The Limits of State Action? The Myths and Realities of ERISA

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Series Editor's Note: Before I began my Health Policy Fellowship in Washington, I—like most physicians—had never heard of ERISA (Employee Retirement Income Security Act) let alone understood what it was or why it was important. I quickly learned, however, that the complex ERISA law has a huge impact on health care financing and reform. Furthermore, now that the federal government has decided—at least for the foreseeable future—not to address comprehensive national health care reform and wants to "let the states do it," ERISA has assumed even more critical importance.

In brief, the ERISA law says that only the federal government—not the states—can pass laws that regulate health insurance plans for all the people in the state, such as defining minimum benefits or requiring employers to provide or even continue insurance coverage. With ERISA thereby preventing states from making many of the changes necessary to address issues of access and financing of health care, and the federal government failing to provide national regulations, a major catch-22 has been created—ERISA prevents the states from "just doing it"!

Because ERISA has the strong support of both business and the unions (and therefore both Republican and Democratic support), it is unlikely to be changed unless its importance is more widely understood. I have therefore invited Dr. Robert Crittenden—a family physician in the Department of Family Medicine and Director of the Office of Education Policy in the Office of the Dean at the University of Washington School of Medicine, a former Robert Wood Johnson Health Policy Fellow in the office of former Majority Leader Senator George Mitchell (1987-88), and a former Special Assistant for Health, Office of the Governor of the State of Washington (1988-93)—to discuss this issue.

Let the States Do It? ERISA and the Limits of State Action

I first learned about ERISA 10 years ago when I had been asked to staff a commission of the Washington state legislature that was to recommend ways the state could extend insurance coverage to low-income working people who were not insured by Medicaid. One senator wanted to propose a tax to encourage employers to provide insurance for their employees—a solution that seemed simple to me. I was soon informed by a lawyer from the State of Washington's House Insurance Committee that "it can't be done—because of ERISA."

This obscure law has had a major influence on health policy at the state and local level. It greatly limits the actions of states, and it protects employers. This law is even more important now that there is a desire in Congress to move the responsibility for health services for low-income people from Washington, DC, to the states.

What is ERISA? In 1974 Congress was concerned about the abuses and weaknesses in pensions sponsored by private employers.[1] In a spate of very good reform, they passed a bill, the Employee Retirement Income Security Act of 1974 (ERISA) that set uniform federal standards on participation, vesting, and funding that greatly improved the quality of pensions available to employees throughout the country.

Congress also included a few phrases—on purpose—stating that certain other private employee benefit arrangements, including health benefits, would also be under exclusive federal jurisdiction and therefore exempt from state regulation. Unlike the pension section of the law, however, Con-

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gress failed to include in ERISA any federal standards required of these health plans.

These few phrases in ERISA have greatly limited the ability of states to regulate employer-based health plans.[2] While states retain the ability to regulate commercial health insurance companies (and thus have some control over benefits offered by employers who purchase insurance from a commercial insurance company), states do not have the ability to regulate or otherwise affect the content, quality, or form of employer-sponsored health benefits, such as those provided through self-insured plans (in which employers provide their own insurance rather than purchase insurance from a commercial insurer). Self-insured plans now account for almost one half of all employee health insurance. Because the lack of state oversight extends to employers who provide few or no health care benefits, ERISA provides a mechanism whereby employers can unilaterally escape state insurance regulation by deciding to self-insure or not insure. For better or worse, ERISA placed a large part of the health care marketplace outside any state regulation or influence.

What is the effect of this legislation? The major reason why the number of uninsured persons has grown during the past 15 years has been the decline of employer-sponsored insurance; in fact, the vast majority of those who are uninsured are employed or are dependents of employed persons. Many states have tried to respond to the growing gap between the insured and uninsured by expanding coverage for their low-income uninsured population. The rapid increase in coverage through Medicaid found in almost every state —mainly for mothers and children—has been the result of insuring those who were previously insured by employer-sponsored health insurance.

In theory states have only three main alternatives to respond to this problem and expand access: (1) they can impose taxes and use that money to provide coverage; (2) they can decrease the barriers to individuals buying their own insurance; and (3) they can require employers or individuals to provide or buy insurance, ie, an employer or individual mandate. Logically, as the major cause of the problem is the loss of employer-based insurance, the ideal response would be to stabilize and expand employer-provided insurance; and with the mood of the people to avoid any new taxes, this approach seems to be an especially easy alternative. ERISA, however, prohibits this latter course of action and thereby greatly limits the ability of states to address access issues.

Under ERISA states cannot require any employer to provide or pay for any employee health benefit. States cannot adopt any policy that directly regulates employer-sponsored benefit plans. Employers may provide any benefit package or choose to provide no benefits if they please. They are free to limit or change their benefits in any way, and they can discontinue their coverage at any time. Furthermore, employers cannot be compelled to participate in any direct insurance pool that might be established to pay for charity or other uncompensated care.

In summary, the federal government through ERISA has erected a barrier to state oversight of employer health benefit plans and has thereby allowed employers to avoid state regulation. Under ERISA only federal laws can address these issues, but the federal government has chosen not to do so.

Do communities have other alternatives? From the time that ERISA was enacted, the courts have continually interpreted the ERISA law to restrict further direct state actions on employee benefits (such as taxes and other requirements) as well as prohibit any indirect effect on employee benefits (such as hospital taxes that the employer-sponsored plan would indirectly pay). Recently, however, and much to the relief of the states, the Supreme Court in a unanimous decision has for the first time limited the scope of ERISA.

This case, *Travelers Insurance v the State of New York*,[3] held that there are limits to ERISA. The court found that pooling funds by the State of New York through its hospital rate-setting system (ie, requiring health plans and health maintenance organizations to pay a surcharge on inpatient hospital bills to help subsidize the uninsured) was not prohibited under ERISA. They upheld the ability of the State of New York to create a pool for nonpaying patients through its regulatory powers. Importantly, the *Travelers Insurance v the State of New York* decision leaves open the possibility for other states to consider taxing providers to generate funds for uncompensated care, a course of action that might look appealing to states now that the federal government seems intent on decreasing its support for such care.

Why should family physicians care about

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ERISA? Many of my patients have no health insurance at all, and an increasing number of low-income working families seek care each year who have no insurance. Many family physicians have worked hard in their communities to expand health insurance coverage for low-income families. They have been on the forefront of efforts to expand Medicaid and develop direct subsidies so that more pregnant women and children are insured. In many communities efforts have been made to expand employer-sponsored health insurance, and some states have developed insurance pools to pay for the care of those who either have no other insurance or are at high risk.

Some of the efforts can be carried out successfully and legally at the state level. Nevertheless, establishing direct assessments on employers, encouraging employers to insure their employees, and establishing a minimum level of benefits for all persons are beyond the power of states because of ERISA. The limits imposed by ERISA have thus stymied local physicians in their efforts to effect improvements in health care insurance.

We now also have an interesting conundrum: on the one hand, Congress is telling states that the federal government should limit its role and that states should assume an increased responsibility for their health care systems and their own problems; on the other hand, Congress is decreasing the funds available to states for care of low-income people. Many states have already adopted money-saving purchasing strategies, including lowering Medicaid payment rates and increasing the use of managed care.

Of even more serious importance, Congress has not allowed states to address the greatest factor causing the increase in the uninsured—shrinking employer-sponsored health insurance. Despite the current rhetoric, the stated goal of transferring power to the states can take place only partially. States, because of ERISA, have no ability to limit the erosion of employer-sponsored insurance.

Why does the federal government not change this law to allow states to be more active in solving their health care problems? ERISA has almost never been amended in any substantial way since its enactment in 1974 (Hawaii's employer mandate, which was already in existence in 1974, is the only exception). Major businesses with their self-insured health plans and large unions with their Taft-Hartley benefit plans have fought every attempt to allow states to regulate health benefits (on the grounds that having to comply with varying state regulations would be difficult), and they have been effective in stopping nearly every effort. Employer- and union-based health plans do not want any outside regulation, especially state taxes to help pay for the uninsured.

To be fair, most self-insured plans provided by employers and unions have provided good benefits for their employees. Most are responsible and strive for high-quality service. The major problem is not with these plans; it is the large and growing number of employers who provide no benefits at all for their employees.

Congress could make a simple change that would solve many of the problems that states have with ERISA. As is done in the pension section of ERISA, the federal law could require employer health plans to provide a minimum benefit structure if they are to qualify for the federal preemption (ie, be under federal rather than state jurisdiction) through ERISA. This change would allow states to differentiate between employers who provide benefits and those who do not. States could then work with their local employers cooperatively to improve the benefits available to low-income employees.

Although changes to ERISA have been proposed in recent years, all of these efforts have failed. Neither Republican nor Democratic members of Congress have been willing to change this statute.

What opportunities exist within ERISA to improve the health care system? The main opportunity for states was established by the recent Supreme Court decision. It now appears possible that states will be allowed to develop alternative funding mechanisms through indirect taxes, such as hospital taxes, that could enable communities and states to fund broader coverage for low-income uninsured persons. Although self-insured employer plans are free of direct regulation and taxes, they can be required to contribute indirectly to the support of programs that will address some of the revenue needs of the uninsured.

In addition, local communities can use the protections provided in ERISA to meet some of their health care needs. Throughout the country—often in rural communities—local employers with self-insured plans have been responsive to local

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community health needs. Self-insured employers are often highly motivated to create contracts and partnerships with local providers to ensure that their employees receive needed services, that those services are at a reasonable price, and that employees are satisfied with the quality of the services provided.[4] These plans have no insurance carrier (though they might have an administrative services contract) to insulate the self-insured plan from the community. The success of these benefit plans for their employees depends on the ability of the employer to ensure that the quality, cost, and access issues are addressed for their employees.

Many other paths to improving health care systems are not impeded by ERISA, but there is not space to describe them here. Understanding this one big barrier is important, however, as we navigate toward improvements in our complex health care system. Understanding how we can improve ERISA will help should the opportunity for change arise. The lawyer for the Washington State House Insurance Committee was right 10 years ago. We have not been allowed to tax employers or require them to provide benefits, but that has not stopped people throughout the country from experimenting and making improvements in their health care systems.

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