L. REV. 255, 292 (1990) (stating that “state level employer mandates” are preempted).

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

¹³⁶ See *Travelers*, 514 U.S. at 664.

¹³⁷ See *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 192-93 (4th Cir. 2007).

¹³⁸ E.g., *Travelers*, 514 U.S. at 664 (“[N]o showing has been made here that the surcharges are so prohibitive as to force all health insurance consumers to contract with the Blues. As they currently stand, the surcharges do not require plans to deal with only one insurer, or to insure against an entire category of illnesses they might otherwise choose to leave without coverage.”).

¹³⁹ *Shaw v. Delta Airlines*, 463 U.S. 85, 100 (1983).

¹⁴⁰ See *John Hancock Mutual Life Ins. Co. v. Harris Trust & Savings Bank*, 510 U.S. 86, 99 (1993) (finding that Congress did not intend to “fundamentally . . . alter traditional preemption analysis” when it wrote ERISA’s express preemption language). See also *Boggs v. Boggs*, 520 U.S. 833, 833 (1997) (applying conflict preemption to ERISA).

indeterminacy,¹⁴¹ ERISA has wreaked havoc on state health regulation and reform efforts.¹⁴² The expansive “relates to” provision has preempted everything from direct mandates for employer benefits to statutory rules of general applicability that indirectly burden employers’ decisions about their plans and how much those plans will cost. In its most recent ERISA opinion in *Gobeille*, for example, the Supreme Court held that ERISA preempted state all-payer claims data reporting requirements, even where the plans already collected the data at issue and self-funded plans contracted with an insurance company affiliate to do so.¹⁴³

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

¹⁴¹ See generally, McCuskey, *Body of Preemption*, *supra* note 106, at 103-105; Scott L. Greer & Peter D. Jacobson, *Health Care Reform and Federalism*, 35 J. HEALTH POL., POL’Y & L. 203, 220 (2010) (noting that political opportunism in health policy can be counterproductive).

¹⁴² See, e.g., Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U. L. REV. 433, 464-65 (2010) (noting that ERISA’s provisions regularly capture the Supreme Court’s attention); Gregory Acs, et al., *Self-Insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums*, 15 HEALTH AFF. 266, 267 (1996) (“ERISA preemption is very controversial.”).

¹⁴³ *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. ___, 136 S. Ct. 936, 947 (2016).

¹⁴⁴ *Compare* Board of Trade, 506 U.S. 125, 130 (1992) (holding state law specifically referring to employee benefit plans preempted “on that basis alone”) *with* *Dillingham*, 519 U.S. at 328 (holding that state law which can function irrespective of ERISA plans does not impermissibly “reference” ERISA plans).

¹⁴⁵ State legislative purpose is “relevant only as it may relate to the ‘scope of the state law the Congress understood would survive,’” preemption or ‘the nature of the effect of the state law on ERISA plans.’” *Gobeille*, 136 S.Ct. at 946 (quoting *Travelers*, 514 U.S. at 658-59 and *Dillingham*, 519 U.S. at 325). See also *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830, (1988) (“Legislative “good intentions” do not save a state law within the broad pre-emptive scope of” ERISA preemption).

coverage and administration.¹⁴⁶

1. Provider regulation

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

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, the Supreme Court established both the modern understanding of the “connection with” preemption standard, and the modern analysis of how provider regulation may indirectly impact employer-sponsored health benefits.¹⁴⁸ The New York law challenged in *Travelers* imposed a 24% surcharge on hospital bills for patients covered by commercial insurance other than Blue Cross or Blue Shield (“Blue plans”) to

¹⁴⁶ See generally, Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J. L. MED. & ETHICS 86 (2009). States have endeavored to reform other aspects of their health care systems, especially cost structures, which are not as obviously related to the single-payer insurance reforms discussed here. *E.g.*, *Pharm. Care Mgm't. Ass'n v. District of Columbia*, 613 F.3d 179, 190 (D.C. Cir. 2010) (district law regulating pharmaceutical benefits managers partially preempted); *Pharm. Care Mgm't. Ass'n v. Rowe*, 429 F.3d 294, 301 (1st Cir. 2005) (similar legislation not preempted); Erin C. Fuse Brown & Jaime S. King, *ERISA as a Barrier for State Health Care Transparency Efforts*, in *TRANSPARENCY IN HEALTH & HEALTH CARE* (eds. I. Glenn Cohen, Holly Fernandez Lynch, and Barbara Evans, Cambridge U. Press 2019).

¹⁴⁷ See, *e.g.*, *Travelers*, 514 U.S. at 659-65 (arguing that surcharges are non-preempted economic influences because they do not require plans to deal with only one insurer); *Dillingham*, 117 S.Ct. at 840 (noting that traditional areas of state action such as medical care quality standards and hospital workplace regulations are too remote to affect choices made by ERISA plans); *De Buono*, 117 S.Ct. at 1747 (holding that state tax on gross receipts of health care facilities is not preempted by ERISA).

¹⁴⁸ See, *e.g.*, Amy B. Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55. U. KAN. L. REV. 1203, 1208 (2007). This decision came after multiple states attempted to include employers in health care reform without triggering ERISA preemption.

cover the externalized costs – borne by Medicaid, Blue plans, and community hospitals – that enabled commercial insurers and HMOs to charge lower rates and enroll healthier populations.¹⁴⁹ Although the surcharge was based on providers’ bills and was collected by the providers, it was designed to impact the cost-structure for third-party payers of those bills and in particular to make Blue plans more attractive.¹⁵⁰ Thus, the surcharge had an “indirect economic effect on choices made by insurance buyers, including ERISA plans.”¹⁵¹ *Travelers* held that this indirect economic incentive to buy Blue plans did not trigger ERISA preemption because it did not “bind plan administrators to any particular choice” of plan and did not “force” employers to contract with Blue plans.¹⁵²

Travelers established that general health care regulations’ indirect economic influence over employer health insurance choices may survive preemption, but only to a degree. While the 24% surcharge on hospital services was not “so prohibitive as to force all health insurance consumers to contract with” Blue plans, the Court posed that “there might be a point at which an exorbitant tax leaving consumers with a Hobson’s choice would be treated as imposing a substantive mandate” on employers’ insurance choices and therefore preempted.¹⁵³

¹⁴⁹ *Travelers*, 514 U.S. at 650. The law included an additional assessment on HMOs directly, varying with the number of Medicaid enrollees in the HMO, which was paid by the HMO to the state’s general fund. *Id.* At the time, New Jersey enacted a similar rate-setting statute that had survived preemption analysis in the Third Circuit. See *Travelers*, 514 U.S. at 654 (arguing that purposefully interfering with ERISA plan choices constitutes a “connection” that triggers preemption).

¹⁵⁰ *Id.* The law included an additional assessment on HMOs directly, varying with the number of Medicaid enrollees in the HMO, which was paid by the HMO to the state’s general fund. *Id.* at 650. See Monahan, *supra* note 148, at 1208 (finding that state laws with connections to ERISA plans may relate to such plans even if ERISA is not explicitly referenced).

¹⁵¹ *Travelers*, 514 U.S. at 659.

¹⁵² *Id.* at 661, 664 (“[T]he surcharges do not require plans to deal with only one insurer, or to insure against an entire category of illnesses they might otherwise choose to leave without coverage.”).

¹⁵³ *Id.* at 664.

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

2. Employer contributions

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

Massachusetts’s 2006 comprehensive health reform statute,¹⁵⁹ for example, included a requirement that employers with more than ten

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

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

¹⁵⁶ See generally Julia Contreras & Orly Lobel, *Wal-Martization and the Fair Share Health Care Acts*, 19 ST. THOMAS L. REV. 105 (2006) (evaluating Maryland’s Fair Share Health Care Act which was turned down in court for being incompatible with federal uniform treatment laws under ERISA).

¹⁵⁷ See Monahan, *supra* note 148, at 1205-06 (arguing that state laws with relatively weak “pay” provisions are more likely to survive ERISA preemption challenges when not viewed as disguised mandates).

¹⁵⁸ See *id.* at 1211-20.

¹⁵⁹ “Massachusetts Health Care Reform Act”

employees make “fair and reasonable contributions” to employees’ health insurance coverage, or else pay an assessment of \$295 per employee into a state fund.¹⁶⁰ A few years after Massachusetts enacted its reforms, the Affordable Care Act enacted a federal “pay-or-play” provision modeled on the Massachusetts statute,¹⁶¹ now colloquially referred to as the “employer mandate.”¹⁶² The Massachusetts employer mandate, “somewhat surprisingly,” went unchallenged under ERISA,¹⁶³ perhaps because the health reform bill enjoyed widespread political support from employers.¹⁶⁴

Elsewhere, employer trade groups have readily challenged pay-or-play legislation in court, leading to divergent approaches in the Circuit Courts starting in 2007. Maryland’s Fair Share Health Care Act,¹⁶⁵ aimed at

¹⁶⁰ MASS. GEN. LAWS ch. 149, § 188(a) (2006). Employers who do not arrange pre-tax payroll deductions for their employees’ health benefits face an additional assessment if their employees use the state-funded Health Safety Net program. *Id.* ch. 149 § 44.

¹⁶¹ *See, e.g.*, KAISER FAMILY FOUNDATION, MASSACHUSETTS HEALTH CARE REFORM: SIX YEARS LATER, at 1 (May 2012), <https://www.kff.org/health-costs/issue-brief/massachusetts-health-care-reform-six-years-later/> [<https://perma.cc/HTX2-MZHL>] (evaluating former Governor Mitt Romney’s health reform effort to provide near-universal health coverage to state residents and the standard it set for similar national efforts).

¹⁶² *See, e.g.*, Internal Revenue Service, Employer Shared Responsibility Provisions, <https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions> [<https://perma.cc/KCA6-XD3E>] (“The employer shared responsibility provisions are sometimes referred to as ‘the employer mandate’ or ‘the pay or play provisions.’”).

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

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

¹⁶⁵ MD. CODE ANN., HEALTH-GEN. § 15-142 (2007) (“Fair Share Health Care Fund Act”). *See* Retail Industry Leaders Association v. Fielder, 475 F.3d 180, 198 (4th Cir. 2007) (Michael, J., dissenting) (“Maryland enacted the Fair Share Health Care Fund Act [] in 2006 to require very large employers, such as Wal-Mart Stores, Inc., to assume greater

Walmart, required employers with more than 10,000 employees to spend a minimum of 8% of their payroll on health care, or else pay the difference between the employer's actual health care expenditures and the 8% threshold into a state Medicaid fund.¹⁶⁶ Walmart's trade association sued.

The Fourth Circuit in *Retail Industry Leaders Association v. Fielder* held that ERISA preempted Maryland's pay-or-play law.¹⁶⁷ The *Fielder* majority concentrated on the extent to which Maryland's law impacted Walmart's ability to uniformly administer its benefits nationwide.¹⁶⁸ *Fielder* framed the inquiry in terms of choice: A state law that "directly regulates or effectively mandates some element" of employer plans is preempted, while a law that "creates only indirect economic incentives that affect but do not bind the choices of employers" is not.¹⁶⁹ Maryland's law gave Walmart the choice of offering 8% payroll in health benefits to its employees, or paying that amount into the state Medicaid fund.¹⁷⁰

The Fourth Circuit found that "playing" by increasing benefits was, "[i]n effect, the only rational choice."¹⁷¹ Offering the required level of health benefits would make Walmart a more attractive employer and help it recruit and retain employees.¹⁷² But "paying" that money to the state instead would not produce any benefit for Walmart, and might actually harm its employee morale and public opinion.¹⁷³ Because the "pay" option was so undesirable for the employer, the Fourth Circuit held that the Act "effectively mandates that employers structure their employee healthcare plans to provide a certain

responsibility for employee health insurance costs that are now shunted to Medicaid."). Suffolk County, NY enacted a similar "Wal-Mart" law. See Jacobson, *supra* note 146, at 94 (Suffolk County's provision applied only to non-unionized retailers).

¹⁶⁶ MD. CODE ANN., HEALTH-GEN. § 15-142(d), (f), (g). See Contreras & Lobel, *supra* note 156, at 105-06.

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

¹⁶⁸ *Id.* at 193.

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.*

level of benefits,” and therefore formed an impermissible connection with ERISA plans.¹⁷⁴

The Maryland Act “directly” targeted an employer, and nudged too hard on Walmart’s benefits decisions by failing to offer “meaningful alternatives” for compliance.¹⁷⁵ Further, the majority in *Fielder* expressed concern that permitting Maryland to enforce its law would invite other states to regulate similarly and “force Wal-Mart ... to monitor these varying laws and manipulate its healthcare spending to comply with them.”¹⁷⁶

State pay-or-play laws now must navigate around *Fielder* to survive preemption challenge. Shortly after *Fielder* in 2007, a New York district court held that “[a]lthough ... not bound by the decision of the Fourth Circuit in *Fielder*,” a county-level play-or-pay regulation targeting Walmart was “substantially similar to the Maryland Act” and therefore preempted.¹⁷⁷ But in 2008, San Francisco’s Health Care Security Ordinance successfully avoided preemption before the Ninth Circuit in *Golden Gate Restaurant Association v. San Francisco*.¹⁷⁸ San Francisco’s 2006 version of pay-or-play survived largely due to its inclusion of the “meaningful alternatives” missing in *Fielder*.¹⁷⁹ If *Fielder* represents the preempted Hobson’s choice

¹⁷⁴ *Id.* at 193-94 (“The Act thus falls squarely under *Shaw*’s prohibition of state mandates on how employers structure their ERISA plans.”) (citing *Shaw*, 463 U.S. at 96-97). *But see id.* at 201-03 (Michael, J., dissenting) (“The Act expresses no preference for one method of or the other. . . . The Act does not compel an employer to establish or maintain an ERISA plan [or] impede an employer’s ability to administer its ERISA plans under nationally uniform provisions,” or “mandate a certain level of ERISA benefits.”).

¹⁷⁵ *Id.* at 196-97. *See Retail Indus. Leaders Ass’n/RILA v. Suffolk Cty.*, 497 F. Supp. 2d 403, 417 (E.D.N.Y. 2007) (“Although the Act provides employers with various alternative options to comply..., ‘the only rational choice employers have under [the Act] is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold.’). *But see Fielder*, 475 F.3d. at 202-203 (Michael, J., dissenting) (“The choice is real” because the “pay” amount is not “exorbitant.”).

¹⁷⁶ *Id.* at 197.

¹⁷⁷ *See, e.g., Suffolk Cty.*, 497 F. Supp. 2d at 416.

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

¹⁷⁹ *See Golden Gate Restaurant Ass’n v. City and County of San Francisco*, 546 F.3d 639, 660 (9th Cir. 2008) (“In stark contrast to the Maryland law in *Fielder*, the City-payment option under the San Francisco Ordinance offers employers a meaningful alternative that

or forced choice for employer contributions, *Golden Gate* represents the non-preempted “meaningful” or true choice.

The San Francisco Health Care Security Ordinance established a city-run health care program for low-to-moderate income residents.¹⁸⁰ To help capture and maintain employer health care contributions in funding the program, the ordinance requires that employers make “required health care expenditures to or on behalf of” employees at regular intervals.¹⁸¹ The ordinance set the “health care expenditure rate”¹⁸² based on the number of hours worked, but left up to the employers what type of expenditures to make.¹⁸³ Employers had “discretion” in choosing among all possible commercial and private options.¹⁸⁴ Employers also could choose a mix of different expenditures, as long as they met the required rate in total spend.¹⁸⁵

The Ninth Circuit observed that the ordinance did not force “creation” of ERISA plan, require employers to start offering health plans or change any existing health plans, or demand they provide specific benefits in any particular way.¹⁸⁶ Rather, the ordinance prescribed only the dollar amount employers must spend and did not scrutinize much about *how* they spend the money or the “benefits derived from those dollars.”¹⁸⁷ Combining a required expenditure rate with such broad discretion in how to spend it constituted an “even less direct ... influence” on employer benefit decision than the one the Supreme Court upheld in *Travelers*.¹⁸⁸

The nature of the choices facing San Francisco employers distinguished the ordinance from Maryland’s preempted law. The two laws differed little

allows them to preserve the existing structure of their ERISA plans.”).

¹⁸⁰ S.F. ADMIN. CODE §§ 14.1-14.8 (2007)

¹⁸¹ S.F. ADMIN. CODE § 14.3(a). *Golden Gate*, 546 F.3d at 642.

¹⁸² S.F. ADMIN. CODE § 14.1(b)(68).

¹⁸³ *Golden Gate*, 546 F.3d at 644.

¹⁸⁴ *Id.* at 644-45 (citing S.F. ADMIN. CODE § 14.1(b)(7) and ESR Reg. 4.2(A)).

¹⁸⁵ *Id.* at 645-646.

¹⁸⁶ *Id.* at 646, 649-52.

¹⁸⁷ *Id.* at 647.

¹⁸⁸ *Id.* at 656 (citing *Travelers*, 514 U.S. at 658-59).

in the ultimate expenditure required from employers, with Maryland's calculated as a percentage of payroll and San Francisco's calculated as a flat dollar amount per hour worked. The Maryland law, however, offered nothing new for the employer who chose the "pay" option, effectively rendering it a penalty for not offering suitable health insurance benefits.¹⁸⁹ By contrast, the ordinance establishing San Francisco's city-run benefits program "offers employers a meaningful alternative" to an ERISA plan, and "provides tangible benefits to employees when their employers choose to pay" the city.¹⁹⁰ Employers who already offered health care benefits could keep their ERISA plan, and employers who did not could simply pay the tax and their employees could rely on the City program.¹⁹¹ Employers who rely on the City program would have a way to keep their employees healthy without the burden and complexity of selecting and administering their own ERISA plans.

Pay-or-play laws thus survive or fail ERISA preemption based on the nature of the employer choices they establish and courts' characterizations of them.¹⁹² Two years after the *Golden Gate* opinion, Congress enacted a federal-level employer mandate in the Affordable Care Act, likely obviating the urgency for many more states to pursue pay-or-play regulations.¹⁹³ Massachusetts repealed its state employer mandate during the initial years of Affordable Care Act implementation.¹⁹⁴ Some cities and counties, meanwhile, have continued to pursue expanded health care programs with some pay-or-play features likely designed with the *Fielder-Golden Gate* split

¹⁸⁹ *Id.* at 659-60 (quoting *Fielder*, 475 F.3d at 193, 196).

¹⁹⁰ *Id.* at 660.

¹⁹¹ *See id.* at 6061.Id.

¹⁹² *See Monahan, supra* note 148 at 1205.

¹⁹³ *See Wiley, supra* note 8, at 859 (stating that, "[t]he [pay-or-play preemption] issue became moot when the ACA federalized the employer mandate, so the question remains unresolved").

¹⁹⁴ *See Benjamin D. Sommers, Mark Shepard, & Katherine Hempstead, Why Did Employer Coverage Fall in Massachusetts After the ACA? Potential Consequences of a Changing Employer Mandate*, 37 HEALTH AFF. (2018) (examining employer-sponsored coverage rates before and after Massachusetts repealed its state-level mandate in 2014).

in mind. For example in 2016, the City of Seattle enacted a *Golden Gate*-style ordinance aimed at employer health care contributions for hotel workers.¹⁹⁵ The ERISA Industry Committee has sued the City, relying on *Fielder* to argue that ERISA preempts the ordinance; the litigation remains ongoing.¹⁹⁶ Massachusetts revived its pay-or-play mandate in 2018, suggesting that the preemption of pay-or-play provisions remains a relevant concern despite the ACA's federal employer mandate.¹⁹⁷

The Supreme Court has not considered ERISA preemption in the pay-or-play context, and litigation outcomes remain unpredictable when navigating the distinctions between diverging circuit court opinions in *Fielder* and *Golden Gate*.¹⁹⁸ The pair of cases has reverberated beyond the Fourth and Ninth Circuits. Other courts rely on *Fielder* and *Golden Gate* in a variety of ERISA contexts as exemplars of preempted and permitted employer incentive impacts, respectively.¹⁹⁹

¹⁹⁵ See Carmen Castro-Pagan, "Seattle Faces Legal Test Over Hotel Worker Insurance Mandate," BLOOMBERGLAW.COM (Aug. 14, 2018).

¹⁹⁶ *Id.*; ERISA Indus. Cmte. v. City of Seattle, 2:18-CV-01188 (W.D. Wash. Aug. 2018).

¹⁹⁷ See Katie Lannan, "Mass. Employers Face New Health Care Assessments in 2018," WBUR.ORG (Dec. 29, 2017), <https://www.wbur.org/commonhealth/2017/12/29/mass-employers-face-new-health-care-assessments-in-2018>.

¹⁹⁸ See, e.g., *Fielder*, 475 F.3d at 201 (Michael, J., dissenting) (lamenting the inconsistency of ERISA preemption holdings); *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 558 F.3d 1000, 1004 (2009) (Smith, J., dissenting from denial of rehearing en banc); *id.* at 1001 (Fletcher, J., concurring in panel opinion); *The ERISA Indus. Cmte. v. City of Seattle*, 2:18-CV-01188 (W.D. Wash. Aug. 2018) (pending litigation challenging Seattle pay-or-play ordinance for hotels). See generally, Catherine L. Fisk & Michael M. Oswalt, *Preemption and Civic Democracy in the Battle over Wal-Mart*, 92 MINN. L. REV. 1502, 1514–20 (2008) (arguing that the Fourth Circuit's majority analysis in *Fielder* is inconsistent with recent Supreme Court holdings in other ERISA preemption cases); Chirba-Martin, *supra* note 155, at 411 (observing "the unfortunate reality that when it comes to ERISA preemption litigation, anything can happen").

¹⁹⁹ See, e.g., *Self-Ins. Inst. of Am., Inc. v. Snyder*, 761 F.3d 631, 637 (6th Cir. 2014) (distinguishing *Fielder* in a hospital receipts tax context), *cert. granted, judgment vacated*, 136 S. Ct. 1355 (2016), *aff'd*, 827 F.3d 549 (6th Cir. 2016), *cert. denied*, 137 S.Ct. 660 (2017); *Merit Const. All. v. City of Quincy*, 759 F.3d 122, 130 (1st Cir. 2014) (citing the pair of cases in assessing whether compliance with a city public-bidding ordinance "by

3. Insurance regulation versus self-funded plans

ERISA's express preemption provision contains an exception: a "savings" clause that saves from preemption state laws that regulate insurance.²⁰⁰ However, the savings clause contains an exception-to-the-exception, the "deemer" clause, which has been interpreted to exempt self-funded employer plans from the state insurance regulations saved by the savings clause.²⁰¹ The upshot of the convoluted interplay between ERISA's savings and deemer clauses is that states may regulate so-called "fully insured" employee health plans, but self-funded plans are completely beyond the reach of state law.

ERISA's savings clause preserves significant spheres of state regulatory authority over health insurance. The statute does not define "insurance,"²⁰² but under current ERISA precedent, it saves state laws that are "specifically directed toward entities engaged in insurance" and "substantially affect the risk pooling arrangement between the insurer and the insured."²⁰³

Thus, employers who provide health benefits by buying insurance policies for their employees must abide by state health insurance regulations that govern those policies. This method of providing employee health benefits is known as a "fully-insured" plan because the employer purchases insurance policies for its employees from an insurance company, who takes on the contracted risks in exchange for premiums.²⁰⁴ For these fully-insured plans, states retain broad authority to regulate. For example, state insurance rules prohibiting subrogation by health insurance plans affect employer

means of a non-ERISA plan" avoids preemption).

²⁰⁰ 29 U.S.C. § 1144(b)(2)(A).

²⁰¹ 29 U.S.C. § 1144(b)(2)(B); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985).

²⁰² Compare 29 § 1144(b)(2)(A) ("nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance") with 29 § 1002 (definitions section, no entry for insurance).

²⁰³ *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341–42 (2003) (making "a clean break from the [three] McCarran-Ferguson factors" in favor of two factors).

²⁰⁴ See, e.g., Kaiser Family Foundation, *Employer Health Benefits: 2018 Annual Survey*, 175 (2018).

plans' calculation of benefits but nonetheless avoid preemption under the savings clause.²⁰⁵ States also can regulate the insurance policies available for purchase by employers. States may require that insurers cover certain services,²⁰⁶ set rules for underwriting and administration²⁰⁷ (such as mandatory open enrollment, community rating, and risk-pooling),²⁰⁸ and require that insurers accept all providers willing to meet the plan's terms ("any willing provider" laws).²⁰⁹

Many employers, particularly larger employers, now offer health benefits a different way: they agree to pay for some portion of their employees' health care needs directly from an employer fund, instead of purchasing insurance policies for them.²¹⁰ This form of employer-sponsored health benefit is known as "self-funded"²¹¹ or "self-insured,"²¹² with the "self" referring to the

²⁰⁵ See *FMC Corp. v. Holliday*, 498 U.S. 52, 59-61 (1990).

²⁰⁶ See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 731, 746-47 (1985) (holding that states may require specified mental-health-care benefits be provided to residents in certain employee health-care plans).

²⁰⁷ See, e.g., *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 370-87 (2002) (holding state law requiring external appeals process was enforceable against HMO providing employer-sponsored coverage).

²⁰⁸ See, e.g., *NYS Health Maintenance Org. Conference v. Curiale*, 64 F.3d 794, 803 (2d Cir. 1995) (holding that NY community rating and open enrollment laws were not preempted because their only connection to employer plans was an "indirect effect on rate diversification among insurers"); *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647, 648 (7th Cir. 1995) (holding Wisconsin high-risk pool regulations were not preempted by ERISA).

²⁰⁹ See *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 335-37 (2003) (upholding state "any willing provider" law as within the "business of insurance" under ERISA). Cf. *Pharm. Care Mgmt. Ass'n v. Tufte*, 297 F. Supp. 3d 964, 982 (D.N.D. 2017) (holding that ERISA does not preempt state regulation of pharmacy benefit managers – insurance intermediaries). But cf. *PCMA v. Gerhart*, 852 F.3d 722 (8th Cir. 2018).

²¹⁰ See SELF-INSURANCE INSTITUTE OF AMERICA, SELF-INSURED GROUP HEALTH PLANS, (2018), available at <https://www.siaa.org/i4a/pages/index.cfm?pageID=4546> [<https://perma.cc/96RL-XQCY>].

²¹¹ GARY CLAXTON ET AL., *supra* note 51, at Section 10. Employers often safeguard their funds by purchasing "stop loss" insurance, to protect them if their employees' health care claims exceed the fund amount.

²¹² See Timothy Stoltzfus Jost & Mark A. Hall, *Self-Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options*, 68 N.Y.U. ANN.

employer. In 2018, 61% of Americans with employer-sponsored health care coverage were covered by self-funded plans.²¹³ By contrast, in the 1970s when ERISA was passed, only 7% of those with employer-sponsored health coverage were in self-funded plans.²¹⁴ Although the deemer clause does not mention self-funded plans, the Supreme Court has held that the self-funding mechanism does not sufficiently replicate the “business of insurance” for the purpose of regulation, and thus states may not “deem” self-funded plans to be providing insurance for the purpose of regulating them.²¹⁵

This interpretation of ERISA’s savings and deemer clauses means states may enforce their insurance regulations against fully-insured but not self-funded employer-sponsored health plans.²¹⁶ In essence, ERISA preemption catalyzed the growth of self-funded plans by opening a loophole through which employers could provide their employees with health benefits and avoid state insurance regulation.²¹⁷ Further, courts have allowed employer plans to be “self-insured in name only, with the [employer] bearing minimal risk and most of the risk borne by the insurer” providing stop-loss coverage

SURV. AM. L. 539, 554-56 (2013) (noting no definition of “self-insured” in ERISA, but tracing definitions through the Internal Revenue Code and Affordable Care Act).

²¹³GARY CLAXTON ET AL., *supra* note 51, at Section 10.

²¹⁴ Phyllis C. Borzi, *There's "Private" and Then There's "Private": ERISA, Its Impact, and Options for Reform*, 36 J. L. MED. & ETHICS 660, 661 (2008).

²¹⁵ See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (holding that self-insured plans are exempt from state insurance regulation under the “deemer” clause).

²¹⁶ See *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (“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,” thus preemption state anti-subrogation law applied to self-funded plans).

²¹⁷ See Timothy Stoltzfus Jost & Mark A. Hall, *Self-Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options*, 68 N.Y.U. ANN. SURV. AM. L. 539, 552-54 (2013); Chirba-Martin & Brennan *supra* note 126, at 146; Russell Korobkin, *The Battle over Self-Insured Health Plans, or “One Good Loophole Deserves Another”*, 5 YALE J. HEALTH POL’Y, L., & ETHICS 90 (2005). But see *FMC Corp.*, 498 U.S. at 68 (Stevens, J., dissenting) (noting that, “The number of self-insured employee benefit plans grew dramatically in the 1960’s and early 1970’s.”).

to the employer.²¹⁸

ERISA's savings clause thus allows states to regulate 40% of the employer-sponsored insurance market that is fully insured, but the deemer clause preempts the same state regulation as applied to the remaining 60% of employer self-funded plans.²¹⁹ The diminishing practical distinction between fully insured and self-insured plans strains credulity.²²⁰ Yet this technical distinction triggers ERISA preemption for self-funded plans and thereby frustrates state efforts to enact uniform health care reforms,²²¹ as self-funded plans have swallowed the savings clause.

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

B. State Single-Payer Plans under ERISA

The intricate threat of ERISA preemption appears to have informed state legislative drafting in the most recent waves of single-payer legislation.²²²

²¹⁸ Jost & Hall, *supra* note **Error! Bookmark not defined.**, at 554.

²¹⁹ See Korobkin, *supra* note 217, at 136.

²²⁰ See *FMC Corp.*, 498 U.S. at 65 (Stevens, J., dissenting) (“The Court’s construction of the statute draws a broad and illogical distinction between benefit plans that are funded by the employer (self-insured plans) and those that are insured by regulated insurance companies (insured plans).”)

²²¹ See, e.g., Bobinski, *supra* note 134, at 294. See also Gregory Acs, et al., *Self-Insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums*, 15 HEALTH AFF. 266, 267 (1996) (ERISA “limits many of the health care financing and cost containment initiatives that states have considered” and “[b]ecause self-insured plans do not have to comply with state mandated benefits, ERISA prevents states from legislating a minimum benefit package for all of their residents.”).

²²² As detailed in part I, *supra*, state single-payer plans establish broad eligibility and coverage rules, then employ one or more types of provisions to fund the plans and draw enrollees from private coverage into the plan. These provisions typically involve payroll and income taxes (Type A – Funding Plans), restrictions on provider reimbursement outside the state plan (Type B – Provider Restrictions), and some means of recouping state-plan payments for those who continue to maintain employer coverage (Type C – Assignment, Subrogation, Secondary-Payer). See Figure 2, *supra*.

Many provisions in the single-payer plans outlined in Part I fall well beyond ERISA’s preemptive reach because they address the state’s operation of its own plan and do not “relate to” employer-sponsored health plans, including the resident eligibility, cost-sharing, comprehensive coverage, and care coordination provisions.²²³ Similarly, the provider eligibility and rate-setting provisions, as well as rate setting for medical goods like prescription drugs, target core features of the health care market without regard to employer plans, and with permissibly tangential effects on them.²²⁴ They have a strong foundation in Supreme Court precedent²²⁵ and should easily survive litigation challenge.

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

1. Type A—Funding Plans

State individual income taxes, meant to capture employees’ contributions to premiums and cost-sharing, do not trigger ERISA preemption because they do not target or impact employers. Employer payroll taxes also *should* easily survive preemption under *Travelers*. Payroll taxes keyed to employers’ health care expenditures, however, may need to navigate through the

²²³ See Part I.A, *infra* (listing examples of these common provisions). Cf. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 370-87 (2002) (holding state law dictating plan administration was enforceable against HMO providing employer-sponsored coverage); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (state-mandated coverage of particular services, as applied to employer plans, not preempted as regulating insurance).

²²⁴ See Part I.A, *infra* (providing examples).

²²⁵ E.g., *Kentucky Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 336 (2003) (upholding state “any willing provider” law as within the “business of insurance” under ERISA); *Travelers*, 514 U.S. at 659-65; *Dillingham*, 117 S.Ct. at 840; *De Buono*, 117 S.Ct. at 1747.

impenetrable hash of appellate precedent on pay-or-play laws, which obscures prediction.

Although states enjoy fairly wide latitude on how they raise revenues, Type A's payroll taxes ultimately could influence employers' benefit decisions and therefore may run afoul of ERISA preemption. Assessments targeting particular employers and offering the employer nothing in return, as in *Fielder*,²²⁶ and/or setting the tax rate exorbitantly high²²⁷ may exert a preempted level of influence on the employer's benefit plan decisions. On the other hand, laws that preserve discretion for employers on how to meet a required health care expenditure rate and that offer tangible options for employers that choose pay instead of play, as in *Golden Gate*, create the kind of "legitimate alternatives that survive preemption."²²⁸

The payroll taxes in Funding Plans have several structural advantages over the pay-or-play assessments in *Fielder* and *Golden Gate*. First, payroll tax provisions do not depend on the existence or amount of employers' health benefits and need not make any mention of them. Payroll taxes are calculated as a percentage of the wages paid to employees.²²⁹ The lack of an explicit reference to employer plans, and the fact that the tax is assessed without regard to existing ERISA plans or plan choices helps legislation of Type A pass through ERISA preemption's first "relates to" hurdle.²³⁰

Second, a payroll tax is far less likely than pay-or-play assessments to have an impermissible "connection" to ERISA plans via its indirect economic effects on employers' decisions whether to offer health benefits.²³¹ In *Travelers*, the Supreme Court posited that ERISA would preempt a

²²⁶ See *Fielder*, 475 F.3d at 196.

²²⁷ See *Travelers*, 514 U.S. at 664 (speculating that "an exorbitant tax" might leave employers "with a Hobson's choice," but holding that the tax at issue was not exorbitant).

²²⁸ See *Golden Gate*, 546 F.3d at 660-61.

²²⁹ See Brittain, *supra* note 61, at 110.

²³⁰ See *Travelers*, 514 U.S. at 656 (using "reference to" as one definition of "relates to"); *Dillingham*, 519 U.S. at 325 (warning that laws may "relate to" ERISA plans by "act[ing] immediately and exclusively upon ERISA plans" or by making "the existence of ERISA plans essential to the law's operation.").

²³¹ *Travelers*, 514 U.S. at 668; *Egelhoff*, 532 U.S. at 146-48.

hypothetical state law that did not directly regulate ERISA plans, but still “produce[d] such acute, albeit indirect, economic effects ... as to force an ERISA plan[’s]” choice of substantive coverage or source of insurance.²³² This hypothesis may guide states’ calculation of the amount of a payroll tax. Set the payroll tax too low, and employers might still want to provide health benefits to attract employees. This could preserve a “meaningful choice” for employers, as in *Golden Gate*, but may compete with the state’s plan and erode the goals of single-payer.²³³ A higher payroll tax should make it less rational for employers to continue to offer its own health benefits and pay the tax, though still not run afoul of ERISA preemption by its indirect economic effects. At some point, a payroll tax could become so “exorbitant” as to leave only a “Hobson’s choice.”²³⁴ But the Supreme Court has yet to define that point and the state single-payer laws surveyed here do not appear to approach it.

For courts still tempted toward preemption by the indirect incentives of a payroll tax, Type A’s establishment of a state health insurance program should help it survive preemption under the reasoning of *Golden Gate* and *Fielder*. While Maryland’s pay-or-play law created only one “rational” choice for employers because the “pay” option still left their employees without insurance,²³⁵ the establishment of a public insurance program in *Golden Gate* created the “meaningful alternative” essential to the pay-or-play law’s survival.²³⁶

The Type A payroll tax has a third advantage over pay-or-play laws, which is that it is not tied to any particular benefit levels or coverage decisions

²³² The Supreme Court in *Travelers* speculated that an “exorbitant” tax would force a Hobson’s choice, but upheld a less-than-exorbitant one. *Travelers*, 514 U.S. at 668.

²³³ Payroll taxes are all *pay* – the choice is either *pay* or *pay-and-play*. The employer pays the state fund either way.

²³⁴ *Travelers*, 514 U.S. at 664 (upholding a state surcharge of up to 24% on commercial insurance claims paid to hospitals).

²³⁵ *Fielder*, 475 F.3d at 196. The Fourth Circuit apparently ignored the fact that many Walmart employees would be eligible for Medicaid.

²³⁶ *Golden Gate*, 546 F.3d at 661.

by employers.²³⁷ Circuit courts have upheld taxes of general applicability with indirect impacts on employer choices.²³⁸ And the ordinance in *Golden Gate* dictated that employers spend a certain *amount* on employee health care, allowed them to satisfy their expenditure by offering benefits, and gave them wide discretion about how to do so if they chose. The Type A payroll tax does even less nudging than the *Golden Gate* ordinance because it does not dictate that employers spend funds on employees at all. The payroll tax would thus have little or no impact on decisions about covered services, funding levels, or plan administration.

Last, the payroll tax enjoys some advantage in that it because it does not impose additional administrative or compliance burdens on employers or their ERISA plans. Instead, it might actually relieve some existing burdens. If an employer chooses to offer benefits and pay the tax, its benefits plan would not be subject to any additional compliance requirements in the single-payer state. If an employer chooses to pay the tax and drop coverage, it sheds some existing compliance burdens under both ERISA and state laws. Reliance on a state-program in one state creates “disuniformity” for multistate employers’ benefit plans, it does so in a way that would ease the employers’ burdens in the single-payer state, furthering a “primary objective” of ERISA to minimize administrative burden.²³⁹ Concerns for nationwide

²³⁷ State taxes specifically targeting employee benefit plans or based on the value of benefits provided by a plan have been invalidated. *See* *Birdsong v. Olson*, 708 F.Supp. 792, 798-99 (W.D. Tex.1989) (state tax on the insurance company administrative fees for ERISA plans was preempted); *National Carriers v. Heffernan*, 454 F.Supp. 914, 915 (D. Conn.1978) (preempting state law imposing tax on employers maintaining employee benefit plans, based on the amount of benefits paid annually). *But see* *General Motors Corp. v. California Bd. of Equalization*, 815 F.2d 1305, 1309-10 (9th Cir.1987) (premium tax on insurance companies, which included ERISA plans, not preempted under the savings clause).

²³⁸ *E.g.*, *Self-Ins. Inst. of Am., Inc. v. Snyder*, 827 F.3d 549, 553, 557-558 (6th Cir. 2016), *cert. denied*, 137 S. Ct. 660 (2017) (holding that Michigan’s one-percent tax on all “paid claims” by “carriers” or “third party administrators” for services rendered was not preempted because the tax “does not directly regulate any integral aspects of ERISA.”).

²³⁹ *Compare* *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (“To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits.”) *with* *Retail Indus. Leaders Ass’n v. RILA v. Fielder*, 475 F.3d 180,

uniformity and multi-state compliance burdens helped doom the pay-or-play law in *Fielder*, the anti-subrogation laws in *FMC Corp.*, and the all-payer claims database in *Gobeille*, while *Golden Gate* found that some light recordkeeping and reporting did not rise to the level of concern.²⁴⁰

As the Supreme Court has recognized, “[a]ny state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute.”²⁴¹ Despite strong arguments that a general payroll tax preserves employer discretion and decreases the burdens of providing benefits, its underlying intent to nudge employers to drop coverage in favor of the state’s single-payer plan has a whiff of employer choice to it such that states should expect litigation challenges. The actual outcome of those challenges, especially in circuits other than the Fourth and Ninth,²⁴² remains difficult to predict.

2. Type B—Provider Restriction

State laws that channel all payments to providers through the single-payer entity likewise should survive preemption, though their operation still raises some ERISA preemption concerns. Type B legislation restricts providers from accepting payment from any third parties other than the state program.²⁴³ These provider restrictions avoid explicit “reference to” employer insurance²⁴⁴ and by targeting providers, rather than employers,

191 (2007) (describing uniformity and minimizing administrative burden as ERISA’s “primary objective”).

²⁴⁰ See *Golden Gate*, 546 F.3d. at 645, 657 (noting that employers providing self-funded health plans could use an average expenditure and not track actual per-employee spend, and that the ordinance’s recordkeeping and inspection requirements did not create conflicting directives that would burden employers or their plans because those recordkeeping requirements exist regardless of the ordinance). But cf. *Gobeille*, 136 S. Ct. at 943 (holding claims data reporting requirements preempted despite that self-funded plan administrators already collected the required data).

²⁴¹ *De Buono*, 117 S.Ct. at 1753.520 U.S. at 816.

²⁴² And probably the Sixth, too. *Self-Ins. Inst.*, 827 F.3d at 553.

²⁴³ See Part I.V.2, *supra*. The Type B proposals commonly contain an exception for federal programs that lack an approved waiver.

²⁴⁴ *Travelers*, 514 U.S. at 656.

situate themselves in the realm of provider regulation that typically avoids ERISA preemption.²⁴⁵

The provider restriction would, by design, have indirect influence on ERISA plans because those plans would no longer be able to find a network of providers who could accept their reimbursement. Whether this influence crosses the preemptive coercion line from *Travelers* and *DeBuono*²⁴⁶ will determine the preemption question. Prohibiting providers from accepting reimbursement from commercial payers, including employer plans, should effectively force employers to drop coverage,²⁴⁷ or at least to make major modifications in how they administer their plans.²⁴⁸ The shift wrought by the provider restriction could invite litigation based on the murky precedent on what constitutes an impermissible “connection with” ERISA plans. The most logical reading of provider restrictions, however, is that they avoid ERISA preemption by targeting providers.

3. Type C—Assignment, Subrogation, Secondary Payer

The addition of a subrogation, assignment, or secondary payer provision, typically included in Type C legislation, mitigates the state law’s coercive impact by giving the employer plan a way to exist, funneling the plan’s reimbursements through the state single-payer entity. Although mostly similar in function, subrogation may prove slightly more suspect than assignment or secondary payer provisions due to some tricky precedent.²⁴⁹

²⁴⁵ See, e.g., *Travelers*, 514 U.S. at 659-65; *Dillingham*, 117 S.Ct. at 840; *De Buono*, 117 S.Ct. at 1747. Cf. *Mass. Med. Soc’y v. Dukakis*, 815 F.2d 790, 790, 791-92 (1st Cir. 1987) (holding that the Medicare Act did not preempt a state law prohibiting balance billing because provider regulation is traditionally a state concern).

²⁴⁶ See, e.g., *Travelers*, 514 U.S. at 659-65; *De Buono*, 117 S.Ct. at 1747.

²⁴⁷ See *Travelers*, 514 U.S. at 668.

²⁴⁸ See *Egelhoff*, 532 U.S. at 148 (preemption laws that “govern[] a central matter of plan administration,” or “interfere[] with nationally uniform plan administration”).

²⁴⁹ See *id.* at 147 (The “payment of benefits [is] a central matter of plan administration,” and at state law requiring plan administrators to go beyond the plan documents to determine beneficiaries is a preempted burden); *FMC Corp. v. Holliday*, 498 U.S. 52, 60-61 (1990) (holding that a state law prohibiting insurer subrogation from a tort claimant’s recovery was “related to” employer plans because it would interfere with the plan’s usual financial calculations in that state and “frustrate plan administrators’ continuing obligation to calculate

None of the Type C provisions change the amount the employer plan will spend on claims – by design, they maintain employer plans’ existing calculation of benefits.²⁵⁰ Secondary payer provisions also do not alter the process of payment, while subrogation and assignment provisions merely redirect the existing payments from providers to the state single-payer entity. Type C provisions thus minimize the impact on claims payment, though they pose some preemption risk because claim payment is a sacred and “central matter of plan administration.”²⁵¹

In *Egelhoff*, for example, the Supreme Court held ERISA preempted a state probate statute automatically assigning a beneficiary after divorce because the law created too much of an administrative burden on multistate employers.²⁵² The majority in *Egelhoff* was particularly concerned that because of the state law, “[p]lan administrators cannot make payments simply by [reading] the plan documents” and “[i]nstead [] must familiarize themselves with state statutes” to determine whether state law has revoked the plan’s named beneficiary.²⁵³

The secondary payer provisions in Type C preserve the status quo of claim payment for employers who choose to continue offering benefits and therefore do not implicate ERISA. The subrogation and assignment provisions in the Type C category in some circumstances redirect payments from an ERISA plan and therefore could invite litigation, though they, too, ought to survive preemption challenge under the logic of Supreme Court

uniform benefit levels nationwide,” and that ERISA’s savings clause saved the state anti-subrogation law only with respect to fully-insured plans because it “directly control[led] the terms of insurance contracts”).

²⁵⁰ See, e.g., *id.*, at 61.

²⁵¹ Cf. *Gobeille*, 136 S.Ct. at 945 (reporting claim information “intrudes upon ‘a central matter of plan administration’” and therefore is preempted) (quoting *Egelhoff*, 532 U.S. at 148); *Fort Halifax Packing Co. Inc., v. Coyne*, 482 U.S. 1, 9, (1987) (“making disbursements” is central to plan administration). But cf. OR SB 631 (2017), § 15(2), (3) (explicitly referencing employer plans in subrogating the state entity “to the rights of any participant that has a claim against an . . . employer, third party administrator, . . . or any other person that may be liable for the cost of health services provided to the participant.”).

²⁵² *Egelhoff*, 532 U.S. at 150.

²⁵³ *Id.* at 148-49.

precedent. Type C provisions do not intrude on any provisions in ERISA plan documents as between the plan and its beneficiaries – they primarily govern the relationship between the single-payer plan and the individual, allowing the single-payer to assert the individual’s right to payment for covered services.²⁵⁴ They do not, therefore, “bind[] plan administrators to a particular choice of rules for determining beneficiary status,” as *Egelhoff* had preempted.²⁵⁵ If, however, an ERISA plan contains a provision prohibiting the beneficiary from assigning rights, several Circuit Courts of Appeal recently held that these clauses enforceable, despite that ERISA itself “does not provide clear guidance” on the issue.²⁵⁶

Further obscuring the arguments, the Supreme Court has opined that ERISA does not preempt “trivial” burdens imposed on plan administration by the need to review different state law requirements.²⁵⁷ But it has not clarified principles for triviality, which invites litigation. Type C’s assignment and subrogation provisions will redirect ERISA plan payments, but whether they may do so without significantly burdening plan administration in the eyes of a court remains unclear.

Ultimately, the combination of the features of Types A, B, and C, like in Ohio’s bill, creates an even more “meaningful alternative” or “legitimate choice” for employers in the single-payer system. The existence of the subrogation mechanism in the unified provider payment system opens an avenue for employers to maintain their plans’ relationships with providers, as well as to make use of the state plan infrastructure supported by the payroll tax revenue. Further, combining the tax in Type A with a Type B provider

²⁵⁴ *Travelers*, 514 U.S. at 661, 664.

²⁵⁵ *Egelhoff*, 532 U.S. at 147-42.

²⁵⁶ *E.g.*, *Univ. Spine Ctr. v. Aetna, Inc.*, Dkt. 18-2842 (slip op. at 6) (3d Cir. May 16, 2019) (citing *Am. Orthopedic & Sports Med. V. Independence Blue Cross Blue Shield*, 890 F.3d 445, 451 (3d Cir. 2018)). Note also that subrogation does not create a preempted state remedy under § 502. ERISA does not address the assignment of beneficiaries’ claims and the use of a state subrogation provision in these circumstances does not create inconsistencies with ERISA’s underlying policies., *See, e.g.*, *Brown v. American Intern. Life Assur. Co. of New York*, 778 F. Supp. 912, 917 (S.D. Miss. 1991) (courts should develop federal common law of ERISA with the aid of state law, as long as state law is consistent with ERISA’s goals).

²⁵⁷ *E.g. Egelhoff*, 532 U.S. at 151.

payment system enables a state to achieve the desired results with at a lower tax rate. The lower the tax rate, the less likely it will be held to be “exorbitant” and therefore preemptively coercive of employer benefits decisions.²⁵⁸ At a lower tax rate, an employer could rationally choose to both pay the tax and continue offering its ERISA plan.

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

4. Non-Duplication Provisions

Many of the bills of all three Types contain nonduplication provisions prohibiting insurers from offering state-plan-covered health benefits. These backstop provisions are intended to remove commercial competitors to the single-payer plan benefits and permit insurers only to offer “wraparound” services that supplement the single payer coverage. Nonduplication provisions directly target insurers, rather than employers, but have the intended effect of eliminating employer-based coverage and shifting covered employees to the single-payer plan. Employers still could choose to self-fund health insurance for their employees, or to rely on the state plan and offer wraparound insurance as a benefit. Like other types of insurance regulation, the preemption analysis of states’ nonduplication provisions would diverge for fully insured and self-funded plans.

Assuming a court would find nonduplication provisions have an impermissible connection to employer-sponsored insurance, ERISA’s savings clause would restore the nonduplication provision for those employers offering fully insured health benefits. To avoid preemption, a state law must (1) be specifically directed toward entities engaged in insurance, and (2) substantially affect the risk-pooling arrangement between insurer and insured.²⁵⁹ The nonduplication provisions impose prohibitions on insurers, satisfying the first requirement. The prohibition on covering state-plan services and benefits substantially affects the risk-pooling arrangement by

²⁵⁸ *Travelers* 514 U.S. at 664-65; *De Buono*, 520 U.S. at 815.

²⁵⁹ *Kentucky Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 334-38 (2003).

removing the state-plan services from coverable risks. The only risks an insurer *may* cover under nonduplication are those wraparound services not covered by the state plan. While nonduplication provisions prohibit coverage, the savings clause logic saves them in precisely the same way that laws requiring coverage or underwriting have been saved.²⁶⁰ As long as state regulation of the insurance industry affects risk-pooling, it does not matter whether the law expands or contracts risks in the pool.

As to self-funded plans, however, the nonduplication provision would remain preempted and therefore ineffective. For example, California's S.B. 562 contained a nonduplication provision that prohibited "carriers" from offering coverage for services that are covered under the state's single payer plan.²⁶¹ The bill's definition of "carrier" included insurers licensed by the state's insurance department and "health care service plans" as defined under the state's managed care law, the Knox-Keene Act.²⁶² Prior cases have held that the Knox-Keene Act's regulation of "health care service plans" is preempted by ERISA with respect to self-funded employer plans.²⁶³ With existing precedent carving self-funded employee health benefit plans from California's definition of a "health care service plan," SB 562's nonduplication provision for health care service plans would also be inapplicable to self-funded ERISA plans.

The application of the deemer clause means that employers could offer self-funded benefit plans that duplicate the state single-payer plan, as well as covering additional services. If employers chose to continue self-funding under the state single-payer system, preemption would keep this significant segment of lower-risk people out of the state plan's risk pool, threatening its

²⁶⁰ See *id.* at 336 n.1; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 370-87 (2002); *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647, 648 (7th Cir. 1995); *Pharm. Care Mgmt. Ass'n v. Tufte*, 297 F. Supp. 3d 964, 982 (D.N.D. 2017).

²⁶¹ CA SB 562 (1006.12)(g) (nonduplication).

²⁶² CA SB 562 (100602(f)), (definition of 'carrier' and Knox-Keene definition of health care service plan).

²⁶³ *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294, 1300 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir. 1978).

sustainability.²⁶⁴ Because of ERISA preemption, nonduplication provisions will not work to move self-funded employers to the single-payer plan. Thus, states must turn to other tools, such as the payroll tax in Type A or the provider restrictions in Type B to make the choice to self-fund benefits offered by the state plan considerably less attractive to employers, yet this meaningful choice would remain available in both theory and reality.

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

C. Drafting ERISA-Resistant Single-Payer Legislation

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

States would be well-served to exclude any explicit references to employers' benefit plans in their employer contribution provisions,²⁶⁵ but courts ultimately will judge state efforts on how they impact ERISA plans.²⁶⁶

²⁶⁴ Cf. Amy B. Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 146-53 (2011) (explaining that even employers with large-group plans engage in risk selection among employees). See generally MARILYN J. FIELD & HAROLD T. SHAPIRO, EDS., EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 167 (1993). ("In general, because large employers almost universally provide health benefits and have more predictable costs, large groups present fewer problems with risk selection than either individuals or small groups.").

²⁶⁵ E.g., Board of Trade, 506 U.S. 125, 130 (1992) (holding state law specifically referring to employee benefit plans preempted "on that basis alone").

²⁶⁶ E.g., *Dillingham*, 519 U.S. at 328 (holding that state law which can function irrespective of ERISA plans does not impermissibly "reference" ERISA plans).

A funding plan combining payroll and income taxes captures employer expenditures and individual spending, which provides incentives for both employers and employees to drop their employer-based coverage in favor of single-payer coverage. Payroll taxes *should not* be preempted by ERISA, but courts have reached contradictory conclusions, which invite litigation. By combining individual income taxes, which are never preempted, with payroll taxes, state single-payer plans can set a lower payroll tax rate more likely to survive challenge.

Provider restriction provisions create additional incentives for employees to drop their employer-plans by shrinking the network of participating providers in employer-based plans. ERISA generally does not preempt provider regulation, even if it has indirect effects on employee benefit plans.²⁶⁷ Compared with nonduplication provisions prohibiting the sale or offer of coverage that duplicates benefits covered by the single-payer, a provider restriction is less likely be preempted with respect to self-funded ERISA plans. If they survive, provider restrictions could fill an important gap created by ERISA preemption of nonduplication provisions, shrinking consumers' demand for employer-based plans and creating incentives for participation in the single-payer plan.

Provider restrictions become more powerful when paired with an assignment/subrogation/secondary payer provision to allow the single payer to capture additional employer and other third-party payers' expenditures by seeking reimbursement for claims paid by the single payer for patients with dual coverage.²⁶⁸ There are strong arguments that the way assignment/subrogation/secondary payer provisions work in the single-payer context would not be preempted by ERISA.²⁶⁹ Thus, pairing a Type B (provider restriction) with a Type C (assignment, subrogation, secondary payer) provision would create additional mechanisms beyond tax incentives to pull individuals into the single-payer plan *and* to capture third-party

²⁶⁷ See text accompanying notes 147-154, *supra*.

²⁶⁸ See *supra* notes 81-98 and text accompanying notes.

²⁶⁹ See *supra* notes 249-258 and text accompanying notes.

expenditures, both of which would be resistant to ERISA preemption.²⁷⁰

A state may want to pursue an ABC, belt-and-suspenders approach to increase the overall durability of the plan through diversification of policy tools. For example, having elements B and C could preserve the single-payer system even if the payroll tax is preempted by ERISA.²⁷¹ If a court erroneously invalidated a payroll tax, a severability provision in the state statute might permit conversion of the state's mandatory single-payer payroll tax into a pay-or-play option, like the San Francisco ordinance upheld in *Golden Gate*.²⁷² Under those circumstances, a state with a pay-or-play payroll tax would be better off if it also has a provider restriction and a subrogation/assignment/secondary payer provision, because the latter elements could take on more of the work of pulling enrollees and employer expenditures into the single-payer system. In a pay-or-play system, many more employers and employees would likely retain their employer-based coverage, so the incentives created by the Type B and C elements would become more critical to creating a broad and unified single-payer system.

Given the tenuousness of the politics of establishing a single-payer system, a state legislature may be interested in building a redundant system, utilizing an A-B-C approach, that can continue to stand even if preemption erodes one mechanism to move money or enrollees into the system. The legislature may be better able to patch or fix a system that continues to function, even in a diminished form, rather than return to the voters and the floor of the chamber to design a new single-payer system from scratch. It is better to build a durable program that can withstand some degree of attack, letting the endowment effect of newly acquired benefits take hold to protect the system from political repeal in the face of a challenge.²⁷³

²⁷⁰ See text accompanying notes 94-95, *supra*.

²⁷¹ We think this is the wrong result, as explained above, but ERISA jurisprudence is nothing if not incoherent and unpredictable.

²⁷² See text accompanying notes 178-191, *supra*.

²⁷³ See, e.g. Erin C. Fuse Brown, *Developing a Durable Right to Health Care*, 14 MINN. J. L. SCI. TECH. 439, 481-85 (2013).

III. ERISA REFORM AS HEALTH REFORM

The recent wave of state single-payer legislation painfully illustrates how ERISA preemption – and the uncertainty that swirls around it – undercuts states’ potential role in health reform. This project focuses on state single-payer bills as emblematic of the kind of bold experimentation and testing-ground often associated with state law in a federal system,²⁷⁴ and on ERISA preemption’s subversion of that role. Over the past 50 years, federal health care statutes have established a regulatory infrastructure with baseline protections and federal funding sources, inviting states to participate in implementation and experimentation.²⁷⁵ ERISA, meanwhile, prohibits state experiments largely without substituting a comprehensive federal scheme for employer-sponsored health benefits, leaving a regulatory void.

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

A. *The Federalism Trap*

Volumes have been written about the role of federalism in health care.²⁷⁶ The debates often conceive of a scale of power between states at one pole and the federal government at the other and focus on either determining the optimal balance point between the poles or what legal or policy structures promote or inhibit federalism’s various goals.²⁷⁷ This Article sidesteps those

²⁷⁴ See, e.g. Abbe Gluck & Nicole Huberfeld, *What is Federalism in Health Care For?* 70 STANFORD L. REV. 1689, 1689 (2018); Kristin M. Madison, *Building a Better Laboratory: The Federal Role in Promoting Health System Experimentation*, 41 PEPPERDINE L. REV. 765, 766 (2014).

²⁷⁵ See Gluck & Huberfeld, *supra* note 274.

²⁷⁶ See, e.g., Bagley, *supra* note 8; Bobinski, *supra* note 134; Gluck & Huberfeld, *supra* note 274; Greer & Jacobson, *supra* note 141; Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 CONN. L. REV. 115 (1995); Richard Nathan, *Federalism and Health Policy*, 24 HEALTH AFF. 1458 (2005); Wendy E. Parmet, *Regulation and Federalism: Legal Impediments to State Health Care Reform*, 19 AM. J.L. & MED. 121 (1993).

²⁷⁷ Compare Bagley, *supra* note 8, at 4 (“For health reform, the federal government

federalism questions, and instead starts with an assumption that some degree of health care federalism—a division of power between the federal government and the states—is desirable to achieve health policy goals, whether they are increasing coverage, controlling costs, improving quality, or broader equitable aims.²⁷⁸ Federalism can improve policy by allowing states to innovate, test, and learn from experimental models.²⁷⁹ Federalism also can enhance democratic goals of self-governance, divided power, pluralism, and government responsiveness.²⁸⁰

In health care, there are numerous political, economic, and historical reasons to prefer federal reforms. Politically, state “health reform” cuts both ways – some states aim for universal coverage and patient protections, others pass health laws restricting access, perpetuating discrimination, and responding to inaccurate assumptions.²⁸¹ Though federal legislation is not inherently prone to protecting access, federal baseline protections can guard against discrimination and codify evidence-based solutions, counteracting local prejudices.²⁸² Economically, federal reforms enjoy the advantages of economies of scale and deficit spending, as well as cost-control power in

really is the only game in town.”); with Mashaw & Marmor, *supra* note 276, at 117 (“What is both practical and desirable varies enough to make federalist variation both normatively attractive and politically wise as an alternative to national stalemate.”)

²⁷⁸ See Gluck & Huberfeld, *supra* note 274, at 1788 (noting that access, costs, and quality are “some of many potential outcome metrics commonly used—and fought over—in health policy circles.”).

²⁷⁹ *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis J., dissenting) (describing states as laboratories for experimentation).

²⁸⁰ Robert R.M. Verchick & Nina Mendelson, *Preemption and Theories of Federalism*, in *PREEMPTION CHOICE* 32 13-14 (William W. Buzbee, ed., 2009).

²⁸¹ See, e.g., J. Craig Wilson & Joseph Thompson, “Nation’s First Medicaid Work Requirement Sheds Thousands from Rolls in Arkansas,” *HEALTH AFFAIRS BLOG* (Oct. 2, 2018).

²⁸² See, e.g., Elizabeth Y. McCuskey, *The Body Politic: Federalism as Feminism in Health Reform*, 11 *ST. LOUIS U. J. HEALTH L. & POL’Y* 303, 306 (2018); Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care Act*, 36 *B.C. J.L. & SOC. JUST.* 235, 275–76 (2016).

interstate markets.²⁸³ Historically, the decades before the ACA witnessed the widespread failure of state regulation to rein in cost and expand access to care, with the exception of Massachusetts's bold universal coverage experiment and a handful of other state reforms.²⁸⁴ The ACA then built comprehensive federal reforms on the results of Massachusetts's experiment.²⁸⁵ The decade since the ACA's enactment has also witnessed some of federalism's pitfalls, as a shift in the federal Executive has undermined the ACA's core protections and encouraged states to pursue variations that contradict the purposes of federal laws, while receiving funding provided by those laws.²⁸⁶

So, without deciding where the balance between state and federal authority should lie, we accept that some level of power-sharing between states and the federal government is normatively desirable both as an instrumental means to improve health of the population and as a democratic ideal of diffusion of power and allowing diversity of policy solutions to reflect a diversity of political preferences.

This project's central federalism concern is that ERISA is an extremely anti-federalist statute,²⁸⁷ which contravenes nearly all federal health care statutes by not allowing for state flexibility, variation, or indeed any state regulation of self-funded ERISA plans.²⁸⁸ In health care regulation, ERISA

²⁸³ See Greer & Jacobson, *supra* note 141 at 217.

²⁸⁴ E.g., Niraj Chokshi, "Historians take note: What America looked like before Obamacare," WASH. POST. (March 26, 2014). Some part of states' historical struggles to effectively manage health care costs and access stems from ERISA's preemption hamstringing system-wide reforms. See Part II.A, *supra*.

²⁸⁵ See Jonathan Oberlander, *Implementing the Affordable Care Act: The Promise and Limits of Health Care Reform*, 41 J. HEALTH POLITICS, POL'Y & L. 803, 805 (2016).

²⁸⁶ See, e.g., Nicole Huberfeld, *Can Work Be Required in the Medicaid Program?*, 378 N. ENGL. J. MED. 788-791 (March 1, 2018); Timothy S. Jost, "Using the 1332 State Waiver Program to Undermine the Affordable Care Act State by State," COMMONWEALTH FUND BLOG (Oct. 30, 2018).

²⁸⁷ Brendan S. Maher, *The Benefits of Opt-In Federalism*, 52 B.C. L. REV. 1733, 1765 (2011) ("ERISA, in effect, lashes much of the country's benefit rules to a single federal mast in a ship captained by judges. It is a classic piece of anti-federalism.").

²⁸⁸ See Part II.B., *supra*.

is an interloper. ERISA was not originally intended to target health care, but the expansion of employer-sponsored health benefits to reach 49% of the U.S. population has wrought unintended consequences.²⁸⁹ Most federal statutes that intentionally regulate health care coverage, like Medicare, Medicaid, and the ACA, contain provisions that enable states to pursue policy experiments, while ERISA does not.²⁹⁰ For example, Medicare heavily favors federal control without obstructing states' interests.²⁹¹ By contrast, ERISA is both heavily federal and largely deregulatory for health care benefits,²⁹² so the balance is struck not in favor of federal regulation over state regulation, but in favor of deregulation over state regulation.

Indeed, as interpreted by the courts, ERISA preemption places self-funded employer plans beyond the reach of all manner of state health regulation, not just those that seek to mandate health benefits, but also reforms that seek to increase health coverage, to control health care costs, or even to seek information about health care prices.²⁹³ While the rest of the federal health law infrastructure invites some level of state regulation, ERISA obstructs the potential benefits of state experimentation and diversity. States

²⁸⁹ See, e.g., Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?*, 74 TUL. L. REV. 951, 952-53 (2000); Wooten, *supra* note 102, at 31-35.

²⁹⁰ See McCuskey, *Agency Imprimatur*, *supra* note 21, at 1103-05. Further, ERISA significantly affects the U.S. health care financing system, yet it is administered by the Department of Labor, rather than the U.S. Department of Health & Human Services.

²⁹¹ See Parmet, *supra* note 276, at 143.

²⁹² *Id.* at 135-136, 140. ERISA preemption has a particularly deregulatory tilt for health care benefits as opposed to pensions (which it heavily regulates), but federal preemption generally has a deregulatory effect. ERNEST A. YOUNG, FEDERAL PREEMPTION AND STATE AUTONOMY, IN FEDERAL PREEMPTION: STATES' POWERS, NATIONAL INTERESTS 263 (Richard A. Epstein & Michael S. Greve eds., 2007) ("[P]reemption will generally have a deregulatory impact"). The ACA diluted ERISA's deregulatory effect on employee health benefits by extending several health plan benefit and administrative rules to employer-based health plans as well as increasing state regulatory authority over non-group plans. See Brendan S. Maher, Radha A. Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance Under the ACA*, 31 YALE L. & POL'Y REV. 275, 276-277 (2013).

²⁹³ See Erin C. Fuse Brown & Ameet Sarpatwari, *Removing ERISA's Impediment to State Health Reform*, 378 NEW ENG. J. MED. 5, 6 (2018).

that seek to enact reforms to expand access or rein in their health care costs are needlessly hamstrung because ERISA preemption places a large portion of the market entirely beyond their regulatory reach.²⁹⁴ ERISA preempts state reforms without regard to policy or party – if, for example, a state wanted to pass a law prohibiting employers from offering contraceptive coverage, ERISA would preempt that, too. But ERISA preemption’s effects have a lopsided impact on state efforts aim at at expanding access to insurance.

One risk of ERISA’s federalism trap is regulatory failure for health care—particularly stasis and a system that fails to reflect the preferences of the states’ citizens.²⁹⁵ If the federal government fails to act, ERISA’s broad preemption means the states cannot step in to solve the problem. Broad federal preemption eliminates beneficial institutional diversity from federalism: “[i]f one set of regulators fails to address the problem, another set provides an alternative avenue for relief.”²⁹⁶

Further, ERISA preemption’s 1974 concerns for multisate employers and interstate commerce have had the effect in health reform of elevating the interests of private, employers above those of a sovereign state: in essence, placing Walmart’s preferences above California’s and giving private businesses the power to veto state laws in the absence of Congressional

²⁹⁴ See Borzi, *supra* note 214, at 661 (noting that even as of the 1990s the half of covered workers who were in self-insured plans were “beyond the reach of state insurance regulators.”); Parmet, *supra* note 276, at 135-36 (noting ERISA’s preference for interstate uniformity and antiregulatory bias creates doubt as to the viability of state single-payer health reform.). Note, however, that many other forces complicate states’ ability to achieve these goals, such as the federal tax preference given to employer-sponsored health insurance and many states’ inability to deficit spend in times of recession due to balanced-budget laws. See, e.g., Bagley, *supra* note 8, at 4.

²⁹⁵ See William W. Buzbee, *Asymmetrical Regulation: Risk, Preemption, and the Floor/Ceiling Distinction*, 82 N.Y.U. L. REV. 1547, 1576 (2007)(noting that with regard to “broad federal preemption . . . recent ceiling preemption assertions create heightened risks of dysfunction and stasis.”)

²⁹⁶ Robert A. Schapiro, *From Dualism to Polyphony*, in PREEMPTION CHOICE 344 (William W. Buzbee, ed., 2009). See also, Buzbee, *supra* note 295, at 1576 (critiquing broad federal preemption for how it “displaces multilayered institutional arrangements offering different actors, venues, and modalities for addressing a social problem.”)

action.²⁹⁷

The common policy justification for ERISA's sweeping preemption is that nationally uniform employee benefit rules enable multi-state employers to offer health coverage.²⁹⁸ But this emphasis on national uniformity is overblown and outdated. As Justice Blackmun recognized in *Metlife*, state-by-state disuniformities "are the inevitable result of the congressional decision to "save" local insurance regulation."²⁹⁹ ERISA's legislative history does not indicate that Congress intended total national uniformity for health benefit plans, or for multi-state employers to defeat this traditional area of state regulation for such a broad swath of the population.³⁰⁰ To the extent that Congress thought about health benefit plans at all when it drafted ERISA, it would have assumed that the vast majority of employers would continue to use fully-insured plans and be subject to varying state insurance laws under the savings clause.³⁰¹ Over time, interpretations of the deemer clause have left almost 30% of the population's health coverage untouchable by state laws, including state health reforms.³⁰²

²⁹⁷ Broad schemes of federal preemption tend to benefit the deregulated industry while sacrificing the preferences of states. See Buzbee, *supra* note 295, at 1590-92. Congress could, of course, remedy these failings by imposing federal regulations. Thus subsequent Congresses should share some of the blame for this failure.

²⁹⁸ *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 402(2002) (Thomas, J., dissenting) ("[T]he Court would do well to remember that no employer is required to provide any health benefit plan under ERISA . . . [The state law] independent review provisions could create a disincentive to the formation of employee health benefit plans, a problem that Congress addressed by making ERISA's remedial scheme exclusive and uniform.").

²⁹⁹ *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747(1985).

³⁰⁰ See, e.g., Borzi, *supra* note 214, at 663; Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?*, 74 TUL. L. REV. 951, 952-53, 964-65 (2000).

³⁰¹ See Borzi, *supra* note 214, at 661 ("[E]ven if some in Congress had thought about the effect on health plans, they probably would have believed that the insurance savings clause in ERISA's preemption provisions would have been sufficient to address any future problems. ")

³⁰² Kaiser Family Foundation, *supra* note 51 (noting that 49% of the population has employer sponsored coverage); GARY CLAXTON ET AL., *supra* note 51, at Section 10 (noting that 61% of those with employer-sponsored coverage are in self-funded plans). So 49% *

Just as the 1974 Congress did not contemplate the exemption of self-funded employer health plans when it passed ERISA, it likewise responded to very different employer incentives to provide health benefits in the first place. In the past four decades, the ACA's national employer mandate, the creation of a sizeable tax-break for employers' health benefits, and shifting labor market demands cast doubt on the assumption that employers will abandon health coverage in response to state regulations.³⁰³ Further, many single-state and small-size firms self-fund to take advantage of the regulatory vacuum without any claim to the advantages of multi-state uniformity.³⁰⁴

In sum, ERISA elevates the convenience of employers over state sovereignty and sacrifices the federalism benefits of states as engines of policy innovation.³⁰⁵ The upshot of courts' voluminous and tortured ERISA preemption jurisprudence is that it is so concerned with shielding multi-state employers from having to comply with 50 states' employee benefit regulations that it is willing to trade away the ability of a sovereign state to shape the health care system for its millions of citizens.

61% = 29.89% of the U.S. population).

³⁰³ See, e.g., Michelle Long et al., Kaiser Family Foundation, Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999-2014, at 5, 8 (Mar. 2016), http://www.nationaldisabilitynavigator.org/wp-content/uploads/news-items/KFF_trends-in-employer-sponsored-insurance_March-2016.pdf [https://perma.cc/Z7X7-AV2H].

³⁰⁴ See, e.g., Jay Greene, *Even Small Employers Are Striking Out on Their Own*, Managed Care Magazine, May 28, 2019, <https://www.managedcaremag.com/archives/2019/6/even-small-employers-are-striking-out-their-own> (last visited Sept. 12, 2019). Indeed, because of the ready availability of stop-loss insurance, smaller employers can self-fund for an extremely narrow band of risk, in order to take advantage of the deemer clause. *Id.*

³⁰⁵ There are critiques of the "state sovereignty" account of federalism. However, even critics acknowledge that states' play a key democratic role in today's federalism. See, e.g., Heather Gerken, *Federalism 3.0*, 105 CAL. L. REV. 1695, 1722 (2017):

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

B. Clearing a Path for State Health Reform

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

1. Altering ERISA’s Preemption Provisions

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

The first potential amendment would be for Congress to replace ERISA’s broad “relates to” express preemption with traditional floor preemption.³⁰⁶

³⁰⁶ To implement floor preemption in ERISA, 29 U.S.C. § 1144(a) could be amended as follows:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III shall supersede any and all State laws ~~insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.~~ only to the extent that such State laws actually

Floor preemption allows the federal government to establish a national standard that displaces less stringent state laws, but it permits more stringent state regulation.³⁰⁷ Floor preemption acts as a “one-way ratchet,” preserving only those state laws more protective than the federal floor.³⁰⁸ By contrast, ERISA’s current express preemption provision displaces “any and all” state laws that “relate to” employee benefit plans,³⁰⁹ which means all state laws that make reference or bear a connection to employer-based health plans are preempted, whether or not they conflict with federal requirements.³¹⁰

Floor preemption would restore some power-sharing between the state and national authorities and would be more consistent with other federal health care statutes’ approaches to federalism and preemption.³¹¹ It also allows a degree of federal uniformity in the setting of the floor, but balances this federal standard with state flexibility, so long as the state laws are consistent with and no less protective than the federal floor. Floor preemption offers a more desirable solution than broad federal preemption because multiple levels of governments bring institutional diversity, more opportunities for regulatory reexamination, and can serve as antidotes to regulatory stasis or failure.³¹² In the context of single-payer health care, changing ERISA preemption to floor preemption would allow states with the political will to reform their health care systems to do so, for other states and

conflict with the provisions of this subchapter and subchapter III. State laws that impose requirements in addition to the provisions of this subchapter and subchapter III shall not be superseded.

³⁰⁷ See Buzbee, *supra* note 295, at 1554 (“Federal floors preclude less stringent state and local regulation, but allow for additional and more stringent regulation and typically are accompanied by savings clauses and cooperative regulatory structures.”).

³⁰⁸ See Buzbee, *supra* note 295, at 1566.

³⁰⁹ 29 U.S.C. § 1144(a).

³¹⁰ See Fuse Brown & Sarpatwari, *supra* note 293, at 6-77.

³¹¹ See McCuskey, *Agency Imprimatur*, *supra* note 21, at 1122-1123 (discussing the use of conflict preemption—a type of floor preemption—in the ACA, HIPAA, and other federal statutes).

³¹² See Buzbee, *supra* note 295, at 1576 (suggesting that floor preemption, as an alternative to ceiling preemption, utilizes institutional diversity and is less likely to risk dysfunction)..

the federal government to learn from these state experiments, and for diversity in policy choices that may better reflect the desires of the people in those states. Floor preemption also increases interaction between the federal and state governments, which improves policymaking through joint regulation, mutual learning, regulatory improvement, and regulatory competition.³¹³

To be sure, there are critics of floor preemption, namely from the business community. One critique is that floor preemption sacrifices the uniformity and certainty of a single national standard. Broad federal preemption often tilts toward deregulation, particularly if the federal law acts as a ceiling—a regulatory maximum—rather than as a floor.³¹⁴ If the national standard serves as a floor and not as a ceiling, then it eliminates the possibility that states will engage in pro-business deregulatory competition.³¹⁵ Thus, businesses may abandon their position in favor of states’ rights if the states are only able to innovate in a pro-regulatory direction under the one-way ratchet of floor preemption. Of course, the ordinary workings of conflict preemption doctrine would still preempt state regulations that contradict federal law in ERISA, and our floor preemption proposal could state so explicitly.³¹⁶

Second, Congress could amend ERISA’s deemer clause to eliminate its applicability to health benefit plans.³¹⁷ This could be accomplished by simply deleting 29 U.S.C. § 1144(b)(2)(B), or by adding language to the clause stating that it does not protect employers’ self-funded health benefit plans.³¹⁸

³¹³ See Gerken, *supra* note 305, at 1720.

³¹⁴ See Buzbee, *supra* note 295, at 1579.

³¹⁵ See Michael S. Greve, *Business, The States, and Federalism’s Political Economy*, 25 HARV. J. L. & PUB. POL’Y 895, 903 (2002).

³¹⁶ See n.306, *supra*; *John Hancock Mutual Life Ins. Co. v. Harris Trust & Savings Bank*, 510 U.S. 86, 99 (1993) (finding “traditional preemption analysis” applies even in context of ERISA’s express preemption language).

³¹⁷ See Bobinski, *supra* note 134, at 342-343.

³¹⁸ For example, 29 U.S.C. § 1144(b)(2)(B) could be revised to read:

Neither an employee benefit plan described in section 1003(a) of this title, which is not

Either revision would close the deemer clause’s loophole in the savings clause, the-exception-within-an-exception that shields self-funded health plans from state insurance regulation. Thus all health benefit plans, whether self-funded or fully insured, would be subject to state insurance laws that are saved by ERISA’s savings clause. The deemer clause, as interpreted by the Court, deems self-funded health benefit plans to operate outside the business of insurance, and exempts them from state insurance regulations.³¹⁹ As noted above, when Congress wrote ERISA and the deemer clause in 1974, most employer-based health plans were fully insured, not self-funded.³²⁰ Moreover, the text of deemer clause is not a model of clarity and was only interpreted to exempt self-funded plans from the state insurance regulation by the Court more than a decade after ERISA was passed.³²¹

Eliminating the deemer clause would not automatically open up employer-based plans to *all* state regulation—only to those state laws regulating insurance.³²² In the context of state single-payer, eliminating the

exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. This provision shall not apply to any “employee welfare benefit plan” established or maintained by an employer that provides medical care for participants or their dependents directly or through insurance, reimbursement, or otherwise.

³¹⁹ See *Metropolitan Life Ins. Co.*, 471 U.S. at 747, 105 S. Ct. at 2393 (“[O]ur We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the “deemer clause,” a distinction Congress is aware of and one it . . . has chosen not to alter.”); *FMC Corp.*, 498 U.S. at 61 (“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.”)

³²⁰ See text accompanying note 301.

³²¹ See *Metropolitan Life Ins. Co.*, 471 U.S. 724, 739-40 (1985); *FMC Corp.*, 498 U.S. at 6152.

³²² This is because the deemer clause is an exception from the savings clause, which only saves state insurance regulation from preemption. See Part II.A.2.c, *supra*.

deemer clause's distinction between self-funded and fully insured plans would allow the non-duplication provision to avoid preemption and could put the subrogation/assignment/secondary payer provisions on surer footing.³²³ However, it is less clear whether an employer mandate to participate in the state single-payer plan or payroll taxes would be considered health insurance regulation.

The main drawback of eliminating the deemer clause for health benefit plans is the loss of regulatory uniformity, which could increase the costs of these plans by exposing self-funded plans to state insurance laws, such as benefit mandates (e.g., to cover fertility services) and state premium taxes.³²⁴ This conventional policy argument in favor of broad ERISA preemption for self-funded plans is not clearly supported by the empirical literature.³²⁵ State benefit mandates' effect on firms' decision to self-fund their health benefits is mixed,³²⁶ and self-funded premiums are not necessarily cheaper than premiums for purchased insurance.³²⁷ Other factors beyond avoiding state regulations also drive employers' decisions whether to self-fund or purchase insurance.³²⁸ In short, it is unclear that exposing self-funded health plans to state insurance laws would increase the costs of these plans. Without a deemer clause, employers could still self-fund their health plans to take

³²³ See discussion in Parts II.B.3 and II.B.4, *supra*.

³²⁴ Roger Feldman, *Why Do Employers Self-Insure?* 37 GENEVA PAPERS 696, 697 (2012). According to industry self-report, the other incentive to self-fund is to retain the "float" of interest on funds not paid as premiums to an insurer. *Id.*

³²⁵ See, e.g., *id.*

³²⁶ Christina M. Dalton & Sara B. Holland, *Why Do Firms Use Insurance to Fund Worker Health Benefits? The Role of Corporate Finance*, 86 J. RISK & INSURANCE 183, 1875 (2017).

³²⁷ Feldman, *supra* note 324, at 708.

³²⁸ For example, firm size, the ability of employers to engage in risk-assessment to negotiate fees with third-party administrators, and the availability of external capital to fund firm investments may contribute to decisions to self-insure. See Dalton & Holland, *supra* note 326, at 1853 (explaining that "when firms face costly external finance, they are more likely to purchase insurance. Purchasing insurance reduces the risk that health benefit payouts will tie up internal funds and force the firm to raise additional outside investment capital."); Feldman, *supra* note 324, at 709.

advantage of nonregulatory financial incentives; they would just be subject to state health insurance laws. There is no evidence that the employers would drop coverage altogether given labor market demands, favorable tax-treatment of health benefits, and the ACA's employer mandate.³²⁹ Nevertheless, large, self-funded firms argue that their costs would increase if their health plans were subject to state regulation.³³⁰

A more practical concern is the political difficulty of convincing Congress to eliminate the deemer clause's applicability to self-funded health plans. Large, multi-state employers would oppose any change to ERISA that would expose them to additional state regulations. This group's powerful lobby would argue that any alteration to ERISA preemption that subjects employers to multiple state regulations would increase their administrative burden and stifle private market forces.³³¹

2. Adding an ERISA Waiver

Alternatively, Congress could preserve ERISA's preemption baseline, but add a statutory waiver mechanism authorizing the Secretary of Labor to waive ERISA preemption provisions for states pursuing health care reforms. A statutory waiver would not clear the path for all state reforms; it would lift the gate for certain state efforts, based on review and approval by federal agencies. And it would complement the waivers in other federal statutes (notably Medicaid and the ACA) necessary to fully fund a state single-payer plan.³³²

Congress has used statutory waivers with increasing frequency over the past few decades to infuse statutory structures with flexibility,³³³ to mitigate

³²⁹ See Long et al., *supra* note 303, at 5 (noting that data from the National Health Interview Survey does not indicate that employer coverage is "diminishing in its importance" despite the changes that accompanied the Affordable Care Act)).

³³⁰ See Self-Insurance Institute of America, *Self-Insured Group Health Plans*, <https://www.sjia.org/i4a/pages/Index.cfm?pageID=4546> [<https://perma.cc/4VXF-4UAU>].

³³¹ See Bagley, *supra* note 8, at 12. ("[B]ecause of the intensity of the business lobby's resistance to limiting ERISA's preemptive scope, Congress is very unlikely to amend the law to address the concern").

³³² See, e.g., Wiley, *supra* note 50.

³³³ See David J. Barron & Todd D. Rakoff, *In Defense of Big Waiver*, 113 COLUM. L.

the federalism impacts of nationwide rules,³³⁴ to encourage supervised state experimentation,³³⁵ and sometimes to suspend preemption.³³⁶ Waivers may support state experiments with federal funding, as well as access to the nationwide perspective and substantive expertise of federal agencies,³³⁷ a model frequently employed in federal health care coverage statutes. Amending ERISA to add a statutory waiver mechanism for its preemption provisions in 29 U.S.C. § 1144 could accomplish all of these goals.

ERISA currently has no waiver provision and arguably delegates no waiver authority to the Department of Labor over state regulations.³³⁸ Although ERISA allows the federal agency to coordinate with states on enforcing the federal statute,³³⁹ ERISA does not expressly delegate the power

REV. 265, 278 (2013) (identifying the phenomenon of “big” waivers that suspend the core tenets of federal statutes).

³³⁴ See *id.*; Martin A. Kurzweil, *Disciplined Devolution and the New Education Federalism*, 103 CAL. L. REV. 565, 567–68 (2015) (discussing waivers in federal education law).

³³⁵ *E.g.*, 42 U.S.C. §§1315, 1396n (2012) (Medicaid’s state experimentation waivers); 42 U.S.C. § 18052 (Affordable Care Act’s “State Innovation” waiver). See McCuskey, *Agency Imprimatur*, *supra* note 21, at 1127-36 (describing the purposes and effects of the ACA’s State Innovation waiver); Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV.1, 29 (2013) (discussing the role of waiver in Medicaid); Sidney D. Watson, *Out of the Black Box and into the Light: Using Section 1115 Medicaid Waivers To Implement the Affordable Care Act’s Medicaid Expansion*, 15 YALE J. HEALTH POL’Y & ETHICS 213, 214(2015) (discussing the 1115 waiver’s role in Medicaid).

³³⁶ *Cf.* 49 U.S.C. § 5125(e) (Federal Highways Act); 42 U.S.C. § 6297(d) (Energy Policy and Conservation Act); 42 U.S.C. § 7543(b) (Clean Air Act).

³³⁷ See McCuskey, *Agency Imprimatur*, *supra* note 21, at 1151-56.

³³⁸ ERISA does not expressly provide authority for the federal agencies to waive statutory requirements on behalf of states. ERISA does, however, authorize the Secretaries of Labor and Treasury to waive certain substantive and administrative requirements on behalf of employers, plans, and participants. See, *e.g.*, 29 U.S.C. § 1023(a)(3)(A), (4)(A); §§ 1082(c) - 1084; § 1132(c)(10); § 1132(l)(3); § 1202(b); § 1203(a); § 1202a(a); § 1025(a)(2)(A) (Notes). And the statute expressly saves a few specific categories of state laws on insurance and fraud. *E.g.*, 29 U.S.C. §§ 1144a; § 1150; § 1191(a)(1), (b)(1) & (b)(2).

³³⁹ 29 U.S.C. § 1136(a) (2012).

to waive its preemptive effects, as many other statutes have done.³⁴⁰ Absent such an express delegation or waiver, an agency's power to *waive* preemption is hazy at best,³⁴¹ despite that an agency's views on the preemptive *effect* of its substantive regulations may merit some deference.³⁴² The statute does contain one exemption for Hawaii's 1974 health reform law, which does not operate as a waiver. On June 12, 1974 – three months before ERISA was enacted³⁴³ – Hawaii passed a law requiring employers in the state to provide health coverage for employees, either by purchasing a state-approved plan or funding their own.³⁴⁴ In 1983, Congress amended ERISA to exempt Hawaii's 1974 law from the “relates to” preemption provision, but narrowed the exemption with several corollary provisions.³⁴⁵ No other state has a

³⁴⁰ Cf. 21 U.S.C. § 360k (Medical Devices Amendments); 42 U.S.C. § 7543 (Clean Air Act); 42 U.S.C. § 6297(d) (Energy Policy and Conservation Act); 49 U.S.C. § 5125(e) (Federal Highways Act). Cf. 21 U.S.C. § 360k (Medical Devices Amendments).

³⁴¹ Cf. Nicholas F. Bagley, “The Labor Department and *Liberty Mutual v. Gobeille*,” THE INCIDENTAL ECONOMIST BLOG (Jan. 6, 2016), <https://theincidentaleconomist.com/wordpress/the-labor-department-and-liberty-mutual-v-gobeille/> [https://perma.cc/E73U-VVRH] (arguing that Justice Breyer's suggestion “that the Labor Department should have a say in whether [state] law is preempted” is correct and “that Scalia's concerns about the Labor Department's authority are misplaced”).

³⁴² E.g., *Wyeth v. Levine*, 555 U.S. 555, 577 (2009) (applying *Mead* and *Skidmore* to conclude that “[t]he weight we accord the agency's explanation of state law's impact on the federal scheme depends on its thoroughness, consistency, and persuasiveness”). See Catherine Sharkey, *Products Liability Preemption: An Institutional Approach*, 76 GEO. WASH. L. REV. 449, 471-72 (2008) (illustrating that Supreme Court decisions since 1992 on products liability preemption have “aligned with the relevant underlying federal agency's take on preemption”).

³⁴³ President Ford signed ERISA into law on September 2, 1974 (Labor Day).

³⁴⁴ See Hawaii Prepaid Health Care Act, HAW. REV. STAT. §§ 393-3(8), 393-11 (1974). Hawaii employers must pay “at least one-half of the premium” and the employees' remaining share cannot exceed 1.5% of their wages. HAW. REV. STAT. § 393-13.

³⁴⁵ See 29 U.S.C. § 1144(b)(5)(A) (stating that the “relate to” preemption “shall not apply to the Hawaii Prepaid Health Care Act”). First, the Hawaii exemption applies only to the original 1974 state law and administrative updates to it. § 1144(b)(5)(B). Second, the Hawaii exemption does not extend to “any State tax law relating to employee benefit plans.” § 1144(b)(5)(A). Third, the Hawaii exemption states that ERISA reporting requirements and fiduciary responsibilities *do* supersede the Hawaii Act, but notes that the Department of Labor may use its “cooperative arrangements” delegation to “assist” Hawaii “in effectuating

statutory exemption from ERISA. Without a state waiver mechanism, the issue of state flexibility mostly gets hashed out in the chaotic and reactive realm of preemption litigation.³⁴⁶

An ERISA preemption waiver could mirror some of the substantial flexibility in other federal health care statutes, including Medicare, Medicaid, and the ACA, emphasizing the value of state policy innovation by allowing states to apply to the federal government for approval to deviate from federal standards.³⁴⁷ These waivers delegate to an agency the power to suspend certain core statutory rules by approving state applications for waivers.³⁴⁸ To receive a waiver, states typically must demonstrate the ways in which their proposed variations would further federal goals.³⁴⁹ An ERISA waiver could create a process whereby states apply to the Department of Labor for a waiver of any or all of § 1144's preemption provisions to pursue state reforms. To focus an ERISA waiver on health reform,³⁵⁰ the provision could specifically apply only to state laws impacting employee welfare benefit plans, excluding pension plans. Our proposed statutory revision, adopted by the National Council of Insurance Legislators and available at their web page, provides an example of how to reform ERISA with a waiver.³⁵¹

the policies” of those state provisions still subjected to preemption. § 1144(b)(5)(C).

³⁴⁶ See discussion in Part II.B., *supra*. See generally McCuskey, *supra* note 21, at 1153-57.

³⁴⁷ See 42 U.S.C. § 18052 (providing the ACA's waivers for State Innovation) Barron & Rakoff, *supra* note 333, at 278 (describing paradigm “big” waivers); 42 U.S.C. § 18052 (providing the ACA's waivers for State Innovation); McCuskey, *Agency Imprimatur*, *supra* note 21, at 1127-37.

³⁴⁸ See McCuskey, *Agency Imprimatur*, *supra* note 21, at 1127-37.

³⁴⁹ See *id.* Cf. Christen Linke Young, *Pay or Play Programs and ERISA Section 514: Proposals for Amending the Statutory Scheme*, 1 YALE J. HEALTH POL'Y, L. & ETHICS 197, 235 (2010) (arguing that “any system of federal agency de-preemption would require statutory criteria by which state or local programs could be evaluated”).

³⁵⁰ And potentially to diminish objections to the amendment based on pension concerns.

³⁵¹ NCOIL Health Insurance and Long Term Care Issues Committee, “Health Reform Waiver Proposal” (Dec. 7, 2018), available at <http://ncoil.org/wp-content/uploads/2018/12/ERISA-1144-Waiver-Proposal-12.7.18.pdf> [<https://perma.cc/8VP9-YF3J>].

From a federalism perspective, an ERISA waiver offers several theoretical benefits. Federal baseline regulation with an option for state waivers restores some of states' autonomy and ability to experiment with policy solutions to benefit their citizens.³⁵² From an institutional competence perspective, an ERISA preemption waiver would shift some of the authority over state health reform options from courts to agencies, relying on agencies' substantive expertise rather than courts' preemption precedents.³⁵³ This shift portends benefits not only in the availability of state health care reforms, but also in the transparency, participation, and federalism dimensions of health care regulation.³⁵⁴ Because Congress initiates the statutory waiver, this mechanism also has advantages over agency preemption clarifications or rulemaking,³⁵⁵ namely that it explicitly authorizes the agency action and conclusively effectuates the suspension of preemption for approved applications.³⁵⁶

To maximize these benefits, the statutory waiver should provide for coordination between the Departments of Labor, Treasury, and Health & Human Services for purposes of both expertise and efficiency. A coordination provision would enable Labor to draw on the health insurance and market expertise of HHS in determining which waiver applications satisfy the substantive criteria.³⁵⁷ And, a provision for cross-referencing state ERISA waiver applications with their ACA, Medicaid, and Medicare waiver applications would enable states to pursue all the waivers needed for

³⁵² See Part III.B, *supra*.

³⁵³ See, e.g., McCuskey, *supra* note 21, at 1153-56; Meltzer, *supra* note 110, at 39; Thomas W. Merrill, *Preemption and Institutional Choice*, 102 NW. U. L. REV. 727 (2008). McCuskey, *Agency Imprimatur*, *supra* note , at 1153-56.

³⁵⁴ See McCuskey, *Agency Imprimatur*, *supra* note 21, at 1162-64.

³⁵⁵ See, e.g., Michael Serota & Michelle Singer, *Maintaining Healthy Laboratories of Experimentation: Federalism, Health Care Reform, and ERISA*, 99 CAL. L. REV. 557, 600-04 (2011) (arguing for DOL clarification of preemption via guidance or rulemaking).

³⁵⁶ See McCuskey, *Agency Imprimatur*, *supra* note 21, at 1157-62 (detailing the reviewability and review of the ACA's 1332 waiver). *Cf.* *Wyeth v. Levine*, 555 U.S. 555 (2009) (refusing deference to agency's statement about the preemptive intent of its authorizing statute and the preemptive effect of its own regulations).

³⁵⁷ See McCuskey, *Agency Imprimatur*, *supra* note 21, at 1155.

transformative health system changes, while giving the federal agencies a comprehensive view of the state's proposal.³⁵⁸

Of course, the details of legislative drafting will matter enormously, and the guardrails imposed on agency discretion to grant or deny state waiver applications will determine the ultimate efficacy of any waiver mechanism.³⁵⁹ As the administration of Medicaid and ACA waivers have illustrated, an agency's discretion in granting waivers may prove exceedingly political and threaten the statute's core infrastructure.³⁶⁰ Yet this may prove less of a concern in the context of ERISA preemption waiver because the provision being waived – preemption of *additional* state regulatory efforts – arguably threatens only the uniformity of regulation large employers enjoy, and does not threaten ERISA's regulations protecting employee benefits.

Proposals to add a waiver to ERISA are neither new, nor entirely academic. In the early 1990s, as states pursued reforms to deal with rising health care costs and growing ranks of uninsured citizens,³⁶¹ several members of Congress introduced proposals for ERISA waivers that would permit specific universal coverage reforms in their own states,³⁶² reminiscent of the

³⁵⁸ Cf. 42 U.S.C. § 18052(a)(5) (providing for combined Medicaid 1115 and ACA 1332 waiver applications to go to HHS). *But see* McCuskey, *Agency Imprimatur*, *supra* note 21, at 1152-53 (warning about allowing the ACA 1332 waiver's expansive outlook to "bleed over" into consideration of the narrower Medicaid 1115 waiver); Marea B. Tumber, *The ACA's 2017 State Innovation Waiver: Is ERISA a Roadblock to Meaningful Healthcare Reform*, 10 U. MASS. L. REV. 388 (2015).

³⁵⁹ See McCuskey, *Agency Imprimatur*, *supra* note 21, at 1151-53. *E.g.*, NCOIL Health Reform Waiver Proposal, *supra* note 351324.

³⁶⁰ See, e.g., McCuskey, *Statutory Sabotage*, *supra* note 2; Rachel Sachs, "Medicaid Expansion Through Section 1115 Waivers: Evaluating The Tradeoffs," HEALTH AFFAIRS BLOG (Mar. 15, 2016) <https://www.healthaffairs.org/doi/10.1377/hblog20160315.053925/full/> [<https://perma.cc/3XDX-SXT2>]; Watson, *supra* note 335.

³⁶¹ See generally Lawrence D. Brown & Michael S. Sparer, *Window Shopping: State Health Reform Politics in the 1990s*, 20 HEALTH AFF. 50 (2001) (articulating three phases of state health reform from 1990 to 2000).

³⁶² See Devon P. Groves, *ERISA Waivers and State Health Care Reform*, 28 COLUM. J.L. & SOC. PROBS. 609, 635-44 (1995) (cataloging legislative proposals by Senators and Representatives from Washington, Vermont, Kentucky, Minnesota, New York, and

Hawaii exemption Congress had enacted in 1983.³⁶³ Others introduced more ambitious legislation that would catalyze and fund state universal health care efforts, supported by administrative waivers of ERISA.³⁶⁴ When those bills stalled, House members from Hawaii, New York, Minnesota, and Maryland tried to pass two-year ERISA waivers for their states' reforms,³⁶⁵ but those stalled, too.³⁶⁶ After the Clinton Administration's efforts at federal health reform failed in 1994,³⁶⁷ a bipartisan group of senators introduced another bill that would fund state reform efforts, supported by expansion of the savings clause and specific preemption waivers for Hawaii, Oregon, Minnesota, Washington, and Connecticut.³⁶⁸ That bill also died in Congress.³⁶⁹

The Affordable Care Act era has seen some recent revival of ERISA waiver legislation, couched in efforts to tweak the ACA's Section 1332 waiver process. In 2018, a group of Democratic Representatives introduced

Maryland, which would have waived aspects of ERISA – all of which “failed miserably” to pass in 1992-1993).

³⁶³ 29 U.S.C. §S 1144(b)(5)(A)-(C).

³⁶⁴ *E.g.*, State Care Act of 1992, S. 3180, 102d Cong. (1992) (introduced by Senators Patrick Leahy (VT) and Ron Wyden (OR)); The State-Based Comprehensive Care Act of 1992, H.R. 4218, 102d Cong. (1992) (introduced by Washington Rep. Jim McDermott) [supported]. *See* Groves, *supra* note 362, at 640.

³⁶⁵ H.R. Rep. No. 103-111, at 109-12 103d Cong., 1st Sess. (1993).

³⁶⁶ *See* Groves, *supra* note 362, at 634-44.

³⁶⁷ *See* Jonathan Oberlander, *Learning from Failure in Health Reform*, 357 N. ENG. J. MED. 1677 (Oct. 25, 2007) (describing the failure of the Clinton Health Security Act); Walter A. Zelman, *The Rationale Behind the Clinton Health Care Reform Plan*, 13 HEALTH AFF. 9 (1994) (describing the plan before its failure).

³⁶⁸ *E.g.*, Health Innovation Partnership Act, S. 2452, 103d Cong., 2d Sess. (1994), reprinted in 140 Cong. Rec. S13, 354-70 (daily ed. Sept. 26, 1994) (discussed in Groves, *supra* note 362, at 648).

³⁶⁹ *See* H.R. 54119, 103d Cong., (1994) (not enacted), <https://www.govtrack.us/congress/bills/103/hr5119>; H.R. 5119, 103d Cong., (1994), 103 H.R. 5119 (ProQuest Congressional) (<https://congressional-proquest-com.proxy.library.upenn.edu/congressional/result/congressional/congdocumentview?accountid=14707&groupid=95549&parmid=16C25586CB9&rsid=16C25583428#69>) [<https://perma.cc/5Y8Y-ZTT4>] (showing that the Bill has not been enacted).

the "State-Based Universal Health Care Act" (SBUHCA) which would, among other provisions, add an ERISA preemption waiver within the ACA's 1332 waiver infrastructure.³⁷⁰ The ACA's existing 1332 waiver provision already permits the Department of Health & Human Services to waive the ACA's federal employer mandate under certain circumstances,³⁷¹ but the proposed SBUHCA modification would give the Department of Labor some authority to suspend ERISA preemption for states enacting ACA-replacement legislation.³⁷² Couching the ERISA preemption waiver within the ACA 1332 infrastructure would slightly limit the scope of the preemption waiver because the state's application must be part of an effort to replace the ACA, and the Department of Labor's grant of any such waiver must stay within the "guardrails" established by the ACA.³⁷³ SBUHCA, too, died in Congress without a vote.³⁷⁴

Despite these efforts, ERISA preemption stands untouched as an obstruction of health care federalism, and an obstacle to state health reform efforts – even to those that further the aims of existing federal law. As our research illustrates, the post-ACA wave of state single-payer proposals interacts with ERISA preemption obstacles in some ingenious ways.³⁷⁵ But the indeterminacy of ERISA's preemption language, the opacity of ERISA preemption jurisprudence, and the centrality of employer-based health care funding force state legislation to contort and wriggle through exceedingly narrow pathways with the expectation of a potential challenge through

³⁷⁰ H.R. 6097, 115th Cong., (2018), <https://www.congress.gov/bill/115th-congress/house-bill/6097>.

³⁷¹ 26 U.S.C. §4980H (enacting the federal employer mandate). See McCuskey, *Agency Imprimatur*, *supra* note 21, at 1129, 1131-33 (explaining the ACA's 1332 waiver authority over to the insurance mandates, as well as limitations on that authority).

³⁷² H.R. 6097 (a)(2)(J), 115th Cong., (2018), <https://www.congress.gov/bill/115th-congress/house-bill/6097/text>

³⁷³ See McCuskey, *Agency Imprimatur*, *supra* note 21, 1133-37 (articulating the limitations on agency discretion in the ACA 1332 waiver process).

³⁷⁴ H.R. 6097, 115th Cong., (not enacted), <https://www.congress.gov/bill/115th-congress/house-bill/6097/all-actions>.

³⁷⁵ See Part I.B, *supra*.

litigation.³⁷⁶ An ERISA preemption waiver would alleviate some of the pressure of ERISA preemption for promising state experiments, while maintaining a federal baseline of preemption.³⁷⁷

As with any statutory revision, its implementation depends on political will.³⁷⁸ Recent Congresses with majorities politically opposed to the ACA have shown increased appetite for statutory waiver and state experimentation, at least rhetorically.³⁷⁹ But the current administration has granted statutory waivers in ways that erode statutory goals, arguably exceeding the delegated authority.³⁸⁰ Additionally, the ACA's imposition of a nationwide employer mandate and other insurance-related requirements draw from some of the baseline arguments about ERISA's deregulatory "uniformity" function for the majority of fully-insured plans.³⁸¹ And the ACA's creation of opportunities for pass-through funding and other statutory waivers for states signals that waiver and state experimentation are core features of ongoing reform efforts.³⁸² Amending ERISA with a statutory waiver for preemption seems even more urgent and more feasible at this moment in health reform.

³⁷⁶ See Part II.B, *supra*.

³⁷⁷ Note that we have not proposed the case-by-case statutory exemptions granted to Hawaii and sought by Massachusetts and other states in the early 1990s. Cf. Sidney D. Watson, et al., *The Road from Massachusetts to Missouri: What Will It Take for Other States to Replicate Massachusetts Health Reform?*, 55 U. KAN. L. REV. 1331 (2007).

³⁷⁸ Cf. Linke Young, *supra* note **Error! Bookmark not defined.**, at 221 (arguing that debate of the ACA in 2010 offered an opportunity and "legislative vehicle" for altering ERISA).

³⁷⁹ See McCuskey, *Agency Imprimatur*, *supra* note 21, at 1139-40, 1164-67; McCuskey, *Statutory Sabotage*, *supra* note 2, at 233-36. Cf. Exec. Order 13,765, 82 Fed. Reg. at 8351 (emphasizing state flexibility and instructing HHS to exercise its waiver authority "to the maximum extent permitted" by law).

³⁸⁰ See, e.g., Sidney D. Watson, *Medicaid, Work, and the Courts: Reining in HHS Overreach*, 46 J. L. MED. & ETHICS, 887, 888-89 (2019); Nicole Huberfeld, *Can Work Be Required in the Medicaid Program?*, 378 N. ENGL. J. MED. 788-91 (2018).

³⁸¹ See, e.g., *Travelers*, 514 U.S. at 657; *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 191 (2007) (emphasizing uniformity); McCuskey, *Agency Imprimatur*, *supra* note 21, at 1144-45 (describing how the ACA filled some of the regulatory void ERISA had created).

³⁸² See McCuskey, *Agency Imprimatur*, *supra* note 21, at 1101-08, 1155-57.

3. Shoring up ERISA Preemption Jurisprudence

Even without Congressional intervention, courts could strike a better balance between federalism and national uniformity in ERISA preemption by restoring some gestalt principles of ERISA preemption jurisprudence. As described in Part II, courts could more precisely apply the Supreme Court's ERISA precedent from *Travelers*³⁸³ by limiting "relates to" preemption only for those state statutes that eliminate all meaningful choice of health benefits for employers,³⁸⁴ rather than extending preemption to state laws that merely make one choice less economically desirable than another.³⁸⁵

And courts could return to some jurisprudential principles which mitigate in favor of state regulation, namely the presumption against preemption and the broader intent behind the ERISA statute. Supreme Court ERISA jurisprudence since *Travelers* has framed preemption analysis with the longstanding presumption against preemption, which the Supreme Court has acknowledged applies with even greater force to regulation in historical spheres of state authority, such as insurance and health care.³⁸⁶ While the presumption against preemption does not itself save state laws,³⁸⁷ it should favor preservation of historically state authority – such as regulation of insurance, health care providers, and raising general revenue – in close cases.³⁸⁸ Self-funded plans, however, remain nearly unreachable by state laws under existing interpretations of deemer and savings clauses, despite the

³⁸³ *Travelers*, 514 U.S. 645.

³⁸⁴ *E.g.*, *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 546 F.3d 639 (9th Cir. 2008).

³⁸⁵ *E.g.*, *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180, 193 (4th Cir. 2007).

³⁸⁶ *See, e.g.*, *Travelers*, 514 U.S. at 654-55; *De Buono*, 520 U.S. at 814.

³⁸⁷ *See, e.g.*, *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d at 191 (holding a state law preempted, but "recognizing that ERISA is not presumed to supplant state law, especially in cases involving 'fields of traditional state regulation,' which include 'the regulation of matters of health and safety'" (quoting *De Buono*, 520 U.S. at 814 n. 8).

³⁸⁸ *See McCuskey, Body of Preemption, supra* note 106. *See, e.g.*, *Golden Gate*, 546 F.3d at 647-48.

presumption against preemption.³⁸⁹

On a more fundamental level, courts could interpret ERISA's preemption provisions with greater fidelity to the statute's context and history, which suggest that employee benefit protection and the preservation of state insurance laws ought to feature more prominently than the current obsession with uniformity. Congress's primary concern in enacting ERISA was "promot[ing] the interests of employees and their beneficiaries in employee benefit plans"³⁹⁰ To gain support from large employers toward that broader goal, ERISA included the employer-friendly preemption clause designed "to permit nationally uniform administration of employee benefit plans."³⁹¹ The inclusion of the savings clause, however, explicitly contemplated a regulatory regime embracing state-by-state "disuniformities" in the law of health insurance.³⁹² Courts analyzing preemption often focus on the goal of employer-friendly uniformity and neglect both the savings clause and the statute's broader employee-protection goal.³⁹³ Courts would do well to recognize the import of ERISA's savings clause and the statute's broader

³⁸⁹ See *FMC Corp. v. Holliday*, 498 U.S. 52, 62 (1990).

³⁹⁰ *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983); see also 29 U.S.C. § 1001(c); 120 Cong. Rec. 29,193 (Aug. 20, 1974) (statement of Sen. Biaggi describing ERISA "an emancipation proclamation" for employees); *Massachusetts v. Morash*, 490 U.S. 107, 112, 115 (1989).

³⁹¹ *Travelers*, 514 U.S. at 657. See Wooten, *supra* note 102.

³⁹² *Metropolitan Life*, 471 U.S. at 747. See also *Self-Ins. Inst. of Am., Inc. v. Snyder*, 827 F.3d 549, 555 (6th Cir. 2016), *cert. denied*, 137 S. Ct. 660 (2017) ("ERISA, in other words, does not 'create a state-law-free zone around everything that affects an ERISA plan.'").

³⁹³ Compare *Travelers*, 514 U.S. at 657 (emphasizing uniformity), *FMC Corp.*, 498 U.S. at 60 ("To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits."), and *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 191 (2007) (describing uniformity and minimizing administrative burden as ERISA's "primary objective"), with *Andrews-Clarke*, 984 F. Supp. at 56 (lamenting that "in the health insurance context, ERISA has evolved into a shield of immunity which thwarts the legitimate claims of the very people it was designed to protect"), and *Self-Insurance Institute*, 827 F.3d at 555 (contesting the notion that ERISA could fully shield ERISA plans from state regulation).

employee-protection goal, as measured against the bounded uniformity in the concession to employers.

In the end, we see little reason to expect that courts can fix the dysfunction they have added to a dysfunctional statutory provision. While these jurisprudential adjustments might help clear some way for state single-payer reforms without legislative intervention, they lack the clarity and predictability that statutory revisions can offer.³⁹⁴ Most of the necessary jurisprudential adjustments would need to come from new Supreme Court opinions,³⁹⁵ which is an unlikely prospect.³⁹⁶ And jurisprudential changes deal only with the symptoms of ERISA's obstructionism, not the root cause: the statute's wording, which courts so frequently have lamented and called on Congress to revise,³⁹⁷ as we do now.

CONCLUSION

The Affordable Care Act has catalyzed a new era of health reform momentum in state and local governments, as evidenced by the voluminous and robust state single-payer legislation catalogued here. While states may successfully contort their health reform efforts to avoid ERISA preemption, they should not have to do so any longer. ERISA preemption has outlived its utility as applied to health insurance and has elevated the preferences of

³⁹⁴ See Sharpe, *supra* note 111, at 230.

³⁹⁵ Cf. *Egelhoff v. Egelhoff*, 532 U.S. 141, 152-53 (2001) (Scalia, J., and Ginsburg, J., concurring) (lamenting in dissent that Supreme Court precedents provide no clear guidance and recommending a return to "ordinary preemption jurisprudence" instead of ERISA exceptionalism).

³⁹⁶ Cf. *Egelhoff v. Egelhoff*, 532 U.S. 141, 152-53 (2001) (Scalia, J., and Ginsburg, J.,) (lamenting in dissent that Supreme Court precedents provide no clear guidance and recommending a return to "ordinary preemption jurisprudence" instead of ERISA exceptionalism).

³⁹⁷ See, e.g., *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 53 (D. Mass. 1997) (Young, J.) ("This case, thus, becomes yet another illustration of the glaring need for Congress to amend ERISA to account for the changing realities of the modern health care system. Enacted to safeguard the interests of employees and their beneficiaries, ERISA has evolved into a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits.").

private businesses above the interests of sovereign states in ways that subvert federalism. The time has come to remove ERISA's obstructions and to unlock states' capacities as laboratories of health reform.

APPENDIX A – STATE SINGLE-PAYER PROPOSALS, 2010-2019

State	Proposal	Date	A	B	C	Type	State	Proposal	Date	A	B	C	Type
1. CA	SB 562	05/2017		•		B	NH	HB 686	01/2015				—
CA	SB 810	01/2012	•			A	13. NJ	SB 2598	05/2018				—
2. DE	HB 74	04/2013	•			A	NJ	AB 5310	12/2017				—
DE	HB 392	06/2012	•			A	NJ	AB 4945	06/2017	•	•		A B
3. FL	SB 1486	03/2019		•		B	14. NY	AB 5248	02/2019	•	•		A B
FL	SB 1872	01/2018		•		B	NY	SB 4840	02/2018	•	•		A B
4. HI	HB 1286	01/2019				—	NY	AB 5062	04/2016	•	•		A B
HI	SB 2207	01/2018				—	NY	AB 5389	04/2013	•	•		A B
5. IA	HF 96	01/2019	•	•		A B	NY	AB 7860	05/2011	•			A
IA	HF 2352	02/2018	•	•		A B	15. OH	HB 292	06/2019	•	•	•	A B C
6. IL	HB 207	01/2019	•	•		A B	OH	HB 440	12/2017	•	•	•	A B C
IL	HF 2436	02/2017	•	•		A B	OH	SB 137	04/2015	•	•	•	A B C
IL	SB 2177	10/2015	•	•		A B	OH	SB 104	04/2013	•	•	•	A B C
IL	HB 942	01/2013	•	•		A B	OH	HB 287	06/2011		•	•	B C
IL	HB 311	01/2011	•	•		A B	16. OR	SB 631	02/2015			•	C
7. MA	HB 2987	01/2017	•	•		A B	17. PA	SB 1014	02/2018	•		•	A C
MA	HB 1026	01/2015	•	•		A B	PA	HB 1688	11/2015	•		•	A C
MA	SB 515	01/2013	•	•		A B	PA	SB 400	01/2013	•		•	A C
MA	SB 501	01/2011	•	•		A B	PA	HB 2551	07/2012	•		•	A C
8. MD	HB 1087	02/2019	•	•		A B	18. RI	HB 5611	02/2019	•	•	•	A B C
MD	HB 1516	02/2018		•		B	RI	SB 2237	02/2018	•	•	•	A B C
MD	SB 667	01/2014				—	RI	SB 2824	03/2016	•	•		A B
9. ME	HP 316	01/2019			•	C	19. SC	SB 786	05/2015	•	•		A B
ME	HP 887	04/2017			•	C	20. VT	HB 202	05/2011	•		•	A C
ME	HP 962	04/2013		•	•	B C	VT	HB 80	01/2011		•		B
ME	HP 1026	04/2011	•	•	•	A B C	21. WA	SB 5222	02/2019			•	C
10. MI	HB 6285	08/2018			•	C	WA	HB 1104	01/2019	•		•	A C
11. MN	SF 1125	01/2019	•		•	A C	WA	SB 5957	06/2017		•		B
MN	SF 219	01/2017	•		•	A C	WA	SB 5747	02/2017	•			A
MN	SF 2163	05/2015	•		•	A C	WA	SB 5741	01/2015	•			A
MN	SF 912	02/2013	•		•	A C	WA	SB 5609	02/2013	•			A
MN	SF 18	01/2013	•		•	A C	WA	SB 5224	01/2013	•			A
12. NH	HB 697	02/2019				—	Proposals			A	B	C	Any
NH	HB 1793	01/2018				—	TOTAL NO.	66		45	34	25	58

Legend: A=Funding Plan; B=Provider Restriction; C=Assignment, Subrogation, Secondary Payer

APPENDIX B – SEARCH METHODOLOGY TO IDENTIFY STATE SINGLE-PAYER BILLS

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

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

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

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

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

After exclusions, 66 proposals remained and were analyzed for their provisions to capture employer health expenditures and/or move individuals with employer-based coverage into the single-payer plan. While comprehensive, this set is not necessarily a census of all unique legislative proposals during this period. Some bills may have been missed during the initial search and others erroneously removed during the subsequent exclusion process.