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Breaking through the ERISA Blockade: The Ability of States to Access Employer Health Plan Information in Medicaid Expansion Initiatives

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Introduction

Since the enactment of the State Children's Health Insurance Program (SCHIP) in 1997, some states, like Wisconsin, have expanded health coverage to low-income families through publicly sponsored health insurance. This expansion has caused some concern among state leaders that employer-sponsored health insurance is being replaced or "crowded out" by the new public programs. Although some health advocates may view crowd out as an avenue toward universal public health insurance, many other stakeholders prefer fostering the current public-private provision of health care at the state level. If that preference represents current political inclinations, then states must find ways to balance public and private health coverage to ensure universal access to health insurance without going broke.

One important element to ensure a balance in public-private health coverage lies in state access to employer health plan information. Without employer health plan information, states will find it difficult to assess crowd out, coordinate with private entities, and assure that those in publicly sponsored programs truly have no access to employer-sponsored health insurance. Unfortunately, federal preemption of state regulation of employer benefit plans through the Employment Retirement Income Security Act (ERISA) of 1974 creates a significant barrier for states to get complete employer or "ERISA" health plan information. Using Wisconsin's Medicaid expansion program,

† J.D. (University of Wisconsin, 2001), M.P.H. (University of Michigan, 1996), 2001 Skadden Fellow. I would like to thank Louise G. Trubek for her fervent support, invaluable insight, and for inspiring me to write in the health law field. I am also indebted to my husband, Kevin Lodholz, for his continued support and his critical attention to detail.

BadgerCare, as a primary example, this paper offers three legal arguments that states could use to require employers to provide states with health plan information.

To effectively make these arguments, this paper consists of several parts. Part I of this paper provides a brief discussion of Medicaid expansion programs, with a particular focus on the Wisconsin BadgerCare program, and the trend toward state-based solutions that emphasize public-private partnerships in expanding health coverage. Part II of this paper explores how the Wisconsin BadgerCare verification process attempts to access employer health plan information and how traditional thinking of ERISA preemption may thwart those efforts. Part III of this paper presents three legal arguments favoring state access to employer health plan information, despite current ERISA preemption thought. These arguments include ERISA preemption exceptions relating to "other federal law," Qualified Medical Child Support Orders (QMCSOs), and Title XIX. Finally, this paper concludes with a discussion on how, given the current trends in managed care organization (MCO) and provider involvement with Medicaid, state access to employer health plan information may be the best solution at this time to ensure seamless health insurance coverage for everyone.

I. Of Partnership and Not Displacement – A Look At BadgerCare Design and Current Trends in Public and Private Health Coverage

The origins of Medicaid expansion programs like BadgerCare can be traced back to welfare reform under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).[1] PRWORA replaced Aid to Families with Dependent Children (AFDC), an entitlement program for low-income families, with Temporary Assistance for Needy Families (TANF), a non-entitlement cash assistance program, to encourage low-income individuals to find jobs and become self-sufficient.[2] The

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[1] Louise G. Trubek, *The Health Care Puzzle, in* HARD LABOR: WOMEN AND WORK IN THE POST-WELFARE ERA (Joel F. Handler & Lucie White eds. 1990) 143, 148.

[2] COIMBRA SIRICA, MILBANK MEMORIAL FUND, THE ORIGINS AND IMPLEMENTATION OF BADGERCARE: WISCONSIN'S EXPERIENCE WITH THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) 6 (Jan. 2001), *available at* http://www.milbank.org/010123badgercare.html (last visited Jan. 31, 2001).

premise behind BadgerCare was to provide public health insurance for former AFDC families so that they would not be discouraged from entering the job market, which may lack health insurance for low-skill, entry-level work.[3] As a result, Wisconsin leaders wanted to expand Medicaid to cover low-income working parents, as well as their children.[4] Wisconsin leaders got their wish with the passage of SCHIP (or Title XXI) in 1997, which provided Wisconsin with $39 million in federal funds in 1998 to expand health insurance to children.[5] To achieve the goal of covering low-income working parents of those children, Wisconsin submitted a waiver, eventually approved by the federal Health Care Financing Administration (HCFA) in 1999, to allow the Wisconsin BadgerCare program to cover low-income working parents up to 185% of the Federal Poverty Level (FPL) using Medicaid (Title XIX) funds.[6] In January 2001, HCFA granted another waiver to allow BadgerCare coverage for parents using SCHIP funds, allowing Wisconsin to claim approximately $6 million more in federal funds per year due to the higher federal match rate under SCHIP.[7]

With initial BadgerCare funding secured, the program was launched in July 1999, offering the same comprehensive benefits

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[3] Trubek, *supra* note 1, at 149. *But see* Sharon Dietrich et al., *Symposium: Work Reform: The Other Side of Welfare Reform*, 9 STAN. L. & POL'Y REV. 53, 53-54 (Winter, 1998) (noting that while some former welfare recipients have no prior work history, others have had "significant employment" and receive public assistance because of their low wages).

[4] Trubek, *supra* note 1, at 148-49; SIRICA, *supra* note 2, at 3-4.

[5] SIRICA, *supra* note 2, at 6.

[6] *Id.* at 7. Note that traditionally, Wisconsin's Medicaid program covered nondisabled custodial parents "only if they did not earn more than 55% of the federal poverty level." *Id.* Fifty-five percent of the federal poverty level (FPL) amounts to $648.45 per month for a family of three. RACHEL CARABELL AND RICHARD MEGNA, WIS. LEGISLATIVE FISCAL BUREAU, MEDICAL ASSISTANCE AND BADGERCARE – INFORMATIONAL PAPER #43, 4 (Jan. 2001) (multiplying the 2000 FPL monthly amount of $1,179 for a family of three by 55% to arrive at the 55% FPL amount). Under BadgerCare, parents with incomes up to 185% of the FPL are eligible for public health insurance benefits, which amounts to $2,181 in monthly income, using the 2000 FPL standards. *Id.* at 58. HCFA granted Wisconsin's waiver request with the condition that Wisconsin would be allowed to implement an "enrollment trigger," thereby reducing the income limit of 185% should BadgerCare become too expensive for the State to operate. SIRICA, *supra* note 2, at 8.

[7] Press Release, Wis. Dept. of Health and Family Services, *Governor Announces New Waiver for BadgerCare, at* http://www.dhfs.state.wi.us/news/pressreleases/BadgerCare Waiver.htm (last revised July 31, 2001). Under Medicaid, the federal match rate for Wisconsin is for approximately 59% of the state's costs, whereas under SCHIP, the federal match rate is approximately 71%. CARABELL & MEGNA, *supra* note 6, at 60.

to enrollees as the Wisconsin Medicaid program.[8] Since the program's inception, enrollment has skyrocketed. As of December 2000, 51,994 adults and 22,667 children were enrolled in BadgerCare.[9] This higher than expected growth, particularly with adult enrollment,[10] caused concern among some state leaders about employer-sponsored health insurance crowd out.[11] Medicaid expansion programs created under SCHIP, such as BadgerCare, were not intended to supplant employer-sponsored insurance.[12] In fact, the Title XXI legislation required states that were developing Medicaid expansion programs using SCHIP funds to submit a plan that described how the program would "not substitute for coverage under group health plans."[13]

Wisconsin designed BadgerCare to prevent crowd out of group health plans (i.e., employer-sponsored plans) by imposing the following eligibility limits on applicants to the program: (a) during the three months prior to applying, the applicant must have been without health insurance[14]; (b) the applicant must

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8 SIRICA, *supra* note 2, at 15 (indicating that "Medicaid recipients in Wisconsin receive one of the nation's most comprehensive benefits packages," including coverage for "medical social workers and chiropractors, nurse midwives, podiatrists, dentists, and optometrists as well as respiratory care and hospice care services").

9 CARABELL & MEGNA, *supra* note 6, at 61.

10 JON PEACOCK, WIS. COUNCIL ON CHILDREN AND FAMILIES, WIS. BUDGET PROJECT, BADGERCARE COMING OF AGE: PROMISE AND REALITY 14 (2000) (noting that "original projections anticipated a ratio of 1.7 parents in BadgerCare for each child enrolled, but the current ratio is 2.6 adults to each child"). This higher ratio of adults to children causes the program to be more expensive than anticipated, since adults are more costly to treat than children and the federal reimbursement rate under Medicaid, which is the funding program used to cover adults, is less than the reimbursement rate for children under SCHIP. *Id.* However, it should be noted that the newly approved waiver, discussed in the text above, will allow Wisconsin to cover some adults at the higher reimbursement rate, reducing some of the costs associated with the higher than expected adult enrollment. Press Release, *supra* note 7.

11 *See, e.g.*, Patricia Simms, *Fewer Insured by Employers – A Major Drop Could be Threat to BadgerCare*, WIS. STATE J., Sept. 26, 2000, at 1B (quoting Wisconsin's Department of Health and Family Services (DHFS) Secretary Joe Leean as saying crowd out "would be the fastest thing that could destroy the BadgerCare program," and State Representative John Gard (R-Peshtigo) as believing that BadgerCare is becoming "government-run health care for everybody").

12 John V. Jacobi, *Medicaid Expansion, Crowd-Out, and Limits of Incremental Reform*, 45 ST. LOUIS U. L.J. 79, 97 (2001).

13 42 U.S.C. § 1397bb(b)(3)(C) (2000). "Group health plan" is defined as "an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1002(1)] to the extent that the plan provides medical care . . . to employees or their dependents . . . directly or through insurance, reimbursement, or otherwise." 42 U.S.C. § 300gg-91(a)(1) (2000).

14 WIS. ADM. CODE § 103.03(1)(f)(2) (2000). It should be noted that the Governor's 2001-03 biennial budget for DHFS requires DHFS to submit a waiver to HCFA "to

not have current access to employer-sponsored health insurance for which the employer pays at least 80% of the cost of the plan (excluding any cost-sharing requirements by the applicant)[15]; and (c) for the preceding eighteen months prior to applying for BadgerCare, the applicant must not have had access to employer-sponsored health insurance.[16] Furthermore, applicants who have access to an employer-sponsored health plan that pays between 60% and 80% of the cost of the group plan may be eligible for BadgerCare through the Health Insurance Premium Payment (HIPP) program.[17] The HIPP program allows Wisconsin to buy into the employer-sponsored health plan if such buy-in proves to be more cost-effective than covering the low-income family solely in the BadgerCare program.[18] The HIPP program advances Wisconsin's plan to not displace employer-sponsored health insurance. Specifically, in addition to the cost-saving goal, the HIPP program has the goal of acclimating working families to the idea of receiving health benefits through their employer, not the government.[19]

California has also enacted legislation to limit crowd out by imposing "legal obligations on employers and insurers to not alter their coverage policies in response to SCHIP."[20] One component of the California legislation prohibits employers from modifying (i.e., reducing) employee health benefits to en-

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increase the time a person must be without insurance coverage prior to applying for BadgerCare from three to six months in the majority of cases." SUMMARY OF HIGHLIGHTS OF 01-03 BIENNIAL BUDGET FOR DHFS 9 (Mar. 7, 2001), *available at* http://www.dhfs.state.wi.us/aboutDHFS/OSF/BudgetSum030701.pdf.

15 WIS. ADM. CODE HFS § 103.03 (2000). Employer-sponsored health insurance is clarified to mean "family" coverage, thereby allowing those employees who may have access to employee-only health insurance through their employer to still be eligible for BadgerCare. *See* WIS. ADM. CODE § 103.03(1)(f)(3) (2000).

16 WIS. STAT. § 49.665(4) (2000).

17 WIS. ADM. CODE HFS § 108.02(13) (2000).

18 *Id. See also* Interview with Don Schneider, Chief of Coordination of Benefits Section, DHFS, in Madison, Wis. (Feb. 23, 2001) (noting that cost-effectiveness is based upon the cost of a BadgerCare participant enrolled in a managed care plan compared to the cost of the wraparound coverage and extra administrative costs provided in the HIPP program). The HIPP program pays the wraparound costs of the employer plan so that the HIPP enrollee receives the same benefits as they would under straight BadgerCare. *Id.* As of the end of February 2001, approximately thirty-four families were enrolled in the HIPP program, mostly with smaller employers. *Id.*

19 Interview with Don Schneider, *supra* note 18.

20 AMY WESTPFAHL LUTZKY & IAN HILL, THE URB. INST., HAS THE JURY REACHED A VERDICT? STATES' EARLY EXPERIENCES WITH CROWD OUT UNDER SCHIP, OCCASIONAL PAPER # 47, 14 (2001).

courage employees and their families to enroll in the state SCHIP program, *Healthy Families.*[21]

Despite the efforts of Wisconsin and other states to limit crowd out, researchers have noted that as states expand Medicaid programs to working families at higher income levels, targeting the truly uninsured becomes more difficult "because there is more employer-sponsored coverage at higher incomes that could be displaced or 'crowded out.'"[22] Consequently, state access to employer health plan information is critical to successfully targeting those low-income families with no access to health insurance, as opposed to families who have access to employer-sponsored health insurance but who may also prefer the reduced cost-sharing levels and more comprehensive benefits of public programs.[23]

Some health policy workers support the provision of public insurance to people with access to employer insurance, since the employer plan may be unaffordable; the public program therefore fulfills a societal need by providing health insurance to those who could not otherwise afford health coverage on their low income.[24] However worthy that goal is, this author believes that providing health insurance to those with access to employer-sponsored coverage ignores the intent of programs like BadgerCare, which was not to displace employer-sponsored coverage.

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21 *Id.*

22 LISA DUBAY ET AL., THE URB. INST. NEW FEDERALISM PROGRAM, EXTENDING MEDICAID TO PARENTS: AN INCREMENTAL STRATEGY FOR REDUCING THE NUMBER OF UNINSURED 2 (2000).

23 Interview with Angela Dombrowicki, Director, Bureau of Managed Health Care Programs, DHFS, in Madison, Wis. (Nov. 3, 2000) (noting that the benefits under BadgerCare are more comprehensive than those offered under private insurance plans). *See also* Interview with Bill Smith, State Director, National Federation of Independent Businesses, in Madison, Wis. (Nov. 14, 2000) (indicating that BadgerCare enrollees get a much better deal and much better cost [with respect to health insurance] than those who have the typical plans offered by small business employers). In fact, most low income people are covered by employer-based health insurance. *See, e.g.*, Louise G. Trubek, *Health Care and Low-Wage Work: Linking Local Action,* Paper prepared for the conference on Reconfiguring Work and Welfare in the New Economy: A Transatlantic Dialogue, 6 (May 2001) (on file with author) (indicating that "fifty-one percent of low-income people are covered by employer-based health insurance, thirty-five percent are covered by public programs such as Medicaid, and fifteen percent are uninsured").

24 *See, e.g.*, Interview with Don Schneider, *supra* note 18 (explaining that the crowd out concern depends on how one defines the goal of BadgerCare, which if defined as providing health coverage to poor people, then those who are enrolling in the program despite having access to employer health insurance are achieving the program's coverage goal).

More importantly, however, current public sentiment and limited state dollars essentially require those who desire at least minimal health coverage for everyone, to preserve and foster employer-sponsored health insurance. For example, the National Governor's Association (NGA) recently adopted a bipartisan policy that aims to provide "some access to basic health care for everyone, rather than a rich plan of health benefits for just a small group of people."[25] The NGA policy supports combining Medicaid with private health insurance and allowing states to use Medicaid money to pay for portions of employer health premiums,[26] similar to Wisconsin's HIPP program under BadgerCare. In addition, according to a recent national survey of workers' health insurance, 85% of the surveyed adults preferred that the government assist low-income families in affording employer-sponsored health insurance, rather than establishing new or expanding existing government programs to provide health coverage.[27]

This public sentiment is reflective of two major shifts in health care policy and administration: the movement from federal-based solutions down to the states, and the movement from government-based programs to private ones. The federal government has encouraged state experimentation with public-private coordination to expand health coverage through federal waivers and new grant programs. Particularly since 1993, the federal government has permitted more state diversity in federally funded programs such as Medicaid by granting waivers to accommodate state experimentation.[28] "The development of relatively easy waivers to obtain significant amounts of federal funding from both Medicaid and SCHIP has allowed the states to develop their own unique health care coverage programs."[29] These state

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[25] Robert Pear, *Governors Offer 'Radical' Revision of Medicaid Plan: Increasing Costs Cited – More People Would Be Insured, but the Package of Benefits Would Be More Modest*, N.Y. TIMES, Feb. 25, 2001, at A1.

[26] *Id.* It should be noted that President George H. W. Bush, in response to the NGA policy, indicated that he would be "more attentive and responsive to the states." *Id.*

[27] CATHY SCHOEN ET AL., THE COMMONWEALTH FUND, A VOTE OF CONFIDENCE: ATTITUDES TOWARD EMPLOYER SPONSORED HEALTH INSURANCE 5 (Jan. 2000), *available at* http://www.cmwf.org/programs/insurance/schoen_voteofconf_ib_363.asp (last visited Sept. 19, 2001).

[28] SIRICA, *supra* note 2, at 8.

[29] Trubek, *supra* note 23, at 10.

health care programs, such as BadgerCare, have taken the responsibility to expand coverage to the uninsured and underinsured population.

Yet states are not taking on that responsibility alone. The federal government has also encouraged states to develop creative methods of covering the uninsured through the State Planning Grant initiative, which awarded $13.6 million to eleven states in 2000 (including Wisconsin) to study how public-private partnerships can expand health coverage.[30] Wisconsin's State Planning Grant initiative, which will be completed by September 30, 2001, builds upon Wisconsin's employer-based health care coverage system.[31] Specifically, Wisconsin's State Planning Grant initiative hopes to close the gap between the uninsured and the insured by: (a) integrating "employer health insurance and Medicaid/BadgerCare"; (b) creating "affordable and administratively simple options for low-income employers and employees"; (c) assuring "access to health care for all families without access to employer-based insurance"; (d) promoting "personal responsibility through cost sharing"; (e) improving "health outcomes for all uninsured families with children and individuals"; and (f) "reducing uncompensated health care costs."[32] To achieve these goals, DHFS meets regularly with business and community groups, allowing for a more cooperative and seamless health coverage expansion plan.[33]

The coordination of private organizations, such as corporations, charitable organizations, advocacy groups and individual families with public entities is essential to ensure the success of new health care programs such as BadgerCare.[34] For example, the BadgerCare Coordination Network based in Milwaukee, Wisconsin was formed to "promote healthy individuals and families by providing easy access to publicly funded resources through

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30 Dennis Chaptman, *State wins funds to find out who lack health insurance, why*, MILW. J. SENTINEL, Sept. 23, 2000, at 01B, *available at* http://www.jsonlone.com/news/state/sep00/insure23092200.asp (last visited Sept. 23, 2000). *See also* Telephone Interview with Marcia Brand, Health Resources and Services Administration (Feb. 22, 2000).

31 Letter from Joe Leean, DHFS Secretary, to Claude Earl Fox, M.D., M.P.H., HRSA Administrator (July 7, 2000) (on file with author).

32 WIS. DEPT. OF HEALTH AND FAMILY SERVICES, WISCONSIN STATE PLANNING GRANT PROGRAM, 4 (July 10, 2000) (on file with author) [hereinafter SPG Plan].

33 *Id.* at 35.

34 Trubek, *supra* note 23, at 10-12.

collaboration and coordination by community organizations and local and state government agencies."[35] The Network meets regularly to strategize on how best to enroll eligible families into BadgerCare.[36]

State leaders and citizens alike believe public-private coordination is the current method of choice in ensuring more universal access to health insurance. However, if states are to coordinate successfully with employer-sponsored plans and other community groups, they must gain access to employer health plan information. Furthermore, if Wisconsin hopes to accomplish its goals listed under the State Planning Grant initiative, the state must have access to employer health plan information. Without such information, achieving full integration between employer health insurance and BadgerCare as well as reducing the rate of uninsurance will be unlikely. Currently, the BadgerCare program attempts to access employer health plan information through its verification process. However, this process does not have a mandatory participation provision. Without the ability to require employers to submit information, Wisconsin's verification process will not gather complete employer health plan information.

II. State Access to Employer Health Plan Information and the ERISA Blockade

A. The Importance of Verifying Employer Health Plan Information

In Wisconsin, to verify whether a BadgerCare applicant has access to employer-sponsored family health insurance, the Wisconsin Department of Health and Family Services (DHFS) sends to the applicant's employer an Employer Verification of Insurance Coverage (EVIC) form.[37] The form asks employers, or their "designated representatives," to provide the following information for each health plan offered by the employer: (a) whether the employee has access to "family" coverage under the plan; (b) whether the plan is managed care based or major med-

35 *Id.* at 12.

36 *Id.*

37 Interview with Don Schneider, Chief of Coordination of Benefits Section, DHFS, Madison, Wis. (Nov.15, 2000) [hereinafter Nov. 15 Don Schneider Interview].

ical; (c) the plan's group number, billing address and other contact information; (d) enrollment periods; (e) employer and employee monthly premium contributions; (f) employer-provided drug and dental carrier information (if applicable); and (g) whether the employer has a full or partially self-funded plan.[38] The results of this form are used to determine whether the employer pays for at least 80% of an employee's health coverage (in which case the employee and his or her family are not eligible for BadgerCare), or pays between 60-80% of the employee's health coverage (in which case the employee and his or her family are eligible for the HIPP program).[39] As a result, the information provided on the EVIC form is crucial for Wisconsin to ensure that only those who have no other access to employer health insurance are enrolled in BadgerCare.

Although 66% of Wisconsin employers return the EVIC form to DHFS, participation is completely voluntary and can be administratively burdensome on employers.[40] Even if an employer returns the EVIC form, DHFS will not pursue further information if the employer indicates that they are "self-insured" or "self-funded."[41] Approximately 15-16% of the EVIC forms returned to DHFS indicate that the employer is self-insured.[42] In those cases, DHFS ends the verification process and keeps the BadgerCare recipient in the program.[43] DHFS officials reason that pursuing further information from self-insured plans is inefficient since it is not cost-effective for the state to buy into those plans.[44] However, such reasoning does not account for the possibility that some BadgerCare recipients may be dually covered by the BadgerCare program as well as the self-funded plan of-

38 Wis. Dept. of Health and Family Services, BadgerCare Employer Verification of Insurance Coverage (EVIC) Form, *available at* http://www.dhfs.state.wi.us/badgercare/pdfs/evicformsample.pdf.

39 Nov. 15 Don Schneider Interview, *supra* note 37.

40 DHFS BadgerCare Fact Sheet, *Wisconsin Health Insurance Premium Payment (HIPP) Overview*, 2 (Oct. 1, 2000); Interview with Don Schneider, *supra* note 18 [hereinafter DHFS BadgerCare Fact Sheet] (admitting that filling out the EVIC form is burdensome for employers).

41 Nov. 15 Don Schneider Interview, *supra* note 37. Self-insured plans bear the risk of loss themselves rather than contracting with an insurer to bear the risk of loss. *See infra* note 50.

42 Nov. 15 Don Schneider Interview, *supra* note 37.

43 *Id.*

44 *Id.*

fered by their employer.[45] Therefore, gathering information from all employer plans, including those that are self-insured, is critical to avoid duplicating health coverage by public and private entities.

Furthermore, follow-up with employers who do provide information is "difficult and time consuming."[46] DHFS may follow-up with employers each time the employer renegotiates a new managed care package to gain an understanding of the new premium rates and benefit packages, information that is essential to determine the cost-effectiveness of enrolling BadgerCare recipients in the HIPP program.[47] By requiring employers to submit health plan information, states would likely perform fewer follow-up inquiries when employer health care contracts are renegotiated.

Therefore, the collection of employer health plan information may be more complete and operate more efficiently if states had legal authority to require such information directly from employers. For example, if the State of Wisconsin could require employers to submit health plan information regularly to DHFS, a very valuable database of health coverage information could be developed and shared with community groups, such as the BadgerCare Coordination Network. Armed with this information, these groups could more accurately target the most needy families to enroll in BadgerCare or the BadgerCare HIPP program. States like California could also use employer health plan information to ensure that employers were not violating the state law prohibiting modifications to employer-based health plans (assuming such law does not violate ERISA, see discussion below). Currently, Wisconsin law requires insurers to provide DHFS information concerning whether a Medicaid beneficiary has access to benefits under a disability insurance policy.[48] Ex-

[45] In fact, there is anecdotal evidence of such dual coverage. Interview with Judy Peirick, Vice President of Human Resources, Webcrafters, Inc., in Madison, Wis. (July 26, 2001) (stating that one employee who was discharged from the company was not concerned about losing health benefits through the company's self-insured plan because the employee also was covered under BadgerCare, which would not terminate with the employee's loss of employment).

[46] DHFS BadgerCare Fact Sheet, *supra* note 40, at 2.

[47] Interview with Don Schneider, *supra* note 18.

[48] WIS. STAT. § 49.475(2)(a)(1) (1999). Wisconsin law defines "disability insurance policy" as "surgical, medical, hospital, major medical or other health service coverage but does not include hospital indemnity policies or ancillary coverage such as

tending such a requirement to employers may invite ERISA preemption challenges.

B. ERISA Preemption

ERISA generally preempts "any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan."[49] Employee benefit plans affected by ERISA include both insured and self-insured plans.[50] This "relate to" clause, found in ERISA section 514(a), has been interpreted to preempt state laws that directly refer to ERISA plans by imposing obligations on them, regulate the same areas as ERISA (such as reporting, disclosure, or remedies), or regulate an ERISA plan's benefits, structure, or administration.[51] Thus, a state law requiring employer health plans to submit information to the state would likely violate ERISA section 514(a) because it would directly refer to ERISA plans, impose a reporting obligation on them, and probably impact ERISA plan benefits, structure, and administration (particularly if states required the information for implementing programs like HIPP, which would have a direct impact on the benefits, structure, and administration of an ERISA plan). It is unlikely such a law would be "saved" by ERISA's "insurance savings clause," found in ERISA section 514(b)(2)(A),[52] because the law would neither be generally applicable to the insurance industry[53] nor exist to regulate the business of insur-

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income continuation, loss of time or accident benefits." WIS. STAT. § 632.895(1)(a) (1999).

49 29 U.S.C. § 1144(a) (2000) (emphasis added).

50 PATRICIA A. BUTLER, *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles*, THE COMMONWEALTH FUND, (Oct. 2000) at 2, *available at* http://www.epn.org/whatsnew/ful_cite/613.html (last visited Sept. 19, 2001). Under an insured employer arrangement, the employer contracts "with health insurance plans on behalf of their employees and the insurance plan ultimately bears the risk of loss." Rebecca Lewin, *Job Lock: Will HIPAA Solve the Job Mobility Problem?* 2 U. PA. J. LAB. & EMP. L. 507, 509 (2000). Self-insured employer plans "do not contract with insurers (except perhaps with Administrative Services Only (ASO) or Third Party Administrators (TPAs) to administer claims only), but pay health insurance claims directly and thus bear at least some of the risk of loss." Barbara Zabawa, *The Access Problem: How Employee and Employer Issues May Increase BadgerCare Participation by Impeding the Verification Process*, WIS. WOMEN'S L.J. (forthcoming Spring/Summer 2001).

51 BUTLER, *supra* note 50, at 4.

52 29 U.S.C. § 1144(b)(2)(A) (2000) (stating that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities").

53 *See, e.g.*, N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995) (stating that the hospital surcharges imposed by the

ance,[54] but would exist only to extract information directly from employer health plans. This argument is further supported by ERISA's "deemer clause," found in ERISA section 514(b)(2)(B),[55] which states that employer health plans are not deemed to be insurers for purposes of state regulation.[56] Therefore, any state law requiring employer health plans to submit plan information to the State would likely be preempted by ERISA, if the law is challenged by an ERISA plan or its representative claiming the law is overly burdensome.

In addition to ERISA section 514(a) preemption, states face an ERISA preemption barrier relating to available remedies pur-

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state were "imposed upon patients and HMO's regardless of whether the commercial coverage or membership, respectively, is ultimately secured by an ERISA plan, private purchase, or otherwise . . . ."). A state law requiring employer health plans to provide states with information would not apply to those with private purchase or other non-employer based insurance.

[54] Regulating the "business of insurance" is traditionally a state activity. Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co., 471 U.S. 724, 740 (1985). The "business of insurance" is defined by the McCarran-Ferguson Act of 1945 (15 U.S.C. §§ 1011-1015) which identifies three criteria courts use to determine whether a state practice falls within the "business of insurance" and is therefore saved by the ERISA insurance savings clause. *Id.* at 743. Those three criteria are (1) "whether the practice has the effect of transferring or spreading a policyholder's risk"; (2) "whether the practice is an integral part of the policy relationship between the insurer and the insured"; and (3) "whether the practice is limited to entities within the insurance industry." *Id.* As previously noted, a state law requiring employee health plans to submit information to the state would not be directed at the insurance industry but at employers, and so would not likely be saved by ERISA's insurance savings clause. *See also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50 (1987) (explaining that a fair interpretation of the word "regulates" as used in ERISA's insurance savings clause would be "a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry").

[55] 29 U.S.C. § 1144(b)(2)(B) (2000).

[56] *See, e.g.*, FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990) (stating that "the deemer clause relieves [employee benefit] plans from state laws 'purporting to regulate insurance'"). The deemer clause is especially pertinent to self-funded employer health plans. *Id.* (indicating that "[s]tate laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws"). However, "employee benefit plans that are insured are subject to indirect state insurance regulation." *Id.* Yet, with the availability of stop-loss insurance, more employers (including small employers) are able to self-insure and thereby avoid state regulation. Jana K. Strain and Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 LOY. U. CHI. L.J. 29, 53 (1999). *See also* Jeffrey Ralph Pettit, Note, *Help! We've Fallen and We Can't Get Up: The Problems Families Face Because of Employment-Based Health Insurance*, 46 VAND. L. REV. 779, 785, n.39 (1993) (stating that in "1988, only 8% of smaller firms (firms with fewer than 100 employees) and only 26% of medium-sized firms (firms with 100 to 500 employees) were self-insured. In 1991, these percentages were 22% and 41% respectively").

suant to ERISA's civil enforcement scheme, under section 502(a).[57] For example, ERISA section 502(a)(1)(B) allows a participant or beneficiary of an ERISA plan to "recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."[58] As a result, even if a state law is not preempted by ERISA section 514, the law may be preempted by section 502(a) if the law provides for an alternative remedy not covered by ERISA. The Supreme Court, in *Pilot Life Insurance Co. v. Dedeaux*, stated that ERISA section 502(a) is the exclusive remedy for actions brought by ERISA plan participants or beneficiaries, and "that varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress."[59] A state law requiring employer health plans to submit plan information to the State would not be seeking an alternative remedy other than that provided under ERISA section 502(a). Rather, such a law would seek similar information as provided by an ERISA plan's summary plan document (SPD). Currently, ERISA plan participants have the right, upon written request, to obtain a "copy of the latest updated summary plan description,"[60] which would indicate "the plan's requirements respecting eligibility for participa-

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57 29. U.S.C. § 1132(a) (2000). "Participant" is defined as "any employee or former employee of an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit." 29 U.S.C. § 1002(7) (2000).

58 29 U.S.C. § 1132(a)(1)(B) (2000).

59 *Pilot Life*, 481 U.S. at 52. Currently, ERISA § 502(a) remedies are at issue in the ability of states to require external review of health decisions for all health plans, including ERISA plans (both insured and self-insured). *See, e.g.*, Corporate Health Ins. Inc. v. Texas Dep't of Ins., 215 F.3d 526 (5th Cir. 2000) (holding that state independent review legislation "creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan – the identical relief offered under § 1132(a)(1)(B) of ERISA. As such, independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the saving clause"); Moran v. Rush Prudential HMO, Inc., 230 F.3d 959 (7th Cir. 2000) (holding that an Illinois independent review provision was incorporated into the plaintiff's insurance contract, and thus a suit by plaintiff to enforce the provision "is simply a suit to enforce the terms of the plan – *precisely* the sort of suit that is contemplated by § 502(a)(1)(B) 'to enforce rights' and 'to recover benefits' under the plan"). The U.S. Supreme Court has granted the petition for certiorari and will decide next term whether states may enforce independent review laws. Linda Greenhouse, *Supreme Court to Hear Case on Patients' Rights*, N.Y. TIMES, June 30, 2001, at A10, *available at* http://www.nytimes.com/2001/06/60/politics/30SCOT.html (last visited June 30, 2001).

60 29 U.S.C. § 1024(b)(4) (2000). *See also* Lewin, *supra* note 50, at 515 (stating that

tion and benefits . . . ."[61] Therefore, a state law requiring employers to provide copies of their SPDs to the State would not likely run into ERISA section 502(a) problems, because such a request would not be creating an alternative remedy or a remedy beyond what a plan beneficiary would already have under ERISA.[62] However, the key question under section 502(a) is whether a state has standing to request such information as a plan "participant" or "beneficiary." Several courts have already permitted state standing under section 502(a) as it pertains to states assigning rights of Medicaid beneficiaries for reimbursement purposes under the ERISA preemption exception section 514(b)(8) (discussed in Part III, below).[63] As a result, it may be possible to make an argument that state assignment of Medicaid rights should allow states to request health plan information from employers under section 502(a). This argument will be explored in more depth in Part III, infra.

State leaders are keenly aware of the ERISA preemption barriers described above.[64] In particular, state leaders have expressed a need for the federal government to allow states more flexibility with respect to ERISA plans when implementing health care reform initiatives. For example, the NGA has recognized that recent court interpretations of ERISA preemption prohibit states from "requiring all health plans to provide states with information crucial to developing a comprehensive understanding of the status of the states' health care access and deliv-

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"employers must provide to employees, upon request, information regarding plan benefits as well as reports detailing benefits accrued to date").

61 29 U.S.C. § 1022(b) (2000).

62 *See, e.g.*, Commonwealth, Dep't of Public Welfare v. Lubrizol Corp. Employee Benefit Plan, 737 A.2d 862, 868 (Pa. Commw. Ct. 1999) (indicating that states suing ERISA plans on behalf of ERISA plan beneficiaries using the Medicaid preemption exception cannot seek to enforce additional rights that the beneficiary would not have under the plan).

63 *See id.* (stating that ERISA § 514(b)(8) "lifts preemption for 'any State cause of action' with respect to which a state Medicaid program is exercising (as an assignee or subrogee) the rights of a participant of the benefit plan"). *See also* Morrone v. Thuring, 759 A.2d 1238, 1246-47 (N.J. Super. 2000) (stating that ERISA § 514(b)(8) indicates that "'state laws relating to Medicaid reimbursement are precluded from preemption only to the extent that the state Medicaid program is exercising (as an assignee or subrogee) the rights of the beneficiary of the benefit plan'") (quoting 29 U.S.C. § 1144(b)(8)(2000)).

64 NATIONAL GOVERNORS' ASS'N, NGA POLICY POSITION DETAIL, HR-37: PRIVATE SECTOR HEALTH CARE REFORM POLICY, § 37.2.1, 3 (2000) (stating that ERISA presents one of the "greatest barriers to some state reform initiatives").

ery systems."[65] In its State Planning Grant program plan, DHFS noted that "ERISA preemption has become among the most challenging policy issues for states with the lowest rates of uninsured population. State/federal partnerships to expand access to health insurance must better understand the importance and implication of [the self-insured] sector."[66] Without employer health plan information, it will be nearly impossible for states to develop the desired public-private partnerships in health coverage. Although states believe that ERISA imposes a barrier in accessing employer health plan information, there may be three legal arguments that states could use to require more employers to report health plan information.

III. Three Legal Arguments that May Help States in Accessing Employer Health Plan Information

Despite the seemingly enormous ERISA blockade preventing state Medicaid expansion programs from requiring access to employer health plan information, ERISA does provide several loopholes that may allow states to require employers to provide them with such information.[67] These loopholes include ERISA preemption exceptions for the "other federal laws" exception under ERISA § 514(d), Qualified Medical Child Support Orders (QMCSOs) found under ERISA § 514(b)(7), and perhaps the Title XIX preemption exception (ERISA § 514(b)(8)). Each of these ERISA preemption exception arguments will be presented from what this author believes to be the strongest and most helpful arguments to the weakest.

Before discussing the three legal arguments, however, it is important to address why states cannot currently collect employee health plan information directly from the U.S. Department of Labor. In 1997, the requirement of ERISA plans to file SPDs with the Department of Labor was eliminated.[68] Now, ER-

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65 *Id.* at 4.

66 SPG Plan, *supra* note 32, at 13.

67 The legal arguments presented in this paper assume that ERISA would not be amended to allow for state regulation of employer-based health plans.

68 Revenue Reconciliation Act of 1997, Pub. L. No. 105-34, § 1503(c), 111 Stat. 788, 1062 (1997). *See also* E-Mail from Susan G. Lahne, Attorney, Office of Regulations and Interpretations, U.S. Dept. of Labor, to Barbara Zabawa (Feb. 5, 2001 07:00:00 CST) [hereinafter Susan Lahne Email].

ISA plans must only file annual reports with the Department of Labor (which contain such information as a financial statement of the plan, the number of employees covered by the plan, and fiduciary information).[69] ERISA plans must file SPDs with the Department of Labor only upon request.[70] As a result, the Department of Labor is not a comprehensive resource for states to access ERISA plan information. It should be noted, however, that even when the SPD filing requirement was mandatory, the Department of Labor did not analyze the data nor place the information into a usable format for states to access.[71] Accordingly, states must rely on other legal mechanisms to access employer health plan information for the benefit of Medicaid expansion programs.

A. "Other Federal Laws" Preemption Exception under § 514(d)

ERISA section 514(d) may offer one of the most helpful arguments states may make when attempting to require employer health plans to submit information to the State. ERISA section 514(d) states, "nothing in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States. . .or any rule or regulation issued under any such law."[72] In *Shaw v. Delta Airlines, Inc.*, this section of ERISA was interpreted to mean that state laws enacted to enforce federal laws are not preempted by ERISA.[73] Although ERISA section 514 was not specifically addressed, a Wisconsin federal court in *Wisconsin Department of Health and Social Services v. Upholsterers International Union Health and Welfare Fund (Upholsterers)* used similar reasoning as in *Shaw* to allow the State of Wisconsin standing in bringing a suit against a self-funded health plan for Medicaid reimbursement.[74] The *Upholsterers* court noted that when Congress enacted a provision requiring states to compel assignment of health benefits, in order for a beneficiary to be eligible for

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[69] 29 U.S.C. §§ 1023-24 (2000).

[70] 29 U.S.C. § 1024(a)(6) (2000).

[71] Susan Lahne E-Mail, *supra* note 68 (indicating that when the SPD filing requirement was in effect, the "Department did not do any analysis based on the SPDs, which I think were just warehoused").

[72] 29 U.S.C. § 1144(d) (2000).

[73] Shaw v. Delta Airlines, Inc., 463 U.S. 85, 104 (1983).

[74] Wis. Dep't of Health and Soc. Serv. v. Upholsterers Int'l Union Health and Welfare Fund, 686 F. Supp. 708, 714 (W.D. Wis. 1988).

Medicaid, states would be dealing with ERISA plans.[75] State funding was contingent upon adhering to this federal requirement.[76] Consequently, if states were unable to coordinate benefits (making Medicaid the secondary payer) with ERISA plans, then the purpose of the federal requirement would be compromised.[77]

Using the same line of reasoning as found in *Upholsterers*, one could argue that if a state passed a law requiring employer health plans to submit information to the state, in order to enforce a federal provision, the state law may be saved from preemption under ERISA section 514(d). This argument may be most helpful if the State passed such a law in relation to Medicaid expansion programs, such as BadgerCare. BadgerCare, which is funded with federal dollars under Title XIX (Medicaid) and Title XXI (SCHIP), state dollars, and premium payments made by some families in the program,[78] was made possible due to the passage of the federal SCHIP legislation.[79] Therefore, one could argue that the federal provisions in SCHIP should guide states as they implement laws to comply with the federal SCHIP provisions. One SCHIP provision, similar to the federal Medicaid funding law discussed in *Upholsterers*, imposes a condition of federal funding on states not to use SCHIP funding for providing health insurance to children who should have been insured through an employer plan despite a contract provision that excludes SCHIP program-eligible children from the employer plan.[80] This SCHIP provision is attempting to address the

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75 *Id.*

76 *Id.*

77 *Id.*

78 Memorandum from Charles Morgan, Legis. Fiscal Bureau, to Senators Chvala, Grobschmidt, Robson and Wirch, *BadgerCare Enrollment Based on Current Authorized Funding* (Feb. 24, 2000) (on file with author) [hereinafter Morgan Memorandum].

79 Trubek, *supra* note 1, at 149.

80 42 U.S.C. § 1397ee(c)(6)(A) (2000) (stating that:

> No payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 1167(1) of Title 29 [ERISA]), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided child health assistance under the plan).

private insurance crowd out issue. Furthermore, the federal SCHIP law conditions payments to states unless states submit a plan to the Department of Health and Human Services Secretary[81] that describes how the SCHIP program will "not substitute for coverage under group health plans,"[82] and how the state will accomplish coordination of the SCHIP program with "other public and private health insurance programs."[83]

Thus, following the reasoning of the *Upholsterers* court, Congress should have known that states would be dealing with ERISA plans when it passed SCHIP which conditioned state payment on the development of a plan to coordinate with private insurers and to not substitute private insurance with SCHIP coverage. If states are unable to access ERISA plan information, it will be nearly impossible for them to carry out the federal SCHIP conditions of coordination and zero substitution with any success. Consequently, one could argue that under ERISA section 514(d), state laws requiring access to ERISA plan information would frustrate the federal SCHIP provisions if preempted by ERISA.

As strong as this argument may be, there is one glitch in its effectiveness. When passing SCHIP, one could argue that Congress had an opportunity to amend ERISA to allow states to gather health plan information directly from ERISA plans. However, Congress did not amend ERISA under SCHIP. In fact, rather than being silent as to SCHIP's effect on ERISA, Congress specifically stated that SCHIP did not affect or modify ERISA "with respect to a group health plan."[84] Therefore, one could also argue that Congress did not intend for states, when implementing Medicaid expansion programs, to interfere with ERISA-governed plans. Yet, Congress may not have felt compelled to modify ERISA due to the existence of ERISA section 514(d), which allows states to interfere with ERISA plans if such interfer-

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[81] 42 U.S.C. § 1397aa(b)(1) (2000) (stating:
A State is not eligible for payment under section 1397ee of this title unless the State has submitted to the Secretary under section 1397ff of this title a plan that—(1) sets forth how the State intends to use the funds provided under this subchapter to provide child health assistance to needy children consistent with the provisions of this subchapter).

[82] 42 U.S.C. § 1397bb(b)(3)(C) (2000).

[83] 42 U.S.C. § 1397bb(c)(2) (2000).

[84] 42 U.S.C. § 1397ii(a)(2) (2000).

ence is necessary to carry out other federal provisions. Nevertheless, if a state attempts to require ERISA plans to submit information to the state using an ERISA section 514(d) argument, this opposing argument should at least be recognized.

B. The Qualified Medical Child Support Order (QMCSO) Exception

States could also require ERISA plans to submit health plan information to states using ERISA section 514(b)(7), which exempts from preemption laws passed in relation to QMCSO's.[85] After a brief overview of QMCSO's, the legal argument presented in this section will focus on the National Medical Support Notice (NMSN) version of QMCSO's, since this version likely speaks to the future of medical support enforcement[86] and contains regulatory language that this author believes to be most effective for states in achieving access to employer health plan information.[87]

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85 29 U.S.C. § 1144(b)(7) (2000).

86 According to the Medical Child Support Working Group, "amendments to § 466(a)(19) of the Social Security Act require States to enact laws that mandate State agencies' use the Notice [NMSN] as the prescribed method of enforcing the health care coverage provisions in child support orders." THE MEDICAL CHILD SUPPORT WORKING GROUP'S REPORT TO THE HON. DONNA E. SHALALA, SEC'Y DEPT. OF HEALTH AND HUMAN SERV. AND THE HON. ALEXIS M. HERMAN, SEC'Y DEPT. OF LABOR, 21 MILLION CHILDREN'S HEALTH: OUR SHARED RESPONSIBILITY 2-3 (June 2000) [hereinafter THE WORKING GROUP REPORT]. The Working Group was created under the Child Support Performance and Incentive Act of 1998 (CSPIA) to identify "barriers to effective medical support enforcement" and develop recommendations in the following six areas: (a) "assess the National Medical Support Notice"; (b) "identify the priority of withholding from an employee's income, including medical support obligations"; (c) "coordinate medical child support with Medicaid/SCHIP"; (d) "examine alternates to a medical support model focused exclusively on the noncustodial parent's employer-provided health plan"; (e) "evaluate the standard for 'reasonable cost' in federal law"; and (f) "recommend other measures to eliminate impediments to medical support enforcement." *Id.* at xii. The Medical Child Support Working Group "includes thirty members with representatives from the U.S. Department of Labor, the U.S. Department of Health and Human Services, State IV-D Child Support Directors and State Medical Child Support Programs, State Medicaid Directors and SCHIP programs, employers, . . . plan administrators, . . . child advocacy organizations, and organizations representing State child support programs." *Id.* at xiii.

87 There are other federal provisions that one could argue give states access to employer health plan information concerning medical child support orders. The first provision is found under the Social Security Act, which requires states to enact certain procedures to increase the effectiveness of child support enforcement. 42 U.S.C. § 666(a) (2000). Specifically, states are required to enact procedures that require all entities in the State (including employers) to provide promptly "information on the employment, compensation, and *benefits* of any individual employed by such entity as an employee or contractor, and to sanction failure to respond to any such request." 42

QMCSO's are medical support orders that are usually attached to child support orders.[88] According to a 1998 survey, "93 percent of child support orders had provisions requiring medical support for dependent children."[89] QMCSO's were created under the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), which also amended ERISA to exclude QMCSO's from preemption.[90] Under ERISA, a QMCSO is a medical child support order that clearly specifies:

> (1) the name and last known mailing address (if any) of the participant and the name and mailing address of each child covered by the order; (2) a reasonable description of the type of coverage to be provided, or the manner in which the coverage will be determined; and (3) the period to which the order applies.[91]

The purpose of amending ERISA to establish QMCSO's was to clear up any ambiguity with state authority over ERISA plans concerning state court or administrative orders that provide for health coverage of children of employer health plan participants (i.e., typically the noncustodial parent). According to the Medical Child Support Working Group's Report (The Working

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U.S.C. § 666(c)(1)(C) (2000) (emphasis added). This requirement on employers was incorporated into the NMSN, so further exploration of the Social Security Act provision is unnecessary for this analysis. National Medical Support Notice, 65 Fed. Reg. 82,128, 82,131 (Dec. 27, 2000) (to be codified at 29 C.F.R. pt. 2590 and 45 C.F.R. pt. 303) [hereinafter Fed. Reg.]. A second federal provision is found in Title XIX, which requires states to have in place certain laws relating to medical child support. 42 U.S.C. § 1396g-1 (2000). Although none of the laws listed specifically allow states to require employer health plans to provide detailed descriptions of their plans, one could argue that states could enact such a law in order to determine, for example, whether a noncustodial parent is eligible for an employer health plan. *See, e.g.*, 42 U.S.C. 1396g-1(a)(3) (2000). *See also* E-mail from Susan G. Lahne, Attorney, Office of Regulations and Interpretations, U.S. Dept. of Labor, to Barbara Zabawa (Jan. 16, 2001, 11:05:00 CST) (stating that states seeking ERISA plan information "could be a province of these 1908 [i.e., 42 U.S.C. 1396g-1] laws"). The laws enacted by Wisconsin relating to medical support enforcement do not address state access to employer health plan information. WIS. STAT. § 767.25(4m)(d) (only requiring employers to provide copies of "necessary program or policy identification to the child's other parent"). As a result, the § 1908 provisions are not as directly applicable to state acquisition of employer health plan information as the NMSN provision.

88 THE WORKING GROUP REPORT, *supra* note 86, at 1-4 (stating that "in 1984 State child support enforcement ("IV-D") programs were given the responsibility to include medical support establishment and enforcement as part of their child support efforts").

89 *Id.* at 1-5.

90 *Id.* at 2-3.

91 *Id.* at 2-5. *See also* 29 U.S.C. § 1169(a)(3) (2000).

Group), the QMCSO amendment to ERISA reflected Congressional intent for states to pursue private health coverage for children who do not live with both of their biological or adoptive parents, provided such coverage was available through a noncustodial parent at a reasonable cost.[92]

As of October 1, 2001, QMCSO's will take the form of a National Medical Support Notice (NMSN), which was mandated under the Child Support Performance and Incentive Act of 1998 as "a uniform medical child support order to be issued by State IV-D agencies (i.e., State child support agencies or "issuing agencies") and that would, if appropriately completed, be deemed to be a QMCSO."[93] ERISA requires ERISA plan administrators, upon receipt of a qualified NMSN, to notify the state agency issuing the NMSN within forty business days after the date of the NMSN "whether coverage of the child is available under the terms of the plan and, if so, whether such child is covered under the plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent . . . to effectuate the coverage."[94] Thus, ERISA requires employer health plan administrators to provide the state with basic coverage availability information. However, under the administrative rules recently released by the Department of Labor and Department of Health and Human Services pertaining to NMSN's, ERISA plan administrators are also required to furnish state child support agencies with more detailed employer health plan informa-

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92 THE WORKING GROUP REPORT, *supra* note 86, at 1-4. It should be noted that a QMCSO "cannot require a group health plan to provide any type or form of benefit, or any option, not otherwise provided under the plan." *Id.* at 2-5. *See also* 29 U.S.C. § 1169(a)(4) (2000). Furthermore, The Working Group recognized that "custodial and noncustodial parents of child support-eligible children fall disproportionately into the income categories who have less access to employer-based health care coverage and less ability to pay for coverage, even if offered." The Working Group Report, *supra* note 86, at 2-13. As a result, The Working Group suggested, "unless coverage is offered at no or very low cost, neither custodial nor noncustodial parents whose income is at or near the poverty line should be required to provide health care coverage." *Id.* at 2-17-18.

93 THE WORKING GROUP REPORT, *supra* note 86, at 4-2, 4-15 n.2. It should be noted that in Wisconsin, employers have not demanded that medical support orders issued by child support agencies satisfy QMCSO requirements. Telephone Interview with Kathy Fullin, Supervisor, Bureau of Child Support, Dept. of Workforce Development (Mar. 6, 2001) [hereinafter Kathy Fullin Interview]. Apparently, employer health plans are complying with a "check box" notice, which is found on the child support income withholding form, and if checked, mandates health insurance coverage to the employee's child(ren). *Id.*

94 29 U.S.C. § 1169(a)(5)(C)(ii)(I) (2000).

tion.[95] This information may be satisfied by furnishing the state child support agency with a copy of the plan's SPD, so long as the SPD "includes sufficient information concerning required contributions, benefit levels, and limitations (including geographic or service area limitations) of the plan or plan options."[96]

Consequently, beginning in October 2001, the NMSN system will allow state child support agencies to access the employer health plan information which Medicaid expansion programs need to ensure coordination between public and private health coverage. The Working Group noted that state child support agencies "have immediate access to necessary information regarding the children's health coverage and the parents' income, employment, and other financial information."[97] The Working Group further noted that such information would be invaluable to Medicaid and SCHIP programs.[98]

However, coordination between state child support agencies and agencies that administer Medicaid expansion programs may be difficult. For example, according to a Wisconsin Department of Workforce Development (DWD) official (the state agency that administers Wisconsin's child support system), ERISA plan administrators will send NMSN responses back to county child support agencies.[99] Without additional resources, it will be difficult for DWD to centralize the employer health plan information at the state-level where it could be shared with DHFS (the state agency that administers BadgerCare).[100] The Working Group was aware of these resource barriers and recommended additional funding be provided to states to ensure greater access to health care coverage for children.[101] Specifically, the Working Group recommended federal grant projects that might examine "States' efforts to coordinate health care coverage availability between the Child Support, Medicaid, TANF, and SCHIPs programs."[102] In addition, the Working Group recommended

95 Fed. Reg., *supra* note 87, at 82,131.
96 *Id.*
97 THE WORKING GROUP REPORT, *supra* note 86, at 6-3.
98 *Id.*
99 Kathy Fullin Interview, *supra* note 93.
100 *Id.*
101 *See, e.g.*, THE WORKING GROUP REPORT, *supra* note 86, at 7-6, 8-6.
102 *Id.* at 8-6.

enhanced federal funding for a five-year period to allow states to implement the Working Group's recommendations, including improved communication between SCHIP and state child support enforcement agencies.[103]

Consequently, the strength of using the QMCSO ERISA preemption exception to allow states access to employer health plan information for the benefit of Medicaid expansion programs depends upon several factors. First, as in Wisconsin, the health coverage information provided by ERISA plans may not be centralized making it inaccessible to Medicaid expansion programs. Second, to the extent that the ERISA plan information is accessible, it will only cover those plans that are subject to medical support orders, which are likely to be just a subset of those plans involved with Medicaid expansion programs. However, on a national scale, there are approximately twenty-one million children who could be the subject of medical support orders[104] that would provide states with the necessary ERISA plan information to ensure the eligibility and financial integrity of Medicaid expansion programs.

C. The Title XIX ERISA Preemption Exception

As noted in Part II, ERISA already exempts from preemption state causes of action against group health plans (i.e., insured and self-insured employer health plans) when a state exercises its acquired rights for making payments under Title XIX (Medicaid).[105] Specifically, ERISA provides that when a state makes payments to group health plan participants under Title XIX, group health plans are required to make payments in accordance with "any State law that provides that the State has acquired the rights with respect to a participant to such payment for such items or services."[106] In Wisconsin, when the state pro-

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103 *Id.* at 6-11, 7-6.

104 *Id.* at A-32.

105 29 U.S.C. § 1144(b)(8) (2000). ERISA defines "Group health plan" as "an employee welfare benefit plan providing medical care . . . to participants or beneficiaries directly or through insurance, reimbursement, or otherwise." 29 U.S.C. § 1167(1) (2000). ERISA defines "Employee welfare benefit plan" as plans that provide medical benefits "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1) (2000).

106 29 U.S.C. § 1169(b)(3) (2000). ERISA defines "Participant" as "any employee or former employee of an employer . . . who is or *may become eligible* to receive a benefit of any type from an employee benefit plan which covers employees of such employer or

vides Medicaid services (which includes services provided under BadgerCare)[107] to a participant in an employer-sponsored health plan, the Medicaid recipient assigns their rights to the State.[108] The *Upholsterers* case examined state assignment of rights under Title XIX in Wisconsin.[109]

In the *Upholsterers* case, the court allowed DHFS to bring a lawsuit for recovery of Medicaid payments made to individuals who were also covered under a self-insured plan.[110] [Interestingly, the *Upholsterers* court noted that Congress adopted the § 514(b)(8) provision to ensure the "efficient operation of Medicaid" by requiring states to make Medicaid a secondary payer to employer-sponsored health plans (i.e,, essentially preventing against "crowd out").[111]] Currently, ERISA sections 514(b)(8) and 609(b)(3), and Wis. Stats. s. 49.493 allow the State to assign to itself the rights of Medicaid beneficiaries and therefore acquire a limited preemption exception.[112] In the *Upholsterers* case, members of the self-insured plan had assigned their rights under the plan over to DHFS.[113] However, according to the *Upholsterers* court, the rights for which the state was able to sue the self-insured plan were dictated by ERISA section 502(a)(1)(B) (the civil enforcement provision).[114] As discussed in Part II, above, this section of ERISA allows a participant or beneficiary of an employer benefit plan to "recover benefits due to him under the terms of his plan, *to enforce his rights under the terms of the plan,* or

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members of such organization, or whose beneficiaries may be eligible to receive any such benefit." 29 U.S.C. § 1002(7) (2000) (emphasis added).

107 WIS. STAT. § 49.46(2) (1999). *See also* WIS. STAT. § 49.665(3) (1999); WIS. STAT. § 49.43(8) (1999).

108 WIS. STAT. § 49.493(2) (1999).

109 Wis. Dep't of Health and Soc. Serv. v. Upholsterer's Int'l Union Health and Welfare Fund, 686 F. Supp. 708 (W.D. Wis. 1988). It should be noted that this decision was based on a prior version of ERISA § 514(b)(8) (effective Oct. 1, 1986). Morrone v. Thuring, 759 A.2d 1238, 1246, (N.J. Super. 2000). However, this fact did not preclude the *Morrone* court from using the *Upholsterers* case as guidance in making its decision based on the current version of ERISA § 514(b)(8) (effective Aug. 10, 1993). *Id.*

110 *Upholsterers,* 686 F. Supp. at 710-713. It should be noted that DHFS was unable to recover Medicaid payments from the self-insured plan in *Upholsteres* because the plan had a coordination of benefits provision that made the plan the secondary payor to other sources of coverage, such as Medicaid. *Id.* Although such a provision would now be preempted by ERISA under 29 U.S.C. § 1144(b)(8), that ERISA provision was enacted after the time period for which DHFS sought recoupment. *Id.* at 716.

111 *Upholsterers,* 686 F. Supp. at 715-16.

112 29 U.S.C. § 1144(b)(8); 29 U.S.C. § 1169(b)(3); WIS. STAT. § 49.493.

113 *Upholsterers,* 686 F. Supp. at 712.

114 *Id.*

to clarify his rights to future benefits under the terms of the plan."[115] The *Upholsterers* court stated that an assignment transfers to the assignee "all the right, title, or interest of the assignor in the thing assigned, but not to confer upon the assignee any greater right or interest than that possessed by the assignor."[116] Therefore, in *Upholsterer's*, ERISA section 502(a)(1)(B) provided DHFS with legal standing to sue the self-insured plan on behalf of plan members to recover benefits due those members.

ERISA section 502(a)(1)(B) also allows a plan participant to "enforce" their rights under the terms of the plan. As Part II noted, ERISA plan participants have the right to request, in writing, a copy of the plan SPD. Since a plan participant could require access to the SPD, one could argue that by assigning these rights to DHFS when receiving Medicaid, DHFS could also obtain a copy of the SPD, which likely contains the employer health plan information sought by state Medicaid expansion programs.

However, ERISA's preemption exception for states' acquired rights only applies to Title XIX programs.[117] The question remains, then, whether BadgerCare is part of Title XIX and therefore included in ERISA's preemption exception for Medicaid. If BadgerCare is considered a program under Title XIX, DHFS may be able to access health plan information directly from employers (both insured and self-insured) using ERISA sections 502(a)(1)(B) (the enforcement provision) and 514(b)(8) (the Title XIX preemption exception).

To determine whether BadgerCare is included under the ERISA section 514(b)(8) preemption exception, one must first analyze whether BadgerCare is really part of MA, or a separate program. As discussed in Part I above, BadgerCare is a Medicaid expansion program. Furthermore, as noted earlier, both BadgerCare and Medicaid provide the same benefits to recipients. In fact, even though BadgerCare is marketed separately from Medicaid to eliminate the "welfare stigma," DHFS views the two programs as the same.[118] Thus, one might think that

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115 *Id.* at 713; 29 U.S.C. § 1132(a)(1)(B) (2000) (emphasis added).

116 *Upholsterers*, 686 F. Supp. at 712.

117 29 U.S.C. § 1169(b)(3) (2000).

118 Interview with Angela Dombrowicki, *supra* note 23. *See also* WIS. STAT. § 20.435(4)(bm) (1999) (showing the appropriation that provides funding for administering both the Medicaid and BadgerCare programs).

BadgerCare and Medicaid are both "Medicaid" programs.[119]

However, one could argue that Congress did not intend to identify BadgerCare as a Medicaid program that would therefore allow it to qualify for the 514(b)(8) preemption exception. First, Congress did not amend ERISA to include Title XXI, which made BadgerCare possible, as a funding source to which a state may assign itself rights and therefore require group health plans to comply with state requests under assignment of those rights.[120] Furthermore, as previously noted, Title XXI specifically states that nothing in Title XXI "shall be construed as affecting or modifying" the preemption section of ERISA "with respect to a group health plan."[121] As a result, it is possible to argue that if Congress wanted to exempt from preemption direct state regulation of employer-sponsored health plans under programs initiated by Title XXI, it would not have created the explicit provision that prohibits disturbing ERISA's preemption section.

The fact that Title XXI initiated BadgerCare and provides funding for the program complicates the question of whether BadgerCare is really a separate program from MA. However, in addition to Title XXI dollars, BadgerCare is funded with Title XIX dollars,[122] the latter of which do fall under the ERISA preemption exception.[123] Under other federal provisions, courts have varied as to how broadly they interpret a "program" based

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119 In addition, Congress may have intended states to have access to employer health plan information under SCHIP. Specifically, the SCHIP legislation requires states to describe how they will coordinate the administration of the state program with other "public and *private* health insurance programs." 42 U.S.C. § 1397bb(c) (2000) (emphasis added). As a result, one could argue that Congress wanted employers to cooperate with state programs under SCHIP, especially with state buy-in programs. Hence, SCHIP may give states indirect authority to access employer plan information through the verification process.

120 29 U.S.C. § 1169(b)(1) (2000) (noting the inclusion of "Title XIX" and the absence of "Title XXI").

121 42 U.S.C. § 1397ii(a)(2) (2000). The statute refers to 42 U.S.C. § 300gg-91(a)(1) for defining "group health plan," which defines the term as "an employee welfare benefit plan" as defined by ERISA. 42 U.S.C. § 300gg-91(a)(1) (2000). See *supra* note 87 for the definition of "employee welfare benefit plan."

122 Morgan Memorandum, *supra* note 78.

123 It should also be noted that, as stated in Part I, unlike Medicaid, BadgerCare is not an entitlement program. Therefore, a BadgerCare recipient who receives benefits with Title XIX funding is not entitled to those benefits, which arguably distinguishes BadgerCare as a separate program from MA, even though both programs are funded with Title XIX monies.

on the source of funding. For example, under Title IX, which prohibits "sex discrimination in 'any education program or activity receiving federal financial assistance,'"[124] courts have used a "direct-funding interpretation of [T]itle IX,"[125] and an "educational perspective."[126] Under the direct-funding interpretation, courts have stated that "only those parts of a [school that receive federal aid directly] are covered by [T]itle IX's prohibition."[127] Analogously, to the extent that DHFS could separate the BadgerCare recipients who receive Title XXI dollars (i.e., children)[128] from those who receive benefits through Title XIX dollars (i.e., adults), under a "direct-funding" interpretation DHFS could assign itself rights for the Title XIX beneficiaries and use that assignment to verify access to employer health plans.

Under the educational perspective, however, courts have concluded that "[T]itle IX's prohibition extends to 'programs or activities' receiving federal monies directly or indirectly."[129] Applying this interpretation to BadgerCare, one could argue, to the extent that BadgerCare is considered a "program"[130] that was initiated by Title XXI, Title XXI's prohibition on disturbing ERISA's preemption clause would apply to the whole BadgerCare "program." As a result, under the "educational perspective," one could reason that because BadgerCare is funded with Title XXI funds, ERISA preempts state assignment of rights of any participant (whether they are funded with Title XIX or Title XXI monies) under the program. Hence, the State would be prohibited from direct employer verification of whether an employee has access to family health insurance.

As a result, arguments could be made either for or against states' ability to directly access employer health plan information

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124 Paul J. Van de Graaf, *The Program-Specific Reach of Title IX*, 83 COLUM. L. REV. 1210, 1210 (1983) (internal quotations omitted).

125 *Id.* at 1213.

126 *Id.* at 1216.

127 *Id.* at 1214.

128 SIRICA, *supra* note 2, at 4.

129 Van de Graaf, *supra* note 124, at 1216.

130 Telephone Interview with Therese Klitenic, Health Insurance Specialist, Health Care Financing Administration (Nov. 9, 2000) (indicating that "BadgerCare" is the HCFA 1115 waiver name, not the "program" name). *But see* DHFS BADGERCARE BROCHURE (June 1999) (on file with author) ("BadgerCare is Wisconsin's new state *program* to provide health insurance for uninsured working families.") (emphasis added). *See also* WIS. STAT. § 20.435(4)(b) and § 20.435 (4)(bc) (1999) (creating separate appropriations for Medicaid and BadgerCare).

using the ERISA preemption exception for Title XIX. It may be possible for DHFS to assign itself rights to those BadgerCare recipients who receive benefits under Title XIX funding only. Under such assignment, when using ERISA's enforcement provision, states could possibly request in writing that an employer provide the State with information concerning the employer's benefit plan.[131]

However, one could argue that under current law, states could not directly access employer health plan information. One could support this position using the educational perspective argument or the argument that Congress did not amend ERISA under Title XXI and specifically stated within that Title that ERISA's preemption provision should not be disturbed. Under this position, states may only be able to indirectly access employer-sponsored family coverage information through insurers.[132]

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131 There may be support for this argument. *See* E-mail from Patricia Butler, J.D., Dr.P.H., to Barbara Zabawa (Nov. 29, 2000, 09:57:00 CST) (stating that the general purpose of ERISA's § 514(b)(8) amendment is consistent with an obligation of employee plans to provide data to the State, and that the *Upholsterers* case under ERISA § 502(a) bolsters that argument with respect to the summary plan document or other individual participant data) (on file with author).

132 Yet, as more businesses self-insure, the verification process will become less effective in acquiring such information. According to one source, "self-funded programs have grown dramatically and are used by sixty-five percent of employers nationwide." Kevin Caster, *The Future of Self-Funded Health Plans*, 79 IOWA L. REV. 413, 419 (1994). One reason for the increase may be the availability of stop loss insurance, which guards employers against risk of large claims. *Id.* Nevertheless, DHFS may be able to verify access to partially self-insured employers through stop-loss insurers. In *SafeCo Life Insurance Company v. Musser*, the Seventh Circuit ruled that ERISA did not preempt Wisconsin's ability to impose Health Insurance Risk Sharing Plan (HIRSP) assessments on a stop-loss insurer. 65 F.3d 647, 653 (1995). (HIRSP is a public health insurance program that "offers health insurance to Wisconsin residents who, due to their medical conditions, are unable to find adequate health insurance coverage in the private market." DHFS, *Is Wisconsin's Health Insurance Risk Sharing Plan for You?*, *available at* http://www.dhfs.state.wi.us/hirsp/index.htm (last visited Dec.1, 2000)). The *SafeCo* court noted that "a Wisconsin employer sponsoring a self-funded employee benefit plan may find it somewhat more expensive to obtain stop-loss coverage as a result of the HIRSP assessment imposed on the insurance companies who provide that coverage," but such effect is "beyond the purview of ERISA." *Id.* at 653-54. Consequently, ERISA would not preempt state regulation of stop-loss insurers in Wisconsin, even though those insurers contracted with self-insured plans. Therefore, one could contend that under *SafeCo*, DHFS could at least verify employee access to family coverage offered by partially self-insured plans through those plans' stop-loss insurers (presuming those insurers would have the necessary information regarding the employer health plan). However, for those employers that bear 100% of their health insurance risk, self-insurance may still impede the BadgerCare verification process.

It should be noted that of the three legal arguments presented, this last argument is the weakest. First, it may be administratively difficult to determine which BadgerCare recipients are funded through Medicaid as opposed to SCHIP funds. However, to the extent that states could make such a determination, this argument would most likely work only for those enrollees who were funded through Title XIX dollars. Secondly, in light of Wisconsin's recent waiver approved by HCFA allowing the State to use SCHIP funds to cover parents of children, the number of BadgerCare enrollees being funded with Title XIX dollars only is reduced even further. Therefore, at least in Wisconsin, implementation of this argument will probably produce the fewest number of employer health plans from which the State could require information.

IV. Conclusion

Given the current political desire to coordinate public and private programs at the state level, state access to employer health plan information is critical in achieving a seamless, cost-effective health coverage system that avoids private insurance crowd out. State Medicaid programs face rising expenditures in general.[133] As states expand Medicaid programs to include more low-income working families, these expenditures are likely to increase even more.[134] To curb this growth, states are attempting to protect employment-based insurance coverage as the main source of health coverage.[135] This is reflected in Wisconsin's intent behind the HIPP program and the goals listed as part of Wisconsin's State Planning Grant initiative, which seek to coordinate BadgerCare with employer-based health insurance coverage. However, some health advocates have expressed a desire for private insurance crowd out to occur because it would force a universal public health system once again to the top of the

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133 Brian Bruen & John Holahan, The Kaiser Commission on Medicaid and the Uninsured, *Medicaid Spending Growth Remained Modest in 1998, But Likely Headed Upward* 1, 1 (Feb. 2001), *available at* http://www.kff.org (concluding that growth rates in Medicaid are likely headed upward). *See also* CARABELL & MEGNA, *supra* note 6, at 62 (showing that Medicaid and BadgerCare expenditures (all funds) have increased from approximately $1.27 billion in fiscal year 1989 to $2.86 billion in fiscal year 2000).

134 Bruen & Holahan, *supra* note 133, at 13.

135 Jacobi, *supra* note 12, at 80.

health policy agenda.[136] Indeed, some health policy researchers believe Medicaid expansion programs are pushing the United States in that direction.[137]

Yet, as noted earlier, many state leaders, particularly as represented by the NGA, are not ready to give up on the idea that the United States can have a workable, coordinated public-private system of health care coverage. Furthermore, with President Bush's support of the NGA agenda, attempts to coordinate public and employer-sponsored coverage are likely to be the state health policy priority for the next several years.[138] Groups such as the BadgerCare Coordination Network are building upon the idea of public-private partnerships by creating innovative enrollment solutions, such as enrolling eligible families into BadgerCare through the Milwaukee Public School system.[139]

While promoting coordination among various public and private entities, states must work toward achieving a seamless system of coverage that allows for continuity of care between public and private programs. This seamless system is especially important when one considers the potential fate of commercial managed care organizations (MCOs) and provider participation in Medicaid expansion programs. Currently, Medicaid reimbursement rates, especially for MCOs and physicians, are much lower than private insurance reimbursement rates.[140] Consequently, some commercial MCOs and providers have opted out of providing services to public programs such as Medicaid and BadgerCare,[141] even though MCOs are the dominant vehicle for

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136 Collaboration for Healthcare Consumer Protection bimonthly meeting, in Madison, Wis. (Feb. 16, 2001) (where one CHCP member stated that he hopes crowd out does occur so that state leaders, many of whom are ready to discuss universal health insurance, will be forced to address universal public coverage).

137 Jacobi, *supra* note 12, at 116 (stating that "[u]nder reasonable assumptions about the future cost of health care and the American labor market, this trend can be anticipated to lead to a transformation of America's mixed public-private health insurance system from one dominated by private coverage to one in which public coverage is the norm").

138 *See supra* note 26 and accompanying text.

139 *"Back-to-School" 2001 Health Fair*, BadgerCare Coordination Network Enrollment Outreach Committee Proposal, (2001) (on file with author) (indicating participants in the Back-to-School initiative include health advocacy agencies, community-based organizations, Milwaukee area hospitals, other providers, as well as representatives of the City of Milwaukee, Milwaukee County, and the State of Wisconsin).

140 Sidney D. Watson, *Commercialization of Medicaid*, 45 ST. LOUIS U. L.J., 53, 55 (2001); Bruen & Holahan, *supra* note 133, at 13-14.

141 Watson, *supra* note 140, at 56 (noting that due to the low reimbursement rate,

providing services under those programs.[142] If exit by commercial MCOs and providers continues, states may face a dichotomous insurance system – one for privately insured people and one for the publicly-insured. One researcher noted that "today, the fastest growing category of Medicaid managed care is the 'Medicaid only' plan [or, "Welfare HMO"], one in which seventy-five percent or more of enrollees are Medicaid recipients."[143] As a result, "welfare HMOs return Medicaid recipients to the segregated world of welfare medicine,"[144] rather than "one managed care plan for both privately insured people and those with Medicaid."[145]

A better intermeshing of public and private health coverage might alleviate the dichotomous nature of the current insurance system. First, by promoting private employer health coverage through programs like BadgerCare's HIPP, providers and MCOs will likely receive higher reimbursement rates overall since privately covered services will be reimbursed at a higher rate than the services covered under the public program.[146] Second, pooling the publicly insured with the privately insured will make the pooled enrollees more attractive to HMOs.[147] Pooling enrollees will facilitate averaging costs of high use versus low use patients, as well as "allow for economies of size and scale."[148] Third, better coordination of public and private health insurance will promote continuity of care and reduce the stigma that is connected with public insurance programs.[149] As one researcher noted, "[a]s the intermeshing of public and private coverage proceeds, low-income workers are more likely to maintain coverage as their

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nationally, "nearly one-quarter of physicians refuse to treat Medicaid patients"); Telephone Interview with Tom Hefty, President, Wis. Blue Cross Blue Shield, Nov. 3, 2000 (stating that Wisconsin HMOs are losing money with BadgerCare, thus explaining why several HMOs, including CompCare and Physician's Plus Insurance Corp. have dropped out of both BadgerCare and Medicaid).

142 Watson, *supra* note 140, at 54 (noting that "sixty-four percent of Medicaid enrollees obtain care through commercial HMOs – private, for-profit entities"). *See also* CARABELL & MEGNA, *supra* note 6, at 60 (stating that "approximately 70% of BadgerCare recipients are enrolled in HMOs").

143 Watson, *supra* note 140, at 69.

144 *Id.*

145 *Id.* at 64.

146 Interview with Don Schneider, *supra* note 18.

147 Watson, *supra* note 140, at 73.

148 *Id.* at 74.

149 Jacobi, *supra* note 12, at 114-15.

employment status changes . . . [and] their membership in a health plan could remain continuous."[150]

However, to achieve such coordination successfully, states will need access to employer health plan information. The three legal arguments to avoid ERISA preemption presented in this paper offer some options for states to use as they attempt to extract the employer health plan information needed for effective implementation of Medicaid expansion programs. As a result of these ERISA loopholes, ERISA does not have to be the blockade that some state leaders believe it to be. With additional resources devoted to centralizing employer health plan information into an accessible database, ERISA plan information may become available to states and the public-private partnerships they foster, if only to learn about current trends in employer-based coverage and how states can most effectively respond to those trends and ensure health coverage for all.

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[150] *Id.* at 115.