MEMORANDUM

TO: NCOIL Health, Long Term Care and Health Retirement Issues Committee

FROM: Elizabeth Y. McCuskey

RE: ERISA Waiver Proposal

DATE: Dec. 7, 2018

In health care regulation, ERISA is an outlier. ERISA significantly affects the U.S. health care financing system, yet it is the only major federal health care statute administered by the Department of Labor, rather than the U.S. Department of Health & Human Services. More fundamentally, most federal health care statutes, like Medicare, Medicaid, and the ACA, contain waiver provisions that enable states to pursue policy experiments, while ERISA does not. And ERISA prohibits state experiments largely without substituting a comprehensive federal scheme, leaving a regulatory void. On an existential level, ERISA subverts the federalism of health care regulation that has evolved over the past fifty years.

Many federal laws include statutory waivers, authorizing federal agencies to waive certain federal requirements and preemptions for states that seek to craft their own laws.[1] Statutory waivers can soften the federalism impact and unintended consequences of federal laws, giving states the flexibility to work within a federal statutory scheme and reopening the "laboratories of democracy" despite preemption. Waivers also may support state experiments with federal funding, as well as access to the nationwide perspective and substantive expertise of federal agencies.[2] ERISA, however, does not have a waiver for its preemption provisions.

Hefty preemption without a waiver mechanism renders ERISA an anti-federalist statute,[3] which breaks from all nearly all other federal health care statutes by not allowing for state flexibility, variation, or indeed any state regulation of self-funded ERISA plans. As interpreted by the courts, ERISA preemption is so broad that self-funded employer plans are 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.[4] The benefits of state experimentation and diversity are thwarted by ERISA, and states that seek to enact reforms to expand access or gain control over their health care costs have few mechanisms to do so because ERISA preemption places a large portion of the market (self-funded employer plans) beyond states' reach.

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[1] *See* David J. Barron & Todd D. Rakoff, *In Defense of Big Waiver*, 113 COLUM. L. REV. 265, 278 (2013); Daniel T. Deacon, *Administrative Forbearance*, 125 YALE L. J. 1548 (2016).

[2] *See* Elizabeth Y. McCuskey, *Agency Imprimatur & Health Reform Preemption*, 78 OHIO ST. L. J. 1095, 1150-55 (2017).

[3] 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.").

[4] *See* Erin C. Fuse Brown & Ameet Sarpatwari, *Removing ERISA's Impediment to State Health Reform*, 378 NEW ENG. J. MED. 5 (2018).

The risk of ERISA's obstructive federalism is regulatory failure—particularly stasis and failing to reflect the preferences of the states' citizens.[5] 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."[6]

A federal solution is needed to clear the way for state health reforms and reduce ERISA's obstructive federalism. Congress should consider converting 29 U.S.C. 1144(a) to floor preemption, eliminating the deemer clause in 1144(b)(2)(B), or, at a minimum, adding 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.

Through a waiver provision, Congress could preserve ERISA's preemption baseline, but authorize 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 a review and approval by federal agencies. Congress has used statutory waivers with increasing frequency over the past few decades to infuse statutory structures with flexibility,[7] to mitigate the federalism impacts of nationwide rules,[8] to encourage supervised state experimentation,[9] and sometimes to suspend preemption.[10] Amending ERISA to add a statutory waiver mechanism for its preemption provisions in 29 U.S.C. § 1144 could accomplish all of these goals.

An ERISA preemption waiver could mirror some of the waivers 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.[11] These waivers delegate to an agency the power to suspend certain core statutory rules by approving state applications for waivers. To receive a waiver, states typically

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[5] *See* William W. Buzbee, *Asymmetrical Regulation: Risk, Preemption, and the Floor/Ceiling Distinction*, 82 N.Y.U. L. REV. 1547, 1548 (2007)

[6] Robert A. Schapiro, *From Dualism to Polyphony*, *in* PREEMPTION CHOICE 344 (William W. Buzbee, ed., 2009).

[7] *See* David J. Barron & Todd D. Rakoff, *In Defense of Big Waiver*, 113 COLUM. L. REV. 265, 278 (2013) (identifying the phenomenon of "big" waivers that suspend the core tenets of federal statutes).

[8] *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).

[9] *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*, 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).

[10] *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 (Clean Air Act).

[11] *See* 42 U.S.C. § 18052 (providing the ACA's waivers for State Innovation)

must demonstrate the ways in which their proposed variations would further federal goals. 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, the provision could specifically apply only to state laws impacting employee welfare benefit plans, excluding pension plans.

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. 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.[12] 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.

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. And, a provision for combining state ERISA waiver applications with their ACA and Medicaid waiver applications would enable states to pursue all the waivers needed for transformative health system changes, while giving the federal agencies a comprehensive, nationwide view of the state's proposal.

More than four decades after its enactment, 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. The ERISA preemption waiver proposed here would alleviate some of the pressure of ERISA preemption for promising state experiments, while maintaining the federal baseline of preemption. The ACA's imposition of a nationwide employer mandate and other insurance-related requirements change the baseline arguments about ERISA's deregulatory "uniformity" function.[13] 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. Amending ERISA with a statutory waiver for preemption is even more urgent at this moment to unshackle state efforts to pursue a range of reforms impacting health care cost, access, and quality.

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[12] *See, e.g.*, Daniel J. Meltzer, *Preemption and Textualism*, 112 MICH. L. REV. 1, 39 (2013); Thomas W. Merrill, *Preemption and Institutional Choice*, 102 NW. U. L. REV. 727 (2008); McCuskey, *Agency Imprimatur*, *supra*, at 1153-56.

[13] *See, e.g.*, *Travelers*, 514 U.S. at 657; *RILA v. Fielder*, 475 F.3d 180, 191 (2007) (emphasizing uniformity).