Presuppositions for Universal Health Insurance in Oregon #1: ERISA

In January 2017, the Rand Corporation published a report commissioned by the Oregon legislature to assess options for universal health insurance in a state-based system. Results showed the option with single payer features promised the greatest benefits, but all according to the RAND analysts faced a major political obstacle in the federal Employee Retirement Income Security Act (ERISA) of 1974, which removes self-insured firms from the purview of state regulators.

ERISA Basics

According to ERISA language, a state cannot recognize ("deem") a self-insured employer plan in any way, or interfere with its operation. The literature on ERISA court battles that spooked the RAND analysts culminated in a slim victory for San Francisco in 2008, aiming to implement an employer health care tax. Current attention is drawn to the Supreme Court ruling in *Gobeille v. Liberty Mutual Insurance Company* in March 2016, that preempted a plan in Vermont to require self-insured firms to report claims data for a state-run all payer all claims (APAC) database. Both cases, and a long trail before them, represent direct assaults on ERISA-protected plans through some version of designating or demanding something from employer health plans.

The court track record for ERISA has consistently favored the inviolability of business plans and disfavored the states, except San Francisco and a few other notable victories commonly mentioned, proving the rule by their rarity. Court decisions since 1995 cracked the ERISA shield in favor of state health-system planning, but managed care programs have been litigious, including jurisdiction issues between state and federal courts.

The persistence of the ERISA barrier illustrates how thoroughly states have accepted the current context that links health insurance directly to employment. The states have always held it in their power to redefine the context, as Hawaii officials recognized during congressional ERISA debates in 1978. Finance can be arranged by general taxation, with no explicit relationship to employers or existing health insurance plans. The ultimate challenge here is not ERISA, but this one simple, but demanding decision for a global view in public finance that no state has yet chosen to make.

ERISA in Oregon

The best current estimate shows about 20 percent of the Oregon population is covered by self-insured benefit plans, representing about 57 percent of the workforce. The first version of universal health insurance reform in Oregon, in the early 1990s, relied on an employer mandate to bring everyone together into one system. Failure to obtain an ERISA waiver from the federal government by a deadline in 1995 marked the end of early ambitions for the first Oregon Health Plan.

The federal refusal was reasonable. An employer mandate was the basis for needing an ERISA waiver, and since applying for the waiver, state leaders and business interests visibly lost confidence in the mandate, due to cumulative exposure to it's inherent flaws. A research report on the employer mandate contracted by the Oregon legislature brought home the unfavorable conclusions (cf., Howard Leichter, ed., 1997; National Economic Research Associates 1995; Senate Special Committee on the Oregon Health Plan 1993). Genuinely unappealing prospects, and not mere politics, appear to have given the final word in the failure.

With this background, a waiver is moot. The problem in Oregon since 1995 has always been how to avoid ERISA all together.

Oregon's current views on a single payer version of universal health insurance originated from Vermont. The Vermont plan was designed by a team of prominent health economists, and analysts from the Harvard School of Public Health. The team reviewed ERISA court decisions thoroughly enough to conclude correctly that states may avoid ERISA with "broad-based tax financing"; yet, subsequently proceeded straight into ERISA territory at three critical points, repeated in the Oregon plan, with (a) a payroll tax, (b) integrated delivery systems, and (c) the failed idea of a data reporting requirement. These points need specific attention.

Payroll Tax

Experience with the employer mandate in health insurance reforms in the early 1990s led to a summary statement on "The Logic of Tax-Based Financing for Health Care," by Thomas Bodenheimer and Kip Sullivan (1997), including an assessment of the payroll tax, that remains definitive. The authors condensed essential tax logic into two concepts of *fairness* and *simplicity*. The tax has to make sense.

Sense is relevant to ERISA preemption. Applying a tax to employers makes them stakeholders capable of challenging the law in court. A payroll tax is vulnerable in court because it is illogical as a source of funds for universal health insurance.

The 2014 Vermont plan for Green Mountain Care acknowledged a possible double burden on employers: paying for a payroll tax, and their own benefit plans. The stated intent, repeated from the original designers, aims to apply a burden that will force employers to negotiate, and possibly "buy in" voluntarily to the public plan. Careful as this language might be to name the employer and not the employer benefit plan, the expected dynamic is clearly the same as an employer mandate. The payroll tax is nearly the same as an employer mandate.

In the 1990s, employers fiercely resisted a mandate to pay for their employees, and they are not likely to feel better about a mandate to pay for health insurance for everyone. Nor does it make sense. The employer is not an insured household accountable for a premium. In any case, a universal system was supposed to relieve the mounting burden on employers, not increase it. The payroll tax ensures powerful enemies with reasonable opposing arguments.

Details of the payroll tax make it less likely to survive preemption. The designers of the Vermont plan obtained an endorsement for a payroll tax from ERISA expert Patricia Butler, who earlier recommended the tax, and concluded states could expect an ERISA challenge, but "should be able successfully to defend" it. Yet, Butler also made clear that employer tax exemptions are one easy way to get snared in ERISA, and must be avoided. This draws suspicion toward the distinct tax brackets in the Vermont plan, intended to relieve the burden on smaller businesses. Self-insured firms are concentrated among larger firms, and a case could possibly be made that size distinctions target ERISA-protected firms and invite preemption, as occurred in the *RILA v. Fielder* ruling against Maryland in 2006.

Complexity and conflict in the payroll tax pose problems with ERISA. Yet the issues can be easily avoided.

A Logical Tax

Wages generally comprise about three-fourths of total income. A payroll tax is regressive, because it does not cover higher incomes nor the whole tax base. A tax for social insurance needs to apply equally to all income levels as a percentage of income as a clear sign of income solidarity. Bodenheimer and Sullivan argue an income tax is the simplest and most equitable solution for social health insurance, because it efficiently targets a percentage of all income in a transparent contribution from all households. The income-tax option also avoids ERISA: no hint of employers as stakeholders.

In such a globally financed system, self-insured firms and other employers can operate as usual, if they choose, by the state "buying into" the employer plan, paying a premium to pass along the risk, opposite to the buy-in procedure recommended in the Vermont plan. Patricia Butler in a manual for state health policymakers advised this flow of funds from public to private programs has succeeded, and is the most likely to avoid an ERISA challenge.

János Kornai and Karen Eggleston, in regard to reforms in Eastern Europe, emphasized the importance of transparency in financing universal health care, with four requirements:

1. A dedicated trust fund, based primarily on citizen contributions
2. Tax awareness
3. Collection channels open to scrutiny
4. Evidence-based policy

By these standards, the payroll tax fails, because the incidence is mysterious, commonly observed to move from the employer to employees, or to prices, or backward to fewer jobs, but always speculative. This is the final condition that makes the payroll tax inappropriate for universal health insurance; it defeats transparency. If the incidence gets connected to an ERISA-protected plan, so much the worse.

Integrated Health Systems

The Vermont plan for a single payer system imported a number of components from the current health care system, based on managed competition between insurers and clinical governance. These features are repeated in the Oregon single payer plan, with "options for integrated health systems"—begun in embryo in the state's system of coordinated care organizations to manage the Medicaid population in a vast array of legislative rules, price schedules, fiscal incentives, and contracted networks. This is the kind of thing that aroused ERISA preemption in the first place.

The details of what might or might not be permitted in health system planning only matter if they really must be faced. As with the payroll tax above, a simple alternative exists to avoid ERISA all together. Stop state planning. This is one of the administrative efficiencies of a single payer system. Simply pay true costs. A single payer system has significant power through a global budget that has not been adequately applied or understood yet. Capitation and risk adjustment can be greatly simplified in a universal system with regional funds. Compression can be applied in unique ways, because all providers and prices can be defined and contained within a limited budget. The risk ultimately moves downstream to providers as a set; and the delivery system becomes a market—that elusive market that was moved to the realm of insurance in the current system, where a market does not make sense. The delivery system as a market with scarce resources does make sense.

State monopsony power is the first fear evinced in providers in the face of universal health insurance proposals. Instead, consider that integrated health systems might be an option for the future, or not, but these plans can be implemented in the delivery system by the delivery system. The state does not designate anything. System planning by the system itself does not impinge on ERISA.

Such a framework can work, with one caveat. A market requires information. Regional health care funds will need to collect, analyze, and use claims data to inform providers as agents of care. New developments in these areas make such a system feasible, perhaps for the first time.

All Payer All Claims Database

Oregon is one of several states developing an APAC database, aiming to analyze health care utilization. In the manual for state policymakers, Patricia Butler warned of possible ERISA problems with data requirements, but later apparently changed her mind and endorsed the APAC data reporting plan, along with the designers of the Vermont single payer plan. Yet, other ERISA experts knew well enough beforehand the data reporting requirement would fail. After the *Gobeille* ruling, William Sage commented in the *Health Affairs* blog (March 10, 2016) that he “accurately predicted the outcome.”

On the data issue, as for the payroll tax and delivery system issues above, ERISA court cases only matter if they must be faced. Once again, the goal is to avoid the courts all together. A single payer system can route claims for all medically necessary care by licensed providers through the organized regional funds, making it unnecessary to gather data from disparate sources. The fund becomes the data source.

From this basis, it is possible to imagine a system where other payers operate as usual, even in provider contracting, only with the fund giving not receiving data. Insurers, too, might be organized as fundholders and operate much the same as they do now in claims administration. Such a system would have many of the same addresses and need not disrupt so much as is sometimes supposed.

Conclusion

In all of these specific areas, it appears the single payer plan designed for Vermont, now influencing Oregon, lacks sufficient vision to comprehend a truly global view. Thinking first about ERISA, a global view is the only option for the state to reach a system of universal health insurance that can work.