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Federal Court of Appeals Agrees ERISA Preempts Maryland's "Fair Share Act"

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ERISA Update:

Federal Court of Appeals Agrees ERISA Preempts Maryland's "Fair Share Act"

In January 2007, the Fourth Circuit Court of Appeals upheld a lower court's July 2006 decision in *Retail Industry Leaders Association v. Fielder* that ERISA preempts Maryland's "Fair Share Act," which required large employers to spend up to 8 percent of their payroll on employee health benefits or pay the difference to fund the state's Medicaid program.¹ Two of the three Court of Appeals judges applied the same reasoning as the lower court, while the third would have held that ERISA does not preempt the Maryland law. This memo updates the November 2006 Issue Brief on the earlier Maryland court decision published by State Coverage Initiatives and the National Academy for State Health Policy.² That brief discusses the lower court's decision in detail and its implications for health care access initiatives enacted or under development in many states.

Majority Opinion

Like the district court, the Court of Appeals majority held that the Maryland law was a mandate, not a tax, because its purpose was not to raise revenue but to "force" Wal-Mart (the only employer that would have had to spend more on health care to comply with the law) to increase health care spending.³ Addressing the ERISA preemption questions, the court first held that, despite its "noble purpose" to support Medicaid, the Maryland law is contrary to the objective of ERISA's preemption clause "to provide a uniform regulatory regime over employee benefit plans." The law interferes with employee benefit plan administration by directly regulating how employers structure and contribute to their ERISA plans

because they must "provide a certain level of benefits" and also would have to "structure their recordkeeping" to comply with the law. The Maryland law would conflict with laws enacted or under consideration in other states and localities and require employers to "monitor" laws to decide under each one whether to expand coverage, offer other benefits, or pay the state. The court disagreed that the Maryland law falls within principles set out in Supreme Court cases like *Travelers Insurance*⁴ and *Dillingham Construction*,⁵ for example because in its view the law "directly regulates" how employers will structure their health plans

Noting that Wal-Mart was the sole target of the law, the Court of Appeals majority agreed with the district court that the "amount that the Act prescribes for payment to the State is actually a fee or a penalty that gives the employer an irresistible incentive to provide its employees with a greater level of health benefits."

The court dismissed the state's attempts to defend the Fair Share Act as offering employers various choices (so as not to "bind plan administrators to a particular choice," which the Supreme Court noted in *Travelers* protected New York's hospital rate-setting law from preemption⁶). For example, although Wal-Mart could have avoided any change to its employee coverage by paying the state the difference between its spending and 8 percent of payroll, the court held that "in most scenarios, the Act would cause an employer to alter the administration of its health care plans."

The court based this conclusion on its belief that employers generally would prefer to spend money on their own employees than pay a state assessment and also on the fact that Wal-Mart executives indicated the firm would augment its existing ERISA health plan to avoid paying the state. The court also held that spending alternatives to funding ERISA plans (such as creating HSAs or offering employee clinics) were impractical and unlikely to be "a serious means by which employers could increase healthcare spending to comply with" the law. Furthermore, because "the vast majority any of employer's healthcare spending occurs through ERISA plans," any attempt to comply with the law would have direct effects on such plans (for example, coordinating HSAs—which are not themselves ERISA plans—with high deductible health plans).

Rejecting the idea that ERISA does not preempt a state law allowing employers to "opt out" of a state requirement, the Court of Appeals cited *Egelhoff v. Egelhoff*, a 2001 Supreme Court case that held ERISA preempted a Washington state law requiring plan administrators to pay benefits to state-designated beneficiaries of nonprobate assets (including ERISA-governed life insurance policies), rather than the beneficiaries designated in plan documents.⁷ Even though the state law allowed employers to opt out of the law by using specific plan language, the Court held it preempted because it required plan administrators to either accede to state law or alter the terms of their plans to indicate they would not follow it.

Dissenting Opinion

Much more sympathetic to the state's arguments and its Medicaid funding "crisis," the dissenting judge would have upheld the Fair Share Act. The dissenting judge asserted that the law does not compel an employer to establish or maintain an ERISA plan because it can comply with the law by paying the state and that this fee was not so substantial as to require Wal-Mart to augment its benefit plan.⁸ In his opinion, the Act does not interfere with uniform national health plan administration because its only direct requirement is reporting about its payroll and ERISA plan costs for employees in Maryland and this impact is "too slight to trigger ERISA preemption." Citing the Supreme Court's language in *Travelers* that "cost uniformity was almost certainly not an object of preemption," the dissent argued that the law does not mandate a level of benefits but only involves spending, which is not an ERISA concern. In the judge's view, relieving the state's burden of funding Medicaid falls within traditional areas of state regulation such as health and safety and is consistent with congressional objectives for state Medicaid financing innovation.

Analysis of the Court's Opinion

As discussed in the November issue brief regarding the district court's decision, it is certainly arguable that the Court of Appeals incorrectly interpreted the implications of the reasoning in *Travelers* and *Dillingham* for state laws that require employers to pay assessments that are waived or credited based on the costs of actual employee health coverage. As noted by the dissenting judge, a spending requirement is not necessarily a benefits mandate and there are ways other than creating or expanding an ERISA plan to obtain a waiver of or credit against state tax laws.

Unlike the lower court, the Court of Appeals relied on a post-*Travelers* Supreme Court case holding that ERISA preempted a state law even though it offered employers a choice of how to

comply. In *Egelhoff*, the Supreme Court held that a state law could not usurp an ERISA plan participant's designation of life insurance beneficiaries. This case can be distinguished from a state health care financing law on several grounds. First (as noted in the *Fielder* dissent), ERISA specifically requires plan administrators to pay benefits to beneficiaries designated in plan documents, and courts have consistently held that ERISA preempts state laws affecting areas that ERISA already regulates.⁹ Second, unlike the Washington law's "opt out" provisions regarding life insurance beneficiaries, a state tax law with a credit for actual employer health care spending does not require any alteration of the employer's ERISA plan. Furthermore, some federal courts have held that taxation is an area of traditional state authority.¹⁰ Therefore, a state tax on employers that does not directly tax ERISA plans is distinguishable from a law attempting directly to regulate ERISA plan administration. Because employers already have to monitor tax laws in different states and localities, such a practical obligation (along with reporting requirements¹¹) is an insignificant administrative burden that should not cause preemption.

Application to State Health Care Access Options

Courts in states outside of the Fourth Circuit¹² are not obligated to follow the Court of Appeals decision. It may be difficult, however, to defend a law identical to Maryland's Fair Share Act, for example, one that targets only a few employers and sets the tax at a level close to what they spend so that it can be argued to require them to expand existing plans.

It should still be possible to argue that much lower fees, such as those in Massachusetts or Vermont, not only apply to a broad array of employers but also are not "irresistible incentives" to expand employee benefits. Proposals

with somewhat higher fee levels, such as California Governor Schwarzenegger's proposed 4 percent payroll assessment also can be defended if they are not so high as to look like a coverage mandate.

An assessment might best be designed at a level that avoids putting very many employers in the position to argue they have no choice but to alter their existing ERISA plans. One way to do so would be setting the assessment at a level so that relatively few currently offering employers would have to increase their spending (i.e., modify their ERISA plans) to avoid liability for the fee. On the other hand, firms spending little or nothing on employee care might decide to pay the assessment. Such employer choices would be based on broader business considerations including the costs of various coverage options available in the market, the practical complexity of administering a health plan (e.g., for small firms), as well as whether their workers would be likely to benefit from any premium subsidies or other advantages to the public program. (The Court in *Travelers* noted that the need to weigh such considerations in making business decisions does not by itself implicate preemption.) Information on the distribution of employer health care spending patterns could help inform discussion on setting the level of the assessment.

Furthermore, although the Court of Appeals opinion did not include the helpful footnote in the Maryland lower court's decision that suggested it might reach a different result in the case of a "comprehensive" state reform law, including an employer assessment in such a broad-based law should make it easier to defend because health care access is a long-standing area of primary state authority.

State policy makers should be able to distinguish the *Egelhoff* case to defend tax-based "pay or play" proposals like those discussed in the November issue

brief. For example, a state revenue law funding a public health care program does not require an ERISA plan to alter its health coverage program. There is no direct conflict between the assessment and ERISA's standards or fiduciary requirements. And such a state law does not "implicate an area of ERISA concern" like the law in *Egelhoff* involving a system for processing claims and paying benefits.¹³ As long as a tax law can avoid being characterized as a coverage mandate, allowing an employer to offer coverage instead of paying the assessment does not "dictate" an ERISA health plan administrator's choices by requiring alteration of the plan's terms to comply with the law.

Keeping track of state tax laws itself should not be the type of administrative burden ERISA was meant to preempt (as employers already must do so for other purposes).¹⁴ But the *Fielder* opinion does raise another record-keeping problem. If multi-state employers do not keep records of their health care spending according to the states in which their employees work, they may argue that tracking expenditures in each state is unduly costly and burdensome. While this obligation does not necessarily rise to the level of "segregating a pool of expenditures for Maryland employees" as the Court of Appeals suggests, it will be important for states to consider how to minimize the burden of employee health spending reporting, for example, by reference to state income tax or other pre-existing reporting obligations, if possible.¹⁵

Conclusion

To minimize the risk of coming within the Fourth Circuit's reasoning, a state law should be drafted, to the extent possible, to avoid being characterized as a mandate based on its legislative objectives and actual impact. For example, its purpose should be to raise revenue to finance a public program, and it should apply broadly to a large

proportion of employers and not be set at a level (relative to current employer spending patterns) to make offering or expanding coverage the only practical option for "most" employers.¹⁶ While the new *Fielder* decision provides fuel for those opposed to including employers as a source of financing state health care access initiatives, states should be able to overcome preemption challenges by crafting programs such as a public coverage program funded by an employer assessment against which employer health care spending is credited.¹⁷ It will be important in defending a preemption challenge to be able to argue that the choice to "pay" or "play" is real, that employers will make such choices based on multiple considerations, and that neither paying the assessment nor paying for workers' health care directly is a foregone conclusion for all employers subject to the assessment. Even before *Fielder*, state innovations were bound to be challenged in court, and it is helpful for state health policy makers to be aware of ERISA risks in conceiving, drafting, and explaining their proposals, but the prospect of court challenges should not discourage states from moving ahead on health care reform.

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Legislative Council); and Sonya Schwartz (National Academy for State Health Policy).

End notes

- 1 *Retail Industry Leaders Association v. Fielder*, 4th Cir. January 17, 2007.
- 2 ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland "Fair Share Act" Court Decision. November 2006, available from www.statecoverage.net and www.nashp.org.
- 3 Going beyond the district court's discussion, the Court of Appeals cited evidence that legislators aimed at Wal-Mart's "substandard level of healthcare benefits." And the court noted that it would rely on the law's "actual purpose and effect" rather than the "superficial characterization" in the law's declaration of legislative purpose (to support the state's Medicaid program).
- 4 *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Insurance*, 514 U.S. 645 (1995).
- 5 *California Div. of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997).
- 6 In this seminal case, the Supreme Court upheld a New York hospital rate-setting law that imposed higher hospital costs on ERISA (and other) plans buying commercial coverage compared to Blues plans. ERISA was held not to preempt this law because its effects were indirect and the law did not "bind plan administrators to a particular choice" of either type of health coverage.
- 7 532 U.S. 141 (2001). The state law voided the plan's designation of a spouse as beneficiary in case of divorce. The life insurance proceeds would then be payable not to the former spouse but either to beneficiaries named in a will or, if no will, as provided under the state's intestacy laws.
- 8 The judge noted that Wal-Mart's claim it would increase benefits "appears dubious" considering the firm had not up to that point offered more generous benefits. Furthermore, the law allows but does not compel such a choice.
- 9 See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).
- 10 *Hattem v. Schwarzenegger*, 449 F. 3d 423 (2d Cir. 2006). This is in addition to state authority over health and welfare as determined by the Court in *Travelers*.
- 11 *Burgio and Campofelice, Inc. v. NYS Dept of Labor*, 107 F. 2d 1000 (2d Cir. 1997).
- 12 The Fourth Circuit covers Maryland, North Carolina, South Carolina, Virginia and West Virginia.
- 13 *Egelhoff*, 532 U.S. at 141.
- 14 E.g., state health and safety laws such as the one upheld in *Travelers* or state garnishment laws at issue in *Mackey v. Lanier Collection Agency*, 486 U.S. 825 (1988). See also, *Aetna Life Ins. v. Borges*, 869 F. 2d 142 (2d Cir. 1989), cert. den., 483 U.S. 811 (1989).
- 15 One advantage to President Bush's proposed change in the tax treatment of employer-provided health coverage (that would make the employer's contribution income to employees but offer them a deduction for health insurance premiums up to a ceiling) would be that employers would have to keep track of their employee insurance spending, eliminating the burden on employers to track this spending at the state level.
- 16 If the assessment applies to a large number of employers, determining whether employers are likely to pay the assessment or augment coverage should be a question of fact to be determined at a trial, rather than resolving the case based on only legal arguments.
- 17 The November 2006 Issue Brief discusses in greater detail how to defend such a broad-based pay or play law.



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