What Can We Learn About Federal ERISA Law from Maryland's Court Decision?

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Because voluntary approaches have not reversed the trend of declining employer health insurance, states have begun to consider more mandatory approaches. However, legislating employer financing of health care access initiatives runs the risk of a legal challenge under federal ERISA law. ERISA clearly prohibits states from requiring private employers or unions to offer coverage. Yet policymakers should be able to overcome ERISA challenges by drafting laws that (a) rely on traditional state authority, (b) avoid direct references to ERISA health plans, and (c) minimize impacts for multi-state employers desiring uniform national plans. For example, mandating individual coverage, as Massachusetts did, raises no ERISA problems. ERISA should not preempt a well-designed pay or play law that offers dollar-for-dollar credit for employer health care spending. States should be able to require employers to establish Section 125 cafeteria plans, as long as the law does not specify what type of health coverage should be offered.

Health insurance premiums are increasing four times faster than earnings for the average American worker.[1] Each year, more families are unable to afford health insurance and still pay the rent. At the same time, there has been a widespread decline in employer-sponsored insurance, particularly among small employers. In response, many states have encouraged employers to voluntarily offer health insurance to their employees and contribute to the cost of health benefits. Because these voluntary approaches have not reversed the trend of declining health insurance, some states have begun to consider more mandatory approaches. However, these mandatory programs run the risk of a legal challenge under ERISA, the 1974 federal Employee Retirement Income Security Act.

Health care access initiatives involving employer contributions run the risk of a legal challenge under federal ERISA law.

To comply with ERISA, state policymakers must carefully design health care access initiatives that involve employer contributions. In that spirit, this chapter provides background on the federal ERISA law, explains why state policymakers are concerned, and describes what states can and cannot do in designing access legislation under ERISA. I also discuss which strategies policymakers might consider, how they might finance access initiatives, and what the ERISA implications are of approaches used in Maryland and Massachusetts.

What is ERISA?

In 1974, Congress enacted ERISA, the Employee Retirement Income Security Act, primarily to remedy fraud and mismanagement of private employer pension plans. In addition to regulating pension plans, ERISA also applies to other employee benefits including health coverage. When the law was passed, one main concern

of Congress was encouraging employers to offer health insurance without being subject to varying state laws.

ERISA does apply to both insured and self-insured plans offered by private sector employers and/or unions. However, it does not apply to churches or to public employer health benefits.

Why are State Policymakers Concerned About ERISA?

State policymakers are concerned about ERISA for several reasons, three which are covered here. First, federal law usually preempts or supersedes only state laws that are in direct conflict with federal law. However, ERISA has a broad preemption clause that supersedes state law related to employee health benefit plans, even when there is no conflict with federal law.

Second, ERISA is interpreted, not by the Department of Labor, but instead by the courts. The problem with allowing courts to interpret the law is that policymakers do not know what is allowed or disallowed until cases have been filed and the courts have decided. Third, ERISA affects what strategies states can use to include employer financing in access initiatives, although vast grey areas exist regarding what states can and cannot do.

What States Cannot Do Under ERISA

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ERISA clearly prohibits states from requiring private employers or unions to offer health coverage. The one exception to this is Hawaii. Just before ERISA passed in 1974, Hawaii mandated employers to provide health coverage to full-time employees. In 1983, Hawaii was granted an explicit exemption that does not apply to any other state.

To identify what states cannot do under ERISA, the Supreme Court set out a series of basic tests to provide guidance for lower courts. For 20 years, these tests were interpreted broadly, but recently the courts have narrowed the scope in ways that are more favorable to states wanting to expand health care coverage. State laws must, however, still pass the following tests:

(1) Does state law refer to ERISA plans either explicitly or implicitly?

(2) Does state law have a connection to ERISA plans by affecting its benefits, structure, or administration? Does it regulate areas ERISA addresses or impose substantial costs on plans?

If the answer to any of these questions is yes, the law will likely be preempted.

What States Can Do Under ERISA

States are prohibited from directly regulating employee health plans. However, the most important exception to ERISA is the "savings clause," which allows states to regulate the insurers who provide employee health plans. Thus, the state has some influence over insured employee health plans, but not self-insured plans.

Using the savings clause, states can mandate:

- benefits requirements of health plans (e.g., mental health),
- provider coverage (plans that offer a service such as acupuncture are required to include some acupuncturists to provide that service),
- any willing provider (e.g., the use of managed care plans), and
- external review laws (allowing health plan enrollees to appeal to an outside medical expert when denied coverage under a plan's internal appeals process).

For states interested in expanding coverage, the 1995 *Traveler's Insurance* case is important. This decision upheld a New York rate setting law that made commercial insurance pay higher costs than Blue Cross plans. The 24% hospital surcharge imposed on plans other than Blue Cross made choosing Blue Cross more attractive. However, the court reasoned that it did not violate ERISA because it did not bind plan administrators to a particular choice of benefits or plans. The court also ruled that Congress did not mean to undermine the state role in traditional areas of state authority such as hospital rate setting and health care cost containment.

What this means for state policy initiatives is that states cannot directly regulate how ERISA plans are designed or administered, but states can raise the costs of these plans as long as the cost increases are not substantial. Moreover, policymakers can design plans in ways that are consistent with traditional lines of state authority.

What are the ERISA Implications of State Health Care Access Initiatives?

This section describes the potential ERISA implications of several initiatives that states could try, and that Maryland and Massachusetts have tried.

Maryland's Fair Share Act. The Maryland legislature passed this law in early 2006. If for-profit employers of 10,000 or more workers did not spend at least 8% of payroll on health insurance costs, they were required to pay the difference into a state Medicaid fund. The standard for non-profit employers was 6%. This law ended up affecting only Wal-Mart because of its size and limited health care spending.

In July 2006, a federal district court ruled that ERISA preempts this state law. In *RILA vs. Fielder*, the court held that the purpose and impact of the law required Wal-Mart to expand its ERISA health plan. Moreover, this law was found to interfere with uniform national administration of Wal-Mart's health plans in other states. The judge did suggest he might have ruled differently if state laws, like the 2006 Massachusetts law, addressed health care issues more comprehensively with only incidental effects on ERISA health plans.

On appeal, Maryland has argued that Supreme Court precedent does not prohibit laws that merely raise the cost of plans. What the law does is to mandate spending, which is different from mandating employers to maintain ERISA plans.

If this decision is not reversed upon appeal, it will be difficult for states to enact spending requirements like Maryland did. States should avoid laws that target only a small number of employers and that appear to mandate health benefits. Taxes

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on employers for employees who use public programs might survive an ERISA challenge if they are assessed without regard to whether employees are covered under an employer-sponsored plan.

Pay or play laws could comply with ERISA depending on how they are designed.

Pay or Play Plans. Pay or play plans could comply with ERISA depending upon how they are designed. States should be able to create a public health plan financed by taxing employers (not plans); employers offering coverage would then be allowed a dollar-for-dollar credit for spending on employee health care. In essence, the state is creating a public health coverage program that allows a credit for employers that help the state provide health coverage.

The classic example was a 1988 Massachusetts law. For companies with more than five employees, employers were taxed on 12% of the payroll for full-time workers up to $14,000 (indexed to health care costs); a dollar-for-dollar credit was granted for employee expenses for health care coverage. This tax was one source of funding for a universal health care access program in the state. The law was challenged in court on ERISA grounds, but was repealed before a court ruling.

This approach should withstand an ERISA preemption challenge because: (a) it does not interfere with the choices of the ERISA health plan administrators—they can either offer coverage or pay an assessment, and (b) taxing is a traditional area of state authority. A pay or play law could most easily overcome a preemption challenge if it:

- does not refer to ERISA plans.
- is neutral about whether employers pay or offer coverage (not a disguised mandate)
- applies to any health care spending (not only to more traditional health insurance or formal health plans)
- is not conditioned on whether an employer's plan meets certain benefits or requirements, and
- does not require employers to pay for employees to qualify for coverage under the public program.

Massachusetts 2006 Health Care Access Bill. In 2006, Massachusetts passed an individual health care mandate. This law requires all state residents who can afford it to buy health care coverage or face substantial penalties. The law creates the Connector, a quasi-governmental organization to link individuals and firms with approved insurance products. The thrust of this bill is on individuals, but it requires employers with more than 10 employees to:

- establish IRS Section 125 plans allowing workers to purchase health insurance with pre-tax funds,
- pay a "free-rider surcharge" of between 10% and 100% of the cost of their employees' uncompensated care if the employer does not create a Section 125 plan,
- pay the state a "fair share" assessment up to $295 per full-time equivalent per year if they do not contribute a "fair and reasonable"

amount toward employee health insurance; this was interpreted in recent regulations to require employers to pay at least one-third of the employee's premium if at least one-quarter of employees are not enrolled in the employer's plan, and

- report to the state if a Section 125 plan is offered, whether employees decline the employer's health plan, and other information needed to implement the free-rider surcharge.

The Section 125 plans, also known as cafeteria plans, allow employees to pay for health coverage and other specified benefits with pre-tax wages. Employers can also exclude these contributions from the wages on which they pay FICA and unemployment taxes. The Department of Labor (DOL) does not consider these plans an employer-sponsored benefit under ERISA, so they are not considered ERISA plans. If the courts agree with DOL, a law requiring employers to establish Section 125 plans should not be preempted. Nor should plans that employees purchase through the Connector or on their own be considered ERISA plans.

The free-rider surcharge applies if employers do not establish a Section 125 plan. The purpose of the surcharge is to finance uncompensated care—a long-recognized state responsibility. Theoretically, the fair share assignment might raise preemption concerns because it attempts to affect ERISA plan structure (i.e., by waiving the assessment only if the employer pays a given share of the premium). However, the state could argue that $295 per full-time employee is so insubstantial that it is not likely to have much of an impact. Practically, the law was supported by much of the business community, so it is unclear whether any employers will challenge it. The reporting requirements are minimal and should not bring a preemption challenge.

Premium Assistance Programs. Some states use Medicaid or SCHIP funding to assist low-wage workers in paying the employee share of employer health care; these premium subsidies should not be an ERISA problem. However, the biggest challenge in operating premium assistance programs is that states cannot require employers to provide information on their health care coverage. States often work with individuals to get the information they need to determine if premium assistance is cost effective.

This is one of the most likely areas in which the federal ERISA law could be amended. Federal law already requires employers to provide information to child support enforcement authorities. Similar language could be used to require employers to provide the information needed for operating premium assistance programs.

Single-Payer Plans. Universal publicly administered programs like single-payer systems can raise ERISA problems. Such plans may create incentives for employers to terminate or modify health plans, thereby influencing the structure of ERISA plans. ERISA preemptions become more complicated if a universal public program is financed by an employer payroll tax. Conceivably, multi-state employers might feel they are being forced to pay twice—their own health coverage costs as well as the payroll tax. For this reason, a single-payer plan funded by income tax (or an employee-only payroll tax) might be easier to defend from an ERISA challenge than an employer-paid payroll tax.

For financing universal public health programs, an employee payroll tax is easier to defend than an employer payroll tax.

States could defend tax-financed, single-payer plans on the grounds that it is hard to imagine the 1974 Congress intended to preempt such programs. Also, states could argue that financing health care is a long-standing state power. To date, no court has decided a case on a neutral financing scheme that eliminates the need for employer-sponsored coverage.

How Can States Raise Money for Access Initiatives Under ERISA?

In tight budget times, policymakers are asking how to raise money for health care access initiatives that can withstand an ERISA challenge.

- Taxes imposed on employer- or union-sponsored plans probably will face an ERISA challenge.
- Taxing insurers or health care providers should not be preempted, even if this increases the costs of ERISA plans.
- Taxes on employers, if they are allowed a dollar-for-dollar credit for spending on employee health care, are not likely to face an ERISA challenge.
- Payroll taxes on employees (not employers) to support universal, publicly-financed health programs ought to be okay; however, a state would need to successfully argue that Congress did not intend to preempt a public program, even if it does eliminate the need for employer-sponsored health plans.

Conclusion

Mandating individual coverage, as Massachusetts did, raises no ERISA problems.

Mandating individual coverage, as Massachusetts just did, raises no ERISA problems, even if employees enroll in employer coverage. ERISA should not be an issue in purely voluntary employer incentives such as health coverage tax credits or premium assistance subsidies for lower-wage workers enrolling in employer-sponsored plans.

Imposing mandatory requirements can raise ERISA concerns. Yet states should be able to tax employers to finance comprehensive public health care coverage if (a) the tax for employers whose employees use public programs is assessed without regard to whether employees are covered under an employer-sponsored plan, and (b) the program has only incidental effects on ERISA health plans. ERISA should not preempt a well-designed pay or play law that offers a dollar-for-dollar credit for employer health care spending, because it would not interfere with ERISA plan administrators' choices. States should also be able to require employers to establish Section 125 cafeteria plans, as long as the law does not specify what type of health coverage should be offered.

Unfortunately a large grey area exists in ERISA preemption. Policymakers will know for sure only when the Supreme Court decides a case. However, states should be able to overcome ERISA challenges by drafting laws that (a) rely on traditional state authority, (b) avoid direct references to ERISA plans, and (c) minimize impacts for multi-state employers desiring uniform national plans.

Maryland's court decision makes some laws difficult to defend from ERISA preemption challenges. Other financing approaches stand a better chance and are worth pursuing.

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This chapter is excerpted from a November 2006 paper written for AcademyHealth and the National Academy for State Health Policy by Patricia A. Butler, "*ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland "Fair Share Act" Court Decision* (http://www.statecoverage.net/SCINASHP.pdf) and a March 2005 Cyber Seminar presentation for the Robert Wood Johnson Foundation's State Coverage Initiative Program and the National Academy for State Health Policy by Patricia A. Butler, "*ERISA's Implications for State Health Care Access Initiatives"* (http://www.statecoverage.net/cyberseminar/index.htm).