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ERISA Implications for State Health Care Access Initiatives:

Impact of the Maryland "Fair Share Act" Court Decision

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This issue brief is part of a continuing series of policy papers published by the Robert Wood Johnson Foundation's State Coverage Initiatives program, housed at AcademyHealth, and the National Academy for State Health Policy on the state health policy implications of ERISA's preemption clause.[1] The purpose of this brief is to explore the implications for state health care access initiatives of the recent federal court decision that ERISA preempts Maryland's "Fair Share Act."

Summary

Because it supercedes state laws that "relate to" private sector-sponsored health benefit programs, ERISA complicates state efforts to include employer financing in initiatives to expand access to health care. This issue brief discusses implications of the recent court decision holding that ERISA preempts one such law, the Maryland Fair Share Health Care Fund Act.

ERISA, the federal Employee Retirement Income Security Act of 1974, applies to pension and other employee fringe benefit programs, such as health coverage, sponsored by private sector employers. As interpreted by the U.S. Supreme Court and lower courts, the act preempts state laws that relate to private sector plans because either they refer to such plans or they affect plans' benefits, structure, or administration. While states cannot mandate that employers offer health insurance, the Supreme Court held in its 1995 *Travelers Insurance* decision that ERISA does not preempt state laws in traditional areas of state regulatory authority that are not directed at ERISA plans and do not interfere with uniform national administration of multi-state plans by compelling plan administrators to structure benefits in a particular way. State laws cannot directly regulate ERISA plan conduct but can raise their costs.

In early 2006, the Maryland legislature enacted the "Fair Share Act," requiring for-profit employers of 10,000 or more workers that do not spend at least 8 percent of payroll on "health insurance costs" to pay the difference into a fund supporting the state Medicaid program. (The standard for non-profit employers was 6 percent.) Only Wal-Mart would have been required to pay the assessment by virtue of its size and estimated health care spending. In July 2006, a federal district court held in *RILA v. Fielder* that ERISA preempts the state law because both its purpose and its impact would require Wal-Mart to expand its ERISA health plan; this would interfere with uniform national administration of the firm's plan if other states imposed different requirements, as some have proposed. The judge did suggest that he might rule differently if state laws, like the one recently enacted in Massachusetts, addressed health care issues "comprehensively" with only incidental effects on ERISA plans.

On appeal, the state of Maryland is likely to argue, among other things, that the Fair Share Act is not a mandate for employers to maintain ERISA plans and that Supreme Court precedent does not prohibit state laws that merely raise plan costs—in other words, that a spending mandate is not a benefits mandate. Nevertheless, unless the decision is reversed on appeal, the *RILA* case makes it difficult for states to enact spending requirements like the one in Maryland. For example, states should avoid laws targeting only a small number of employers that may be characterized as health benefits mandates.

Both the court's decision and the previous preemption cases raise some possible challenges to other recently enacted state laws. For example, the 2006 Massachusetts reform law would require employers with more than 10 employees to: create tax code section 125 plans for workers to pay for health insurance with pre-tax funds, pay the uncompensated care costs their employees incur if the firm does not create a 125 plan, pay up to $295 per full-time equivalent worker per year if at least one fourth of employees are not enrolled in an employer plan or if the employer does not contribute at least one third of the premium, and report certain information on employee coverage to the state. Some of these provisions, like the section 125 plan mandate, are more easily defended against an ERISA challenge (because the U.S. Department of Labor, which administers ERISA, takes the position that section 125 plans are not themselves ERISA plans). The annual per employee

assessment raises preemption concerns but might be defended because its purpose is to fund the state's uncompensated care program and insurance subsidies for lower wage workers and because of its small size—it gives employers a choice between paying the assessment and providing health coverage and is not so large as to offer only one practical option and be characterized as an insurance mandate. A 2006 Vermont law imposes a $365 annual "premium" on employers for full-time equivalent employees who are not eligible for or for whom the employer does not contribute to health coverage or who decline offered coverage. This law also raises ERISA issues similar to those in the Massachusetts law, though it also may survive a preemption challenge. Because these laws are drafted differently and have different likely impacts than the Maryland act, the *RILA* decision may not be directly applicable. But, the laws will need to overcome potential challenges based on the Supreme Court's preemption principles.

Despite the *RILA* decision, states should be able to undertake health care access initiatives that involve employers in financing coverage. For example, a "pay or play" law like the one enacted (but never implemented) in Massachusetts in 1988 seems defensible. A broad-based state tax or other assessment (to fund a public coverage program or premium subsidies for lower wage workers) on a large proportion of employers could allow employers to credit against this assessment the cost of any health care spending. Such a program arguably falls within the language in *Travelers* by leaving to each employer complete choice of whether to pay the tax or cover workers. This approach, while not yet evaluated in any court, seems among the easiest to defend against a preemption challenge.

This issue brief discusses in greater detail ERISA preemption principles, the Maryland law and *RILA* decision, implications for state health care access initiatives involving employers in financing, and arguments that may be raised to challenge and defend such state programs.

Introduction

Most working Americans receive health benefits through their employers, but the proportions of both employers offering health benefits and workers covered by these plans are dropping, primarily among small firms.[2] In recent decades, many states have sought to encourage more employers to offer and contribute to employee health benefits programs through voluntary options such as tax credits and purchasing pools. Because coverage offered by employers is often unaffordable to lower wage workers, some states also have provided income-based subsidies to individuals participating in their employers' programs. But because voluntary employer incentives generally have not reversed the trend of declining health coverage, some states have begun to consider more mandatory proposals, such as assessments on non-insuring employers or broader "pay or play" strategies. In contrast to purely voluntary employer incentives, however, mandatory programs run the risk of being challenged under ERISA, the federal pension law.

In the first case examining recent employer assessment strategies, a federal district court held in July 2006 that ERISA preempts Maryland's "Fair Share Health Care Fund Act" (sometimes called a "Wal-Mart law" because only that firm would have been required to pay the assessment). Re-enacted in the 2006 legislative session over the Governor's 2005 veto, the law required for-profit employers of 10,000 or more workers that do not spend at least 8 percent of payroll on health care costs to contribute the difference to the state Medicaid program. The court's decision poses a potential obstacle to similar health care access initiatives under consideration in many states. Some of the court's language is not helpful to state efforts. But state health policymakers can design health care financing programs involving employer contributions that should withstand an ERISA challenge.

ERISA Preemption Principles

ERISA, the federal Employee Retirement Income Security Act of 1974, was enacted to remedy fraud and mismanagement in private-sector employer pension plans. It also applies to other employee benefit plans sponsored by private-sector unions or employers (other than churches). Such employee benefits plans, which include health coverage, are "ERISA plans," regardless of whether they are offered through insurance or self-insured by the sponsor. While regulating pension plans in considerable detail, ERISA provides limited federal regulation of health plans.

Nevertheless, the Act contains a broad preemption provision stating that federal law supersedes any state law that relates to ERISA plans, except those that regulate insurance, banking, and securities. States cannot deem employee plans to be insurers. Consequently, states are prohibited from regulating employee health plans directly. They can, however, regulate the insurers with which the employee plans contract, creating the distinction between insured plans (which states can regulate by regulating insurers) and self-insured plans (which they cannot).

Because ERISA's preemption provisions are not particularly clear on their face, courts have been interpreting them in the 32 years since ERISA was enacted. For two decades, the U.S. Supreme Court took an expansive view of ERISA state law preemption. The Court noted, for example, that the preemption clause was "conspicuous in its breadth," and overturned state laws with any impact on or reference to an ERISA plan's benefits, structure, or administration.[3]

Following early Supreme Court precedent, lower federal courts invalidated Hawaii's 1974 mandate that employers provide worker health coverage[4] and California's 1973 law setting benefit standards for employer-sponsored managed care plans.[5] A 1983 amendment to ERISA reinstated the Hawaii employer mandate.

In its 1995 *Travelers Insurance* decision, the Supreme Court narrowed the reach of ERISA preemption by limiting the types of state law impacts on ERISA plans that cause preemption.[6] It held that ERISA did not preempt New York's hospital rate-setting law, even though the legislation imposed some costs on ERISA health plans (because it made buying coverage from commercial insurers more expensive than coverage from Blue Cross plans). The Court reasoned that the law would not compel plan administrators to structure benefits in a particular way or to limit its ability to design uniform interstate benefit plans. The Court noted that "cost uniformity was almost certainly not an object of preemption."[7] It also observed that a state law might impose cost burdens so exorbitant that they removed any actual choice and therefore could be preempted. But, the 24 percent hospital cost surcharge paid by commercial insurers was not high enough to cause ERISA to preempt the New York law.[8]

The Court also has interpreted ERISA's so-called insurance "savings clause," which exempts state insurance regulations from preemption.[9] In addition to applying the preemption clause, the Supreme Court has held, under general constitutional principles of federalism, that state laws governing coverage disputes between plans and enrollees directly conflict with ERISA and are preempted on that ground alone.[10]

The Court has held in *Travelers* and subsequent cases that it would not presume (without clear evidence to the contrary) that Congress intended ERISA to preempt laws in areas of traditional state authority. Despite greater flexibility granted to state laws, however, the Supreme Court's two basic tests for preemption remain. A state law will be preempted if it:

- Refers to an ERISA plan, either explicitly[12] or by requiring reference to an ERISA plan in order to comply with the state law,[13] or
- Has a connection with an ERISA plan by substantially affecting its benefits,[14] administration,[15] or structure.[16]

The Maryland Law and Court Decision

The Statute

The Maryland legislature enacted the "Fair Share Act" January 12, 2006, overriding a gubernatorial veto of a bill originally passed in 2005.[17] The law requires for-profit employers of 10,000 or more workers that do not spend at least 8 percent of payroll on "health insurance costs" to pay the difference into a fund supporting the state Medicaid program. The health care spending threshold for non-profit organizations (like Johns Hopkins University) is 6 percent of payroll. The law defines "health insurance costs" broadly to include any health care spending (including employer-funded medical savings accounts) deductible by an employer under federal income tax law. Employers subject to the law are required to annually report to the state's Secretary of Labor, Licensing and Regulation their number of workers and the amount and percentage of payroll spent on employee health care.

The Maryland Court's Decision

Wal-Mart is the only employer in Maryland to which the law applies by virtue of its size and proportion of payroll spent for employee health care, which the court noted the bill's sponsors understood and intended. In early 2006, the Retail Industry Leaders Association ("RILA"), of which Wal-Mart is a member, challenged the Fair Share Act in court on the grounds that it both is preempted by ERISA and unconstitutionally discriminates between employers based on their size or profit status. On July 19, 2006 the federal District Court in Maryland held that ERISA does preempt the law, but that it is not unconstitutional.[18]

After deciding that RILA had standing to pursue the case on behalf of its members and the court had jurisdiction to hear it,[19] Judge Motz examined the ERISA preemption issue. The court first noted that it would look only at whether the Fair Share Act has a "connection with" ERISA plans (and would not examine the "reference to" test, but in a footnote, he suggested that he thought the statute does refer to ERISA plans).[20] The court identified Congress' primary objective in enacting the preemption clause as reducing the likelihood of multi-state employer plans being subject to varying state law requirements. It then held that the law thwarts interstate uniformity because its health care spending requirements "are not applicable in most other jurisdictions" and conflict with similar laws passed in at least two local areas (New York City and Suffolk County, NY) and various proposals in other states. Employer health care spending standards would vary by state and require Wal-Mart to "segregate a separate pool of expenditures for its Maryland employees and structure its contributions—and employees' deductibles and co-pays—with an eye to how this will affect the Act's 8 percent spending requirement."[21]

Based partly on public statements of the bill's sponsors and the fact that it was imposed on only one employer,[22] the court held that the law was not a tax to raise revenue but a penalty designed to "force" Wal-Mart to provide health coverage to its workers, which ERISA prohibits. Although such a financial incentive might not always result in employers deciding to expand coverage, court affidavits from Wal-Mart executives indicated the firm would increase contributions to its ERISA plans rather than pay a fee to the state.

The court rejected the Maryland Attorney General's arguments that ERISA does not preempt the law based on *Travelers* and two subsequent Supreme Court preemption cases, holding they involved substantially different types of state laws. For example, the court observed that the New York hospital rate-setting law at issue in *Travelers* had only an incidental effect on employer-sponsored plans (raising costs of those choosing commercial over Blue Cross plans) and did not inhibit plan administrators from designing uniform national benefit levels. The *Dillingham* case[23] held that ERISA did not preempt a state law allowing lower wage levels for public works contractors using state-approved compared to non state-approved apprenticeship programs (some of which were structured as ERISA plans when offered by multiple employers). The *RILA* court held that the financial incentive for plans to be state approved in *Dillingham* was different

than that under the Maryland law's assessment, partly because the California standards were similar to federal standards and therefore would not increase inter-state variation.[24] And the *DeBuono* case[25] involved a tax on health care providers, including one operated by an ERISA plan, but was not preempted because it did not target plan-owned clinics and involved health care provider regulation, a traditional sphere of state authority, both of which facts the *RILA* court said distinguished that state law from the Fair Share Act.

In contrast to these cases, Judge Motz held that the Fair Share Act: 1) is "not merely tangentially related to ERISA plans but is focused upon them," 2) is "targeted directly at the ERISA plan of a particular employer," and 3) has a direct economic impact by requiring Wal-Mart "to increase its health care benefits for Maryland employees and to administer its plan in such a fashion as to ensure that the statutory spending required by the Act is met." The court concluded that "the Act violates ERISA's fundamental purpose of permitting multi-state employers to maintain nationwide health and welfare plans, providing uniform nationwide benefits and permitting uniform national administration."

In a footnote that may help to distinguish the Maryland statute from other state laws, the judge noted that he expressed "no opinion on whether legislative approaches taken by other States to the problems of health care delivery and its attendant costs would be preempted by ERISA." He singled out the recently enacted Massachusetts legislation (discussed later in this issue brief) as addressing "health care issues comprehensively and in a manner that arguably has only incidental effects upon ERISA plans." Furthermore, he stated that, "[i]n light of what is generally perceived as a national health care crisis, it would seem that to the extent ERISA allows, it is strongly in the public interest to permit states to perform their traditional role of serving as laboratories for experiment in controlling the costs and increasing the quality of health care for all citizens."

The court rejected the state's argument that the law does not require an employer to create or expand an ERISA plan because it could be satisfied by other types of spending, such as creating a clinic or funding individual savings accounts – such as health savings accounts (HSAs) or health reimbursement arrangements (HRAs). The Judge noted that the U.S. Department of Labor's policy characterizes HSAs as not ERISA plans only if completely voluntary on the part of employees, which makes them a less certain means to satisfy the spending requirement so that, practically speaking, the law would have an effect on Wal-Mart's ERISA plan. Finally, the court dismissed the argument that the law offered Wal-Mart a choice of paying the fee or expanding worker coverage, noting that "if employers are faced with the choice of paying a sum of money to the State or offering an equal sum of money to their employees in the form of health care, no rational employer would choose to pay the State" and citing evidence that Wal-Mart would expand worker coverage.

Analysis of the Court's Opinion

The holding and some of the language in *RILA v. Fielder* limits the types of access initiatives that can easily withstand an ERISA preemption challenge. Although federal district courts in other states are not bound by the Maryland court's decision, when examining similar laws, they are likely to follow the court's reasoning, especially because it is the first case considering a type of employer health care financing strategy since the late 1970s. If the case, whose appeal will be argued in late November, is upheld by the Fourth Circuit Court of Appeals, it would have even stronger value as precedent. Therefore, as discussed below, it will be important for state policymakers to craft health care access proposals without the elements that troubled the Maryland court.

The court based its preemption analysis on a congressional objective of uniform administration of multi-state employer health plans. Drafters of the preemption clause explicitly defended it as avoiding "conflicting and inconsistent state and local regulation."[26] But the Supreme Court and lower federal courts have held that avoiding inconsistent state laws does not require absolute uniformity in laws that may have some impact on ERISA health plan administration. In *Travelers*, for example, the Supreme Court said that interstate differences in health care costs, workplace standards, or other costs of doing business do not raise ERISA preemption concerns and that Congress did not intend preemption to achieve "cost uniformity." Therefore, state access laws that raise ERISA plans' costs are not necessarily preempted if they are drafted to avoid being characterized as mandates. Once the *RILA* court determined that the law was essentially a mandate that an employer expand its workplace health coverage program, ERISA preemption was inevitable because the ERISA clearly prohibits state laws that mandate employer coverage or the contents of employer plans. But the court's conclusion that a *spending* requirement is the same as a *benefits* mandate does not necessarily follow from Supreme Court preemption analysis.

Furthermore, the *RILA* court's rejection of the state's argument that the law does not require employers to create or amend ERISA plans is inconsistent with Supreme Court precedent. The *Dillingham* case and several federal Court of Appeals decisions have held that ERISA does not preempt state laws applying to employer-provided programs or services that include but are not limited to ERISA plans.[27] The Second Circuit Court of Appeals has held, for example, that "where a legal requirement may be easily satisfied through means unconnected to ERISA plans and only relates to ERISA plans at the election of an employer, it "affect[s] employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."[28] But Judge Motz rejected this defense of the Maryland statute, concluding that other spending options were impractical (workplace clinics) or would not satisfy the state's objective (voluntary HSAs), especially given Wal-Mart's assertion that it would expand its ERISA plan rather than pay the assessment. The court may have misunderstood the U.S.

DOL's characterization of HSAs. While employee participation must be voluntary, DOL does not consider an employer's HSA contribution to create an ERISA plan,[29] so an employer should have been able to satisfy the Maryland spending requirement by creating and funding HSAs.

While laws targeting one or a small number of employers should not automatically be preempted on that ground alone, the Fair Share Act may have been particularly vulnerable due to its narrow focus on Wal-Mart, whose employee health benefits have been the subject of national attention and advocacy campaigns in many states. Limiting the number of employers subject to some type of "pay or play" strategy allows opponents to argue that the law does not impose a tax to fund a broad-based public program but rather is a thinly disguised mandate. A narrow focus also makes it easier for targeted employers to assert that they would expand or adopt ERISA plans to comply, whereas a tax imposed on thousands of employers to fund a publicly-financed health care access program might result in some employers paying the tax.[30] An employer's decision to cover workers or pay an assessment will depend on many factors, such as the amount of the fee relative to the cost of workplace health coverage, whether the employer already provides some level of coverage, and whether a public program funded by the tax in which its employees can participate would be advantageous for the firm and its workers (for example, by offering subsidies), among other considerations.

Although the court in *RILA* observed in a footnote that the Fair Share Act law might be seen to "refer to" ERISA plans, the Maryland law appears to have been rather carefully drafted to avoid a direct reference to ERISA plans. It defines "health insurance" as health care spending beyond that in traditional employer-sponsored plans (i.e., HSAs, direct employer reimbursement of worker health costs, or the establishment of tax code section 125 plans, which the Department of Labor characterizes as not ERISA plans).[31] The Second Circuit Court of Appeals has noted that the Supreme Court's "reference to" cases involve more than a mere allusion to ERISA plans but require examining the law's actual impact on (i.e., connection with) ERISA plans.[32] Therefore it is possible that the "reference to" test is merely another way to decide whether the state law is "connected with" ERISA plans, as Judge Motz conceded in his footnote.[33]

Implications of the *RILA* Case for State Health Care Access Initiatives

Voluntary Employer Programs

ERISA's preemption clause should not pose an obstacle to the many types of programs and incentives states have established to encourage employers to provide health coverage. For example, over the past 20 years, several states have granted income tax credits to small firms offering health coverage. Some states have developed purchasing pools, often combining the purchasing power of public agencies administering state employee benefits, Medicaid, and SCHIP with small employers.[34] Other states have developed insurance options for small businesses and individuals that provide subsidies for lower wage workers, often using federal Medicaid and/or SCHIP funds.[35] Several states use Medicaid or SCHIP funds to help low wage workers enroll in their employers' plans.[36] Some states also have used their authority to regulate health insurers to allow insurers to offer limited benefits policies, often focused on the small group market, or to require insurers to sell plans the state helps finance through reinsurance.[37]

Insofar as these current state programs are purely voluntary, they should raise no ERISA preemption concerns. A state law conditioning employer tax credits on policies meeting certain conditions (such as minimum employer premium contributions) poses a theoretical preemption issue as an attempt to influence an employer plan's structure or benefits. But a purely voluntary credit, even if a strong incentive, would not "bind plan administrators to a particular choice" of conforming its coverage to the credit's qualifications and so, under *Travelers* and *Dillingham* should not raise preemption problems. Nor should ERISA impede state subsidies for employers covering low wage workers with certain benefits or premium contributions or the opportunity for employers to participate in purchasing pools. ERISA can, however, hamper efficient administration of Medicaid and SCHIP premium assistance programs because states cannot require employers to report information about workplace coverage or eligibility, though states can obtain this information through employees.[38]

Mandatory Employer Obligations

Although some incentive programs have generated employer interest, state experience suggests voluntary measures are unlikely to reduce the number of uninsured workers substantially, especially as health insurance costs have continued to grow faster than wages. States therefore have begun to consider imposing mandatory responsibilities on employers, such as payroll taxes or other assessments to finance publicly-administered programs—either Medicaid and SCHIP or broader (if not fully "universal") coverage programs. Some of these approaches raise ERISA preemption issues.

"Pay or Play" Laws

Broadly conceived "pay or play" laws require employers to pay an assessment (whose proceeds partially finance a publicly-administered health coverage program) but provide a credit against that assessment for the amount of employee health care costs. The classic example of a pay or play program was the law enacted by Massachusetts in 1988, imposing a 12 percent tax on wages up to $14,000 of employers with more than five employees but granting a dollar-for-dollar offset to the tax for insurance or other federal income tax-deductible employee health expenses.[39] The tax was one source of funding for a state universal health care access program. Although challenged in court on ERISA grounds, the law was repealed before implementation and no court ruled on its legality.

The rationale for offering a credit for employer coverage is that employers thereby relieve the state of an obligation it has undertaken through a public program (to cover all state residents or subgroups such as lower wage workers). The advantage to such a pay or play strategy from an ERISA perspective is that it falls within the *Travelers* language

of not "binding plan administrators to a particular choice"—multi-state firms can offer uniform national plans or pay into the state pool where their employees can obtain coverage. And these laws can be defended as legislating in areas of long-standing state authority, such as funding health care for the poor and taxation (which some federal courts have held to be such a sphere of state authority).[40] Such broad-based pay or play laws (like the 1988 Massachusetts law or a 2005 Vermont bill vetoed by the Governor) should overcome a preemption challenge if they are explicitly neutral regarding whether employers fund worker health care or pay the assessment (i.e., they are not mandates) and do not condition the credit against the assessment on an employer plan meeting specific standards, such as minimum benefits or premium contribution levels.[41] Workers should be eligible for the public program regardless of whether their employers have paid the fee, further removing any "connection" between the state law and the employer assessment.[42]

Laws Modeled on the Maryland Fair Share Act. While courts in other states are not bound to follow the holding in *RILA v. Fielder*, it will be difficult for states to defend laws identical to the Maryland Fair Share Act that assess only one or a few large employers whose health care spending falls below a specific threshold. Bills like the Maryland law were introduced in many state legislatures in 2006; one passed the California legislature but was vetoed by the Governor in September.[43] Like Maryland's law, most of these proposals would have required employers to contribute an assessment to the state if they did not spend at least a specified amount for employee health care (calculated on the basis of a dollar-per hour figure or a percentage of payroll). The requirements applied primarily to retailers, but also sometimes other industries, and to firms of varying sizes (from 100 employees to 10,000). To the extent that these laws would have applied to a large number of employers and could be characterized as other than a mandate to create or amend an ERISA plan, they might withstand an ERISA preemption challenge.

At least three localities have enacted employer requirements structurally similar to the Maryland Fair Share Act:

- In August 2005, New York City passed an ordinance requiring grocers employing 35 or more employees or with at least 10,000 square feet of retail space to pay "prevailing health care expenditures" (estimated currently to be $2.50 to $3.00 per hour) for their workers or face fines and license revocation.[44] The law defines health care expenditures as employer spending on direct services, reimbursing the cost of services, contributions to HSAs, and similar expenditures.

- In October 2005, Suffolk County, New York, passed a similar law requiring grocery retailers with at least 25,000 square feet of retail space, 3 percent of floor area used for selling groceries, or over $1 billion in revenue (where grocery sales account for at least 20 percent) to spend at least $3 per hour on employee health care expenditures (defined similarly to spending under the New York City ordinance).[45] Failure to comply subjects employers to administrative penalties.

- San Francisco enacted a similar law in August 2006, creating a program through its public health department clinics and hospitals to provide health care to uninsured residents and requiring employers with 100 or more employees to spend at least $1.60 per hour per employee on employee health care ($1.06/hour for firms with 20 to 99 employees or nonprofit organizations with 50 to 99 workers).[46] Health care spending includes contributions to HSAs, direct reimbursement for employee health costs, employer-provided services, payments to third parties, and payments to the city to fund the health care access program. Failure to comply subjects employers to administrative penalties.

The Suffolk County ordinance has been challenged in court, but no decision has yet been issued in that case. All three local ordinances are drafted to avoid a direct reference to ERISA health plans and their requirements can be satisfied by employers paying for employee health care in ways other than through an ERISA plan. Therefore, they arguably are similar to "prevailing wage" laws that several Courts of Appeals have held ERISA does not preempt (as long as employers can satisfy the law without using an ERISA plan).[47] Furthermore, the ordinances differ from the Maryland law by applying to more firms than just Wal-Mart. But because they arguably are designed to encourage firms to pay for employee health care, opponents may argue, as in Maryland, that options other than creating or expanding an ERISA plan are impractical. The San Francisco assessment is designed to help fund the city's health care access program and therefore might fall within Judge Motz's suggestion that ERISA would not preempt an assessment as part of a more "comprehensive" public program.

Massachusetts. In April 2006, the Massachusetts legislature enacted a health care access law (amended with technical corrections in October), requiring all state residents who can afford to buy health coverage to obtain it or face substantial penalties.[48] The law merges the individual and group insurance markets and creates the "Connector," a quasi-governmental organization to link individuals and firms with 50 or fewer employees with approved insurance products. The Connector also administers the Commonwealth Care Health Insurance Program, which subsidizes coverage for residents with incomes below 300 percent of the federal poverty level.[49] In addition, the bill expands income eligibility levels for children's Medicaid coverage and for a program that subsidizes employer-sponsored insurance for low-income workers. While the thrust of the law is on individuals, it requires employers with more than ten employees:

- To establish tax code section 125 plans allowing workers to purchase health insurance with pre-tax funds;

- To pay the state a "fair share" assessment up to $295 per full-time equivalent employee per year[50] if they do not offer and contribute a "fair and reasonable" amount (determined by the state Division of Health Care Finance and Policy) toward employee health insurance premiums;

- To pay a "free rider surcharge" of between 10 and 100 percent of the uncompensated care costs their employees incur (if employees or their dependents individually use more than three health care services in a year or a firm's workers and dependents use at least five and if the total costs to the state's uncompensated care pool [or its successor Health Safety Net Fund] are at least $50,000), if the employer does not comply with the law's requirement to create a section 125 plan; and

- To report to the state agency whether it offers a section 125 plan, whether employees who have declined the employer's health plan have an alternative source of insurance, and other information needed for the state to implement the free rider surcharge.

Internal Revenue Code Section 125 plans (often called cafeteria or salary reduction plans) allow employees to pay for health coverage and other specified benefits with pre-tax wages. Employers can exclude these contributions from the wages on which they pay FICA and unemployment taxes. A section 125 plan can permit employees to use pre-tax funds to pay their share of an employer-sponsored health plan premium or pay for coverage purchased in the individual insurance market.[51] The U.S. Department of Labor (DOL) does not consider section 125 plans to be ERISA plans, even when used to shelter the employee's share of premium for an employer-sponsored plan because their function is to provide a method for paying premiums in a tax-favored manner, an advantage the DOL says is not a "benefit" within the meaning of ERISA.[52] Although some analysts argue that ERISA preempts this Massachusetts law requirement,[53] if a court agrees with DOL that a 125 plan is not an ERISA plan, it seems hard to argue that a state law requiring employers to offer them would be preempted. Nor should the state requirement turns plans that employees purchase through the Connector or on their own into ERISA plans.[54]

The two employer assessments in the Massachusetts law might raise ERISA preemption issues because they are conditioned on the employer being involved in employee health coverage to some degree. The free rider surcharge applies if the employer does not establish a section 125 plan, which the DOL does not consider to be an ERISA plan, so the surcharge should not raise preemption issues. This assessment does not "refer to" ERISA plans and does not have a "connection with" them under the reasoning in *Dillingham* and the prevailing wage cases because an employer can comply with the law by means other than establishing an ERISA plan. Furthermore, the purpose of this surcharge is to recoup some of the state's cost of uncompensated care provided to employees of employers who do not facilitate employee access to health coverage. Financing uncompensated care is a long-recognized area of state responsibility and therefore, like hospital rate-setting in *Travelers*, arguably less likely to be preempted even if it arguably has a connection with employer-sponsored coverage.

The fair share assessment might raise preemption concerns because it defines employers exempt from the assessment as those offering group health plans for which they make a "fair and reasonable" premium contribution. This is defined in recently adopted regulations as having at least 25 percent of employees enrolled in an employer-sponsored plan or, if fewer are enrolled, paying at least 33 percent of the premium. The fair share assessment applies to government as well as private-sector employers and so does not specifically refer to ERISA plans. But the exemption from the assessment is conditioned on employers paying a minimum share of employee premiums if less than one fourth of their employees are enrolled. This qualification arguably attempts to affect ERISA plans' "structure" in violation of the preemption clause.

The state could defend this provision on several grounds: The purpose of the fair share assessment is to spread the burden of financing charity care more equitably beyond insuring employers and others who pay this "cost shift" through health insurance premiums. Therefore, the assessment is part of the state's traditional responsibility to finance uncompensated care (similar to the rate-setting provisions at issue in *Travelers*). Second, the state could argue that the $295 per full time employee worker per year price is so insubstantial (compared to the cost of providing employee coverage) that it is not a de facto coverage mandate and therefore would not have an impact on ERISA plans' structure. And, while the court in *RILA* did not examine the Massachusetts law in any detail, the decision's footnote suggesting a comprehensive program with minimal employer impacts could survive a preemption challenge should be helpful if the state must defend the law in court. As a practical matter, because the law was supported by much of the business community, it is unclear whether any employers will challenge it.

Finally, the reporting requirement might be challenged as burdening employers (and impeding uniform national benefits administration). Despite Judge Motz's observation (in his discussion of standing in the *RILA* case) that reporting requirements are burdensome, the Massachusetts law's minimal reporting obligations do not seem sufficient to bring preemption, and he did not hold that those of the Maryland law did so. Some lower courts have held that ERISA does not preempt record-keeping requirements in prevailing wage law cases.[55]

Vermont. After the Governor vetoed a 2005 health care bill, in 2006, the Vermont legislature enacted the Catamount Health Plan and Catamount Health Assistance Program, which will offer subsidized health products to uninsured Vermont residents, emphasizing care for chronic conditions.[56] Although insurance initially will be voluntary, the legislature apparently will consider making insurance mandatory if at least 96 percent of the state is not insured by 2010. The program is financed by tobacco taxes, income-based premiums paid by enrollees, and employer "premiums" of $365 per year per uninsured full-time equivalent worker (with exemptions for small employers).[57] Uninsured employees are defined as those who are either: 1) not offered coverage for which the employer makes a contribution, 2) not eligible for employer-offered coverage, or 3) offered and eligible but not enrolled in the employer's plan or covered under other public or private sector plans. Proposed regulations will require employers to report to the state the number of hours worked by non-covered employees and

to keep records identifying employees declining employer coverage and indicating whether they are covered by another health plan.
ERISA should not preempt the Vermont law's minimal reporting requirement.[58] But the employer assessment raises potential ERISA problems. While it does not refer directly to ERISA plans (applying to both public and private sector employers), it waives the employer premium payment for employees offered (with some employer contribution), eligible for, or enrolled in employer plans. Opponents might argue, therefore, that in order to determine if the assessment applies, employers must examine their plans' eligibility standards. On the other hand, the law requires, in essence, that employers pay the assessment based on the number of employees the employer does *not* cover (and not covered by another plan or program), information that is readily available to employers without reference to the *terms* of an employer's plan. As far as the "connection with" test is concerned, the law does not condition waiver of the assessment on employer plans meeting any benefits, premium contributions, or eligibility standards. It offers employers a choice of coverage or assessment, and the assessment arguably is not so large as to negate a choice under the *Travelers* case reasoning.

Tax-Financed Universal Coverage Programs

Although proposed in some states in past years, no states have enacted a "single payer" tax-financed universal health coverage program. (In August 2006, the California legislature passed SB 40, a single payer bill, which the Governor vetoed in September.) Universal publicly administered programs like single payer systems can raise ERISA problems, even if not financed by employer assessments, because they create incentives for employers sponsoring health coverage to terminate or modify their plans, even assuming state legislators take no position on whether employers should continue or discontinue their health coverage. State universal programs might be challenged under ERISA on this ground even if funded by, for example, *individual* taxes on sales or income or earmarked "premiums" (the approach of some Canadian provinces to finance their systems). An employer in such a state might terminate its plan or modify it to supplement the public program. Multi-state firms might maintain what amounts to duplicate coverage if they want to maintain nationally uniform coverage. Despite such impacts on ERISA plans, a state could defend a tax-financed universal program on the ground that it is difficult to imagine that Congress intended in 1974 that ERISA preempt such programs. The need for states to expand health coverage seemed remote in 1974, when serious discussion of a national health program was under way in Congress, so (other than possibly Hawaii's 1974 law) state-based systems were not in the minds of ERISA's drafters.[59] Financing health care is an exercise of traditional state power, long preceding federal activity under Medicaid.[60] Consequently, states defending such programs would argue that a court should not presume congressional intent to preempt them and that they do not directly interfere with multi-state employers' choices about how to design employee health coverage.

Wisconsin. ERISA preemption analysis becomes somewhat more complicated if a universal public program is financed by a payroll tax because multi-state employers that wish to maintain uniform national coverage plans may argue that they are forced to pay twice—their health coverage costs and the tax. An example of a payroll tax-financed universal model is Wisconsin's Assembly Bill 1140, introduced in 2006 to create the "Wisconsin Health Plan." The program would establish "health insurance purchasing accounts" for all state residents (living in the state at least 6 months) under age 65. The accounts, administered by a non-profit, nongovernmental corporation, entitle eligible residents to enroll in low cost commercial health plans, but the law allows residents to purchase more costly plans by paying additional premiums to the insurers. The bill sets out required benefits and cost sharing each plan must offer. While the bill does not yet specify financing sources, the program's supporters contemplate that employers and employees would pay payroll taxes (employer payroll tax rates would rise along with total payroll levels).[61] The bill does not refer to employer-sponsored plans and the tax is imposed on employers, not plans. But it raises potential ERISA issues because such a universal coverage program may well affect employers' decisions about whether and how to offer employee health coverage. Employers offering employee health plans before the program is implemented are likely either to: drop coverage (because it duplicates the public program), amend their coverage to supplement the public program's benefits (for example, providing workers funds to buy more costly plans), or, for multi-state employers who want to retain nationally uniform benefit structures, maintain their own plans but pay the payroll tax.

While employers can choose whether to drop, maintain, or modify their plans, they arguably face a strong financial incentive not to maintain full employee coverage because the payroll tax (especially for higher wage employers) may approach the cost of their employee health coverage. Multi-state employers wishing to maintain national plans and facing high payroll taxes for the state plan might argue that this tax imposes the "acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage," which the Supreme Court in *Travelers* suggested might cause ERISA preemption.

To counter this argument, states defending such broad-based payroll tax-financed universal public programs against an ERISA challenge could make a two-step argument. First, they can point out that a payroll tax is not substantively different than an income or other individually applicable tax with no direct employer impact. Although employers would remit the payroll tax, it actually is a tax on workers because it reduces their wages and therefore no different than an income tax (that employers also withhold from wages and remit).[62] Second, they can argue (as discussed above) that taxation and health care financing are traditional areas of state authority and that Congress could not have intended to prohibit any state tax-financed universal coverage plan. As with many other

health care funding strategies, of course, the outcome of a preemption challenge to a payroll tax-supported system remains unclear. No court has decided a case involving a neutral financing scheme that eliminates the need for most employer-sponsored coverage.

Conclusion

Expanding access to health coverage through individual mandates, the primary approach under the new Massachusetts law, raises no ERISA preemption problems, even if the law allows individuals to satisfy this obligation by enrolling in workplace coverage. Nor is ERISA implicated by purely voluntary employer incentives, such as health coverage tax credits, purchasing pool arrangements, or insurance premium subsidies for lower wage workers enrolling in employer-sponsored plans.

Imposing mandatory requirements, such as assessments, on employers, however, can raise preemption concerns. ERISA clearly prohibits states from mandating that employers offer or contribute to employee health coverage. Yet despite some language in *RILA v. Fielder*, states should be able to tax employers to finance a public health care access program. Although such assessments might vary across states, the Supreme Court has ruled that "cost uniformity" is not the objective of ERISA preemption. Laws must be drafted to avoid being labeled a mandate, keeping in mind the statute's language, the sponsors' objectives, and the number of employers to which it applies. States can take guidance from language in the *RILA* decision if they are trying to design "comprehensive" programs addressing health care access with arguably only "incidental effects" upon ERISA plans. A tax on employers whose employees use publicly-subsidized uncompensated care or are enrolled in public programs like Medicaid or SCHIP might not raise preemption concerns if the tax is assessed without regard to whether they are covered under an employer-sponsored plan.[63]

ERISA arguably should not preempt a well-designed pay or play law that offers a dollar-for-dollar credit for employer health care spending because, under the reasoning of the *Travelers* case, it does not interfere with ERISA plan administrators' choices. Laws that do not offer real employer choice between paying and covering their workers are likely to be more difficult to defend. A pay or play law could most easily overcome a preemption challenge if it meets certain criteria:

- It does not refer to ERISA plans.
- Legislative sponsors are explicitly neutral regarding whether the employer pays the assessment or plays by offering coverage.
- The credit applies to any health care spending on behalf of employees (not only to more traditional health insurance or formal health plan).
- The credit is not conditioned on an employer's plan meeting benefits or structural requirements such as employer premium sharing standards.[64]
- An employer's payment of the assessment is not a prerequisite to its employees qualifying for coverage under the public program.

While some states (and most local governments) face limits on imposing taxes (in contrast to other types of fees),[65] defining the assessment to be a tax can bring the law within an area of traditional state authority.[66]

States also should be able to require employers to establish tax code section 125 plans under the authority of the U.S. DOL advisory opinion. If a section 125 plan is not itself an ERISA plan, then requiring employers to establish one should not turn it into an ERISA plan so as to raise preemption concerns. The Massachusetts law provides one drafting approach: it does not specify the types of health coverage that a 125 plan ought to include, leaving to the employer to decide whether to allow employees to purchase individual plans and/or pay their share of an employer-sponsored plan premium. But even if a section 125 plan requirement mentions ERISA plans, that "reference" does not affect the structure of the employer-sponsored plan itself and should not cause preemption.[67]

There is, unfortunately, a large grey area regarding ERISA preemption. Ultimately, we only know whether ERISA preempts a state law when the Supreme Court decides a case, and the Court has decided few cases involving state health care financing, though most of its preemption decisions since 1995 have been favorable to states.[68] There are no guarantees about how a court will analyze a state law. But states should be able to overcome a preemption challenge by drafting health care financing laws that rely on the principles set out in *Travelers* and its successors: legislating in areas of "traditional state authority," avoiding direct reference to ERISA plans, and minimizing impacts on ERISA plans in order to afford multi-state employers the opportunity to design and maintain nationally uniform plans.

Congress rarely has amended ERISA's preemption clause but might be encouraged to grant states more flexibility. Several proposals in the 109th Congress would encourage states to expand access to health care. Some bills would fund pilot projects and others would allow federal agencies to waive statutory obstacles under Medicaid, Medicare, or ERISA.[69] In addition to authorizing such waivers, Congress could be asked to sanction explicit state health care financing strategies, such as a pay or play model that credits employer health spending against an assessment to fund a comprehensive program. While it seems likely courts would uphold this approach, congressional clarification could reduce the uncertainty and delay due to court challenges.

Even without such congressional assistance, however, state health policymakers should not be discouraged by the *RILA v. Fielder* decision from developing health care financing and delivery initiatives that include employer financing. ERISA issues are not the only considerations in crafting state health policy, but while the Maryland court's decision makes some models difficult to defend against ERISA preemption challenges, other financing approaches stand a better chance and are worth pursuing.

Endnotes

1 *Butler, P. ERISA Preemption Manual for State Health Policy Makers.* National Academy for State Health Policy and AcademyHealth, January 2000; Butler, P. *Issue Brief: ERISA Complicates State Efforts to Improve Access to Individual Insurance for the Medically High Risk*. AcademyHealth, August 2000; Butler, P. *Update to ERISA Preemption Manual for State Health Policy Makers.* National Academy for State Health Policy, January 2001; Butler, P. ERISA Pay or Play: *How States Could Expand Employer-Based Coverage within ERISA Constraints.* National Academy for State Health Policy, May 2002; Butler, P. Supreme Court Upholds State External Review Law. National Academy for State Health Policy, 2002; Butler, P. Kentucky's "*Any Willing Provider*" *Law and ERISA: Implications of the Supreme Court's Decision for State Health Insurance Regulation.* National Academy for State Health Policy, 2003; Butler, P. *ERISA Update: The Supreme Court Texas Decision and Other Recent Developments,* AcademyHealth and National Academy for State Health Policy, August 2004.

2 In 2004, for example, only 63 percent of firms with fewer than 200 workers offered health coverage, down from 65 percent in 2003 (though virtually all large firms continued to offer it). The proportion of workers in small firms covered by their employers' insurance dropped from 53 percent in 2003 to 50 percent in 2004, Kaiser Family Foundation/HRET. *Employer Health Benefits: 2004 Survey.* www.kff.org. See also, U.S. Census Bureau. *Income, Poverty and Health Insurance Coverage in the United States*, 2005, Aug. 2006, www.census.gov/prod/2006pubs/p60-231.pdf.

3 *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). For a detailed discussion of the Supreme Court's preemption cases, see, Butler, P. *ERISA Implications for SB2: Full Report, March 2004*, California Healthcare Foundation, www.chcf.org.

4 *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).

5 *Hewlett-Packard v. Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977), *affirmed*, 571 F. 2d 502 (9th Cir. 1978), *certiorari denied*, 439 US. 831 (1978).

6 *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.,* 514 U.S. 645 (1995).

7 514 U.S. at 662 (1995).

8 "There may be a point at which an exorbitant tax leaving consumers with a Hobson's choice would be treated as imposing a substantive mandate," 514 U.S. at 664. "A state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and ... such a state law might indeed be preempted under [ERISA]," 514 U.S. at 668.

9 For example, *in Kentucky Association of Health Plans v. Miller*, 538 U.S. 329 (2003), it upheld Kentucky's "any willing provider" (AWP) law, ruling that state laws are exempt from preemption if they are directed at insurance practices of insurance organizations (e.g., HMOs and indemnity carriers) and substantially affect risk-pooling arrangements between the insurer and insured people. In *Rush-Prudential v. Moran*, 536 U.S 355 (2002) it upheld the Illinois law providing an external review process that health insurance enrollees can use to appeal benefit denials.

10 *In Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987), the Court held that ERISA preempted a state law authorizing damages suits against insurers because the law conflicts with ERISA's remedies for plan misconduct. ERISA allows injured plan enrollees to sue the plan administrator to pay for benefits that were improperly withheld or otherwise enforce the plan's terms, but it does not provide for damages for injuries that a plan's benefit delay or denial may have caused, such as lost wages, pain and suffering, or punitive damages. In 2004 the Supreme Court followed its reasoning in *Pilot Life* in holding that states cannot authorize ERISA health plan enrollees to sue for damages that occur when HMOs deny coverage, *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004).

11 The Court said such areas include hospital rate setting and health planning (*Travelers*, 514 U.S. at 661), wage regulation and labor apprenticeship programs (*Cal. Div. of Labor Standards Enforcement v. Dillingham Constr.,* 519 U.S. 316, 330 (1997), and health and safety (*DeBuono v. NYSA-ILA Medical Services Fund*, 520 U.S. 806, 814 (1997)).

12 In *Mackey v. Lanier Collection Agency*, 486 U.S. 825 (1988) the law referred to ERISA plans by exempting them from a garnishment law.

13 In *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992), the D.C. ordinance imposed requirements on workers' compensation benefits by reference to ERISA plan health benefits. Thus, the Court has held that ERISA preempts laws "[w]here a State's law acts immediately and exclusively upon ERISA plans ... or where the existence of ERISA plans is essential to the law's operations," *Cal. Div. of Labor Standards Enforcement v. Dillingham Const.*, 519 U.S. 316, 325.

14 *Metropolitan Life Ins. v. Massachusetts, 471 U.S. 724* (1985) and District of Columbia v. Greater Washington Board of Trade.

15 *Alessi v. Raybestos-Manhattan,* 451 U.S. 504 (1981), *Mackey v. Lanier Collection Agency, Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990), *FMC Corp v. Holliday and District of Columbia v. Greater Washington Board of Trade.*

16 *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983) and F*MC Corp v. Holliday.*

17 HB 1284 and SB790, 2005.

18 *RILA v. Fielder*, D. Md. CIF No. JFM-06-316, July 19, 2006. The Court held that the law does not violate the Equal Protection clause of the 5th Amendment to the U.S. Constitution. Even though the law does not treat all similarly all employers whose employees may be eligible for Medicaid, the courts give broad latitude to state health and welfare laws. The Court noted that the "distinctions drawn by the General Assembly [based on employer size and profit vs. nonprofit status] are not necessarily irrational in and of themselves." Nor did the law's application to only Wal-Mart raise a constitutional problem.

19 The jurisdictional issue was whether the court was being asked to enjoin the enforcement of a state tax, which is prohibited by the federal Tax Injunction Act ("TJA," 28 U.S.C. 1341) if there is a plain, speed and adequate remedy in state court. The court's analysis of the TJA argument is relevant to its ERISA decision because the court examined in detail whether the Maryland law's fee was a 'tax' under the TJA. Deciding it was not (but rather an indirect way to mandate employers to provide worker health coverage), the court applied that conclusion in examining the law's objective and impact in its ERISA analysis.

20 The court noted: "the reference in the Fair Share Act to ERISA plans is direct and express. The payment required by the Act is measured, in part, by the amount of an employer's 'health insurance costs' which the Act defines as the 'amount paid by an employer to provide health insurance to employees ...' citing *Greater Washington Board of Trade*, but noting that the ordinance in that case "was a benefit-mandating statute that also had a 'connection with' ERISA plans" and that "it is not clear that if a statute did not mandate benefits or otherwise interfere with uniform funding and administration of ERISA plans, the Supreme Court would hold that literal application of the 'reference to' language requires preemption." *RILA v. Fiedler*, note 17.

21 Whether accounting for employee health expenditures imposes a substantial burden is a question of fact that the court did not explore but that might vary across states. In states with business income taxes, for example, employers would probably identify employee health costs as deductible business expenses. In other states, employers might have other reporting responsibilities that minimize the burden of identifying these health care expenditures.

22 These statements were examined in the court's TJA analysis, discussed in endnote 19. Besides sponsors' statements and its single employer target, the court also noted that: 1) the fee is administered not by the state Comptroller (tax administrator) but by the Secretary of Labor; 2) it was considered by a Health, rather than Ways and Means, Committee; and 3) the law was codified in the Maryland Labor and Employment, not Tax, Code.

23 *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316 (1997).

24 Judge Motz's reliance on this distinction may be a stretch: While the Supreme Court in *Dillingham* mentioned the similarity between California's public works wage standards and those of the federal government, the Court did not rely heavily on this point in its holding. In fact, in a footnote it mentioned that similar standards might avoid the burden on multi-state employers of conflicting standards but that "the area of apprenticeship training may be one where uniformity of substantive standards across States is impossible," 519 U.S. note 10.

25 *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997).

26 Remarks of Representative John H. Dent, 120 Cong. Rec. 29197 and Senators Harrison Williams and Jacob Javits, 120 Cong. Rec. 29,933 and 29,942.

27 The state law in *Dillingham* applied to employer apprenticeship programs that both were and were not ERISA plans. In *DaPonte v. Mancredi Motors*, No. 04-5495, 2d Cir., Sept. 15, 2005, the Court of Appeals held that ERISA does not preempt a fraud claim because the defendant "wrongly assumes that an ERISA plan is the exclusive vehicle by which an employer may provide medical benefits." *Burgio and Campofelice, Inc. v. NYS Dept of Labor*, 107 F. 2d 1000 (2d Cir. 1997) is one of many cases challenging state and local "prevailing wage" laws requiring public works contractors to pay a total package of wages and benefits meeting a specific standard. States are authorized to require wages (above federal minimums) but the issue is whether they can also set benefits levels for public contractors. This line of cases holds that, while state and local governments cannot mandate specific fringe benefits, ERISA does not preempt state laws that require contractors to pay a total package of wages and benefits because wage levels are an area of traditional state authority and the laws can be drafted so as not to directly affect an employer's health benefits plan (health costs can be paid independent of a plan). See also, *Associated Builders v. Nunn*, 356 F. 3d 979 (9th Cir. 2004) and *Woodfin Suite Hotels v. City of Emeryville*, N.D. Cal. No. C 06-1254 SBA, Aug. 22, 2006.

28 In *Burgio and Campofelice, Inc. v. NYS Dept of Labor*, the Court of Appeals applied language from an earlier Supreme Court case, *Shaw v. Delta Air Lines.*

29 U.S. Department of Labor, Employee Benefits Security Adminsitration, Field Assistance Bulletin No. 2006-02, October 27, 2006.

30 This might be particularly likely for smaller firms without existing ERISA plans or those with lower

wage workers for whom public subsidies were made available only through the public program.

31 Department of Labor Advisory Opinion 96-12A, July 17, 1996.

32 *NYS H.M.O. Conference v. Curiale*, 64 F. 3d 794 (2d Cir. 1995) involved a state risk-pooling law that applied to employee group health insurance policies. Despite this "reference," the Court of Appeals held the law did not relate to ERISA plans because the insurers' risk pool contributions were not calculated according to the ERISA status of insurers' plans and were imposed irrespective of benefits offered by various plans.

33 See discussion in endnote 20.

34 For example, Kansas, Minnesota, Montana, and West Virginia recently have developed such pooling arrangements. *State of the States: Finding Their Own Way*. January 2006. AcademyHealth State Coverage Initiatives, www.statecoverage.net.

35 For example, Maine's DirigoChoice program, New Mexico's State Coverage Insurance program, Oklahoma's Employer/Employee Partnership for Insurance Coverage offer coverage to small businesses and their employees with federal matching funds under expanded Medicaid programs. *State of the States*.

36 Shirk, C. and J. Ryan. *Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?* Aug. 2006. National Health Policy Forum, George Washington University, www.nhpf.org.

37 For example, New York provides reinsurance to protect HMOs offering these products from part of the risk of high claims. *State of the States*

38 For a discussion of ERISA issues raised by premium assistance program administration, see Butler, P. Issue Brief: *ERISA Update: The Supreme Court Texas Decision and Other Recent Developments*. Aug. 2004. State Coverage Initiatives and National Association for State Health Policy, www.statecoverage.net and www.nashp.org.

39 For a discussion of the law and copy of its text, see Butler, P. *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.

40 *Hattem v. Schwarzenegger*, 449 F. 3d 423 (2d Cir. 2006). De Buono v. NYSA-ILA also involved a state tax, but the Supreme Court focused on the fact that the tax was aimed at health care providers to help fund the state's Medicaid program and therefore an exercise of authority to regulate state health and safety rather than to indicate that taxation is an inherent state power. In footnote 11 of its opinion, the Court noted that the same preemption standard applies to evaluate state tax laws as other laws.

41 For a discussion of how such conditions jeopardized California's (subsequently repealed) S.B. 2, see Butler, *P. ERISA Implications for SB 2: Full Report*. March 2004. California HealthCare Foundation, www.chcf.org.

42 On the theory that employers might be more likely to pay the fee if they feel their employees would benefit directly, one might want to make subsidies available (especially for lower income people) or tax credits more generous to employees receiving coverage from the public program, which could encourage employers to pay the fee. But the state should remain neutral about which tack the employer chooses.

43 Special Report: About 30 States Considering 'Fair Share' Health Care Legislation. *BNA Pension & Benefits Reporter 33(13): 829-837*, March 28, 2006; "California Governor Vetoes Bill Mandating Premium Contribution by Largest Employers," *BNA Pension & Benefits Reporter 33*(37): 2232-2233. September 16, 2006.

44 New York City Ordinance No. 468-A, August 17, 2005.

45 Suffolk County (New York) Resolution No. 1903-2005, October 28, 2005.

46 San Francisco Ordinance No. 218-06, July 25, 2005.

47 *Burgio and Campofelice, Inc. v. NYS Dept of Labor;* WSB Electric, Inc. v. Curry, 88 F. 3d 788 (9th Cir. 1996); *Minnesota Chapter of Assoc. Builders and Contractors, Inc. v. Minnesota Dept of Labor*, 47 F. 3d 975 (8th Cir. 1995); *Keystone Chapter, Assoc. Builders and Contractors, Inc. v. Foley, 37 F. 3d 945* (3d Cir. 1995).

48 Steinbrook, R. 2006. "Health Care Reform in Massachusetts – A Work in Progress," *New England J. of Medicine* 354(20):2095-2098, May 18, 2006. The law was originally passed in 2005; the Governor vetoed a few sections of it and the legislature overrode those vetoes in 2006 enacting Chapter 58 of the 2006 laws. Several provisions of that law were amended by a technical corrections bill, Chapter 324 of the 2006 laws. The first year people who do not have insurance would lose the personal income tax exemption and in later years would pay one half the cost of the state-designated "affordable" premium

49 For a summary of the new law, see McDonough, John E. et al. "The Third Wave of Massachusetts Health Care Access Reform." *Health Affairs* Web Exclusive. September 14, 2006.

50 The actual amount is based on a pro rata share of uncompensated care costs but cannot exceed $295 per worker per year.

51 In the case of individually purchased insurance, IRS rules require employers to be able to assure that the employee is paying the premiums and the insurance is in force.

52 Department of Labor Advisory Opinion 96-12A, July 17, 1996.

53 Schiffbauer, William G. "ERISA Preempts Provisions of Massachusetts 'Pay or Play' Health Care Reform Law. *BNA Pension & Benefits Reporter 33* (38):2315-2318, September 26, 2006.

54 Even when employers do not sponsor plans but allow employees to purchase them, a plan may be an ERISA plan if it falls outside of the U.S. DOL's "safe harbor" regulation that excludes certain benefits arrangements from ERISA's definition of a "plan." The regulation exempts from definition of an ERISA plan one where the employer makes no contributions, employee participation is voluntary, the employer does not endorse the coverage program, the employer's sole functions are to permit the insurer to publicize it, collect premiums, and remit them to the insurer, and the employer receives no consideration other than for administrative services, 29 C.F.R. 2510.3-1(j). While no courts have considered precisely the situation presented by the Massachusetts law, some hold that employers do not create an ERISA plan if their salary reduction program allows choice among more than one benefit plan and where employers do not actively promote the plans (so as to lead an employee to believe the coverage is part of an employer-sponsored plan), *Kerr v. United Teacher Associates, Ins. Co*, 313 F. Supp. 2d 617 (S.D. W.Va. 2004); *Riggs. v. Smith*, 953 F. Supp. 389 (S.D. Fla. 1997); *Johnson v. Watts Regulator Co.*, 63 F. 3d 1129 (1st Cir. 1995). But see, Hrabe v. Paul Revere Life Ins. Co., 951 F. Supp. 997 (M.D. Ala. 1996) and *Stoudemire v. Provident Life and Accident Ins. Co.*, 24 F. Supp. 2d 1252 (M.D. Ala 1998).

55 In *Burgio and Campofelice, Inc. v. NYS Dept of Labor*, the court said a contractor "must produce records showing it has paid the prevailing wage rates and paid or provided supplements, it need not maintain such records in any particular form...We think preemption does not occur where a state law places on ERISA plans administrative requirements so slight that the law 'creates no impediment to an employer's adoption of a uniform benefit administration scheme,'" 107 F. 3d at 1009. The Massachusetts law requires employers to use a state-provided form but still arguably is not extremely burdensome.

56 Residents are eligible if they do not qualify for Medicare, Medicaid, or other public programs, have been uninsured with hospital and medical coverage for at least 12 months or lost employer coverage within the last 12 months, or lost college-sponsored coverage.

57 In 2007 and 2008, employers are not assessed for up to 8 full-time equivalent employees, declining to 4 FTEs in 2010.

58 See discussion note 55.

59 Not only were there myriad bills in the Senate and House, but the Nixon administration itself proposed an employer mandate to cover workers and a revamped Medicaid program for low income families, Institute of Medicine Committee on the Consequences of Uninsurance. 2004. *Insuring America's Health: Principles and Recommendations*. Washington, D.C: National Academy Press.

60 See, e.g., Bovjberg, R. A. and W. G. Kopit. 1986. "Coverage and Care for the Medically Indigent: Public and Private Options," *Indiana Law Review 19(4):857-895*.

61 Wisconsin Health Project, *Concept Paper on the Development of Assembly Bill 1140, the Wisconsin Health Plan*. April 2006, www.wisconsinhealthplan.org. The designers propose, for example, that employers with payrolls up to $50,000 would pay 3 percent, with the rate increasing by payroll so that employers with payrolls greater than $500,000 would pay 12 percent.

62 Blumberg, L.M. 1999. Who Pays for Employer-sponsored Health Insurance?" *Health Affairs* 18(6):58-61.

63 The argument would be that the tax supports the public program and is not designed or intended to affect employer-sponsored coverage. This argument would be more persuasive if it affected a large number of employers whose employees (and/or dependents) used public programs (which might include public employers). As a practical matter, such an assessment would need to be crafted to avoid disincentives for employers to hire post-welfare workers receiving transitional Medicaid coverage or the disabled receiving Medicaid coverage and need to be integrated with Medicaid and SCHIP premium assistance programs.

64. While it is not possible to assure that an employer's health plan meets specific benefits or premium contribution standards, if the fee is set at a level to support a public program and an employer plan costs less, the employer will pay the difference to the state (and the state could offer supplemental benefits to affected employees). It might be possible to allow a credit only if an employer meets a spending threshold, but such a standard might be challenged on preemption grounds as an attempt to affect a health plan's structure, see *ERISA Implications for SB2: Full Report*.

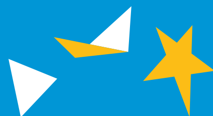
65 For example, California's constitution requires a 2/3 vote of both houses of the legislature to enact a 'tax,' but allows other types of fees to be enacted by majority vote.

66 *Hattem v. Schwarzenegger*.

67 Although the section 125 plan at issue in the 1996 DOL Advisory Opinion allowed employees to pay their share of the employer's ERISA health plan premiums, the DOL said this section 125 plan was not an ERISA plan.

68 The notable exception is *Aetna Health Ins. Co. v. Davila,* where the court held that ERISA preempts state law damages remedies against ERISA health plans (including insured plans).

69 SR 2586 and S 2772, the Health Partnership Act, would provide grants for state comprehensive access programs. HR 3891, the States' Right to Innovate in Health Care Act, would provide grants and authorize the Secretary of the U.S. Department of Health and Human Services to waive ERISA's preemption clause, among other federal laws.



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