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LABORATORIES OF DEMOCRACY: WHY STATE HEALTH CARE EXPERIMENTATION OFFERS THE BEST CHANCE TO ENACT EFFECTIVE FEDERAL HEALTH CARE REFORM

JONATHAN M. KUCSKAR*

INTRODUCTION

In *New State Ice Company v. Liebmann*, a 1932 Supreme Court case, Justice Louis Brandeis discussed how state governments were in a unique position to develop innovative approaches to solve the problems of American society.¹ In a dissenting opinion, Justice Brandeis wrote: “It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”² He believed states fulfilled a crucial responsibility when acting as “laboratories of democracy” by experimenting with social and economic policies to create solutions for the changing needs of American society.³

Presently in the United States, one area ripe for policy experimentation by individual states is health care. In 2006, over forty-three million Americans did not have health insurance, and over fifty-four million Americans lacked health insurance for at least some part of the year.⁴ Though the federal government

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1. 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

2. *Id.*

3. *Id.*; see generally Michael S. Greve, Federalist Outlook, AEI Online, Laboratories of Democracy: Anatomy of a Metaphor (Apr. 1, 2001), http://www.aei.org/publications/pubID.12743/pub_detail.asp (discussing the “laboratories of democracy” metaphor).

4. *Survey Finds 43.6 Million Uninsured in U.S.*, N.Y. TIMES, June 26, 2007, at A13; Victoria Collover, *More in U.S. Lack Health Insurance*, S.F. CHRON., Aug. 30, 2006, at A7.

provides health care to select individuals through Medicare,⁵ Medicaid,⁶ and the State Children's Health Insurance Program (SCHIP),⁷ the World Health Organization ranked the United States' health care system an astoundingly low 37th place among world nations.⁸ Needless to say, there is a health care crisis in America.

Proposals to overhaul the federal health care system are extremely varied.⁹ A Senate Finance committee member, Senator Ron Wyden, introduced a bill that proposed removing responsibility for health care coverage from employers and moving the burden of health care selection onto individuals.¹⁰ Over seventy members of the House of Representatives have sponsored a bill implementing a single payer health care system, similar to the system in Canada, which virtually eliminates traditional for-profit health insurance.¹¹ A bipartisan coalition of Congressmen attempted to significantly increase the coverage provided by SCHIP.¹² Despite the wide variety of options available, the federal government has only enacted limited legislation to improve the nation's health care system.

With the federal government failing to address the health care crisis, states have employed a wide range of policies to improve health care coverage for their residents. For example, Massachusetts enacted a law mandating that all residents have health insurance by sharing responsibilities among employers, government, and individuals.¹³ Maine implemented a similar plan focusing on covering small businesses and their employees,¹⁴ while Vermont specifically focused on

5. Health Insurance for the Aged Act, Pub. L. No. 89-97, 79 Stat. 290 (1965) (codified as amended in scattered sections of 42 U.S.C.).

6. Grants to States for Medical Assistance Programs, Pub. L. No. 89-97, 79 Stat. 343 (1965) (codified as amended at 42 U.S.C. § 1396 (2000)).

7. State Children's Health Insurance Program (SCHIP), Pub. L. No. 105-33, 11 Stat. 552 (1997) (codified as amended at 42 U.S.C. § 1397 (2000)).

8. Press Release, World Health Org., World Health Organization Assesses the World's Health Systems (June 21, 2000), *available at* <http://www.who.int/inf-pr-2000/en/pr2000-44.html>.

9. The Senate Finance Committee has jurisdiction over health care issues such as Medicare, Medicaid, and SCHIP. S. DOC. NO. 110-9, at 23 (2007), *available at* <http://rules.senate.gov/senaterules/Rules091407.pdf>. Therefore, the Finance Committee would have jurisdiction over national health care reform if plans affected any of these programs or in the alternative, involved a specific health program tax or trust fund.

10. Healthy Americans Act, S. 334, 110th Cong. §§ 101-102 (2007). For a list of members on the Senate Committee on Finance, see U.S. Senate Comm. on Finance, Committee Members, <http://www.senate.gov/~finance/sitepages/committee.htm> (last visited Apr. 2, 2008).

11. United States National Health Insurance Act, H.R. 676, 110th Cong., §§ 101-104 (2007). Canada has already enacted federal legislation that mandates universal health care coverage. Canada Health Act, R.S.C., ch. C 6 (1985).

12. Children's Health Insurance Program Reauthorization Act of 2007, H.R. 976, 110th Cong., §§ 2, 101 (2007).

13. Health Care Act of 2006, ch. 58, 2006 Mass. Legis. Serv. 64, 64-123 (West 2006).

14. Dirigo Health Act, ME. REV. STAT. ANN. tit. 24-A §§ 6902, 6910 (Supp. 2006).

preventing and treating chronic illnesses to improve overall health care coverage.¹⁵ In Maryland, the state legislature passed legislation forcing large businesses to pay a specified percentage of their revenue toward the health care costs of their employees.¹⁶

State health care initiatives offer innovative solutions and cautionary tales about finding the best solution to America's health care crisis. Massachusetts's novel plan mandates that all individuals acquire health care coverage through a collaborative effort among three different groups—businesses, individuals, and government.¹⁷ Its individual mandate, however, raises several issues. Maine's Dirigo Health Program depends on cooperation from businesses to make health care more affordable but has encountered problems recruiting businesses to voluntarily participate in the program.¹⁸ Vermont's unique focus on treating chronic illnesses holds promise,¹⁹ while Maryland's inventive health care reform violated federal law.²⁰

States are also limited in their experimentation by two factors that are not applicable to the federal government. The Employee Retirement Income Security Act (ERISA), a federal law regulating employee benefits plans, largely restricts states' efforts to regulate health care coverage.²¹ Maryland's health care reform violated this law,²² and other state health care reform proposals may run afoul of ERISA as well.²³ State balanced budget requirements are another factor that applies to states but not the federal government.²⁴ Most states must propose or pass a balanced budget, which makes it more difficult to enact vital, but expensive, health care reform.²⁵

This paper discusses the two reasons why states are uniquely positioned to take the lead in reforming America's health care system. First, there is no consensus on the best method of national health care reform.²⁶ Reform plans that either eliminate employer responsibility or implement a single payer system hold

15. VT. STAT. ANN. tit. 8, § 4080f(c)(2) (2007).

16. Fair Share Health Care Fund Act, ch. 1, 2006 Md. Laws 1, 1–6 (2006), *invalidated by* Retail Indus. Leaders Ass'n v. Fielder, 435 F. Supp. 2d 481 (D. Md. 2006), *aff'd*, 475 F.3d 180 (4th Cir. 2007).

17. *See infra* Parts III.A, V.A.

18. *See infra* Part V.A.3, V.B.1.

19. *See infra* Part V.A.2.

20. Retail Indus. Leaders Ass'n v. Fielder, 435 F. Supp. 2d 481, 484 (D. Md. 2006), *aff'd*, 475 F.3d 180 (4th Cir. 2007).

21. 29 U.S.C. § 1144(a) (2000).

22. *Retail Indus. Leaders Ass'n*, 435 F. Supp. 2d at 484.

23. *See infra* Part IV.A.

24. *See infra* Part IV.B.

25. *Id.*

26. *See* Robert Pear, *Health Leaders Seek Consensus Over Uninsured*, N.Y. TIMES, May 29, 2005, at § 1, 1.

potential for success but are a radical change from the current system.²⁷ The debate between Congress and the President over the SCHIP reauthorization bill illustrates this lack of consensus and how contentious the national health care debate has become.²⁸ Without a national consensus, states remain in the best position to implement innovative ideas that will contribute to solving America's health care crisis.

Second, the federal government can observe the implementation of these state initiatives and "cherry-pick" the most successful elements.²⁹ Several state initiatives may not be successful at the state level, and the federal government can use this information to create a better national plan. Once health care reform succeeds in a state "laboratory," the federal government may choose to model its reforms after the state plan to address the nationwide health care crisis.³⁰ In fact, the cherry-picking process has already begun. A number of the 2008 Presidential candidates have proposed plans to reform the national health care system that incorporate elements of state plans that have already been implemented.³¹

This paper is not designed to discuss all national health care reform proposals or every state's approach to health care. Instead, this paper aims to show that despite a variety of approaches, states acting as "laboratories of democracy" offer the United States the best chance to enact effective health care reform. Experimentation by the states can identify key components and obstacles to implementing a national health care reform plan that serves the long-term interests of the United States.

I. THE FEDERAL GOVERNMENT'S CURRENT APPROACH TO PROVIDING HEALTH CARE

The federal government currently provides health care to non-veterans primarily through two programs—Medicare and Medicaid.³² Medicare focuses on insuring older Americans, while Medicaid targets poor Americans.³³ In addition, SCHIP covers millions of children not included under their parents' health care

27. See *infra* Part II.A–B.

28. See *infra* Part II.C.

29. See *infra* Part V.

30. See *infra* Part V.B.

31. Michelle Austein, *Health Care Ranks Among U.S. Voters' Top Domestic Concerns*, AMERICA.GOV, Nov. 6, 2007, <http://www.america.gov/su/washfile-english/2007/November/20071106090423hmnietsua0.257641.html>.

32. Veterans receive health care benefits through the U.S. Department of Veterans Affairs, not the Centers for Medicare & Medicaid Services. U.S. Dep't of Veterans Affairs, VA Health Care Eligibility and Enrollment, <http://www.va.gov/healtheligibility> (last visited Apr. 3, 2008); Ctrs. Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., <http://www.cms.hhs.gov> (last visited Apr. 3, 2008).

33. 42 U.S.C. §§ 1395, 1396a(a)(10) (2000).

coverage.³⁴ Though these programs provide insurance to many who cannot afford health care on their own, millions of Americans are still without adequate health care coverage.³⁵ The number of uninsured and underinsured Americans is a testament to the weakness of the federal government's current health care system.

A. Medicare

Founded in 1965 under Title XVIII of the Social Security Act, Medicare is a federally-administered health insurance program that provides health care coverage to millions of elderly Americans.³⁶ Medicare offers hospital insurance known as Medicare Part A (i.e. inpatient medical care),³⁷ supplementary medical insurance known as Medicare Part B (i.e. physician outpatient medical care and preventive services),³⁸ and a voluntary outpatient prescription drug benefit enacted in 2003 known as Medicare Part D.³⁹ Alternatively, individuals can enroll in Medicare Part C, the Medicare Advantage program, which allows private plans to provide Medicare benefits to enrollees.⁴⁰ Individuals qualify for Medicare coverage at age sixty-five if they or their spouse worked for ten years,⁴¹ and they can qualify before reaching the age of sixty-five if they are disabled or have end-stage renal disease.⁴² In 2006, over 43 million people enrolled in either or both Parts A and B of Medicare.⁴³ Eighty-nine percent of Medicare recipients have at least one chronic condition, thirty-seven percent earn over one hundred and fifty percent of the federal poverty level, and twenty-one percent are ethnic or racial minorities.⁴⁴

34. See *id.* § 1397aa (expanding Medicaid to cover children under state-funded health insurance).

35. *Survey Finds 43.6 Million Uninsured in U.S.*, *supra* note 4.

36. Social Security Act of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended in scattered sections of 42 U.S.C.). See also CRAIG CAPLAN, AARP PUBLIC POLICY INST., THE MEDICARE PROGRAM: A BRIEF OVERVIEW 1 (2005), available at http://assets.aarp.org/rgcenter/health/fs103_medicare.pdf.

37. § 1395d.

38. *Id.* § 1395k.

39. *Id.* § 1395w-101.

40. The Medicare Advantage program was known as "Medicare+Choice" until the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Pub. L. No. 108-173, § 201, 117 Stat. 2066, 2176 (codified at 42 U.S.C. § 1395w-21 (2007)).

41. An individual or spouse must pay Social Security taxes for a minimum of 40 calendar quarters or qualify for Railroad Retirement benefits to meet the technical requirements. § 1395c; accord CAPLAN, *supra* note 36, at 1.

42. § 1395c; accord CAPLAN, *supra* note 36, at 1 (explaining that § 1395c mandates that a disabled person must receive Social Security Disability Insurance cash benefits for at least 24 months before qualifying for Medicare).

43. EARL DIRK HOFFMAN, JR. ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., BRIEF SUMMARIES OF MEDICARE & MEDICAID 6 (2006), available at <http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2006.pdf>.

44. CAPLAN, *supra* note 36.

B. Medicaid

The Medicaid program, established in 1965 by Title XIX of the Social Security Act, is a hybrid federal and state entitlement program that funds medical assistance for poor individuals.⁴⁵ Though federal statutes outline broad national guidelines, Medicaid is implemented differently in each state.⁴⁶ Each state establishes individual eligibility standards; determines the form, amount, and range of services; sets rates of payment for services; and administers its own program.⁴⁷ Even among states of similar size or geographic location, Medicaid services differ widely.⁴⁸ Some medical services, such as inpatient and outpatient hospital care, prenatal care, and laboratory work, are generally required by the federal Medicaid guidelines.⁴⁹ Other services approved by the federal government, such as clinical and diagnostic work, and physical therapy, remain optional for implementation at the state level.⁵⁰

A person's income is one of many factors that states consider when determining Medicaid eligibility.⁵¹ Medicaid generally provides medical care to children and pregnant women whose family income is slightly above the poverty level or lower.⁵² Recipients of Supplemental Security Income (SSI) and adoption or foster care assistance are usually eligible for Medicaid.⁵³ Likewise, Medicaid covers children under age nineteen whose family income falls below the poverty line.⁵⁴ A variety of other individuals, including infants, pregnant women, institutionalized individuals, and those with certain physical or mental impairments usually receive Medicaid funding through their state.⁵⁵

C. State Children's Health Insurance Program (SCHIP)

The federal government has also taken further steps to insure more children through SCHIP.⁵⁶ SCHIP sends states additional federal funds "to enable them to initiate and expand the provision of child health assistance to uninsured, low-

45. Social Security Act of 1965, Pub. L. No. 89-97, Title XIX, § 121(a), 79 Stat. 343 (codified as amended in scattered sections of 42 U.S.C.); accord HOFFMAN ET AL., *supra* note 43, at 16.

46. *E.g.*, § 1396a(a)(10)(A)(ii).

47. HOFFMAN ET AL., *supra* note 43, at 16.

48. *Id.*

49. §§ 1396a(10)(A), 1396d(a)(viii), 1396d(a)(xiii)(1)-(3); accord HOFFMAN ET AL. *supra* note 43, at 19-20.

50. §§ 1396a(10)(A), 1396d(a)(xiii)(9), (11), (13); accord HOFFMAN ET AL., *supra* note 43, at 20.

51. § 1396a(a)(10)(A)(i)(I)-(II), (IV)-(VII); accord HOFFMAN ET AL., *supra* note 43, at 17.

52. §§ 1396a(a)(10)(A)(III), 1396d(n); accord HOFFMAN ET AL., *supra* note 43, at 17.

53. § 1396a(a)(10)(A)(I)-(II); accord HOFFMAN ET AL., *supra* note 43, at 17.

54. § 1396a(10)(i)(VII), (I)(1)(D); accord HOFFMAN ET AL., *supra* note 43, at 17.

55. § 1396a(10)(ii)(I), (VI), (IX); accord HOFFMAN ET AL., *supra* note 43, at 17-18.

56. § 1397aa(a).

income children.”⁵⁷ During 2005, SCHIP covered six million low-income children.⁵⁸ Compared to Medicaid spending on children, the cost of providing coverage under SCHIP is relatively low.⁵⁹ SCHIP was recently reauthorized to extend through March 2009, though without funding that would have included an additional four million children under the program.⁶⁰

D. General Problems with the Federal Government’s Current Health Care Coverage

The federal health care system leaves a vast number of people without any health insurance.⁶¹ In 2006, over forty-three million Americans, or about fifteen percent of the population, did not have health insurance.⁶² That number almost doubles, to ninety million people or one-third of the population below the age of sixty-five, when the number of people who spent some portion of the past two years uninsured is included.⁶³ Young adults ages eighteen to twenty-four were the least likely to have insurance with nearly one-third of that age group uninsured.⁶⁴ Though the federal government’s approach to health care generally expects employers to provide health care coverage, only sixty-one percent of employers offered health benefits to their employees in 2005.⁶⁵ Employers question whether it is worth paying skyrocketing health insurance premiums, which leads them to drop health care coverage and demonstrates that employer-sponsored health care is inadequate.⁶⁶

An additional problem is underinsurance. Underinsurance is difficult to define because there is no standard formula to determine whether a person has sufficient health insurance.⁶⁷ Generally, a determination of the number of underinsured individuals involves the adequacy of coverage regarding a person’s financial ability

57. *Id.*

58. KAISER COMM’N ON MEDICAID & THE UNINSURED, HENRY J. KAISER FAMILY FOUND, A DECADE OF SCHIP EXPERIENCE AND ISSUES FOR REAUTHORIZATION 1 (2007), available at <http://www.kff.org/medicaid/upload/7574-2.pdf>.

59. *Id.*

60. Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. No. 110-173, § 201, 121 Stat. 2492, 2509 (2007); *Bush Signs Extension of Child Health Care*, CHI. TRIB., Dec. 30, 2007, at C5.

61. *Survey Finds 43.6 Million Uninsured in U.S.*, *supra* note 4.

62. *Id.*

63. NAT’L COAL. ON HEALTH CARE, FACTS ON HEALTH INSURANCE COVERAGE 1 (2007), available at http://www.nchc.org/facts/coverage_fact_sheet_2007.pdf.

64. *Id.* at 2.

65. HENRY J. KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2005 SUMMARY OF FINDINGS 4 (2005), available at <http://www.kff.org/insurance/7527/upload/7528.pdf>.

66. Julie Appleby, *Health Insurance Premiums Crash Down on Middle Class*, USA TODAY, Mar. 17, 2004, at 1B, available at http://www.usatoday.com/news/health/2004-03-16-healthcost_x.htm.

67. STATE HEALTH ACCESS DATA ASSISTANCE CTR., UNIV. OF MINN. SCH. OF PUB. HEALTH, MEASURING THE ADEQUACY OF COVERAGE OR UNDERINSURANCE 1 (n.d.), <http://www.sph.umn.edu/img/assets/18528/MeasureUnderinsurance.pdf>.

to pay deductibles and out-of-pocket costs, as well as the quality of health benefits provided under the plan.⁶⁸ Taking these factors into consideration, over seventeen million Americans under the age of sixty-five are underinsured.⁶⁹

II. CONGRESSIONAL PROPOSALS FOR FEDERAL HEALTH CARE REFORM

Throughout the nation, numerous plans for federal health care reform have been proposed. While it would be impossible to discuss all major health care reform proposals, three proposals introduced in Congress present a picture of varied reform attempts and contentious debate hindering these legislative efforts. One plan would eliminate the traditional employer-based health care system, a second plan would eliminate for-profit health providers, and a third plan would significantly increase coverage under SCHIP. The failure of these measures to become law shows how slowly the federal government moves when reforming health care and how difficult it can be to build a sufficient consensus to enact health care reform.⁷⁰

A. *The Healthy Americans Act*

One Senator recently made an effort at national health care reform and introduced a bill that would end the traditional employer-based health care system. Senator Ron Wyden (D-OR) unveiled the Healthy Americans Act (HAA) in an attempt to provide coverage for all Americans.⁷¹ The HAA would allow all Americans, except those covered through Medicare or those receiving military health care benefits, to choose health care plans from a selection of private insurance plans called "Health Help Agencies."⁷² Moreover, it would allow workers to take their health insurance with them from job to job.⁷³ To achieve this

68. *Id.*

69. See Jessica S. Banthin & Didem M. Bernard, *Changes in Financial Burdens for Health Care: National Estimates for the Population Younger Than 65 Years, 1996 to 2003*, 296 JAMA 2712, 2718 (2006).

70. "Incrementalism" is a term used by political economists to describe a situation, such as this one, where government tends to make small changes in existing policies as opposed to exploring radical innovations. Paul M. Johnson, Auburn Univ., A Glossary of Political Economy Terms, <http://www.auburn.edu/~johnspm/gloss/incrementalism> (last visited Apr. 6, 2008).

71. Healthy Americans Act, S. 334, 110th Cong., § 102 (2007). For a summary of Senator Wyden's health coverage plan, see *Oregon Senator Prepares Universal Health Coverage Plan*, USA TODAY, Dec. 13, 2006, available at http://www.usatoday.com/news/washington/2006-12-13-wyden_x.htm?loc=interstitialskip. Currently a "large chunk" of the health care coverage in the United States is provided through employer-sponsored coverage plans. Special Report, *America's Health Care Crisis, Desperate Measures*, ECONOMIST, Jan. 28, 2006, at 24.

72. S. 334, § 102(a)(1)(A)(i)-(vi); JOHN SHEILS ET AL., THE LEWIN GROUP, COST AND COVERAGE ESTIMATES FOR THE "HEALTHY AMERICANS ACT" 4 (2006), available at <http://www.lewin.com/NR/rdonlyres/37BD21DB-BEFE-4C2F-AFEA-802BDF91EAD7/0/HealthyAmericansActAnalysis.pdf>.

73. S. 334, § 102(a)(1)(iii).

goal, the HAA proposed that employers terminate current health coverage of their employees and pay the monetary savings to employees as increased wages.⁷⁴ Subsequently, employees would be legally required to purchase private health plans offered through the Health Help Agencies of their resident states.⁷⁵ Eventually, wage hikes would end and employers would pay into an insurance pool based on their revenue and number of full-time employees.⁷⁶ A health care consulting firm said that the HAA would reduce the health care spending of private employers by seventy-five percent and save \$1.4 trillion in overall national health care spending during the next decade.⁷⁷

The HAA relies on cooperation from government and employers to ensure success of its market-based system. The federal government would be responsible for making certain that every American can afford health insurance by providing tax breaks and premium reductions to those who need financial assistance.⁷⁸ By providing financial assistance to each state to create a Health Help Agency, the federal government would help give consumers unbiased information about private health care plans and coordinate payments from employers, individuals and government.⁷⁹ The government would also guarantee that health insurance providers do not discriminate based on pre-existing health conditions, genetic information, gender or age, and insurance companies could not raise prices or deny coverage to sick individuals.⁸⁰ Employers would be required to contribute annual “employer shared responsibility payments,” based on their relative ability to pay, to help reduce the cost of insurance premiums.⁸¹ The plan requires individuals to behave like consumers and shop for the lowest cost health care coverage.⁸² With health insurance offerings no longer constrained by an individual’s employer, Senator Wyden believes that competition between health insurance companies would dramatically increase, thereby driving down costs and promoting quality for health insurance purchasers.⁸³

74. *Id.* § 611; accord SHEILS ET AL., *supra* note 72, at 4.

75. S. 334, §§ 102, 111, 601; accord SHEILS ET AL., *supra* note 72, at 4. Employee premium payments “would be subsidized on a sliding scale with income for those living below 400 percent of the federal poverty level (FPL).” *Id.*

76. *Oregon Senator Prepares Universal Health Coverage Plan*, *supra* note 71.

77. SHEILS ET AL., *supra* note 72, at 2, 21. The consulting firm further estimated that the HAA would reduce private employer healthcare spending from \$428.8 billion to \$119.0 billion. *Id.*

78. S. 334, §§ 121–22, 661–66; accord Ron Wyden, U.S. Senator, Healthy Americans Act (n.d.), http://wyden.senate.gov/issues/Healthy%20Americans%20Act/HAA_How_It_Works.pdf.

79. S. 334, §§ 501–503.

80. *Id.* §§ 111(d)(4), 112(a)(1),(a)(4), (b); accord Wyden, *supra* note 78.

81. S. 334, § 3411; accord Wyden, *supra* note 78.

82. Wyden, *supra* note 78.

83. *Id.*

B. Single Payer System

Numerous legislators endorse a single payer system as the solution to America's health care crisis.⁸⁴ Longtime Congressman John Conyers (D-MI) sponsored the United States National Health Insurance Act (USNHI) to provide health coverage to all individuals residing in the United States.⁸⁵ First introduced in February 2003,⁸⁶ USNHI now has eighty-eight cosponsors in the U.S. House of Representatives.⁸⁷

USNHI contains the traditional elements of a single payer health care system. The bill guarantees every United States resident "a universal, best quality standard of care."⁸⁸ Coverage must include inpatient and outpatient care, prescription drugs, long-term care and various other types of treatment.⁸⁹ This proposal would prohibit for-profit health providers from participating in the single payer system, and private health insurers would be barred from providing benefits that duplicate coverage provided by USNHI.⁹⁰ Thus, as a result of USNHI, traditional private health insurance would be virtually eliminated throughout the United States.

USNHI would establish a nationwide network of administrators to oversee the program. The Director, appointed by the Secretary of Health and Human Services (HHS Secretary), would be responsible for the management of the health care system.⁹¹ Additionally, a director of quality control, several regional directors, and at least one deputy director in every state would assist the Director.⁹² USNHI would also establish a National Board consisting of fifteen members, including at least one representative from each of the following groups: health care professionals; citizen patent advocates; and representatives of health care advocacy groups, providers, and labor unions.⁹³ These board members would be appointed by the President of the United States with the consent of the Senate, serve six-year terms,

84. United States National Health Insurance Act, H.R. 676, 110th Cong. (2007).

85. *Id.*

86. H.R. 676, 108th Cong. (as introduced by House, Feb. 11, 2003).

87. The number of co-sponsors might have increased since publication of this article. See Thomas Library of Congress, Bill Summary and Status, <http://thomas.loc.gov/cgi-bin/bdquery/z?d110:HR00676:@@@P> (last visited Apr. 6, 2008).

88. H.R. 676, § 101 (2007).

89. *Id.* § 102. The full list of mandated benefits consists of the following: "(1) Primary care and prevention; (2) Inpatient care; (3) Outpatient care; (4) Emergency care; (5) Prescription drugs; (6) Durable medical equipment; (7) Long term care; (8) Mental health services; (9) The full scope of dental services (other than for cosmetic dentistry); (10) Substance abuse treatment services; (11) Chiropractic services; (12) Basic vision care and vision correction (other than laser vision correction for cosmetic purposes); [and] (13) Hearing services, including coverage for hearing aids." *Id.*

90. *Id.* §§ 103(a)–104(a).

91. *Id.* § 301(a).

92. *Id.* §§ 302, 303(a)–(b).

93. *Id.* § 305(a)(1)–(2).

and advise the HHS Secretary and Director to “ensure quality, access, and affordability.”⁹⁴

C. SCHIP Expansion

In 2007, Congress passed an extension of the State Children’s Health Insurance Program.⁹⁵ Its objective was to provide quality health care coverage for six million children who were not previously covered under SCHIP.⁹⁶ The extension would have provided \$35 billion in additional spending on SCHIP,⁹⁷ which would have been offset by an increase in tobacco taxes.⁹⁸ Despite bipartisan support in both the Senate and House of Representatives, President Bush twice vetoed the SCHIP expansions due to their large cost of funding.⁹⁹ Instead, the President signed an SCHIP extension with a modest spending increase that would maintain health care coverage for children already enrolled in SCHIP.¹⁰⁰

D. Problems with Congressional Reform Proposals

The federal government has traditionally moved slowly when implementing health care reform. In 1942 Franklin Roosevelt proposed a “second Bill of Rights” that would guarantee every American access to adequate medical care.¹⁰¹ President Harry Truman continued Roosevelt’s policy and proposed universal health care during his Presidential campaign in 1948.¹⁰² Despite this desire for health care reform, it took almost two decades from Truman’s proposal until the government created Medicaid and Medicare.¹⁰³ Though minor adjustments were made to federal health care coverage, the next major attempt at federal health care reform did not occur until 1993 with President Bill Clinton’s Task Force on National Health Care Reform.¹⁰⁴ President Clinton’s efforts, however, failed to achieve even limited

94. *Id.* § 305(a).

95. Children’s Health Insurance Program Reauthorization Act of 2007, H.R. 976, 110th Cong. (2007).

96. *Id.* § 2.

97. *Bush Signs Extension of Child Health Care*, *supra* note 60.

98. *Id.*

99. *Id.*

100. Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. No. 110-173, §§ 201–206, 121 Stat. 2492, 2509–14 (2007). While the current and ongoing debate about SCHIP is important, it is outside the scope of this article.

101. Franklin D. Roosevelt, U.S. President, State of the Union Message to Congress (Jan. 11, 1944), available at <http://www.presidency.ucsb.edu/ws/index.php?pid=16518>.

102. Harry S. Truman, U.S. President, Address in Madison Square Garden, New York City, in PUBLIC PAPERS OF THE PRESIDENTS OF THE UNITED STATES: HARRY S. TRUMAN, 1948 (U.S. Govt. Printing Office 1964).

103. Social Security Amendments of 1965, Pub. L. No. 89–97, 79 Stat. 286, 291, 343 (codified in scattered sections of 42 U.S.C.).

104. Robert Pear & Stephen Labaton, *Clinton’s Health Plan; Officials Predict Deluge of Suits On Health Plan*, N.Y. TIMES, Sept. 27, 1993, at A1.

health care reform.¹⁰⁵ Though SCHIP and Medicare's new prescription benefit have attempted to improve federally-provided health care coverage, the federal government has not undergone a serious attempt to reform the national health care system in recent years.

Even if Congress were committed to passing health care reform, there is no consensus on what type of proposal is appropriate for the nation. The Healthy Americans Act could be the solution to America's health care problems, but it would implement a health care system completely different than the current system.¹⁰⁶ In addition, ending the employer-based plan is controversial because employees would receive their health insurance premiums in cash for the first two years of the plan.¹⁰⁷ While some would argue that a radical approach is needed to solve the current crisis, critics argue that sweeping changes at this time are unwise due to the numerous uncertainties involved in making such changes.¹⁰⁸ Similarly, a single-payer health care system is a fundamental departure from the current American health care system.¹⁰⁹ Under USNHI, for-profit health insurance would be eliminated and the health care system would be dramatically altered.¹¹⁰ Furthermore, when Congress reached a bipartisan agreement about significantly increasing funding for SCHIP, President Bush twice vetoed the legislation.¹¹¹ Without consensus, national health care reform cannot be enacted in the near future.

III. STATE HEALTH CARE INITIATIVES

With numerous gaps in federal health care coverage, several states have passed legislation hoping to solve the health care crisis. Massachusetts recently implemented a highly publicized plan that mandates each person have health insurance coverage through his or her employer, the government or a self-purchased plan.¹¹² The focus of Maine's health care plan is on requiring businesses to cover their employees through private or state-managed insurance.¹¹³ Vermont is attempting to reduce the cost of chronic care, hoping that cost reduction would allow for more money to be spent on insuring everyone in the state.¹¹⁴ Maryland

105. Derek Bok, *The Great Health Care Debate of 1993-94*, PUBLIC TALK (1998), <http://www.upenn.edu/pnc/ptbok.html>.

106. See *supra* Part II.A.

107. Healthy Americans Act, S. 334, 110th Cong., § 3411(c)(1)(A); accord Wyden, *supra* note 78.

108. *America's Health Care Crisis, Desperate Measures*, *supra* note 71, at 24, 26.

109. See *supra* Part II.B.

110. H.R. 676, 110th Cong., § 103 (2007).

111. *Bush Signs Extension of Child Health Care*, *supra* note 60.

112. Act of April 12, 2006, ch. 58, 2006 Mass. Legis. Serv. 64 (West); H.B. 4857, 184th Gen. Court, Reg. Sess. (Mass. 2006) (enacted).

113. Dirigo Health Act, ME. REV. STAT. ANN. tit. 24-A §§ 6902, 6910 (Supp. 2006).

114. VT. STAT. ANN. tit. 3, § 2222a(c)(1) (2007).

attempted, unsuccessfully, to increase coverage of its citizens by forcing the state's largest employers to provide coverage to their employees.¹¹⁵

A. Massachusetts: An Act Providing Access to Affordable, Quality, and Accountable Health Care

On April 12, 2006, Governor Mitt Romney signed into law the "Act Providing Access to Affordable, Quality, and Accountable Health Care."¹¹⁶ This bill required every citizen to have health insurance by July 1, 2007 or face civil penalties.¹¹⁷ The bill's passage made Massachusetts the first state in the nation to mandate that all citizens not only have access to health care, but actually have insurance coverage.¹¹⁸ Governor Romney compared the bill to the state's auto insurance requirement, stating "[w]e insist that everybody who drives a car has insurance . . . and cars are a lot less expensive than people."¹¹⁹

The Massachusetts bill has several components that place responsibility on individuals, government, and the private sector. Under the bill, every citizen of Massachusetts over eighteen years of age is required to purchase health insurance coverage.¹²⁰ The penalty for failure to do so is the loss of the personal exemption on that person's tax filing.¹²¹ Individuals earning less than one hundred percent of the federal poverty limit are eligible for a basic health insurance plan free of charge, and individuals earning between one hundred percent and three hundred percent of the federal poverty limit are eligible for a sliding-scale subsidy that can be used toward the purchase of health insurance coverage.¹²² Requiring individual responsibility was critical to conservatives' support of the bill.¹²³

In addition to providing health insurance coverage or subsidies to low-income residents, the state has created several government agencies to implement and improve the new health care system. Most notably, the bill creates an independent agency, the Commonwealth Health Insurance Connector (Connector), to facilitate

115. Fair Share Health Care Fund Act, ch.1, 2006 Md. Laws 1, 1–6, *invalidated by* Retail Indus. Leaders Ass'n v. Fielder, 435 F. Supp. 2d 481 (D. Md. 2006), *aff'd*, 475 F.3d 180 (4th Cir. 2007).

116. 2006 Mass. Legis. Serv. 64.

117. § 12, 2006 Mass. Legis. Serv. at 77.

118. *Bill Mandates Health Coverage for All in State*, CHI. TRIB., Apr. 5, 2006, at C10.

119. David A. Fahrenthold, *Mass. Bill Requires Health Coverage; State Set to Use Auto Insurance as a Model*, WASH. POST, Apr. 5, 2006, at A1.

120. § 12, 2006 Mass. Legis. Serv. at 77. The bill provides an exception for individuals signing a sworn affidavit that religion is their reason for failing to obtain health insurance coverage. *Id.*

121. *Id.* § 12. For those individuals filing jointly, the penalty for failing to obtain health insurance is half of the personal exemption. *Id.* The personal exemption in Massachusetts on the 2005 tax form was as follows: person filing single - \$3,575; head of household - \$5,525; married filing jointly - \$7,150. MASS. DEP'T OF REVENUE, RESIDENT INCOME TAX RETURN (2005), *available at* <http://www.mass.gov/Ador/docs/dor/Forms/lncTax05/PDFs/1.pdf>.

122. § 45, 2006 Mass. Legis. Serv. at 91–92.

123. William C. Symonds, *In Massachusetts, Health Care for All?*, BUS. WEEK, Apr. 5, 2006, http://www.businessweek.com/investor/content/apr2006/pi20060404_152510.htm.

the purchase of different health insurance programs for qualifying individuals and small group purchasers.¹²⁴ Though not regulating the price or design of each plan, the Connector will certify plans that offer good value to consumers and act as a clearinghouse or middleman from which customers can choose their plan.¹²⁵ The bill also creates other government groups to improve health care quality and control its costs,¹²⁶ analyze Medicaid's effect on the Massachusetts health care system,¹²⁷ and improve overall efficiency of the plan.¹²⁸

Private employers also have responsibilities under this plan. All businesses with more than ten employees must provide workers with health insurance or be subject to a fee approximating \$300 per employee per year.¹²⁹ Although controversial, this "employer mandate" has the support of many members of the business community.¹³⁰ Michael Widmer, president of the Massachusetts Taxpayer Foundation, believes business's strong support is smart as "[t]his equalizes the burden between companies who don't provide health insurance and those who do."¹³¹ Furthermore, an additional penalty awaits employers whose workers receive excessive uncompensated care. A company can be charged a "free-rider surcharge, if it incurs "\$50,000 or more, in any hospital fiscal year, in free care services for any . . . employees, or dependents of such persons . . . regardless of how many state-funded employees are employed by that employer."¹³²

124. § 101, 2006 Mass. Legis. Serv. at 108. Qualifying individuals include non-working individuals, individuals working for companies not offering coverage, individuals not eligible for coverage through their employer, small businesses with fewer than fifty employees, and sole proprietors. *Id.* § 101 at 107.

125. *Id.* § 101 at 109; accord MICHAEL TANNER, CATO INST., BRIEFING PAPERS NO. 97, NO MIRACLE IN MASSACHUSETTS: WHY GOVERNOR ROMNEY'S HEALTH CARE REFORM WON'T WORK 7 (2006), available at <http://www.cato.org/pubs/bp/bp97.pdf>. The Connector allows companies to offer part-time employees a health insurance option, enables individuals to purchase portable coverage, and gives individuals an opportunity to select a plan that meets their particular health care needs. See Commonwealth Connector, <http://www.mahealthconnector.org> (follow "About Us" hyperlink) (last visited Apr. 6, 2007).

126. For instance, the Bill establishes a health care quality and cost control council, a MassHealth payment policy advisory board, and a public health council, to name a few. §§ 3, 5, 6, 2006 Mass. Legis. Serv. at 67-73; accord TANNER, *supra* note 125, at 10.

127. The particular bureaucratic authority assigned this task is the MassHealth payment policy board. § 3, 2006 Mass. Legis. Serv. at 70; accord TANNER, *supra* note 125, at 9-10.

128. The health care quality and cost council is mainly responsible for the efficiency of health care. § 3, 2006 Mass. Legis. Serv. at 67; accord TANNER, *supra* note 125, at 9-10.

129. § 47, 2006 Mass. Legis. Serv. at 93; accord TANNER, *supra* note 125, at 9.

130. Symonds, *supra* note 123.

131. *Id.*

132. § 44, 2006 Mass. Legis. Serv. at 89; accord TANNER, *supra* note 125, at 9.

B. Maine: The Dirigo Health Program

Maine began providing subsidized health coverage to low income residents in 2003 under the Dirigo Health Program.¹³³ The Dirigo Health Act created an independent executive agency to coordinate the provision of comprehensive, affordable health care coverage to individuals, small employers, and the self-employed on a voluntary basis.¹³⁴ Any eligible individual or employee can be considered for a sliding-scale health subsidy under the program if that person's income is less than three hundred percent of the federal poverty level.¹³⁵

The Dirigo Health Program requires the participation of health insurers and businesses. To provide coverage under the program, health insurance carriers and third-party health insurance administrators must contract with Dirigo Health.¹³⁶ To qualify as a Dirigo Health carrier, the insurance provider must offer a standard benefit package that meets minimum coverage specifications.¹³⁷ Providers cannot refuse to cover an individual based on the enrollee's current health status, medical condition or previous insurance status.¹³⁸ In addition, the contracts may include quality assurance, disease management or cost-containment provisions, and the health insurance carriers must qualify under Medicaid.¹³⁹

Businesses must also contract with Dirigo Health and fulfill certain requirements to provide health insurance to their employees under the Dirigo program.¹⁴⁰ Most importantly, every employer participating in Dirigo Health must enroll at least seventy-five percent of their full-time employees who currently are without other credible health insurance coverage.¹⁴¹ Employers must substantially contribute to the costs of providing health care, service improvements, and service administration.¹⁴² Despite the apparent cost burden placed on employers, they are reimbursed for payments made for employees who qualify for subsidies based on income, thus pushing the burden of insurance for low-income individuals onto the Dirigo program.¹⁴³

133. Dirigo Health Act, ch. 469, § A-8, 2003 Me. Laws 1305, 1307 (codified at ME. REV. STAT. ANN. tit. 24-A, §§ 6901, 6971 (Supp. 2006)).

134. ME. REV. STAT. ANN. tit. 24-A, § 6902 (Supp. 2006). The Dirigo Health Act also provided mechanisms to improve the quality of health care. *Id.*

135. *Id.* § 6912(2).

136. *Id.* § 6910(4).

137. *Id.* § 6910(3)(A).

138. *Id.* § 6910(3)(B)(2). Additionally, providers cannot refuse coverage based on the enrollee's "race, color, creed, age, national origin, citizenship status, gender, sexual orientation, disability, or marital status." *Id.*

139. *Id.* § 6910(3)(B)-(4)(A)(2).

140. *Id.* § 6910(4)(B).

141. *Id.* § 6910(4)(B)(4). Thirty or more hours is considered "full-time" for purposes of the seventy-five percent requirement. *Id.*

142. *Id.* § 6910(4)(B)(2)-(3).

143. *Id.* § 6910(4)(B)(5).

C. *Vermont: The Health Care Affordability Act*

In May 2006, Vermont Governor Jim Douglas signed the Health Care Affordability Act.¹⁴⁴ The Act declared that all Vermonters could receive affordable, sustainable health care coverage if the state met three health care goals.¹⁴⁵ First, chronic conditions would be prevented and managed properly.¹⁴⁶ Second, all uninsured Vermonters would be covered through Catamount Health, an affordable and comprehensive benefit plan.¹⁴⁷ Third, a minimum level of preventative services, including immunizations, would be available to all Vermonters.¹⁴⁸ The Act also stated that “[i]t is the policy of the state of Vermont to ensure universal access to and coverage for essential health care services for all Vermonters.”¹⁴⁹

The first objective of the Vermont plan requires the state to prevent and manage chronic illnesses, and the Act created the “Blueprint for Health” for such a purpose.¹⁵⁰ The Blueprint for Health would create a state-wide electronic database, also known as a “chronic care information system,” to compile patient information on every case of a specified chronic condition.¹⁵¹ While there are many logistical challenges to creating an effective electronic database,¹⁵² the information in a comprehensive database could potentially reduce costs and improve quality of chronic care in Vermont by giving medical care providers more accurate patient information.¹⁵³

The second and third objectives of the bill—covering uninsured Vermonters and providing preventative services—are an attempt by the legislature to move toward its goal of providing universal health coverage.¹⁵⁴ Catamount Health will cover individuals who do not have health insurance under an employer-sponsored

144. Act of May 25, 2006, No. 191, 2006 Vt. Acts & Resolves 455, 501; Ross Sneyd, *Douglas Signs Into Law Catamount Health Reform Initiative*, BOSTON GLOBE, May 25, 2006, available at http://www.boston.com/news/local/vermont/articles/2006/05/25/douglas_signs_into_law_catamount_health_reform_initiative/.

145. § 2(a), 2006 Vt. Acts & Resolves at 455.

146. *Id.*

147. *Id.*

148. *Id.*

149. *Id.* § 1(1), 2006 Vt. Acts & Resolves at 455.

150. *Id.* § 4(a), 2006 Vt. Acts & Resolves at 457.

151. *Id.* § 6, 2006 Vt. Acts & Resolves at 460–61 (codified as VT. STAT. ANN. tit. 33, § 1903a(c)(1) (Supp. 2007)); DEB RICHTER & TERRY DORAN, VT. HEALTH CARE FOR ALL, CATAMOUNT HEALTH: THE 2006 HEALTH CARE AFFORDABILITY ACT (n.d.), http://www.vthca.org/pdfs/Catamount_Health_Bill_simplified.pdf.

152. Among the problems anticipated with establishing an efficient database are the current lack of health data stored electronically, the potential inability of the state monitoring agency to save money on overall health care costs, and the failure of health professionals to voluntarily cooperate with the chronic care management program. RICHTER & DORAN, *supra* note 151.

153. *See id.*

154. *Id.*; § 2(a), 2006 Vt. Acts & Resolves at 455.

plan or a state-sponsored plan such as Medicaid.¹⁵⁵ The plans will be offered by private insurers, give consumers defined benefit packages, and the state will subsidize those packages for individuals earning less than three hundred percent of the federal poverty level.¹⁵⁶ Advocates hope that ninety percent of all Vermonters have health insurance within five years.¹⁵⁷

D. *Maryland – The Fair Share Health Care Fund Act*

Maryland's Legislature developed a unique idea to alleviate the health care crisis—blame Wal-Mart. On January 12, 2006, the Maryland legislature overrode Governor Robert Ehrlich's veto and enacted the Fair Share Health Care Fund Act.¹⁵⁸ This act required any private employer with at least 10,000 employees in the state to spend a minimum of eight percent of the total wages paid to employees on health insurance costs, subject to certain exceptions.¹⁵⁹ At the time, Wal-Mart was the only for-profit company with at least 10,000 employees in Maryland that failed to pay eight percent of its wages for health insurance costs, and the legislature was aware of this fact when it passed the bill.¹⁶⁰ Any non-complying employer would be required to pay the difference between its expenditures on health care costs and the eight percent figure to the state and a civil monetary penalty of \$250,000.¹⁶¹

IV. ROADBLOCKS TO SUCCESSFULLY IMPLEMENTING STATE HEALTH CARE INITIATIVES

Despite state innovations, there are two major obstacles to the successful implementation of state health care initiatives. First, the federal law, the Employee Retirement Income Security Act (ERISA), limits the degree to which states can interfere with employee benefit plans, notably health care plans.¹⁶² This law has already influenced states' attempts to develop innovative health care solutions and threatens to thwart other reform efforts.¹⁶³ Second, many states have balanced

155. § 16, 2006 Vt. Acts & Resolves at 473 (codified at Vt. Rev. St. tit. 33, §§ 1981, 1982(2) (2007)).

156. § 15, 2006 Vt. Acts & Resolves at 468 (codified as amended at VT. REV. ST. tit. 8, § 4080f(a)(2)(2007); § 16, 2006 Vt. Acts & Resolves at 474–75 (codified at VT. REV. ST. tit. 33, § 1984(c) (2007)); RICHTER & DORAN, *supra* note 151.

157. Sneyd, *supra* note 144.

158. Fair Share Health Care Fund Act, ch.1, 2006 Md. Laws 1, 6; *see also* Veto of S.B. 790, Reg. Sess. (Md. 2005), *available at* http://mlis.state.md.us/2005rs/veto_letters/sb0790.htm.

159. §§ 8.5-102, 8.5-104, 2006 Md. Laws at 3–4. A non-profit employer was only required to spend six percent of total wages on health care. § 104, 2006 Md. Laws at 4. In addition, an employer could exempt any wages paid to employees in excess of the median income as well as wages paid to employees who were enrolled in or eligible for Medicare. § 103, 2006 Md. Laws at 4.

160. Retail Indus. Leaders Ass'n v. Fielder, 435 F. Supp. 2d 481, 485 (D. Md. 2006), *aff'd*, 475 F.3d 180 (4th Cir. 2007).

161. §§ 8.5-104(B), 8.5-105(B) 2006 Md. Laws at 4–5.

162. 29 U.S.C. § 1144(a) (2000).

163. *E.g.*, Retail Indus. Leaders Ass'n, 435 F. Supp. at 494, *aff'd*, 475 F.3d 180.

budget requirements that limit the amount of financial resources states can invest in a new health care system. While Massachusetts, as a relatively wealthy state,¹⁶⁴ enacted health care reform, many states with more limited financial resources will have trouble enacting broad health care reform due to its high price tag in the face of looming budget deficits.

A. *The Employee Retirement Income Security Act*

ERISA is a federal statute designed to regulate state control over benefits paid by employers to employees. ERISA states that it supersedes “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan” covered by ERISA.¹⁶⁵ Such plans include any system providing benefits to employees that is established or maintained by an employer or employee organization.¹⁶⁶ Section 1003(b) excludes any “governmental plan” established or maintained by the U.S. government or any state or political subdivision, from ERISA restrictions in providing its employees benefits.¹⁶⁷ This broadly-interpreted section invalidates any state law that has either a “reference to” or “connection with” such a plan.¹⁶⁸ In evaluating whether a statute has a “connection with” an ERISA plan, a court should examine (a) the objectives of the ERISA statute in blocking state laws, and (b) the type of effect of the state law on ERISA plans.¹⁶⁹ The purpose of ERISA’s preemption clause is “to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.”¹⁷⁰

A federal court has already found that Maryland’s Fair Share Act violated ERISA.¹⁷¹ In *Retail Industry Leaders Ass’n v. Fielder*, the United States District Court for the District of Maryland ruled that requiring Wal-Mart to segregate its health care expenses due to Maryland’s Act would violate ERISA’s objectives.¹⁷² It noted that uniformity among state benefit plans is impossible if each state has different legal obligations.¹⁷³ In addition, forcing Wal-Mart to increase its health care expenditures would affect its contribution to the company’s ERISA health care

164. News Release, Bureau of Econ. Analysis, U.S. Dep’t of Commerce, State Personal Income 2006 (Mar. 27, 2007), <http://www.bea.gov/newsreleases/regional/spi/2007/pdf/spi0307.pdf> (listing Massachusetts as the third in the nation for the state with the highest per capita income).

165. 29 U.S.C. § 1144(a).

166. 29 U.S.C. § 1003(a).

167. *Id.* § 1003(b), 1002(32).

168. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96–97 (1983); *accord Egelhoff v. Egelhoff*, 532 U.S. 141, 146 (2001) (recognizing that the ERISA’s explicit language is “broadly worded”).

169. *Egelhoff*, 532 U.S. at 147.

170. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995).

171. *Retail Indus. Leaders Ass’n v. Fielder*, 435 F. Supp. 2d 481, 494 (D. Md. 2006), *aff’d*, 475 F.3d 180 (4th Cir. 2007).

172. *Id.* at 495.

173. *Id.* at 494 (quoting *Eglehoff*, 532 U.S. at 148).

plan, and thus the Act is in “connection with” an ERISA plan.¹⁷⁴ On appeal, the Fourth Circuit affirmed the District Court’s ruling.¹⁷⁵

Massachusetts’s new health care initiative potentially violates ERISA as well. In an article written for the American Bar Association Health Law Section, Michael Bernstein and John Seybert discuss the likelihood that the employer-mandate portion of the Massachusetts plan is preempted by ERISA.¹⁷⁶ The authors believe that the plan’s requirement that employers contribute minimum benefits to an employee’s health insurance premiums “does not fall within the savings clause exception to ERISA preemption for laws regulating insurance.”¹⁷⁷ Thus, according to Bernstein and Seybert, the Massachusetts plan is “not likely to withstand judicial scrutiny to the extent that it mandates employer contributions to health insurance.”¹⁷⁸

B. *Balanced Budget Requirements at the State Level*

State balanced budget requirements pose a dangerous roadblock to health care reform in individual states. Forty-nine states have a constitutional or statutory requirement that forces government officials to propose or pass a balanced state budget.¹⁷⁹ Some states require the governor to submit a balanced budget, others require that the legislature must pass a balanced budget, and still other states do not allow budgetary deficits to be carried over into a new year.¹⁸⁰ Several states must follow a combination of these requirements.¹⁸¹ According to the National Conference of State Legislatures, thirty-six of these states have “rigorous” balanced budget requirements.¹⁸²

Due to the large cost of health care reform, these balanced budget requirements will hamper attempts at state health care reform. At least twenty-four

174. *Id.* at 495.

175. *Retail Indus. Leaders Ass’n*, 475 F.3d at 183.

176. Michael H. Bernstein et al., *You Can’t Get There from Here – ERISA Preemption of State Laws Mandating Employer Health Care Contributions*, ABA HEALTH ESOURCE, (Am. Bar Ass’n Health Law Section), Mar. 2007, <http://www.abanet.org/health/esource/Volume3/07/bernstein-seybert.html>.

177. *Id.*

178. *Id.* But see PATRICIA A. BUTLER, NAT’L ACAD. FOR STATE HEALTH POLICY, ERISA IMPLICATIONS FOR STATE HEALTH CARE ACCESS INITIATIVES 9 (2006), available at <http://statecoverage.net/SCINASHP.pdf> (discussing how some experts believe the Massachusetts health care plan will not violate ERISA).

179. Ronald K. Snell, Nat’l Conference of State Legislatures, *State Balanced Budget Requirements: Provisions and Practice* (2004), <http://www.ncsl.org/programs/fiscal/balbuda.htm>. Vermont is the only state that does not have a balanced budget requirement. *Id.*

180. *Id.*

181. *Id.*

182. *Id.* Several states do not fall into the “rigorous” category because while governors are forced to submit balanced budgets, balanced budgets do not need to be enacted. *Id.*

states already have or are projecting budget deficits in the next two years.¹⁸³ When states make necessary budget cuts to balance a budget, they often target public health programs as a means of decreasing expenditures.¹⁸⁴ Balanced budget requirements will make it more difficult for states to develop and implement health care reform plans considering states' current budget predicaments.

V. WHY STATE HEALTH CARE EXPERIMENTATION OFFERS THE BEST CHANCE TO ENACT EFFECTIVE FEDERAL HEALTH CARE REFORM

States are uniquely positioned to take the lead in national health care reform. Unlike the federal government, individual states have been able to build legislative consensus and develop innovative solutions to the health care crisis. These state initiatives provide value to the national health care debate not only for the solutions that are developed, but also for the ability of the federal government to observe the implementation of these initiatives. Many state plans have negative attributes that should be avoided in the future. Through observing state experimentation, the federal government can "cherry-pick" the best elements of state plans to develop a comprehensive national health care solution. In fact, several 2008 Presidential candidates have already borrowed elements of state plans for their national health care plans. Further state experimentation will continue to advance the national health care debate and eventually lead to the most effective solution for the national health care crisis.

A. *States Have Been Able to Develop Innovative Solutions*

States have proven to be a fantastic laboratory for health care experimentation. The Massachusetts mandate has received praise as an inventive way to solve the health care crisis. Vermont's decision to focus on the identification and treatment of chronic illnesses appears to be an excellent way to combat rising health care costs. Massachusetts and Maine have developed plans promoting cooperation between government, individuals, and business.

1. *Mandatory Health Insurance for All Residents*

Massachusetts's mandate requiring health insurance has been hailed as an excellent innovation because it may help lower health care costs. An editorial from the New York Times gave credit to Massachusetts for creatively addressing the problem at the state level.¹⁸⁵ The editorial noted that many uninsured individuals

183. ELIZABETH C. MCNICHOL & IRIS J. LAV, CTR. FOR BUDGET & POLICY PRIORITIES, 13 STATES FACE TOTAL BUDGET SHORTFALL OF AT LEAST \$23 BILLION IN 2009; 11 OTHERS EXPECT BUDGET PROBLEMS 1-2 (2007), available at <http://www.cbpp.org/12-18-07sfp.pdf>.

184. *Id.* at 3.

185. Editorial, *Mandatory Health Insurance*, N.Y. TIMES, Apr. 15, 2006, at A12, available at http://www.nytimes.com/2006/04/15/opinion/15sat1.html?_r=1&oref=slogin.

get health care in emergency rooms, but by forcing all individuals to obtain coverage, this “free rider” problem can be greatly reduced.¹⁸⁶ Similarly, Princeton University Professor Uwe E. Reinhardt applauded Massachusetts’s mandate because it moved away from the traditional American health care system, which allowed people “freedom to mooch” health care services from the government.¹⁸⁷ Even the conservative-leaning Heritage Foundation¹⁸⁸ offered support for the Massachusetts individual mandate. Noting that the mandate is “less problematic” than many conservatives realize, the Foundation observed that individuals can satisfy the mandate by purchasing only catastrophic coverage that will make health insurance more affordable to everybody.¹⁸⁹

2. *Chronic Care Initiatives Can Be Implemented*

It is unquestioned that prevention and treatment of chronic diseases will improve the American health care system,¹⁹⁰ and Vermont’s health care initiative is taking a positive step to solve that problem. Vermont specifically targeted chronic illnesses with its Blueprint for Health system to improve the health care system.¹⁹¹ Improving the prevention and treatment of chronic illnesses and providing preventative services illustrate an innovative approach to improve the state’s health care problems. While those ideas alone may not independently solve Vermont’s health care problems, the plan marks the first step towards enhancing the health care received by Vermonters and hopefully individuals across the nation.

3. *Effective Cooperation Between Businesses, Government, and Private Citizens*

The Massachusetts plan creates a novel responsibility-sharing system between businesses, individuals, and government to provide health insurance to its citizens.¹⁹² By requiring every citizen to obtain health insurance, the Massachusetts plan takes a giant leap forward in its attempt to rectify the state’s substantial health care problems by requiring individual responsibility for health care coverage. In addition, the formation of the Connector may establish the critical link between private health insurance companies, small businesses, and individual consumers

186. *Id.*

187. Fahrenthold, *supra* note 119.

188. The Heritage Found., <http://www.heritage.org/about> (last visited Apr. 7, 2008).

189. Robert E. Moffit & Nina Owcharenko, Heritage Found., *Understanding Key Parts of the Massachusetts Health Plan* (Apr. 20, 2006), <http://www.heritage.org/Research/HealthCare/wm1045.cfm>.

190. Press Release, Partnership to Fight Chronic Diseases, National Bipartisan Coalition Forms to Make Chronic Disease the Key Health Care Issue in 2008 Presidential Election (May 15, 2007), available at <http://www.gwu.edu/~action/2008/interestg08/pfcd051507pr.html>.

191. Act of May 25, 2006, No. 191, § 4, 2006 Vt. Acts & Resolves 455, 457.

192. TANNER, *supra* note 125, at 1.

that permits the acquisition of affordable health insurance by every individual. Massachusetts's health care plan is the first of its kind in the nation and received near-unanimous support in the state legislature.¹⁹³ The plan has been lauded as a visionary blend of liberal and conservative principles, and it also has the strong support of the business community.¹⁹⁴

Maine's Dirigo Health Program is an excellent contrast to the Massachusetts plan because it attempts to address a similar health care coverage problem using a different and less expansive strategy. Maine's program requires businesses to contribute resources to the health care system, making health care more affordable to lower-middle class and middle class individuals.¹⁹⁵ It also establishes comprehensive and affordable health care coverage for all its citizens.¹⁹⁶

B. The Federal Government Can Observe the Implementation of State Plans and Avoid the Negative Consequences of Such Plans

State health care initiatives are not flawless. Maine has struggled to increase health care coverage under a system of voluntary participation.¹⁹⁷ Meanwhile, many issues have been raised about Massachusetts's system mandating that all individuals participate by acquiring health coverage.¹⁹⁸ State health care plans have also increased government bureaucracy, which may reduce the effectiveness and appeal of those plans on the national level.¹⁹⁹ By observing the implementation of state plans, the federal government can avoid implementing the negative parts of those plans that would derail or limit the success of national health care reform.

1. Struggle with Voluntary Coverage

Federal health care reform may be difficult to implement if it requires the voluntary participation of individuals and businesses. Maine has had difficulty in attracting businesses to voluntarily participate in its DirigoChoice program.²⁰⁰ In May 2006, sixteen months after the program began, less than 10,000 individuals were enrolled, and only 5,000 of those individuals previously lacked health

193. Fahrenthold, *supra* note 119.

194. Symonds, *supra* note 123.

195. ME. REV. STAT. ANN. tit. 24-A, § 6910(4)(B)(4) (Supp. 2006).

196. *Id.* § 6902.

197. *Id.*; Pam Belluck, *Maine Learns Expensive Lesson as Universal Health Plan Stalls*, N.Y. TIMES, April 30, 2007, at A1.

198. Symonds, *supra* note 123.

199. *Cf.* Lynda Gledhill, *Assembly Approves Universal Health Care*, S.F. CHRON., Aug. 29, 2006, at A1 (discussing the republican opposition at the state level of a universal health care bill for fear that it creates an "inefficient government bureaucracy").

200. Clarke Canfield, *Dirigo Health Not Attracting Businesses*, BOSTON.COM, May 27, 2006, http://www.boston.com/news/local/maine/articles/2006/05/27/dirigo_health_not_attracting_businesses/.

insurance.²⁰¹ The primary reason for this shortfall is the inability of DirigoChoice to enroll businesses and their employees.²⁰² Business owners believe their failure to choose DirigoChoice is a business decision because the cost of offering DirigoChoice to their employees is greater than buying insurance through a private plan.²⁰³ DirigoChoice also provides fewer health care options for employees.²⁰⁴ Mark Baldwin, owner of a Maine greeting card company, stated, “[t]he Dirigo policy wasn’t as good for our employees . . . I’m just looking for something comparable [to private health insurance] and they didn’t have it.”²⁰⁵

The high rate of subsidies for low-income individuals²⁰⁶ has created a financial dilemma for DirigoChoice that would need to be addressed by federal reform plans. Four out of five enrollees receive subsidies from the state to make DirigoChoice affordable for them, and forty-six percent of enrollees are receiving an eighty percent discount on their coverage, which is more than the state originally expected.²⁰⁷ With the high cost of providing coverage to the poor, DirigoChoice is unable to lower premiums to attract small business owners to the plan.²⁰⁸ The recruitment of more businesses to the plan, however, would help drive down the cost of DirigoChoice.²⁰⁹ Stuck in this predicament, Governor John Baldacci believes that attracting small businesses is the best way to sustain the Dirigo Health program while insuring low income residents.²¹⁰

2. *Unknown Consequences of Mandating Health Care Coverage*

A federal mandate requiring all citizens to acquire health care coverage would be an unprecedented form of government action.²¹¹ As stated by the Congressional Budget Office (CBO), “[t]he government has never required people to buy any good or service as a condition of lawful residence in the United States.”²¹² This individual mandate would also be unique because it would impose a duty on people as members of American society.²¹³ According to the CBO, the only existing

201. *Id.*

202. *Id.*

203. *Id.*

204. *Id.*

205. *Id.*

206. *Id.*

207. *Id.*

208. *Id.*

209. *Id.*; accord Belluck, *supra* note 197.

210. Canfield, *supra* note 200.

211. CONG. BUDGET OFFICE, THE BUDGETARY TREATMENT OF AN INDIVIDUAL MANDATE TO BUY HEALTH INSURANCE 1 (1994), available at <http://www.cbo.gov/ftpdocs/48xx/doc4816/doc38.pdf>.

212. *Id.*

213. *Id.*

federal mandate applying to individuals is the requirement that young men register with the Selective Service System.²¹⁴

The Massachusetts plan imposes a severe restriction on an individual's freedom of personal choice that the federal government may not want to impose on all Americans. Every resident of Massachusetts, whether desiring health coverage or not, will be forced to acquire health insurance through an employer, a government plan, or an individual purchase.²¹⁵ Unless an individual has a religious objection to health insurance, he or she does not have the discretion to forego health insurance without penalty.²¹⁶ Though the plan presents a restriction of individual liberty, the Massachusetts plan does not impose criminal penalties for failing to obtain health insurance.²¹⁷ Thus, an individual could avoid acquiring health insurance and instead choose to pay the monetary penalty imposed by Massachusetts for the failure to obtain insurance.²¹⁸

The federal government would have to consider differences between mandating health insurance coverage and states' current insurance requirements regarding automobiles. Governor Romney likened the Massachusetts plan to the state's requirement that all drivers buy auto insurance;²¹⁹ however, two main differences exist between auto insurance and the mandatory health insurance mandate. First, individuals can choose not to drive if they are opposed to the auto insurance mandate.²²⁰ The government only requires individuals who drive cars to obtain insurance; the government does not require every individual to obtain auto insurance as it does with health insurance.²²¹ Second, states require auto insurance for the protection of others and not for the protection of the person purchasing the insurance.²²² Like most states, Massachusetts does not require individuals to purchase auto insurance to cover their own injuries or repair costs.²²³

3. *Increased Government Bureaucracy*

Based on the experience of numerous states, the federal government must be prepared to accept increased government bureaucracy when implementing health care reform. For example, though the Massachusetts health care plan has received

214. *Id.* at 2.

215. Acts of April 12, 2006, ch. 58, § 12(2)(a), 2006 Mass. Acts 64, 77; TANNER, *supra* note 125, at 3.

216. § 12(2)–(3), 2006 Mass. Acts at 77.

217. *See* § 12(2)(b), 2006 Mass. Acts at 77; TANNER, *supra* note 125, at 5 (noting that the penalties for failure to obtain insurance are loss of the personal exemption from state income tax and a fine equal to fifty percent of the cost of a standard health insurance policy).

218. TANNER, *supra* note 125, at 5.

219. *Id.* at 4.

220. *Id.*

221. *Id.*

222. *Id.*

223. *Id.*

praise from across the political spectrum, it has been criticized for vastly increasing the scope of government regulation in health care coverage.²²⁴ The Cato Institute claims that the Connector, praised by advocates as a state-managed clearinghouse for insurance coverage, is instead a “form of managed competition . . . within an artificial government-designed and government-controlled marketplace” and will “become a monopoly purchaser of health insurance.”²²⁵ In contrast to proponents of managed competition, the Institute says that managed competition reduces the ability of insurers to compete against each other for the best price and results in a reduction of care for sick individuals who need the most treatment.²²⁶ In addition, the Massachusetts health care plan creates an additional ten new organizations to monitor and improve the state’s health care system, supporting the Institute’s criticism that the plan relies too heavily on government to deliver affordable health care coverage.²²⁷ The federal government may discover that Massachusetts-style health care reform does not require more government bureaucracy and adjust its reform accordingly.

Health care reform measures passed in other states also require an increase in government bureaucracy. Maine’s health care plan created Dirigo Health, an independent government agency, to implement the state’s health care initiatives.²²⁸ Vermont’s attempt at health care reform requires the creation of a state-wide information database, Blueprint for Health,²²⁹ and Catamount Health, which requires insurers to offer a health coverage plan detailed by the state.²³⁰ Even Maryland’s “Wal-Mart” legislation created a Maryland Medical Assistance Program and granted new duties concerning information and money collection to the State Treasurer, Comptroller, and Secretary of Labor, Licensing and Regulation.²³¹

C. After Observing These Innovations and Problems, the Federal Government Can “Cherry-Pick” the Best Elements of State Plans

Because every state health care initiative has weaknesses, the federal government should closely observe the implementation of state health care reforms. By observing the plans’ structure and implementation, the federal government can avoid the negative consequences of state plans and choose only their best elements.

224. *See id.* at 3.

225. *Id.* at 8–9.

226. *Id.* at 9.

227. *Id.* at 10.

228. Maine.gov, Frequently Asked Questions & Glossary of Dirigo Health Terms, <http://www.dirigohealth.maine.gov/dhsp01d.html> (last visited Apr. 8, 2008).

229. *See supra* notes 150–51 and accompanying text.

230. Sneyd, *supra* note 144.

231. Fair Share Health Care Fund Act, ch.1, 2006 Md. Laws 1, 1–2, *invalidated by* Retail Indus. Leaders Ass’n v. Fielder, 435 F. Supp. 2d 481 (D. Md. 2006), *aff’d*, 475 F.3d 180 (4th Cir. 2007).

2008 Presidential candidate Senator Joseph Biden (D-DE) spoke about why states should take the lead in health care reform during an April 2007 speech. He stated:

I think the thing that will get us to total health coverage—health insurance for everybody the quickest—is to do what we did on welfare reform. What we did was we allowed the states considerable flexibility and leeway in reorganizing the system and we underwrote the cost of the poor states doing it to get work programs going. Do the same exact thing with health care. You have a dozen states, including big ones, that are now passing legislation requiring universal insurance, just like liability insurance. Once you get to a critical mass of 30 to 35 states, you've established a national consensus. *Cherry-pick those elements of the plans.* Maybe even give them localized flavor rather than one simple standard that exists that require that there be total coverage across the board.²³²

Senator Biden's idea to "cherry-pick" the best elements of state plans is the best way to achieve successful long-term health care reform. Massachusetts, Maine, Vermont, and Maryland provide a few examples of states experimenting with health care coverage. Once these plans are implemented and observed, the federal government may determine that Vermont's decision to treat chronic conditions is a breakthrough that should be replicated nationwide. Alternatively, the federal government may see that Vermont's plan offers little benefit in exchange for a huge investment of time and money. Either way, additional state experimentation will lead to the best solution to the national health care crisis. As stated by Alan Weil, executive director of the National Academy for State Health Policy, "change at the state level is the most promising hope for healthcare reform."²³³

D. *State Health Care Initiatives Have Already Impacted The National Health Care Debate*

Various state health care proposals have already impacted the health care debate among 2008 Presidential candidates. Several candidates unveiled health care plans including a Massachusetts-style individual mandate that all individuals obtain health insurance.²³⁴ In fact, the issue of whether to impose a health care mandate was the largest domestic policy difference among the leading Democratic

232. Joseph Biden, Senator (D-Del.), quote from Speech in New Hampshire (Apr. 14, 2007) (on file with The Journal of Health Care Law & Policy) (emphasis added).

233. KMPG, FLASHPOINT: HEALTHCARE REFORM INITIATIVES 8 (2007), available at <http://www.kpmginsiders.com/pdf/FlashpointSept2007.pdf>.

234. Hillary for President, American Health Choices Plan: Quality, Affordable Health Care for Every American (n.d.), <http://www.hillaryclinton.com/feature/healthcareplan/americanhealthchoicesplan.pdf>; John Edwards08, Universal Health Care Through Shared Responsibility (n.d.), <http://johnedwards.com/about/issues/health-care-overview.pdf>.

Presidential candidates.²³⁵ Certain candidates also stressed the importance of creating a system to better prevent and treat chronic illnesses, as Vermont's chronic care database has done.²³⁶ State health care initiatives are already influencing the national health care debate and will continue to inform federal policy makers about the best options for national health care reform.

1. *The Individual Mandate*

Numerous 2008 Presidential candidates included a Massachusetts-style government mandate as a key component of their health care plan.²³⁷ Former Senator John Edwards (D-NC) introduced a plan that would have forced all individuals to acquire health care coverage.²³⁸ Senator Edwards stressed that his plan "is based on the principle of shared responsibility: businesses, families and government must each do their part" to achieve a better health care system.²³⁹ Sound familiar? Edwards admits that his plan bears a resemblance to the Massachusetts health care initiative.²⁴⁰

Similarly, Senator Hillary Clinton (D-NY) introduced a health care plan mandating that all individuals have health care coverage.²⁴¹ In analyzing Senator Clinton's health care plan, some observers have noted that there are similarities between Massachusetts's health care reform and Senator Clinton's proposal.²⁴² For example, one journalist asserted that "[k]ey elements of Hillary Clinton's healthcare proposal are strikingly similar to the tenets of the health overhaul that Mitt Romney signed into law in Massachusetts last year."²⁴³ The journalist further noted that the Clinton plan's central premise—an individual mandate—is precisely what was enacted in Massachusetts, and the plans also share the common theme of building upon the existing employer-based health care system rather than switching

235. Michael Levenson & Susan Milligan, *Obama, Clinton Clash Over Social Security, Healthcare, Electability*, BOSTON GLOBE, Feb. 4, 2008, at A10.

236. Chris Dodd for President, *Health Care for All: The Dodd Plan*, <http://chrisdodd.com/node/1924> (last visited Apr. 8, 2008); Brian C. Mooney, *N.H. Democrats, GOP Sharply Divided on Healthcare Differences Stark on Government's Role, Poll Finds*, BOSTON GLOBE, Dec. 26, 2007, at A20.

237. In addition to the candidates mentioned in this section, New Mexico Governor Bill Richardson and Connecticut Senator Chris Dodd support mandatory health care coverage for all Americans. Bill Richardson for President, *Issues: Health Care*, <http://www.richardsonforpresident.com/issues/healthcare> (last visited Apr. 8, 2008); Chris Dodd for President, *supra* note 236.

238. John Edwards08, *supra* note 234.

239. *Id.*

240. Dan Balz, *Edwards Introduces Plan for Health-Care Coverage*, WASH. POST, Feb. 6, 2007, at A3.

241. Hillary for President, *supra* note 234, at 1–2.

242. *E.g.*, Lisa Wangness, *In Ways, Clinton Health Care Plan Resembles Romney's Mass. Solution*, BOSTON GLOBE, Sept. 18, 2007, at A8.; Jennifer Liberto, *Romney Says Mass. Health Reforms not 'HillaryCare'*, ST. PETERSBERG TIMES (Florida), Nov. 28, 2007, at 19A.

243. Wangness, *supra* note 242.

to government-run health care.²⁴⁴ MIT Economics professor Jonathan Gruber, an advisor to Romney, remarked, “What Hillary proposed is in many ways the Massachusetts plan gone national, and I think that’s great.”²⁴⁵

2. *Chronic Illnesses & Emphasis on Prevention*

The 2008 Presidential candidates also focused on preventing and treating chronic illnesses, just as Vermont has done, to lower the cost of health insurance. Senator Chris Dodd (D-CT) supported a health care plan focusing on “chronic disease management and preventative measures.”²⁴⁶ To treat and prevent chronic illnesses, he proposed an integrated system of disease management using innovative methods that involve new technology and increased coordination between providers.²⁴⁷ In the same way, former Governor Mike Huckabee (R-AR) supported aggressive action to improve the preventative care system.²⁴⁸ He emphasized that treating chronic disease composes eighty percent of the nation’s health care costs and discussed his belief that the nation must focus on preventative health care.²⁴⁹ Though neither candidate specifically modeled their chronic care initiative on the new Vermont plan, Vermont’s initiative is causing leaders to look at ways to address the extremely high cost of treating chronic illnesses.²⁵⁰

E. *Amending ERISA Would Allow for Further State Experimentation*

While state experimentation has produced positive results, ERISA is restraining states from developing more productive solutions to the health care crisis. The illegality of Maryland’s Fair Share Act once again gave notice to the federal government that state initiatives cannot fully experiment with health care reform without significant legal changes.²⁵¹ ERISA impaired Maryland’s attempt at health care reform and will continue to impair other state initiatives.²⁵² Discussing

244. *Id.*

245. *Id.*

246. Chris Dodd for President, *supra* note 236.

247. *Id.*

248. Mooney, *supra* note 236.

249. *Id.*; On The Issues, Mike Huckabee on Health Care, www.ontheissues.org/2008/Mike_Huckabee_Health_Care.htm (last visited Apr. 13, 2008).

250. *Vermont Selected to Examine Ways to Create Secure National Health Information Network*, U.S. STATE NEWS, May 23, 2006, available at 2006 WLNR 8971890. This article discusses how Vermont was awarded a large research grant in 2006 from the National Governors Association (NGA) in part based on the success of its Chronic Care initiative. *Id.* Ironically, the chairman of the NGA in 2006 was Arkansas Gov. Mike Huckabee. *Id.*

251. *See supra* Part III.D.

252. *E.g.*, Michael S. Sparer, Commentary, *Great Expectations: The Limits of State Health Care Reform*, 14 HEALTH AFF. 191, 192 (1995); Ben Arnoldy, *State and City Healthcare Reform Collide with a U.S. Law*, CHRISTIAN SCIENCE MONITOR, Sept. 27, 2007, at 3 (describing ERISA as a law that limits “the abilities of state legislatures to serve as laboratories for healthcare solutions”).

the need for federal action, Yale University professor Jacob Hacker noted that “states will not be able to deal with this [health care] problem alone; they will need not just federal financial support, but also changes in laws.”²⁵³

Specifically, the federal government should amend ERISA to allow states to more broadly experiment with various health care innovations. Alan Weil, executive director of the National Academy for State Health Policy, noted that ERISA is a roadblock to state health care reform.²⁵⁴ To avoid conflict with ERISA, Weil suggested three approaches that could give states flexibility in creating health care solutions. The federal government could create safe harbors within ERISA for state innovation, develop a waiver process giving states control over health care reform despite ERISA restrictions, or amend ERISA directly.²⁵⁵ Implementing these suggestions would loosen federal restrictions on state experimentation, allowing innovative states to continue to develop comprehensive health care solutions for their residents.

CONCLUSION

The wisest and most practical approach to solve the national health care crisis is for states to continue developing innovative health care solutions. With federal policy-makers unable to agree on a solution, states have been, and will continue to, act as “laboratories of democracy” by implementing health care reform plans that function successfully. Though ERISA limitations and state balanced budget requirements have hindered state experimentation efforts, states have nonetheless developed innovative health care reforms.²⁵⁶ After observing how these innovative solutions operate, the federal government can adopt similar ideas for the nation without suffering the negative consequences that may plague certain state initiatives. Changes to ERISA would give states even more flexibility to act as laboratories and speed the development of innovative health care solutions. These steps will allow the federal government to implement a long-term health care strategy that will help the nation with the top-ranked world economy put forth a top-ranked health insurance plan for all Americans.

253. Leif Wellington Haasa, The Century Found., The Century Forum: Universal Health Insurance and the States (2007), <http://www.tcf.org/Publications/HealthCare/qauniversal.pdf>.

254. KMPG, *supra* note 233, at 8–9.

255. *Id.* at 9. An in-depth discussion regarding possible amendments to ERISA is possible, but such a discussion is complex and outside the scope of this paper.

256. *See supra* Parts IV, V.A.

