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CLEARING THE WAY FOR AN EFFECTIVE FEDERAL-STATE PARTNERSHIP IN HEALTH REFORM

Eleanor D. Kinney*

At century's end, states have assumed a very different role in the design, implementation, and operation of health service programs than they did twenty-five years ago. In the current volatile political atmosphere particularly at the federal level, states have taken up the mantle of healthcare reform in the final years of the 1990s. Yet there remain problems and difficulties with the current federal-state relationship in health reform. The critical question is whether states can successfully accomplish genuine reform given its politically charged, complex and costly nature. This question takes on particular significance for the most important reform—expanding coverage to the uninsured poor.

This Article explores the contours of a federal-state partnership that will move toward the societal goal of universal health coverage, and especially coverage of the uninsured poor. The Article suggests several legislative and regulatory changes. The most practical and immediate steps that Congress could take are to reform the Employment Retirement Income Security Act of 1973 (ERISA) and provide matching funds for state health insurance programs for the uninsured that allow states great flexibility in designing programs that really reach the uninsured within their boundaries.

INTRODUCTION

At century's end, states have assumed a very different role in the design, implementation, and operation of health service programs than they had twenty-five years ago. The Washington Post accurately captured today's state of affairs in its October 10, 1998 headline, the day after health reform legislation failed yet again in the United States Congress. The national section headline read: "Senate Kills 'Patients' Rights' Bill: Managed-Care Measure a Victim of Partisanship, Clinton Scandal, Lobbying." Referring to the respective positions on health reform of the gubernatorial

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candidates in the Maryland election, the metro section headline read: "Doctors Backing Sauerbrey as Glendening Lines Up HMOs." These headlines are revealing. At the national level, a modest proposal for procedural protections for health plan consumers failed in Congress—a victim of partisan politics, special interests and Presidential scandal. In this volatile political atmosphere, particularly at the federal level, states have taken up the mantel of health care reform in the final years of the 1990s. The critical question is whether states can successfully accomplish genuine reform given its politically charged, complex, and costly nature. This question takes on particular significance for the most important reform: expanding coverage to the uninsured poor.

Today, the American health sector is in need of reform for two reasons. First, forty-three million Americans (16.1%) have no health coverage. Second, serious inflation plagues the health care sector. Health care expenditures have risen from 73.2 billion dollars in 1970 to one trillion dollars in 1996 and are estimated to reach over two trillion dollars in 2007. For the last thirty-five years, states and the federal government have grappled with these problems and continue to do so today with varying degrees of success.

The relationship between states and the federal government changed dramatically in the last fifty years. At mid-century, neither the federal government nor the states had direct responsibility for the financing or delivery of health care services. The federal government had a very limited role in the health care sector with support for a very small federal-state medical assistance program for welfare recipients, a small federal public health program, and a nascent biomedical research effort that would subsequently fuel dramatic medical advances and transform the American health care sector. Union pressure for coverage through the workplace and a general demand for health coverage among the middle class

Clearing the Way

led to the expansion of private health insurance coverage in the middle of the twentieth century.7 Historically, states have had dominant responsibility for regulating the commercial insurance industry as well as addressing the needs of the poor.

The federal government assumed a more dominant role in financing and regulating health care services with the enactment of the Medicare and Medicaid programs in 1965.8 By the mid-1970s, the nation was moving toward national health insurance with a minimal state role.9 As with many other domestic problems,10 the federal government in the 1960s played a greater role in addressing problems such as providing health insurance coverage for underserved groups and alleviating poverty.11 The widely held liberal view that many states, particularly southern states with a history of racial segregation, were unreliable in addressing the problems of the poor partly shaped the federal expansion in domestic programming.12 Following the federal activism of the 1960s and 1970s, many commentators on federalism asserted that states were virtually irrelevant in addressing many social problems.13

Beginning with President Nixon, presidential administrations have sought to reinvigorate the role of states in solving domestic problems.14 President Reagan’s brand of federalism was not so

7. See id. at 310–34.
8. See infra notes 19–20 and accompanying text.
14. See Walker, supra note 10, at 129–70. See generally Timothy Conlan, New Federalism: Intergovernmental Reform from Nixon to Reagan (1988) (describing the history of state-federal relations since the 1960s); The State of the States (Carl E. Van
much an allocation of power in solving domestic problems as a reduction in governmental responsibility generally, particularly with respect to the federal government. President Bush paid little attention to federalism issues but generally followed the approaches of the Reagan administration. President Clinton, a former governor with a deep interest in domestic policy issues including health reform, brought a new approach to federalism which has allowed for real state progress in the area of health reform and, in particular, coverage expansion for the low-income poor. The earlier vision of states, in general, being incapable of sustained social reform is waning with the emergence of evidence of states' capabilities in governance since the 1960s.

This Article examines the experience of states in attempting to expand health insurance coverage to their uninsured poor and, in particular, the states' relationship with the federal government in this effort. Part I examines the current status of the state-federal health care relationship including the health of the general population, care for low-income persons, and the regulation of private health insurance. To elucidate the issues facing states, Part II explores the experience of Indiana in developing strategies to enhance coverage for low-income workers and their families. In so doing, the Article concretely describes the barriers and opportunities for states as they endeavor to expand coverage for low-income uninsured. The Article concludes that most states are not capable of significant coverage expansions without federal financial contribution and mandates for consumer protection. The Article suggests a reformed relationship between states and the federal government that empowers states to expand coverage for the uninsured poor and facilitates state innovation and leadership in that effort.

Horn ed., 1989) (assessing the performance of state government after the expansion of states' rights in the 1980s and crediting President Reagan for facilitating greater state responsibility for solving domestic problems).


16. See Walker, supra note 10, at 162-68.

17. See infra notes 91-94 and accompanying text.

18. See generally Bowman & Kearney, supra note 10; Ira Sharkansky, The Malignant States: Policy Accomplishments, Problems, and Opportunities (1972) (articulating the emerging opinion about the capabilities of states); Mavis Mann Reeves, The States as Polities: Reformed, Reinvigorated, Resourceful, ANNALS AM. ACAD. POL. & SOC. SCI., May 1990, at 83 (discussing the states' increased vitality).
I. THE CURRENT STATE-FEDERAL RELATIONSHIP IN HEALTH COVERAGE

Four events have shaped the nature and scope of health coverage in the United States in the latter half of the twentieth century. First, post-World War II employers began providing health insurance as a fringe benefit to union workers in lieu of wages during a period of wage-price controls. Employer-sponsored health insurance grew dramatically, the predominant source of health coverage for non-elderly Americans.19 Second, in 1965 Congress enacted the Medicaid program, which provided that the federal government and states would fund health coverage for welfare program participants under the Social Security Act.20 Third, in 1974 Congress enacted the Employee Retirement Income Security Act (ERISA)21 which located regulation of employer-sponsored health insurance—the predominant source of health insurance for the nonelderly—in the federal government and a step removed from state insurance regulation.22 Finally, in 1997, Congress established the Children’s Health Insurance Program as a joint federal-state program to provide coverage for all low-income children.23

A. Health Coverage of the American Population

Currently, Americans are enrolled in a mix of health plans with multiple public and private sponsors.24 Within the general categories of public and private insurance are markedly different health plan sponsors. Public sponsors include the federal government, states, and both acting together. Private sponsors include employers, commercial insurance companies, and managed care organizations (MCOs), including health maintenance

22. See infra notes 150-54 and accompanying text.
23. See infra notes 96-103 and accompanying text.
24. See Bovbjerg et al., supra note 19, at 153.
organizations (HMOs). Private plans of these different sponsors, as described below, are subject to different regulatory regimes.\textsuperscript{25}

In 1997, about 225 million Americans (83.9% of the population) were enrolled in some type of public or private health plan.\textsuperscript{26} Most non-elderly Americans obtain health insurance through their own employment or the employment of a family member. An estimated sixty-one percent of non-elderly Americans have coverage through employer-sponsored health insurance.\textsuperscript{27} In 1997, 35.5 million Americans had health insurance through the federal Medicare program for the elderly and severely disabled and 28.9 million through the federal-state Medicaid program for some poor.\textsuperscript{28} In 1996, children under age twenty-one and adults in families with dependent children comprised sixty-six percent of all Medicaid beneficiaries.\textsuperscript{29}

Forty-three million Americans had no health coverage in 1997.\textsuperscript{30} This number grew by 1.7 million between 1996 and 1997 alone, leaving 16.1% of the population uninsured\textsuperscript{31}—a disturbing trend given the strong performance of the American economy in the 1990s. Who is uninsured and for how long has been studied extensively in recent years.\textsuperscript{32} The largest group of uninsured are low-income workers.\textsuperscript{33} In a December 1997 poll, more than half of adults in low-income working families (under $35,000 annual

\textsuperscript{25} See infra notes 104-30 and accompanying text.
\textsuperscript{26} See U.S. Census Bureau, supra note 3.
\textsuperscript{27} See Health Insurance Association of America, Source Book of Health Insurance Data, 1997–1998, at 21 fig.2.6 (1998).
\textsuperscript{30} See U.S. Census Bureau, supra note 3. See generally Joel S. Weissman & Arnold M. Epstein, Falling Through the Safety Net: Insurance Status and Access to Health Care (1994) (describing the problems that the uninsured poor have in getting health care).
\textsuperscript{33} See Blumberg & Liska, supra note 32, at 6.
income) reported having been uninsured some time during the last two years.  

There is also evidence that the problem of uninsurance is getting worse as sponsors of health coverage reduce benefits, fail to provide affordable coverage, or provide no coverage at all. Specifically, employer-sponsored health coverage, particularly for families, has declined. The rate of employer coverage fell by six percentage points between 1988 and 1993. Research suggests that cost sharing and benefit limits have increased in recent years in many private health insurance plans and that many employees decline to take up private health insurance coverage even when offered because of the cost. Increasingly, employers are purchasing coverage from HMOs and other MCOs and offering employees prepaid managed care plans. As of 1995, about seventy-five percent of participants in employer-sponsored plans were enrolled in some kind of managed care plan. While beyond the scope of this Article to address fully, some evidence suggests that employer-sponsored health coverage may not ultimately be the best or most appropriate vehicle for providing health coverage to the non-elderly population. Some have even suggested that it is not “just” as a philosophical matter.


36. See Blumberg & Liska, supra note 32, at 2.


38. See Gail A. Jensen et al., The New Dominance of Managed Care: Insurance Trends in the 1990s, Health Aff. Jan./Feb. 1997, at 125, 125.

39. See generally Mary E. O’Connell, On the Fringe: Rethinking the Link Between Wages and Benefits, 67 Tul. L. Rev 1421 (1993) (describing the flaws in distributive devices that fail to provide universal coverage and fail to reward the most productive citizens).

Finally, there are also marked disparities in insurance coverage among states. The percent of non-elderly uninsured varies from a low of seven percent in Tennessee to a high of twenty-six percent in New Mexico. The variation in health coverage is due partly to the extent of Medicaid coverage in the states as well as other available insurance options. While the Medicaid coverage nationwide was twelve percent in 1994–1995, Medicaid coverage ranged from six percent in Colorado to twenty-one percent in Tennessee—a state with a section 1115 Medicaid waiver to support a statewide health insurance program for the uninsured.

B. Health Insurance Programs for the Poor

Historically, states have had the obligation to care for the poor. Such state assistance was targeted to the so-called deserving poor—poor persons who, through no fault of their own, were unable to provide adequately for themselves. As medicine advanced in the nineteenth century, this obligation to the poor began to include some medical care as well. In 1935, Congress enacted the Social Security Act—a pillar of Franklin D. Roosevelt’s New Deal and his enduring response to the catastrophic economic dislocations of the Great Depression. The Act contained several cash assistance programs for different categories of poor, including the aged, blind, disabled, and families with dependent children, who were ostensibly in dire straits through no fault of their own. Designed as state programs, these cash assistance programs included federal requirements that states were obligated to meet to obtain federal matching funds. Despite considerable support from Presidents Roosevelt and Truman for

42. See id. at 12.
43. See id. at 12–13.
44. See infra notes 88–95 and accompanying text.
51. See infra note 62 and accompanying text.
incorporating national health insurance into the Social Security framework, it was not until the 1950s that Congress began to establish a limited medical benefit to welfare programs under the Social Security Act.\(^{52}\) In the 1960s, using the same state-federal model of other Social Security Act welfare programs, Congress enacted the Kerr-Mills Act, which provided limited health benefits for the elderly poor.\(^{53}\) The Medical Assistance program under the Kerr-Mills Act was the model for the 1965 Medicaid program.\(^{54}\)

1. The Medicaid Program—In 1965, Congress enacted the Medicaid and Medicare programs to meet the health insurance needs of the elderly and the poor on cash assistance programs under the Social Security Act.\(^{55}\) The Medicaid program is jointly financed and administered by the federal government and the states.\(^{56}\) State participation in the program is optional, but in order to participate, states must submit a “state plan” to the federal government describing the state program and providing assurances on how the state will meet federal requirements for mandatory and optional components of the program.\(^{57}\) The federal government matches state dollars expended on the Medicaid program, but at different rates depending on the state’s relative per capita income.\(^{58}\) The federal match comes from federal general revenues\(^ {59}\) and the state contribution usually comes from state general revenues.\(^ {60}\) In fiscal year 1997, the federal government paid about fifty-seven percent of total Medicaid expenditures.\(^ {61}\)

   a. Eligibility—Historically, Medicaid eligibility has been linked to eligibility for the two major cash assistance programs under the Social Security Act—the Aid to Families with Dependent Children

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54. See Myers, supra note 52, at 286-306.
(AFDC) and the Supplemental Security Income (SSI) programs. Since the program’s inception, Congress has repeatedly changed eligibility requirements and added additional Medicaid eligible participants to address specific needs.

States are also given the option of covering the medically needy, individuals who, except for their income or resources, meet the eligibility requirements for SSI or AFDC. The medically needy program offers catastrophic health and long term care insurance for lower income people who must “spend down” their income and resources to obtain Medicaid eligibility. Seventy percent of states have a medically needy program. Most of the states without such programs are in the South and Southwest.

In 1983, following the Reagan administration’s sharp cuts in all programs for the poor, Congress began to expand Medicaid eligibility for infants, children, and pregnant mothers. The upshot of this effort was that by April 1990 all states had to cover all poor children (born after 1983 up to age eighteen) with family incomes less than 133% of the poverty level. Thus, by 2002, all poor children under age nineteen will be covered. One important group of the optional categorically needy are children under age seven born after 1983 and pregnant women whose incomes are under 185% of the federal poverty level. This eligibility expansion is a major departure from basing eligibility on state standards for categorical assistance programs, and thus represents a significant step toward treating similarly situated poor in different states in a uniform manner.

64. These eligibility expansions are numerous and have highly technical qualification requirements. The best description of these eligibility expansions and the statutory and regulatory authority on which they are based is contained in 3 Medicare & Medicaid Guide (CCH) ¶¶ 14,211-381 (Apr. 9, 1998). See also Congressional Res. Serv., 103d Cong., 1st Sess., Medicaid Source Book: Background Data and Analysis, 1993 Update 187 (1993) [hereinafter Medicaid Source Book].
66. See id.
68. See id.
In the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Congress fundamentally reformed the American cash assistance program for low-income mothers and children and specifically terminated the AFDC program and its ongoing cash assistance. In its place, the Act substitutes capped block grants for Temporary Assistance to Needy Families (TANF). TANF requires recipients to participate in community service after two months of benefits and to return to work, as defined by the state, after two years of benefits.

This new statute also changed the eligibility rules for Medicaid for former AFDC recipients. States are required to provide Medicaid coverage and benefits to children and parents who otherwise would be eligible for AFDC. The TANF program does not affect Medicaid eligibility for children and pregnant women in families with incomes under 133% of the poverty level who are independently eligible for Medicaid. Also, some poor children are eligible for the Children's Health Insurance Program (CHIP) described below.

b. Benefits and Coverage—The federal Medicaid statute specifies the benefits that state programs must include to qualify for federal matching funds and identifies specific additional benefits that states have the option of covering. States have greater flexibility in structuring the benefit packages for their medically needy programs, although any medically needy program must include prenatal and delivery care for pregnant women, and other specified services.

80. See infra notes 96-103 and accompanying text.
Coverage provided must be "sufficient in amount, duration, and scope to achieve [the services'] purpose." To insure that states do not unduly favor one group of Medicaid eligibles over another, there are limits on the degree to which states can provide coverage of benefits for some groups of Medicaid eligibles and not for others. In addition, states cannot arbitrarily discriminate in benefit coverage for mandatory services on the basis of diagnosis, type of illness, or condition. As a result of these flexible rules, coverage of both mandated and optional Medicaid benefits varies considerably among states.

c. Waivers of Federal Requirements—Waivers play an important role in the Medicaid program by permitting states both to experiment with different approaches to financing and delivering health care services and to meet the particular needs of special groups of beneficiaries. Two waivers in particular have been especially important with respect to coverage for the uninsured poor. The waiver authority for primary care case management systems, established in 1981, has enabled states to bring Medicaid eligibles into managed care plans with savings to the program and enhanced care to recipients. In 1997, Congress authorized states to serve Medicaid beneficiaries through prepaid managed care plans without getting a waiver of program requirements.

87. See MEDICAID SOURCE BOOK, supra note 64, at 1.
Since the beginning of the Clinton administration, which loosened requirements for experimental waivers for state Medicaid programs, many states have used waivers under section 1115 of the Social Security Act to expand coverage for low-income uninsured, including workers, who did not otherwise meet Medicaid eligibility requirements. The Clinton administration policy permits states to include all uninsured poor in prepaid managed care plans so long as the programs are budget neutral. As of 1999, fifteen states had implemented health insurance programs for the uninsured poor under section 1115 waivers and several more are in the process of applying and implementing such programs.

2. The Children’s Health Insurance Program—The Balanced Budget Act of 1997 established the State Children’s Health Insurance Program (CHIP) which provides $24 billion in matching funds to states for five years to expand health insurance coverage for children. States can enroll all children for funding up to 200% of poverty. In addition, states can enroll the


94. See Holahan et al., supra note 93, at 200.


children's parents if they meet certain fiscal constraints. The legislation does not create an entitlement program such as Medicaid for children but rather gives states the opportunity to inaugurate programs to expand health insurance coverage for children. They can expand their Medicaid programs to include covered children or they can establish independent programs. With the latter option, states have greater flexibility, although benefit packages must be comparable to benchmark plans such as the standard Blue Cross and Blue Shield plan for federal employees, the state's health plan for state employees, or the commercial HMO having the largest enrollment in the state.

C. The Regulation of Private Health Insurance

As indicated above, private health insurance finances the health care of most Americans—particularly non-elderly working Americans. Government's role has been to regulate private health insurance to ensure that adequate and affordable health coverage is available to all who wish to purchase it—a goal yet to be achieved.

1. State Regulation of Health Insurance—States historically have regulated insurance and they continue to do so under the unique allocation of federal and state supervision of insurance that Congress established in the 1945 McCarran-Ferguson Act. State insurance regulation addresses insurer solvency and market conduct with respect to consumers. With respect to the regulation of solvency, most states regulate rates to ensure that


100. See Balanced Budget Act, § 4901(a), 111 Stat. at 552 (codified as amended at 42 U.S.C. § 1397aa (1998)).

101. See id.

102. See id.

103. See supra note 27 and accompanying text.

104. See supra note 30–34 and accompanying text.

105. See supra note 27 and accompanying text.


they are adequate to maintain insurer solvency but not excessive. The National Association of Insurance Commissioners (NAIC), a non-profit organization comprised of state and territorial insurance commissioners, effectively coordinates insurance regulation among the states through model laws and regulations and provides common services and technical assistance to state insurance departments.\(^{108}\)

This arrangement of state regulators coordinating regulatory programs through a private organization is unique. In virtually all other areas where national uniformity or consistency is perceived to be necessary, Congress has established federal regulatory programs. The unique arrangements for insurance regulation in the United States evolved in part from the behavior of the insurance industry in the boom and bust cycles that characterized the American economy after the Civil War.\(^{109}\) Specifically, in boom times, under-capitalized and unsophisticated insurers would sell fire and other insurance at unrealistically low rates and use questionable practices, such as deep discounts for desirable, low risk customers, to get business from other insurers that charged higher and more realistic rates. With underwriting profits spent, these insurers would become insolvent and fail to pay claims, particularly in bad economic times. In response, insurers signed compacts with one another to cooperate in setting adequate rates and asked states, which generally addressed regulatory problems during this period, for greater regulatory protection. States began to regulate rates and generally required that rates be adequate and nondiscriminatory between similarly situated policy holders.

State regulation was also allowed to flourish without federal intervention due to the 1869 Supreme Court decision in *Paul v. Virginia*,\(^{110}\) which held that insurance was not a transaction in interstate commerce.\(^{111}\) Many states prohibited compacts among insurers, but state enforcement was weak.\(^{112}\) In the 1930s, the anti-competitive conduct of insurers attracted federal attention. The U.S. Department of Justice sued a multi-state rating bureau for fixing premium rates and boycotting outside insurers in violation

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110. 75 U.S. (8 Wall.) 168 (1869); see also *McDowell, supra* note 109, at 41-44.

111. See *Paul*, 75 U.S. at 183.

112. See id.
of the Sherman Antitrust Act. In United States v. South-Eastern Underwriters, the Supreme Court ruled that insurance was a transaction in interstate commerce subject to the federal antitrust laws. States, the NAIC, and the insurance industry wanted to continue state regulation and persuaded Congress to enact the McCarran-Ferguson Act to shield the insurance industry from federal antitrust laws.

Upon enactment of the McCarran-Ferguson Act, the NAIC became much more influential. In 1947, it developed and approved its Model Unfair Trade Practices Act and by 1949 most states had enacted that model or a similar version. In part, this influence stemmed from state concern that Congress would reform the unique exemption from federal antitrust regulation if states did not effectively regulate insurance—a concern that has persisted since the McCarran-Ferguson Act's enactment. Since that time, the NAIC has developed model legislation on many issues and developed other programs to improve state insurance regulation.

States license and regulate all commercial health insurers and HMOs. The NAIC's Model HMO Act is the basis of most state HMO statutes. State regulation of health insurance historically has focused on improving the benefit packages of health insurance plans by mandating inclusion of specific benefits. Specifically, sixteen states have mandated over twenty kinds of benefits; eight others have mandated as many as ten. More recently, states have been active in legislating consumer protections, such as stronger

114. 322 U.S. 533 (1944).
115. See id. at 582-83.
117. See ETTLINGER ET AL., supra note 107, at 6.
119. See ETTLINGER ET AL., supra note 107, at 6-7.
120. See id. at 6.
121. See NAIC Model Laws, supra note 118.
Clearing the Way

disclosure requirements and more open utilization review, into state HMO statutes. 124

The NAIC also participates in the regulation of managed care plans, including many of the new risk bearing entities that have emerged in recent years. The NAIC has proposed model legislation to strengthen the state regulation of health insurance and launched its “CLEAR” initiative125 to reform state regulation of all managed care plans. 126 Specifically, the “CLEAR” initiative endeavors to increase the use of common definitions and promote uniform regulation of health plans.127 This initiative includes five model statutes aimed at all types of health plans: the Managed Care Plan Network Adequacy, Health Carrier Grievance Procedure, Utilization Review, Quality Assessment and Improvement, and Health Care Professional Credentialing Verification.128 These model statutes impose basic quality standards upon managed care health plans and sponsoring carriers to protect consumers when they are either restricted as to their choice of provider or offered incentives to select a particular provider.129

The NAIC has also focused on the treatment of provider sponsored networks—an increasingly competitive response of providers to HMO expansion in many states. The development of these networks has been controversial. The provider community does not want them to be regulated as insurance companies, as then they would be subject to the strict solvency regulation of state


125. CLEAR stands for Consolidated Licensure for Entities Assuming Risk.


127. See id.

128. See NAIC MODEL LAWS, supra note 118.

129. See Healthcare Quality Hearings, supra note 126, at 66–74.
regulators. The NAIC has taken the position that these entities are "insurers" and should be subject to state insurance regulation. Many are concerned that these health plans do not have adequate capital reserves and other safeguards to ensure their solvency and thus their continued ability to meet the needs for health care services of network members. The NAIC has also analyzed the nature of different types of risk bearing managed care plans and their appropriate regulation.

2. The Employee Retirement Income Security Act—Congress enacted the Employee Retirement Income Security Act of 1974 (ERISA) following a perceived crisis in the availability of pensions for American workers. ERISA regulates pension plans and also "employee benefit plans" which include life, health, and disability insurance plans that are offered to employees. The Act's legislative history suggests that Congress was primarily concerned with regulating pension plans and that the Act's inclusion of other types of employee benefits, such as health insurance, was a secondary concern.

The Act establishes requirements for employee benefit plans that are eligible for favorable federal tax treatment. The key requirements are disclosure and reporting practices regarding the plans' characteristics to plan participants and beneficiaries (dependents of employees). Regarding reporting and disclosure, plan administrators must provide plan participants and beneficiaries with a summary plan description that is both comprehensive
and comprehensible. The Act also establishes the plan's administrator as a "fiduciary" with associated duties and liabilities to plan participants and beneficiaries.

ERISA regulates through enforcement of duties and liabilities of plan fiduciaries, who are required to act solely in the interest of plan participants and beneficiaries. ERISA also specifies the duties of the fiduciary in specific situations and outlines rules of their fiduciary liability. The use of the fiduciary as the regulatory mechanism reflects ERISA's emphasis on pension protection with its associated emphasis on solvency, asset management, and other related issues.

ERISA has very specific enforcement provisions. All plans must maintain internal review procedures under section 503 of ERISA. Section 502(a) authorizes civil actions against plan fiduciaries for any breach of ERISA requirements, including plan fiduciary determinations under section 503. ERISA authorizes equitable relief as well as damages, although damage awards are limited to the recovery of lost benefits. In *Pilot Life Insurance Co. v. Dedeaux*, the Supreme Court ruled that ERISA's enforcement remedies preempted state remedies.

For all covered employee benefit plans, ERISA preempts state laws that would otherwise regulate employee benefit plans. Although ERISA explicitly excludes state insurance codes from preemption, it provides that employee benefit plans will not be deemed insurers for purposes of state insurance regulation. Consequently, a self-insured employee health plan clearly will fall

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139. See id. § 102(a), 88 Stat. at 840.
140. See id. § 404, 88 Stat. at 877, (delineating the duties of fiduciaries under ERISA plans).
141. See id. §§ 404-405, 88 Stat. at 877-79.
142. See id. § 404(a), 88 Stat. at 877.
145. See ERISA § 503, 88 Stat. at 893.
146. See id. § 502(a), 88 Stat. at 891.
147. See id. § 502(a) (1) (B), 88 Stat. at 891–92.
149. See id. at 54–55.
150. See ERISA § 401, 88 Stat. at 874–85.
151. See id. § 514(a), 88 Stat. at 897.
152. See id. § 514(b), 88 Stat. at 897.
153. See id. § 514(c), 88 Stat. at 897.
under the ERISA preemption and be subject only to ERISA requirements. If the employer purchases health insurance from a commercial insurance company, aspects of the health plan that relate to the business of insurance may be regulated by state insurance laws.\(^{154}\)

Historically, courts have interpreted broadly ERISA preemption.\(^{155}\) In *Pilot Life Insurance*,\(^{156}\) the Supreme Court ruled that ERISA preempted state causes of action in tort for bad faith breach against employee welfare benefit plans and the commercial insurers that funded these plans.\(^{157}\) The effect of this decision has been to limit significantly the tort liability of HMOs to members of employer-sponsored health plans. But more importantly, as discussed below, this preemption provision and its interpretation by the federal courts have caused considerable dislocation in the private health insurance market and have thwarted state efforts at reforms.

In an important recent decision, *Corporate Health Insurance Inc. v. Texas Department of Insurance*,\(^{159}\) the United States District Court for the Southern District of Texas ruled that ERISA did not preempt a recent and fairly unique state statute that specifically established a duty, with the associated liability, “to exercise ordinary care when making health care treatment decisions”\(^{160}\) on health insurers,

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158. See infra notes 159–62 and accompanying text.


160. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West 1999).
HMOs and "other managed care entit[ies]." The court ruled that ERISA did not preempt such a Texas statute as Congress did not intend to enable health plans to escape liability for the medical decisions they make, control or influence. It will be interesting to see if other states adopt similar statutes specifically imposing liability on health insurers, HMOs and MCOS for their health care decision making and also whether such statutes withstand judicial challenges. If so, statutes of this type may constitute useful vehicles for addressing some of the problems in the current federal-state partnership and facilitate health care reform.

II. PROBLEMS, PROGRESS, AND POSSIBILITIES IN THE FEDERAL RELATIONSHIP IN HEALTH POLICY

In reforming the federal relationship, it is useful to emphasize the respective strengths and weaknesses of states and the federal government in solving social problems, such as lack of adequate and affordable health coverage, through public programs and regulation. These respective strengths and weaknesses should be accommodated and, indeed, exploited in designing a reformed federal relationship capable of meeting the challenges of health reform.

States have strengths in dealing with the financing and delivery of health care for the poor by virtue of their stewardship of the Medicaid program and other health and welfare programs under the Social Security Act. Further, in both public benefit and regulatory programs, states are able to accommodate local needs and conditions in ways that are simply not possible for the federal government. State policy makers understand local conditions and traditions better and thus presumably have greater sensitivity and flexibility in crafting responsive strategies to local conditions and traditions.

However, states historically have been hampered in the implementation of costly social welfare programs, especially when neighboring states are not taking comparable action. States

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161. Id. § 88.002(a)-(b). Missouri also passed a similar statute. See Mo. Rev. Stat. § 354.627 (Supp. 1999).

compete with one another for businesses and other economic opportunities and are at a severe disadvantage if their taxes are higher than other states. Additionally, if states are tougher regulators compared to neighboring states, they are at a disadvantage in competing for economic opportunity.

The federal government, on the other hand, has the ability to generate sufficient funds through taxation from throughout the United States to launch more expensive social programs. It has done so with the social insurance and cash assistance programs under the Social Security Act. Similarly, the federal government is able to implement regulatory regimes throughout the country to achieve the national uniformity necessary in a national economy. It is thus not surprising that the general model of economic regulation in the United States has been through federal regulatory commissions. The regulation of insurance through states is a historical anomaly and probably has persisted because of the work of the NAIC in providing uniform laws and technical assistance to state regulatory programs to achieve nationwide regulatory uniformity and consistency.

It should be emphasized that a reformed federal-state relationship in health care must be a genuine partnership and must not be created through federal mandates. Indeed, several Supreme Court decisions have limited the ability of Congress to pass laws requiring state regulatory action. Some scholars have suggested that these cases severely limit the ability of the federal government to require states to implement a particular health reform strategy.

164. See id.
165. See supra Part I.C.1.
Clearing the Way, the 104th Congress, in the Unfunded Mandates Reform Act of 1995,\textsuperscript{168} prohibited legislation which imposes financial obligations on states without corresponding federal support. Hopefully, these changes in federal law will not impede the evolution of the kind of constructive federal-state relationship needed in the future to address the complex problems as enhanced access to health care for the poor.

A. The Experience of States with Public Health Coverage

In the last twenty years, states have been quite active in trying to address the problem of the lack of health coverage for the uninsured poor. Over the years, many states have experimented with innovative approaches to expand coverage for underserved persons. At least seven states have enacted comprehensive health reform and major coverage expansions,\textsuperscript{169} although these efforts have not always succeeded, even in big states with large tax bases and sophisticated bureaucracies to finance and manage comprehensive programs.\textsuperscript{170} Many other states have made less ambitious efforts, generally through Medicaid expansions, to expand coverage and/or access to care for the low-income uninsured.\textsuperscript{171} Indeed,
by the close of the Bush administration, in which no Medicaid waivers for statewide health reforms were approved, there was considerable pessimism about the ability of states to sustain state health insurance programs for the uninsured poor. In the 1990s, states have done better in expanding coverage for the uninsured poor when they have joined with the federal government as partners through the Medicaid program. In so doing, they have been able to raise the requisite funds to finance coverage expansions that are difficult for states to get from general revenues and other sources alone. The major reason for this significant success compared to the 1980s and earlier is the Clinton administration’s policy regarding the use of section 1115 waivers under the Social Security Act to fund innovative state programs for the uninsured poor. Specifically, since 1993, when the Clinton administration loosened the requirements for section 1115 waivers, many states have expanded Medicaid coverage to low-income uninsured.

There is one cloud on the horizon with respect to the prospect of public health insurance as a strategy for expanding coverage for
the uninsured poor: constitutional procedural protections for beneficiaries of public entitlement programs are by no means static or secure. Further, to curtail the open-ended financial obligations of entitlement programs, Congress and state legislatures have affirmatively stated that benefits in social programs are not entitlements. For example, in enabling legislation for the new welfare program, Congress explicitly stated that the legislation created no entitlement interest in welfare benefits. The new state Children's Health Insurance Program contains a similar provision. In its 1994 decision in Colson v. Sillman, the United States Court of Appeals for the Second Circuit ruled that a Medicaid recipient did not have a constitutionally protected entitlement interest in certain Medicaid disability benefits because the state’s enabling legislation accorded discretion to the state agency in determining the need for benefits and also limited available benefits to those that could be paid from fiscal appropriations.

This combination of statutory denial of entitlement and thus property status, with subsequent judicial approval and justifications, significantly compromises the status and stability of benefits in public health insurance programs. With the preeminence of prepaid managed care as the primary delivery vehicle for serving the acute care needs of Medicaid and CHIP recipients, the withering of constitutional guarantees for the protection of benefits is particularly distressing. Because of the incentives in managed care plans to curtail services in order to contain costs, strong beneficiary protections are crucial.

180. 35 F.3d 106 (2d Cir. 1994).
181. See id. at 108–09; see also Pierce, supra note 177, at 1989 (noting the decision as an illustration of the ways in which a property right may be converted into an unprotected privilege).
The current federal-state relationship with respect to the regulation of private health insurance is dysfunctional. Because of ERISA preemption, states are unable to regulate the private health insurance market to promote adequate and affordable private health insurance coverage. Specifically, states' ability to curb unfair underwriting practices that compromise health coverage for the seriously ill through regulation of commercial insurers is thwarted by the operation of the ERISA preemption. To get around state regulation of insurance and, in particular, state mandates for benefits in insurance plans, employers are self-funding their employee health plans. Employers can thereby avoid state regulatory requirements for health insurance, such as mandated benefits, that limit employers' ability to offer less expensive benefit packages. When states try to regulate commercial health insurers to prohibit their underwriting practices or rate increases, employers would self-insure if commercial insurance became too expensive. Further, if the regulatory climate became too strict in a state, commercial insurers would leave the state.

One additional source of financial support for state programs to expand coverage—employers—is out of reach for state programs because of ERISA preemption. States cannot impose requirements on employers because such requirements would "relate to" employee welfare benefit plans and therefore be preempted under

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183. See generally Bobinski, supra note 155; Mary Ann Chirba-Martin & Troyen A. Brennan, The Critical Role of ERISA in State Health Reform, HEALTH AFF., Spring (II) 1994, at 142 (suggesting ERISA reform to allow for state experiments); Farrell, supra note 155; Jacobson & Pomfret, supra note 155; Jordan, supra note 155; Wendy K. Mariner, Problems with Employer-Provided Health Insurance—The Employee Retirement Income Security Act and Healthcare Reform, 327 NEW ENG. J. MED. 1682 (1992) (discussing the limitations of ERISA and state efforts to reform employer-based health coverage plans); Deborah A. Stone, Why the States Can't Solve the Healthcare Crisis, AM. PROSPECT, Spring 1992, at 51 (discussing federal versus state reforms).


185. See supra note 155 and accompanying text.


Further, the boundaries of the broadly-interpreted preemption clause are hazy, thereby discouraging state initiatives that are even remotely related to employer-sponsored health insurance. However, in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*, the Supreme Court limited preemption in holding that statutes that provided surcharges on hospital rates paid by commercial insurers did not "relate to" employee welfare benefit plans under ERISA and, accordingly, were not preempted.

Two recent cases exemplify the problem with ERISA regulated plans and the operation of the ERISA preemption provisions. In *McGann v. H & H Music Co.*, the Fifth Circuit upheld the district court's summary judgment against an AIDS victim in an employer-sponsored health plan that had limited coverage for AIDS to $5,000 in the year following diagnosis. In *American Medical Security, Inc. v. Bartlett*, the Fourth Circuit rejected the effort of Maryland's insurance regulators to require employee welfare benefit plans that purchased state-regulated stop loss insurance to comply with state mandated benefit provisions for the primary plan. The Fourth Circuit concluded that "[w]hen ERISA preempted state law relating to ERISA-covered employee benefit plans, it may have created a regulatory gap, but Maryland is without authority to fill that gap ...."

Not surprisingly, many employers—in the quest for cheaper employee benefits—have become self-insured and thus exempt from state regulation. In 1995, about forty percent of all Americans insured through employment were in self-insured employer-sponsored health plans, and evidence suggests that more employers are self-insuring their health plans to escape state insurance regulation. In addition, to protect themselves from undue risk, employers with self-insured plans purchase stop loss insurance to

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191. See id. at 649.
192. For the selection of these cases, I am indebted to the discussion in William S. Curen et al., *Healthcare Law and Ethics* 1068–75 (5th ed. 1998).
194. See id. at 408.
196. See id. at 365.
197. Id. (citation omitted).
pay for losses for a particular patient above a specific dollar amount, which is often set as low as $5,000. One fallout of ERISA preemption is the development of provider sponsored networks that contract directly with employer welfare benefit plans and thereby escape insurance regulation altogether.

The federal government has done little to reform ERISA to improve regulatory oversight of private health insurance. The 105th Congress did not pass any of the proposed ERISA reform legislation, and prospects for effective reform legislation in the 106th Congress seem dim. The Clinton administration proposed changes to ERISA as well as Medicare, Medicaid, and other federal health insurance programs to address some of these serious consumer protection problems and strengthen ERISA's consumer protection provisions.

In sum, ERISA creates a bifurcated structure for the regulation of insurance that is uncoordinated and thus easily manipulated by regulated parties—for example, providers, insurers, and employers—to circumvent requirements of either ERISA or state insurance regulation. Because of this regulatory framework, state insurance regulators are unable to implement reforms effectively. While the NAIC has clearly exhibited leadership in developing model legislation that coordinates regulation of risk bearing

199. See id. at 12-14.
managed care plans and promotes consumer protection, states are precluded from implementing these regulatory protections by ERISA. It is noteworthy that the NAIC has taken a strong official position condemning ERISA and its impact on state insurance regulation.

C. An Illustrative Case of One State—Indiana

The story of the Indiana Commission on Health Care for the Working Poor’s efforts to design coverage expansions for uninsured, low-income workers and families in Indiana exemplifies the problems states face in expanding coverage for the uninsured poor. In 1995, the Indiana legislature established the Commission with bipartisan support from the Republican legislature and the Democratic administration of Governor Evan Bayh. The Commission’s politically-balanced composition included the major stakeholders in Indiana’s health care system—consumers, providers, insurers, and, most importantly, state legislators. During this period, Indiana’s population was 5.68 million, with an uninsurance rate of 12.6%.

The Republican chair of the Senate Health Committee, Senator Pat Miller, and the Commissioner of Health in the Democratic Bayh administration, Dr. John C. Bailey, both served on the Commission and were deeply committed to the Commission’s goals as well as to predominantly private strategies to achieve these goals. Both Dr. Bailey and Senator Miller were the policy “entrepreneurs” that pushed for the program and provided the leadership that has been crucial to successful state coverage expansions. The Democratic administration of Governor Frank O’Bannon remained

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205. See supra notes 125–29 and accompanying text.


207. See Eleanor D. Kinney et al., Three Political Realities in Expanding Coverage for the Working Poor: One State’s Experience, HEALTH AFF. July/Aug. 1999, at 188, 188–89.

208. See id. at 188.

209. See id. tbl. 2.

committed to the Commission’s work after the 1996 election, although the O’Bannon administration focused most of its attention on implementing the Children’s Health Insurance Program in Indiana when it was enacted in 1997.

Indiana is a relatively politically conservative state and its health policy has been conservative as well. Indiana has never launched a public health insurance program nor a major Medicaid expansion for adults. Nor does it have a Medicaid program for the medically needy. Thus, not surprisingly, the Commission proceeded from conservative premises: Indiana workers who receive no public assistance should be protected from financial ruin from health care expenses, and strategies for coverage expansions should be private with public involvement and funding as a last resort.212

Initially, legislators challenged the state’s insurance industry to develop a private health insurance plan that the state might subsidize to make it affordable to low-income workers and/or their employers. Thus, the Commission’s initial work focused on designing such a plan. However, in the course of the Commission’s deliberations, it became clear that a public or even subsidized private health insurance program was not politically feasible.

The Commission estimated that, in 1993 and 1994, there were 105,370 uninsured full time workers and 27,224 uninsured part time workers in Indiana with incomes below 200% of the federal poverty level.213 The Commission estimated that providing coverage to uninsured workers and their families below 200% of the poverty level under the optimal benefit package (comparable to Indiana’s Medicaid benefit package) would cost $413 million per year and the “bare bones” plan would cost $267 million per year.214

The Commission was also impressed with health services research findings that state subsidies for insurance premiums of low-income workers are not sufficient inducements to the poor to enroll in employer-sponsored health plans215 or in individual pri-


214. See Kinney et al., supra note 207, at exhibit 1; see also Indiana, 1996 Report, supra note 213, at tbl.V.

215. See Michael Chernew et al., supra note 37, at 466; Cooper & Schone, supra note 37, at 148.
Private plans. A recent study tracking small firm coverage concluded that the key factor in declining employee enrollment was sharp increases in required worker contributions. The Commission conducted focus groups of low-income workers that confirmed these findings. These research findings were consistent with the experience of a highly advertised, joint insurer-provider program in Anderson, Indiana that offered a low cost minimum benefit health insurance plan to low-income workers and families—a plan much like the Commission’s “bare bones” plan. Low-income workers simply did not purchase the subsidized health coverage—fewer than twenty policies were sold in one year.

These findings were disturbing to the Commission. The price tag for coverage of Indiana’s uninsured workers and families shocked the Commission and especially its legislator members, who recognized that state lawmakers would never adopt a state-funded public program. Indiana could not explore a section 1115 Medicaid waiver despite pressure from the hospital industry and the medical profession because Indiana does not have the requisite Medicaid medically needy program. The Commission was also concerned that a costly public subsidy for even a “bare-bones” insurance product would be necessary.

Because of ERISA, the Commission appreciated that it would be virtually impossible to look to employers for this subsidy. Commercial insurers were also not an attractive source for this subsidy because they compete with employer self-insured plans and would be put at a competitive disadvantage if they had to absorb the cost of the subsidies. Finally, it seemed unlikely that low-income workers were going to purchase even heavily subsidized health insurance to finance their health care. Why should they when there are safety net providers available to provide care—albeit at a cost—when they really need it?

The Commission then explored other options and focused on enhancing access to health care services through direct subsidies to

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218. See Kinney et al., supra note 207, at 189-90.


220. See INDIANA, 1996 REPORT, supra note 213, at 71 app.D.
employers and other means. The Commission recognized that many providers in Indiana were already serving the state’s uninsured population. These “safety net” providers included community health centers, local health departments, and certain public and private nonprofit hospitals that historically cared for the uninsured poor in their areas. Many safety net hospitals in Indiana, in collaboration with community health centers, have sought to “manage” the care of uninsured patients by enrolling them in internal “managed care plans.”

The Commission ultimately rejected a state subsidized insurance program and even a subsidized private insurance program for the low-income uninsured. Instead, it recommended expanded state funding for community health centers participating in networks with safety net hospitals and a stop loss subsidy program to encourage safety net hospitals to provide coordinated care to the uninsured poor and limit their exposure to uncompensated catastrophic care for uninsured poor enrolled in the network.

Many states have also sought to mobilize safety net providers in the care of the uninsured poor. Safety net providers, established explicitly to serve the poor, already provide a substantial volume of services to the uninsured poor and have been critical in maintaining the availability of care for this population. Community health centers serve, with substantial support from direct funding from state and federal agents, many uninsured poor, as two out of every five community health center clients are uninsured and the number of their clients has increased in the 1990s. Public and some private nonprofit hospitals, by virtue of law, mission, or tradition, have actual or perceived obligations to serve the uninsured poor and receive substantial support from local property tax revenues, other tax preferences, and disproportionate share funding under

the Medicare and Medicaid programs. In 1994, hospitals nationally incurred $16.8 billion in uncompensated care expenses—an estimated 6.1% of all hospital costs. Safety net hospitals, community health centers, and other safety net providers have traditionally cooperated in serving the uninsured poor and have active referral relationships with community health centers. More recently, such hospitals have formed networks to attract Medicaid and other third party payer contracts.

Indiana's experience is consistent with that of other states. In general, the cost of covering low-income workers and families is more expensive than small, relatively conservative states are willing to pay. Even more liberal states that have launched state-funded health insurance programs have declined to proceed with planned expansions and have halted programs because of cost concerns. Clearly because of ERISA preemption and other factors, many states have looked to safety net providers to serve the uninsured poor.

The Commission's ultimate recommendations were influenced by two factors in the relationship between the states and the federal government. First, the cost of coverage expansions is beyond the means of a single state, particularly when neighboring states have not taken on comparable commitments. Second, the ability of states to mandate health insurance coverage through employment or even to seek subsidies from employers in financing private health insurance coverage is hampered by the requirements of ERISA. If states pursue the strategy of expanding coverage through insurance, they must find sources of financing beyond state revenues and personal contributions of beneficiaries,
or pursue other strategies for expanding access to services for the low-income uninsured.

The Commission’s recommendations for enhancing access to care for low-income workers and their families have yet to be fully implemented. In 1996 the legislature appropriated funds to assist community health centers in forming safety net provider networks but has not proceeded further. On the other hand, Indiana moved quickly to design and implement the Children’s Health Insurance program when it came on line in 1997. With federal matching funds available to make the program financially feasible and the Medicaid program infrastructure in place to provide the technical expertise and operational support, the program was implemented within one year. These developments suggest that federal funding across states is an important if not dispositive factor in the success of substantive state efforts to expand health coverage for the uninsured.

D. The Contours of a More Productive Federal-State Partnership

Optimally, the concept of federalism calls for a relationship between the federal government and states that allocates responsibilities and power between the two levels of government in a manner that best facilitates the achievement of beneficial public goals. With this norm in mind, it is useful to sketch the contours of a federal-state partnership that will move toward the societal goal of universal health coverage, and especially coverage of the uninsured poor.

In defining the federal-state partnership to achieve this goal, several legislative and regulatory changes are necessary at both the state and federal levels. In crafting these changes, it is important to be mindful of the political and jurisprudential realities that constrain both state and federal legislative and judicial law makers as they design reforms. Specifically, the Republican Congress has exhibited considerable reluctance to impose mandates on states, as evidenced by the enactment of the Unfunded Mandates Act. Also, the United States Supreme Court has interpreted the federal Constitution as being far more deferential to the authority and rights of states than at anytime in recent years. Indeed, in the

233. See id. at 191.
234. See supra note 168 and accompanying text.
235. See supra note 166 and accompanying text.
1990s, the Supreme Court handed down several decisions that sharply limited the ability of Congress to authorize lawsuits against states—an important dimension of federal power.  

The most practical and immediate steps that Congress could take are, first, to reform ERISA and, second, establish health coverage programs that provide matching funds for state health insurance programs for the uninsured and allow states great flexibility in designing state programs that really reach the uninsured in need. Hopefully future federal court decisions will clarify the ERISA preemption clause and delineate the zone in which the states and the federal government can regulate effectively to enhance coverage for the uninsured and protect coverage for the insured. These two approaches are outlined briefly below.

1. Reform ERISA—There are immediate steps that would improve the accessibility and affordability of private health insurance for low-income workers and their employers. Given the reality that most non-elderly Americans obtain health insurance through the workplace, it is necessary to address problems with the ERISA framework for this coverage and, in particular, the bifurcated system for regulating all private health insurance created by the ERISA preemption. Specifically, there are four ways to fix the bifurcated system for regulating private health insurance and other problems created by ERISA.

First, regulate ERISA-regulated employee benefit plans in a manner that assures adequate, affordable, and available health insurance coverage through employment. Congress has already adopted this approach in a piecemeal fashion in extending health coverage to vulnerable groups after employment relationships have been terminated and, more recently, in enhancing the portability of health insurance coverage for people with serious illnesses.

236. See id.
238. See supra notes 152-53 and accompanying text.
Congress has also mandated at least one benefit—mental health care—for ERISA-regulated plans. One area that cries out for federal regulation is the increasingly common practice among employers with self-insured plans of using general liability insurance to insure against excess risk in their health plans and still evade state health insurance regulation.

It is noteworthy that the Clinton administration has already taken significant steps in using extant authority under federal law to strengthen federal regulation to protect patients enrolled in ERISA plans in requiring federal agencies, including the Department of Labor which regulates ERISA plans, to implement the patient protections recommended by the Presidents' Advisory Commission on Consumer Protection and Quality in the Health Care Industry. However, these protections are primarily procedural, such as improved grievance procedures and enhanced publication of plan policies. They do not address the adequacy, affordability, or availability of employer-sponsored health coverage.

Second, narrow and delineate the boundaries of the ERISA preemption to define the scope of states' regulatory authority over health insurance that affects but does not govern employer-sponsored health insurance. Federal legislation should clearly delineate the scope of federal regulation under ERISA and specifically the ERISA preemption clause and its pertinent terms. Specifying just what provisions of ERISA should be amended and how to achieve these objectives is beyond the scope of this Article. Other scholars have addressed this issue in great detail. Nevertheless, at the very least, statutory amendments should clarify

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243. See supra notes 198-99 and accompanying text; see also Strain & Kinney, supra note 239, at 54-57, 67, 68.
245. See, e.g., Robert N. Covington, Amending ERISA's Preemption Scheme, 8 Kan. J.L. & Pub. Pol'y 1 (1999) (containing a detailed analysis of the current problems with the case law on the ERISA preemption clause and specifying amendments that could clarify the current confusion over the scope of the ERISA preemption and its relationship to state regulation); Strain & Kinney, supra note 239 (specifying how ERISA might be amended to enhance federal regulation of ERISA plans and coordinate such regulation with state regulation of health insurers, HMOs and other MCOs).
the scope of state authority to regulate commercial insurers, HMOs, and MCOs that fund employee welfare benefit plans.

Third, Congress should also clarify the circumstances under which managed care organizations that contract with employer plans are liable for their misconduct toward members of employer-sponsored managed care plans. This has proven to be the most contentious issue in the debate over patient protection reform legislation in the 105th and 106th Congresses and, indeed, has been the major stumbling block to the evolution and passage of a bipartisan patient protection bill. Nevertheless, lower federal courts in recent years are exhibiting greater sympathy toward claimants blocked from remedies against HMOs because of the ERISA pre-emption clause and are devising theories to get around these barriers. Also, as discussed above, Texas and Missouri have enacted legislation specifically granting rights to sue health insurers, HMOs, and MCOs for negligent decision making with respect to health care decisions regarding members. Ideally, although unlikely, Congress should recognize the potential effectiveness of tort liability in limiting the excesses and misconduct of managed care organizations in the current environment of cost containment. It is noteworthy that as this Article goes to press, the United States Supreme Court is reviewing a Seventh Circuit decision ruling that a medically injured ERISA plan beneficiary can sue a managed care organization for breach of plan fiduciary duties under ERISA. Hopefully the decision in this case will provide helpful guidance to Congress and states as they endeavor to clarify and even establish tort liability of HMOs and other managed care plans with respect to members of employer sponsored health plans.

Finally, the federal government should authorize carefully crafted waivers from ERISA for states with health insurance programs that meet specific requirements. It is not coincidental that the only state with nearly universal coverage under state programs, Hawaii, has a waiver of ERISA requirements for employee welfare

248. See supra notes 159–62 and accompanying text.
249. See Herdrich v. Pegram, 154 F.3d 362 (7th Cir. 1998), reh'g and reh'g en banc denied, 170 F.3d 683 (7th Cir.), cert. granted, 120 S. Ct. 10 (1999).
benefit plans. Waivers can be designed to preserve interstate uniformity of requirements for ERISA-regulated employee welfare benefit plans while according states latitude in experimenting with ways to promote employer contributions to state health coverage expansions. An expanding waiver authority imaginatively applied could greatly facilitate state innovation in coverage expansions for the uninsured poor.

2. Accord Federal Support for Coverage Expansions—The federal government must become more involved in the financing of health care for the uninsured poor. In recent years, the prevailing model for such financing has been through matching funds for state programs. This model works very well, as exemplified in the Clinton administration’s creative use of Section 1122 waiver authority under the Social Security Act, for coverage expansions for the poor through Medicaid and more recently through the newly enacted CHIP program. Under this model, the federal statute establishes basic criteria that a state program must meet to be eligible for federal matching funds.

Any federal statute should leave considerable flexibility to states as to how they will meet federal criteria as they design and implement state programs. Nevertheless, there are four main criteria that the statute should specify as federal requirements. First, similarly situated beneficiaries should be treated the same and not discriminated against in benefits or coverage. Second, states must be required to maintain their financial commitment to the program over time. Third, the federal government must be assured that states provide comparable value for federal funds. This criterion is more complicated to meet. It implicates program design and, more specifically, performance. It invites detailed federal regulation as to how states design and implement programs and also how they measure and evaluate program performance. The federal government should, however, decline the invitation to micro-regulate state programs to achieve this goal and adopt less intrusive ways to assure comparable value for federal funds across states. For example, the federal government and states could develop


251. See supra notes 175–77 and accompanying text.

252. See supra notes 96–103 and accompanying text.

population-based outcome measures that would provide accurate information on program performance and serve as a basis for nationwide comparison of state performance as well as signal the need for federal enforcement efforts.

Finally, and most importantly, the federal statute should specify protections for consumers in state programs. Regardless of the status of a program as an entitlement or a categorical grant, states should be required to serve all those who meet eligibility criteria. The federal government must provide the requisite funds to enable states to meet this obligation comfortably. Additionally, regardless of the diminished protection of the procedural due process doctrine in public programs, states should ensure that state programs have adequate procedures to enable program beneficiaries to adjudicate disputes and receive needed program benefits. Finally, ERISA should be amended so that program beneficiaries have comparable remedies including tort remedies against managed care plans with which states contract to provide benefits.

Ideally, a properly structured federal-state program could achieve real innovation in coverage expansions for vulnerable groups and break ground for real reform in the health sector generally. States would then have the flexibility to take the approaches, such as developing safety net provider networks along the lines of the approach of the Indiana Commission on Health Care for the Working Poor, that target and reach those uninsured that are unlikely to obtain affordable or consistent employer-sponsored coverage. Such flexibility enables states to capitalize on one of their greatest assets—familiarity with local conditions and resources. This flexibility, coupled with the critical federal funding, could do much to enable states to take the lead in covering those uninsured Americans who are not now eligible for public health insurance programs and who are poorly served, if at all, by employer-sponsored health insurance.

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254. See supra notes 177–81 and accompanying text.
255. See supra notes 239–50 and accompanying text.
256. See supra notes 207–32 and accompanying text.
257. See generally Mary E. O’Connell, supra note 39 (describing how employer benefits do not meet the needs of low-income workers, especially women and the unemployed).
CONCLUSION

In sum, the legal relationship between states and the federal government regarding the financing and regulation of health care is unique, complex, and cumbersome. It must be fundamentally reformed to enable states to shape the content, scope, and direction of their health policy. Given the currently dysfunctional relationship between the Administration and the Congress within the federal government, state involvement in domestic policy as a general matter is desirable. The October headlines of the Washington Post, quoted above, tell the story. Congress and the President are locked in partisan battle and are unable or unwilling to act, at least for the foreseeable future. In this temporary state of federal dysfunction, states can provide leadership and solutions with reform of the federal relationship. In the long run, states have much to offer in the way of flexibility and expertise in meeting the challenge of expanding coverage for the uninsured poor and in health reform generally.

258. See supra notes 1-2 and accompanying text.