ERISA Implications for State "Pay or Play" Employer-Based Coverage

Supplement D to the Report:

Challenges and Alternatives for Employer Pay-or-Play Program Design: *An Implementation and Alternative Scenario Analysis of California's "Health Insurance Act of 2003" (SB 2)*

For the
California Health Care Foundation
and the
California Managed Risk Medical Insurance Board

Project Team Led by the
INSTITUTE FOR HEALTH POLICY SOLUTIONS

March 2005

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Acknowledgements

This supplement is part of a comprehensive report entitled *Challenges and Alternatives for Employer Pay-or-Play Program Design: An Implementation and Alternative Scenario Analysis of California's "Health Insurance Act of 2003" (SB 2).* The study that produced these reports was funded by a grant from the California HealthCare Foundation (CHCF), an independent philanthropy committed to improving California's health care delivery and financing systems.

Pat Butler, J.D., Dr. P.H., was the principal author of this supplement on the ERISA implications and legal considerations surrounding SB 2, the pay-or-play legislation that was passed by the California legislature in 2003 but subsequently overturned by referendum. The lead organizations for the overall study were the Institute for Health Policy Solutions and the RAND Corporation. Rick Curtis, of the Institute for Health Policy Solutions, served as the project director. Please see the main body of the report for a detailed discussion of the study process.

The project team is grateful to Deborah Kelch, President of Kelch Associates and our liaison with the Foundation, who provided substantial assistance with the interview process and whose project management skills helped keep us on track. Last, but not least, Jill M. Yegian, Ph.D., and Marian R. Mulkey, M.P.H, M.P.P., of the California HealthCare Foundation provided analytic insights, helpful comments, and other support throughout the project. Without the assistance of the Foundation and its staff, this project would not have been possible.

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Background

The California Health Insurance Act of 2003 (also known as SB 2) adopted a "pay-or-play" mandate aimed at reducing the size of the state's uninsured population. This law required employers over a certain size to either: (a) "pay" a fee to the state so that their workers and, for employers with 200 or more workers, dependents could be covered through a State Health Purchasing Program established under the Act, or (b) "play" by directly providing health coverage for specified workers and dependents. Although SB 2 was overturned by a narrow margin in a November 2004 referendum, the passage of legislation intended to expand employment-based coverage provides a unique opportunity to assess and to evaluate the implementation issues and challenges presented by a "pay-or-play" program.

ERISA, the federal Employee Retirement Income Security Act of 1974, raises potential problems for state pay-or-play laws because it preempts state laws that "relate to" employer-sponsored benefit plans. This paper examines the ERISA implications and legal considerations surrounding SB 2. In brief, it outlines ERISA's preemption principles, court interpretations of them, and their relevance to state pay-or-play laws.[1]

Congress enacted ERISA primarily to address fraud and mismanagement in private-sector pension plans. But ERISA also applies to other types of workplace fringe benefit programs, including private-sector employer- or union-sponsored health coverage offered through insurance or otherwise. ERISA imposes relatively fewer requirements on health plans than pension plans (for example, it does not set solvency standards and requires health plans to cover only three specific benefits[2]). ERISA does not apply to health coverage obtained in the individual market, from public sector employers like state and local governments, or from churches.

Preemption Provisions

Although federal law typically prevails if it conflicts with state law, ERISA contains an unusually broad preemption clause providing that federal law supercedes state laws that "relate to" private-sector employee benefit plans. The purpose of this broad federal preemption was to encourage voluntary employer-sponsored benefits by relieving plan administrators from complying with multiple, and potentially conflicting, state laws. Responsibility to interpret

[1] For a more detailed examination of ERISA case law and its relevance to SB 2, see Butler, Patricia, *ERISA Implications for SB 2: Full Report*, March 2004, California HealthCare Foundation, www.chcf.org.

[2] Limited mental health parity, post-mastectomy reconstructive surgery, and post-delivery maternity care were enacted in 1996. Through COBRA, ERISA also requires health plans to allow terminating employees to continue as part of the workplace health coverage by paying 102 percent of the premium.

ERISA's preemption clause is left to the courts, which have relied on this stated congressional intent to apply preemption quite broadly to invalidate state laws with sometimes even minimal impacts on employer-sponsored plans, even if they do not directly conflict with federal law.

One important exception to ERISA preemption is the authority for states to regulate insurance (excepted in the so-called "savings clause"). But ERISA forbids states to consider self-insured employer-sponsored plans to be insurers. Consequently, the preemption provisions prohibit states from regulating employer-sponsored plans directly but permit states to regulate insurance products that insurers sell to employer-sponsored plans, thus influencing insured ERISA plans. Both insured and self-insured plans sponsored by private sector employers and unions are ERISA plans.

Court Interpretation of ERISA Preemption

In its over two dozen ERISA preemption cases, the U.S. Supreme Court has attempted to define what state laws "relate to" ERISA plans so as to be preempted. The Court has held that ERISA preempts state laws that attempt to regulate ERISA plans directly or have a substantial indirect effect on a plan. State laws may not *refer to* ERISA plans or have a *connection with* them by affecting a plan's benefits, structure, or administration.

For example, the Court let stand lower court decisions holding that ERISA preempted Hawaii's mandate that employers cover certain workers and that California could not apply managed care standards to self-insured employers.[3] It held that a state law mandating mental health benefits in all group health insurance related to ERISA plans but was saved from preemption as insurance regulation insofar as it applied only to insured plans.[4] It held that ERISA preempted a state law exempting ERISA plans from wage garnishment procedures because it was designed to affect them (even though favorably).[5] It also preempted a law requiring employers that offered health coverage to workers to provide equivalent coverage as part of workers' compensation coverage (workers' comp programs are not governed by ERISA), both because the law referred to ERISA plans and also because it premised workers' comp benefits on the existence of an ERISA plan.[6]

While ERISA preemption seemed almost infinite in the first 20 years of court decisions, in 1995, the Supreme Court tempered its reach in the *Travelers Insurance* case.[7] The decision upheld the New York hospital rate-setting law that imposed surcharges of up to 24 percent on hospital bills paid by commercial insurers but not Blues plans. While acknowledging that the law imposed higher costs on employer-sponsored health plans buying coverage from commercial carriers and created an incentive to choose Blues plans, the Court held that ERISA did not preempt the law because it was not directed at ERISA plans and that such indirect economic influence does not

[3] *Standard Oil Co. of California v. Agsalud*, 442 F. Supp. 695 (N.D. Cal. 1977), *affirmed*, 633 F. 2d 769 (9th Cir. 1980), *affirmed by memorandum*, 454 U.S. 801 (1981); *Hewlett-Packard v. Barnes*, 425 F. Supp. 1294, *affirmed*, 571 F. 2d 502 (9th Cir. 1978), *certiorari denied*, 439 U.S. 831 (1978).

[4] *Metropolitan Life Ins. Co. v. Massachusetts*, 471 724 (1985).

[5] *Mackey v. Lanier Collection Agency*, 486 U.S. 825 (1988).

[6] *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992).

[7] *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance*, 514 U.S. 645 (1995).

"bind plan administrators to any particular choice" or interfere with plans' ability to design uniform national benefit programs.

The Court also has decided several cases interpreting the savings clause, but they are not germane to discussion of state pay-or-play laws.[8]

Implications for State Pay-or-Play Laws

A typical state pay-or-play law would create a public health coverage program, funded, at least in part, by assessing public and private employers and providing health benefits to their workers. (The program also could include other revenue sources and cover other populations, such as unemployed people.) Employers could choose to pay the assessment[9] or to cover their workers, in which case they would receive a credit against the assessment for the cost of this coverage (up to the limit of the assessment). Although the law's purpose would be to cover workers through a public program, it would offer the credit to employers because they relieved the state of this responsibility and to allow multi-state employers the opportunity to design uniform national health plans.

Under the precedent of the *Travelers Insurance* case, such a pay-or-play law seems most likely to survive an ERISA challenge if it does not:

- Directly refer to employer plans but instead impose the assessment on the employer,
- Attempt to mandate employer-sponsored coverage – that is, the law should be neutral with respect to whether an employer pays the assessment or covers its employees and not be a thinly disguised employer mandate, or
- Have an impermissible "connection with" employer coverage by virtue of impacts on plan benefits, structure, or administration – that is, the law should not condition access to the credit on an employer plan's benefits, premium sharing arrangements, or other administrative features or impose exorbitant costs on employer plans.

Although, as a policy matter, states may want to assure that an employee health plan in a pay-or-play program is adequate by some objective standards, as a legal matter, ERISA is likely to prohibit a state from regulating plans in this way.[10] For this reason, California's SB 2 raised several ERISA preemption issues.[11] The pay-or-play law enacted in Massachusetts in 1988 offered a credit against a payroll tax for the actual cost of employer coverage (up to the amount

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[8] In addition to benefits mandates upheld in *Metropolitan Life*, for example, under the savings clause, the Court upheld state laws requiring HMOs and other health insurers to allow enrollees to seek an independent review of coverage decisions in *Rush-Prudential HMO v. Moran* (536 U.S. 355 (2002)) and upheld state laws requiring health insurers to include in networks any provider willing to accept plan terms and payment in *Kentucky Association of Health Plans v. Miller* (123 U.S. 1471 (2003)).

[9] In most states this would be a tax, but to avoid constitutional complications in California, the assessment might be characterized as a "fee," as it was in SB 2.

[10] If an employer-sponsored plan provided very skimpy benefits, presumably it would cost less than the fee or tax, requiring the employer to pay a partial fee or tax, with which the state program could supplement benefits for that employer's workers. This approach could be cumbersome to administer and does not guarantee that an employer-sponsored plan's benefits are "adequate" as a state might define them.

[11] See *ERISA Implications for SB 2*, cited in note 1.

of the tax) without conditioning the credit on a plan's benefits or other features and therefore was easier to defend against an ERISA preemption challenge.[12]

Had SB 2 survived the 2004 referendum, it was likely to be challenged on ERISA preemption grounds. While the rationale in the *Travelers Insurance* case probably prevented the fee itself from being preempted, waiving the fee only for plans covering mandated state insurance benefits and where the employer paid at least 80 percent of the premium presented more serious preemption problems. SB 2's alternate basis for a waiver of the fee (plans costing at least as much as one of two benchmark public programs) might have been easier to defend because it imposed only a threshold cost to qualify for the waiver rather than specific plan design requirements. It is not clear, however, whether a court might hold that even this cost threshold interferes with a plan administrator's freedom to design benefits.

Although no court has yet analyzed ERISA preemption implications of a state pay-or- play law,[13] Supreme Court precedent suggests that a law that does not refer to ERISA health plans and imposes minimal burdens on them could survive an ERISA challenge. The more that a state law attempts to influence workplace coverage, the more vulnerable it is to a successful ERISA preemption lawsuit.

[12] Massachusetts Labor & Industrial Code 151A section 14G, reprinted in Patricia Butler, *Revisiting Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints*, May 2002, National Academy for State Health Policy, www.nashp.org.

[13] The Massachusetts restaurant association challenged the law in court, but dropped the case when the law was suspended (and eventually repealed).