How Do You Solve a Problem Like ERISA? Employer Financing in State and Local Health Reform Initiatives

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A free Web seminar presented by

the National Academy for State Health Policy and State Coverage Initiatives

with the support of the Robert Wood Johnson Foundation

Providing Universal Access to Care:

Healthy San Francisco

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Healthy San Francisco

- A comprehensive medical care program for uninsured San Francisco adults (uninsured children already covered in SF).
- Not insurance
  - Restructuring of county indigent health system to encourage preventive care and continuity in primary care
  - No out of county services

What services are provided under Healthy San Francisco?

- A primary care home
- Preventive care, primary care, specialty care, urgent and emergency care, behavioral health, laboratory, inpatient hospitalization, x-ray and pharmaceuticals.

Who is eligible for Healthy San Francisco?

- Eligibility
  - be an adult,
  - live in San Francisco,
  - be uninsured for at least 90 days, and
  - ineligible for public insurance programs.
- A resident may join via their employer or self-enrollment.
- No exclusions for prior conditions or immigrant status.

How many people will Healthy San Francisco serve?

- 73,000 uninsured San Francisco adults (California Health Interview Survey.
  - Currently enrolled: 33,000
  - Expected enrollment: 60,000

Healthy San Francisco Network

- Primary Care Homes
  - 14 Public (City-run) health clinics
  - 8 Private non-profit community clinics
  - 1 Private hospital-based clinic
  - 1 Private physicians association
- Hospitals
  - Primary Hospital: Public Hospital
  - Five non-profit hospitals participating by linking with a primary care home.
  - State University Hospital providing radiologic back-up.

How will Healthy San Francisco be funded?

- Contributions by
  - Participants
  - Employers
  - City & County
  - Federal and State funding

Healthy San Francisco Participant Fees

	% Federal Poverty Level					
	0-100%	101-200%	201-300%	301-400%	401-500%	501%+
Quarterly Participant Fee	$0	$60	$150	$300	$450	$675
Fee as percent of income	0%	2.3%	2.9%	3.9%	4.4%	5.2%

Healthy San Francisco Point-of-Service Fees			
Service	Family Income ≤100% of FPL	Family Income 101-500% of FPL	Family Income >500% of FPL
		$	
Outpatient primary care	0	10	20
Urgent care	0	20	50
Radiology or physical or occupational therapy	0	20	50
Specialty care	0	20	50
Pharmacy use	0	5 or 25	25 or 50
Emergency department care	25	50	1000
Same-day surgery	0	100	2000
Hospitalization	0	200/admission	350/admission

Employer Health Spending Requirement

Business Size		Rate Schedule		
		01/09/08	**04/01/08**	**01/01/09**
Large	100+ Employees	$1.76/hour		$1.85/hour
Medium	50-99 Employees	$1.17/hour		$1.23/hour
	20-49 Employees	Not Applicable	$1.17/hour	
Small	1-19 Employees	Not Applicable		

Employer choices

- Employers may spend $$ on:
  - Insurance
  - Medical savings account
  - Reimbursement from expenses
  - Healthy San Francisco

Early Employer Experience with HSF

- Over 700 businesses have chosen city option
- 31,432 employees

  15,638 HSF

  15,794 non-SF residents (receive medical reimbursement accounts)
- $26 million (3rd quarter for large; 2nd quarter small)

Court Challenge to Employer Spending Requirement

- Restaurant Association filed lawsuit that employer spending mandate violated Employee Retirement and Income Security Act (ERISA).
- District court ruled in favor of Association and barred implementation of spending mandate.
- Ninth Circuit Appeals Court ruled that employer spending mandate does not violate ERISA.

Financing Healthy San Francisco

Estimated Individual contribution	$ 6 million
Estimated Employer contribution	$20 million
Redirecting of existing county funds for uninsured	$123 million
Federal health care expansion award	$24 million
Federal/State sources	$14 million
	$187 million

Generalizability of Healthy San Francisco

Generalizable features of Healthy San Francisco include:

- Focus on primary care home to reduce duplication and improve coordination
- Centralized eligibility system to maximize public entitlement
- Centralized system of record to create accountability and increase coordination
- Non-insurance (care) model lowers costs and protects federal and state funds for counties
- Establishment of predictable affordable participation fees (not charity)
- Public-private partnership maximizes available resources

Employers and Massachusetts Health Reform

Massachusetts Division of Health Care Finance and Policy

February 6, 2009

Health Care Reform: Massachusetts context

- Pre-reform:
  - High rate of insured population: 93.6% in 2006
  - High rate of employers offering health insurance coverage
  - Funding mechanisms in place for care of uninsured

- Health Care Reform law passed in 2006:
  - Broad support from all sectors including business

- Key elements:
  - 1115 waiver to allow FFP for purchase of insurance for low income individuals
  - Creation of "Connector" to offer quality insurance products, easily accessible to individuals
    - Free or subsidized insurance for qualifying low income individuals
    - Broad range of market products for moderate to higher income individuals
  - Individual mandate
    - Adults must be insured, if affordable to individual
    - Individual's insurance must meet "minimum creditable coverage"
    - Tax penalties as enforcement mechanism
  - Other provisions: insurance market reforms, Medicaid expansion, provider rate increases, Uncompensated Care Pool conversion to Health Safety Net*

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*Health Safety Net pays acute hospitals and community health centers for care provided to eligible low income residents.

Employer Requirements: Section 125 Plans

- Employers* are required to offer a Section 125 Plan
  - Allow pre tax purchase of individual health insurance
    - Must make S. 125 plan available to virtually all employees (full and part-time)
  - Enforced through employer surcharge mechanism
    - Employer may be subject to a surcharge if non-compliant and
      - Employees or their dependents use certain state subsidized health care (Health Safety Net) beyond cost and utilization thresholds
    - Employer surcharge amount varies with employer size, employee/dependent utilization and cost levels
    - Designed to promote compliance rather than generate revenue

* Applies to employers with 11 or more Full Time Equivalent (FTEs) employees. Includes employer's entire workforce. An employer with 22,000 or more annual payroll hours is subject to this requirement.

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Employer Requirements: Fair Share Contribution

- Statutory Design:
  - Defines Contributing employers:
    - Employers with 11 or more FTEs (full-time equivalents) who offer a group health plan to which the employer makes a “fair and reasonable” premium contribution
  - Non-contributing employers liable for Fair Share Contribution
    - If liable, assessment is based on total number of employees, prorated for part timers
  - Fair Share Contribution amount per FTE employee
    - Reflects use of Health Safety Net (HSN) by employees of non-contributing employers
    - Amount may decrease based on HSN use but is capped at $295 per FTE per year

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Employer Requirements: Fair Share Contribution

- Administrative authority shared between two agencies

- Division of Health Care Finance & Policy regulations
  - Define “fair and reasonable” employer contribution
  - Set out subsidiary requirements and definitions
    - FTE’s, full time employees, seasonal employees, temporary employees, etc.

- Division of Unemployment Assistance regulations
  - Rules for FSC reporting and collection of FSC liabilities
  - Employer appeals and enforcement

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Fair Share Contribution: Test Standards

- FY 2007 (Oct 2006 – Sept 2007) applied the following two-pronged test:
  - **Primary Test:** At least 25% participation by full-time employees* in the employer's group health plan
  - **Secondary Test:** Employer offers to contribute at least 33% of the premium cost of individual coverage in employer's health plan
    - All full-time employees employed more than 90 days
- An employer that met <u>either</u> "test" was exempt from having to pay a Fair Share Contribution.

*Full Time Employee: an employee who works at least the lower of:

- 35 hours per week or,
- the number of hours the employer requires to be eligible for full time health benefits.

• Excludes: seasonal employees working up to 16 weeks, temporary employees working less than 12 weeks

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2007 Fair Share Contribution: Results

- Approximately 24,000 employers were subject to the Fair Share Contribution test (11 or more FTE's)

- Based on first year, self-reported data from employers:
  - Approx 96% of firms met one of the compliance tests
    - 86% passed both tests
    - 4% met contribution test, take up less than 25%
    - 6% met take up, did not meet contribution requirement*
  - Approx 3.6% of all firms with ≥11 FTEs were determined liable
    - Owed approximately $7.7 million in FSC liability

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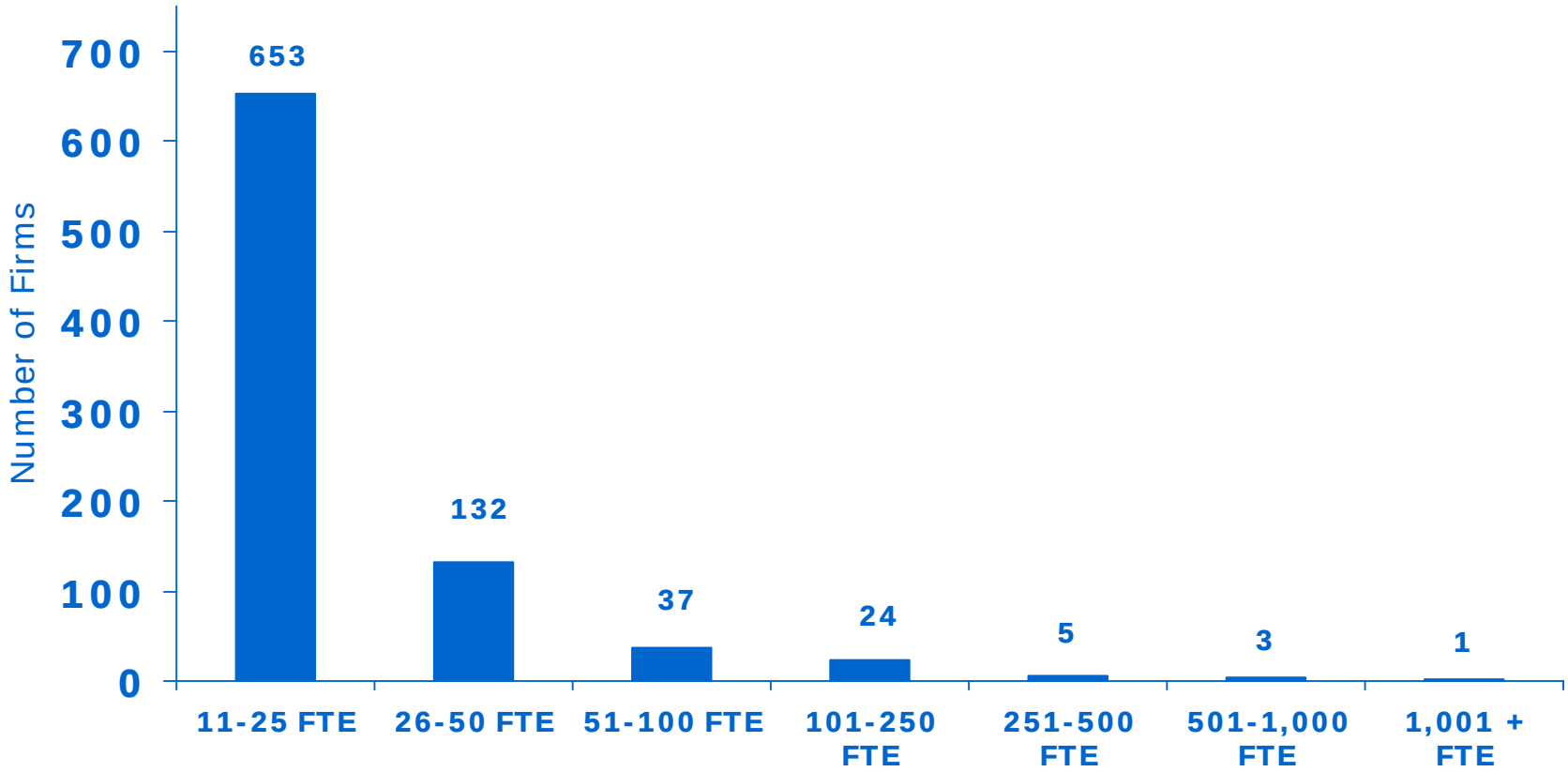
* To meet contribution test employer must offer at least 33% contribution to all full time employees within 90 days.

Data as of September 2008

FSC Liable Firms by Firm Size

(FSC Period October 1, 2006 - September 30, 2007)



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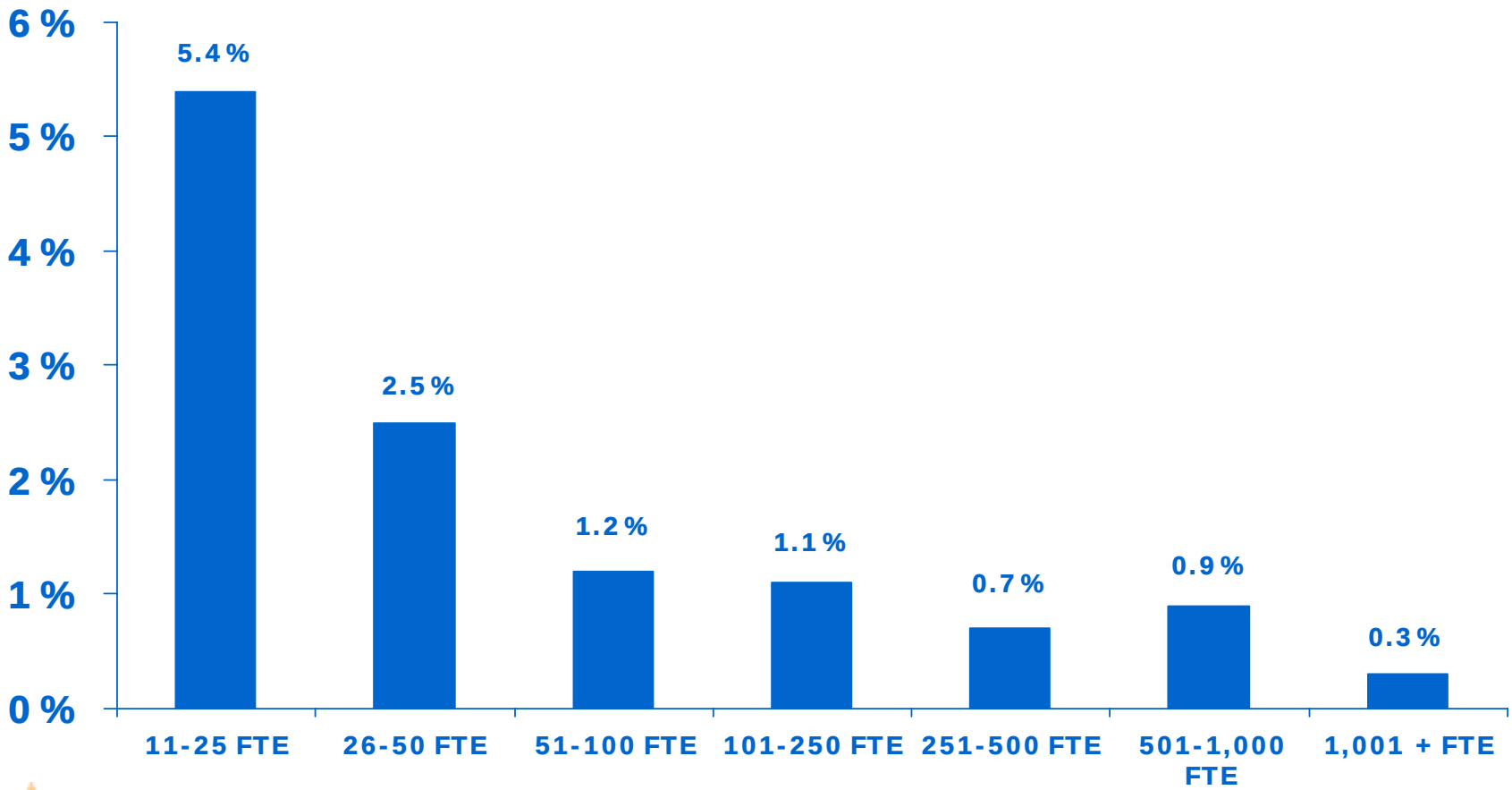
Note: Analysis reflects FSC data as of September 2008.

FSC Liable Firms as Percentage of All Firms in Firm Size Category

(FSC Period October 1, 2006 - September 30, 2007)



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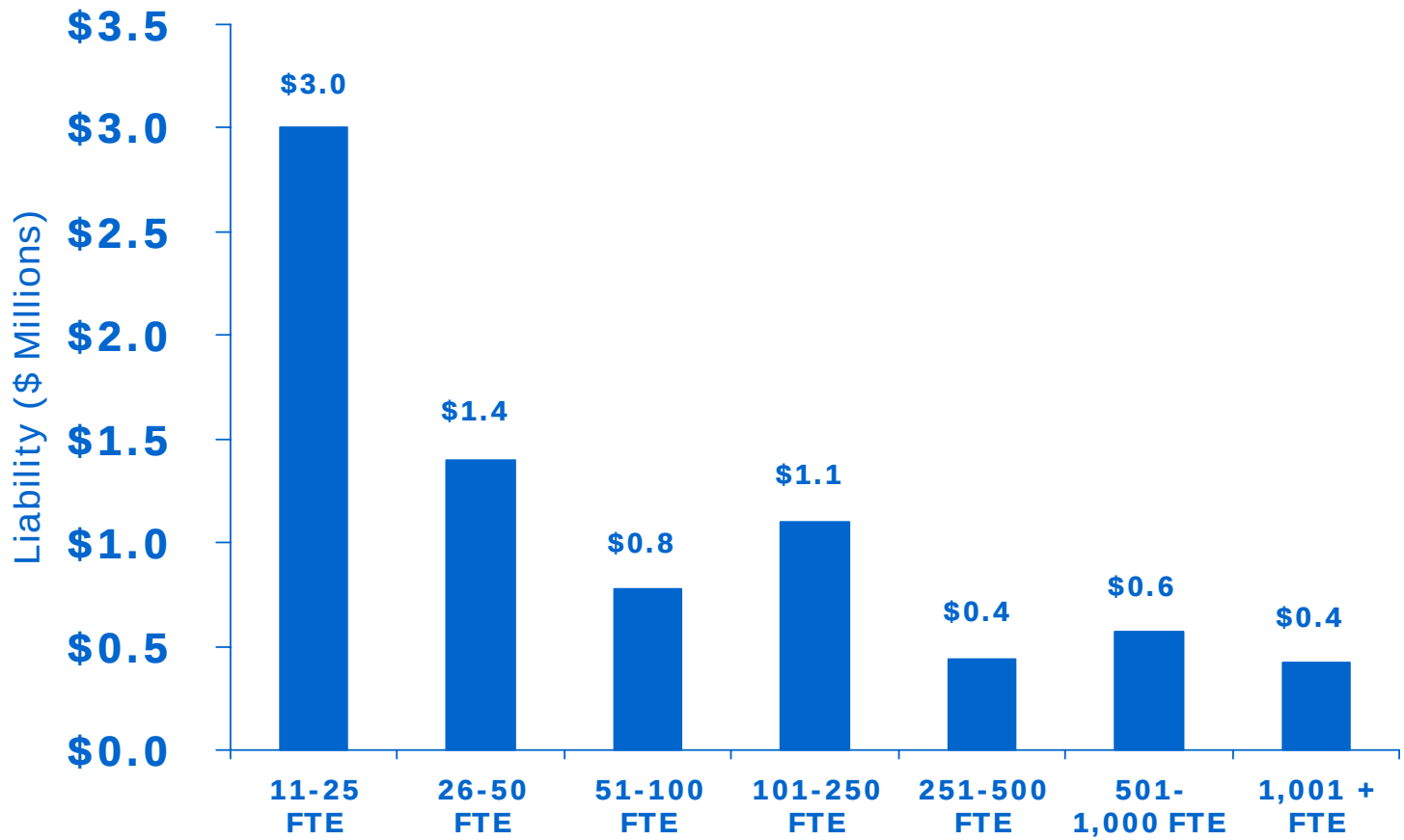
Note: Analysis reflects FSC data as of September 2008.

FSC Liability Amount by Firm Size

(FSC Period October 1, 2006 - September 30, 2007)



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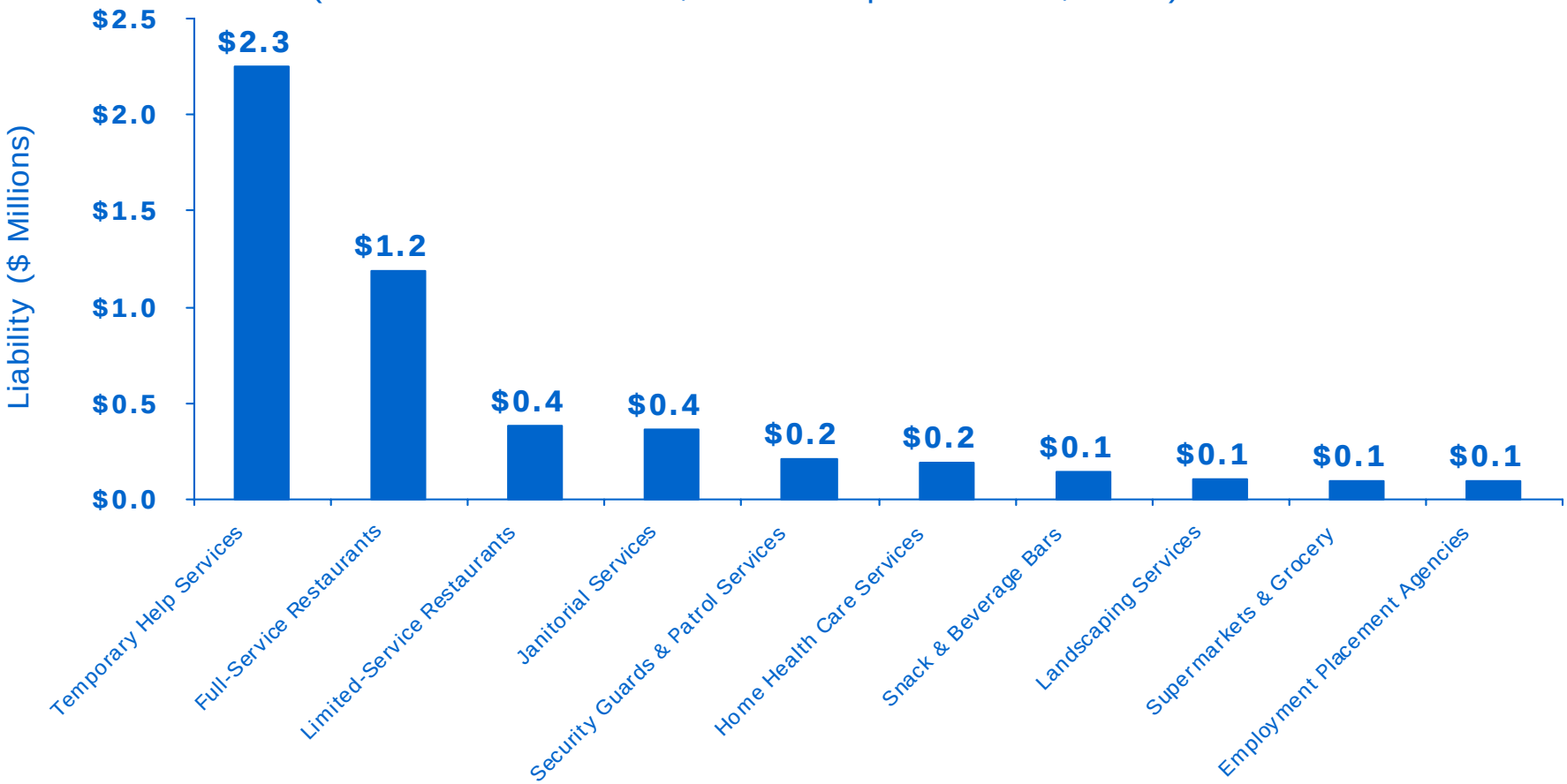
Note: Analysis reflects FSC data as of September 2008.

Top 10 Industries by FSC Liability

(FSC Period October 1, 2006 - September 30, 2007)



Note: Industries based on NAIC codes. For more information, visit:
http://www.census.gov/epcd/www/naics.html

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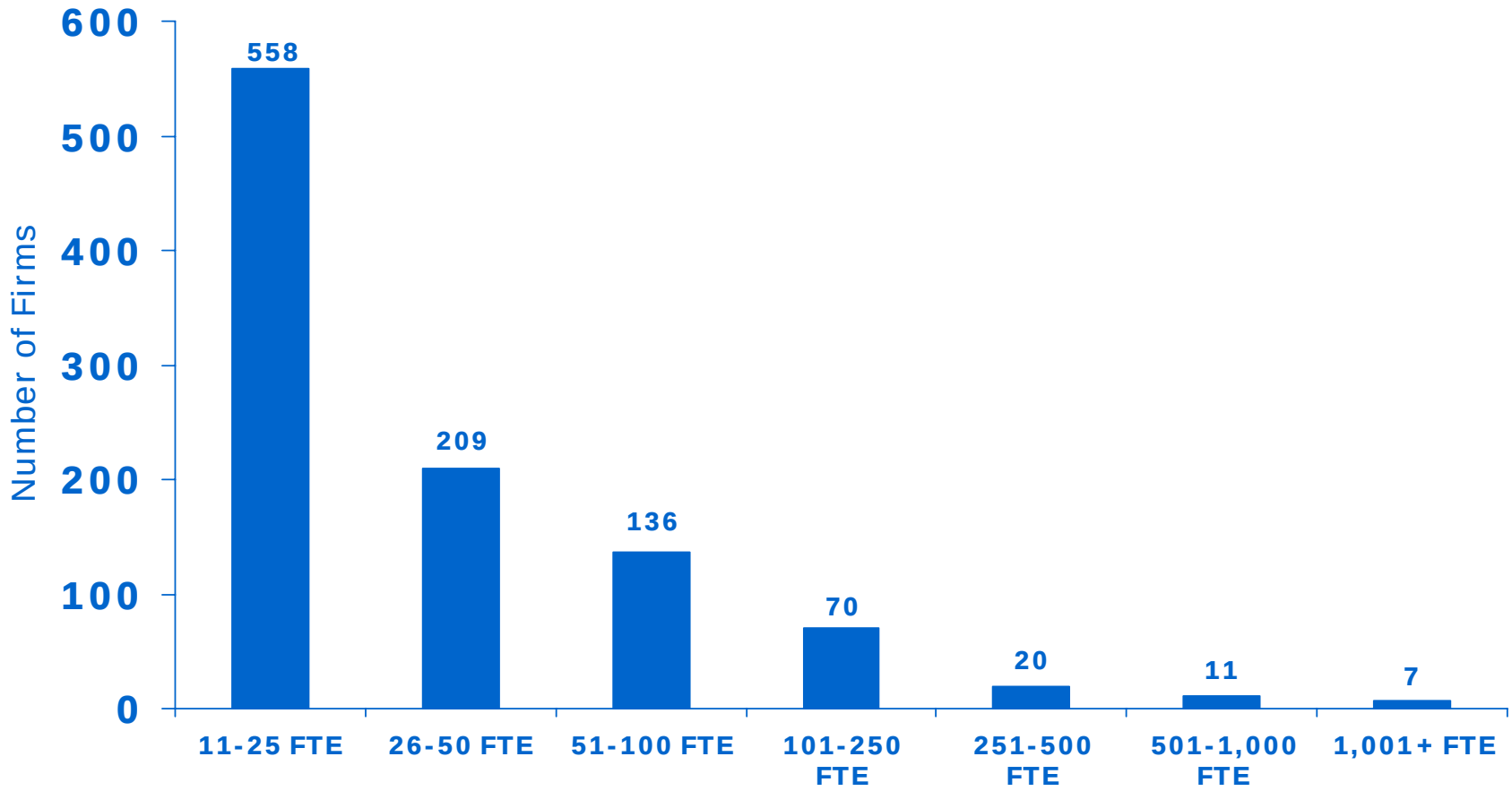
Note: Analysis reflects FSC data as of September 2008.

Passing Firms: Met Contribution Requirement, Take Up Less Than 25% by Firm Size

(FSC Period October 1, 2006 - September 30, 2007)



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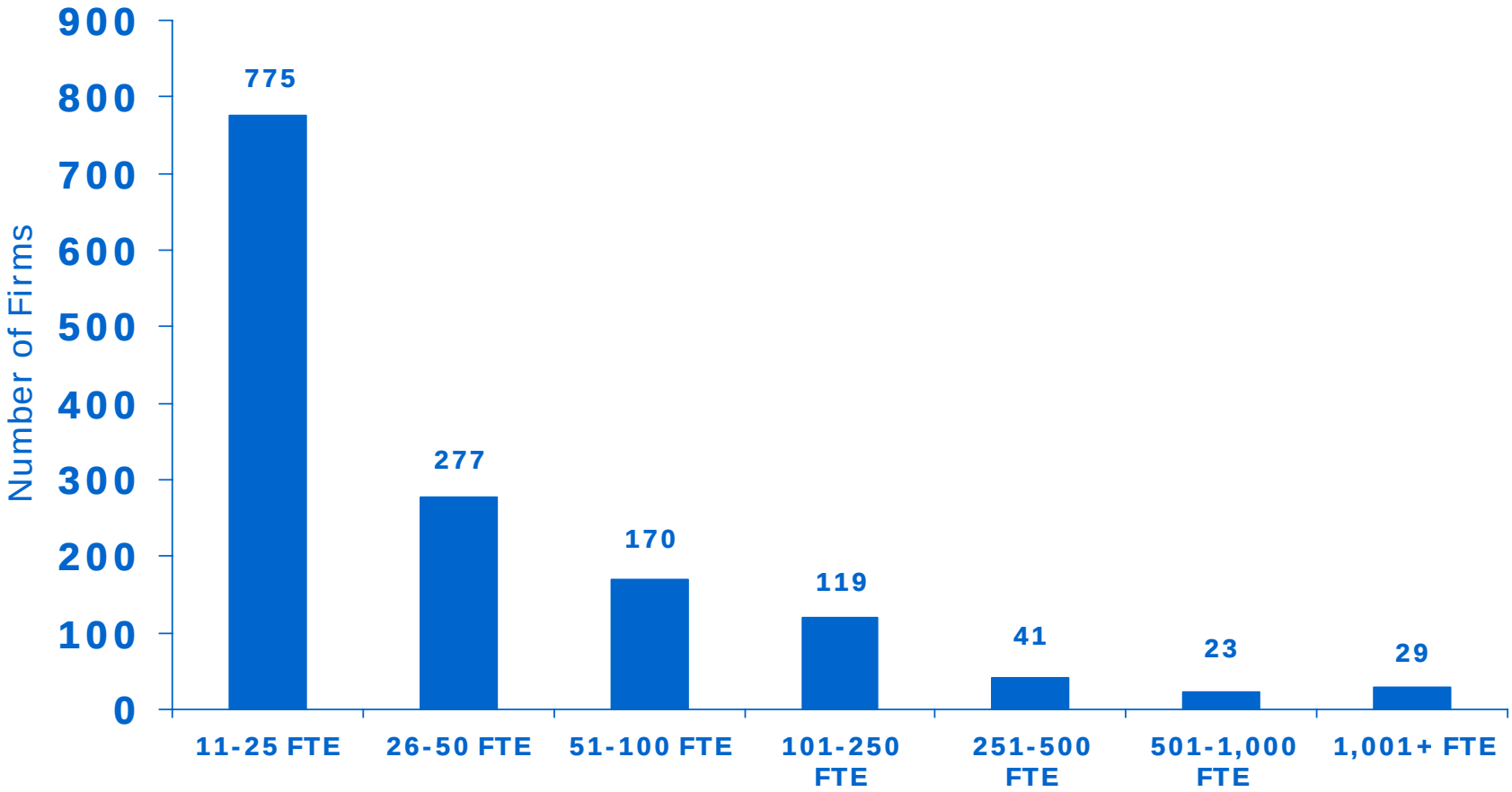
Note: Analysis reflects FSC data as of September 2008.

Passing Firms: Met Take Up Test, Did Not Meet Contribution Requirement by Firm Size

(FSC Period October 1, 2006 - September 30, 2007)



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Note: Analysis reflects FSC data as of September 2008.

Fair Share Contribution: 2008

- FY 2008 test parameters remained at same levels:
    - 25% take up among the employers' full time employees

    Or:

    - 33% employer contribution offer to all full time employees within 90 days
- FY 2008 filing period is just now concluding
  – Anticipate similar results to FY 2007

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Fair Share Contribution: Changes for 2009

- Statute was amended to change FSC filing and assessments to quarterly basis, instead of annually
  - More timely filing, analysis and collection of liability amounts
  - Brings in firms that may be under 11 FTE's annually but above some quarters

- DHCFP issued proposed regulatory changes to the FSC "fair and reasonable" standard:

  - 25% take up among full time employees

  and:

  - 33% employer contribution offer to all full time employees within 90 days

- Business strongly opposed proposal

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Fair Share Contribution: Changes for 2009

- Business groups testified at public hearing
- Raised a number of issues
  - Employees who obtain coverage elsewhere do not count in employer's take up, as they could be:
    - enrolled in spouse's health plan
    - enrolled in government sponsored insurance
  - Employers who offer good plans with excellent take up but don't meet contribution standard due to:
    - longer waiting period than 90 days
    - don't offer to all full time employees (contract workers, etc.)

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Fair Share Contribution: Changes for 2009

- Post public hearing adoption of amended criteria
- Firms with 50 and fewer FTEs – test stays the same
  - 25% take up among full time employees

  or
  - 33% employer contribution offer to all full time employees within 90 days
- Firms with 51 or more FTEs:
  - 25% take up among full time employees

  and
  - 33% employer contribution offer to all full time employees within 90 days

  – or
  - 75% or greater take-up among full time employees
- New standards in effect Jan 1, 2009
  - First quarter filing with new standards due in April - May

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Employers and Health Care Reform

- Business support for Mass Health Care Reform
  - 72% of Mass employers contribute to health care costs of their employees (2007)
    - Rate has held steady while rate has declined nationally from 68% in 2001 to 60% in 2007
  - Since reform 147,000 additional individuals insured through ESI
  - Approximately 81% of Mass insured population (excluding Medicare covered individuals) are insured through private group insurance
- Overall, Mass insurance rate is 97.4%

Sources: DHCFP Key Indicators Report and the Urban Institute

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Resources

- **The Massachusetts Health Connector**
  - Section 125 requirements, Minimum Creditable Coverage requirements, various insurance options

    www.mahealthconnector.org

- **Department of Unemployment Assistance**
  - Fair Share Contribution administration regulations

    www.mass.gov/eolwd

- **Division of Health Care Finance and Policy**
  - Key Indicators and other policy analysis reports
  - Fair Share Contribution and Employer Surcharge for State Funded Health Care Costs regulations

    www.mass.gov/dhcfp

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Minimizing the Threat of ERISA Challenges

Patricia A. Butler, JD, Dr.P.H.

NASHP/SCI Webcast (Employer Financing in State and Local Health Reform Initiatives)

February 6, 2009

ERISA

- Federal Employee Retirement Income Security Act of 1974
- Regulates private sector pension programs and (to a limited extent) employee welfare benefit programs, including health coverage
- Applies to all plans offered by private sector employers or unions (except churches) *whether offered through insurance or self-insured*
  - *Both types of plans are "ERISA plans"*

ERISA Preemption

- Preempts state laws that “relate to” employee benefit plans (including health plans) (even if they don’t conflict with federal law)
- Exception to preemption:
  - State regulation of the business of insurance (“savings clause”)
- But states cannot deem private employer or union plans to be insurers, therefore:
  - States cannot regulate ERISA plans directly, but by regulating health insurers, states can affect insured ERISA plans

ERISA Preemption

- Preemption applies despite limited federal regulation of ERISA health plans (in comparison with state health insurance standards)
- Object of preemption was to encourage employers to sponsor plans and not be subject to multiple, varying state laws
- Courts interpret meaning of preemption clause

Court Interpretations of ERISA's Preemption Clause

- Does state law "relate to" private union- or employer-sponsored health plan?
  - Does it refer to such plans?
  - Does it have a connection with such plans by:
    - Regulating areas ERISA addresses?
    - Regulating plan benefits, structure, or administration?
    - Imposing substantial costs on plans?

ERISA Preemption

- Increasingly broad court interpretation of preemption from 1974 to 1994
    - Narrowed in 1995*Travelers* case (*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance* (S. Ct. 1995))
        - Upheld NY hospital rate-setting law that could raise ERISA plan costs to some extent
- Basic tests for preemption remain:
    - State law cannot refer to or have a connection with ERISA plans

ERISA Preemption

- Courts have held that states cannot:
  - Require employers to offer health coverage (*Standard Oil v. Agsalud,* invalidating Hawaii employer mandate (9th Cir.1980))
    - NB: Hawaii's 1983 congressional exemption to its employer mandate
  - Dictate the terms of an ERISA health plan's coverage, employer's premium share, etc. (*Hewlett-Packard v. Barnes, holding* California HMO law inapplicable to self-insured employer plans (9th Cir. 1978)
  - Tax employer-sponsored health plans (*Bricklayers Local No. 1 v. Louisiana Health Ins. Assoc*., holding that state cannot assess self-insured employer plans to fund high risk pool (E.D. La. 1991)

ERISA “Savings Clause”

- Important exception to ERISA preemption:
  - State laws regulating *insurance* (as well as banking and securities) [can have access implications]
  - U.S. Supreme Court has recently simplified the test for what state laws constitute insurance regulation (*Kentucky Health Plan Assoc. v. Miller (S. Ct. 2003))*
    - Laws must be aimed at insurers and insurance practices (not just any insurer activities)
    - Laws must “substantially affect risk pooling arrangements” between insurer and insured

ERISA Implications for State Employer-Based Access Initiatives

- Broad-based “Pay or Play” Initiatives
  - State creates a public program, financed partially with taxes on employers (not plans)
  - Employers offering employee health coverage receive a credit for coverage costs
  - Likely to withstand an ERISA challenge if:
    - Broad-based tax-financed program
    - State is neutral regarding whether employers offer coverage or pay tax [not a disguised mandate]
    - State does not set standards to qualify for tax credit or otherwise refer to ERISA plans

Maryland “Fair Share Law” & RILA case

- 2006 law required for-profit employers >10,000 workers to pay into state Medicaid fund difference between what they spend on employee health care & 8% of payroll
- In *RILA v. Fielder*, 4th Circuit Court of Appeals held ERISA preempts this law because it is ‘connected with’ ERISA plans

RILA v. Fielder 4th Circuit Decision

- Law is a mandate not a tax
  - Targeted at plan of a particular employer and Wal-Mart indicated it would expand coverage rather than pay fee
  - Bill sponsors said it was intended as a mandate
- Court not persuaded that affected firm could satisfy law by health spending other than through establishing or expanding an ERISA plan
- Law interferes with multi-state plans' uniform national administration
  - Conflicts with other state laws and proposals
  - Requires employer to segregate its expenditures in each state

Suffolk County (NY) Court Decision (RILA v. Suffolk County)

- County required large grocery retailers to make health care expenditures for workers in an amount that equals the per person cost of the county to treat an uninsured worker
  - Employer spending defined similar to MD law
  - Employer spending less than required amount would pay the shortfall to the county
  - Although not directed only at Wal-Mart, it would be affected by law and was one target
- Federal court held ERISA preempts this law
  - Analysis similar to that of 4th Circuit in MD case

San Francisco Program

- SF “Health Access Program” = public health (hospital and clinic) delivery system for uninsured city residents
  - Enrollees pay sliding scale premiums
  - Employers pay a per-hour-worked assessment:
    - $1.17/hr: private employers with 20-99 workers or nonprofits with 50 or more workers
    - $1.76/hr: private employers with 100 or more workers
    - Qualifying employer spending defined broadly (reimbursement for employee health spending, HSA contributions, insurance, direct care costs)
  - Employees of ‘pay’ employers can enroll in city program or, if not city residents, have a health reimbursement account with which to buy care

San Francisco Program: Court of Appeals Decision

- In late 2008 federal Court of Appeals reversed district court and held ERISA does NOT preempt the law
  - Held ordinance does not refer to and is not connected with ERISA plans
    - Requires employers only to pay city, not provide employee benefits
    - Employer obligations can be met through means other than an ERISA plan
- Distinguished 4th Circuit case on the ground that Wal-Mart employees would not benefit from the MD assessment so Wal-Mart had no meaningful choice other than to expand its ERISA plan – SF payment helps fund programs in which employees can enroll
- SF Restaurant Association has requested a hearing before a larger panel of the Court of Appeals

Massachusetts 2006 Health Care Access Law

- Requires all residents to obtain coverage (if affordable) or face income tax penalty
- Requires employers of 11 or more FTEs to:
  - offer section 125 plans (for employees to buy coverage w/ pre-tax $)
    - Or be liable for up to 100% of uncompensated care costs of employees & dependents with high uncompensated care costs
  - Pay up to $295/FTE/yr (to fund Commonwealth Care and uncompensated hospital care):
    - Firms of over 50 FT employees owe fee: if at least ¼ of FT employees are not enrolled in firm's plan **and** firm does not pay at least 1/3 of premium **or** if at least ¾ of FT employees are not enrolled in firm's plan
    - Smaller firms owe fee if neither ¼ of their FT employees are enrolled in firm's plan **nor** employer pays at least 1/3 premium for FT employees

Massachusetts 2006 Health Care Access Law: ERISA Issues

- Even individual mandate could raise ERISA problems
  - Arguably, requiring individuals to have minimum coverage is an attempt to influence employer-sponsored plan design
- DOL policy: Section 125 plans are not ERISA plans
  - so arguably neither 125 plan mandate nor “Free Rider” penalty has ‘connection with’ ERISA plans
- “Fair Share” contribution arguably has an impermissible ‘connection with’ ERISA plans because exemption from fee depends on employer contribution levels
  - Low cost may not encourage employers to litigate
  - Business community broadly supported the law

Designing Employer Assessments to Avoid ERISA Preemption

- Do not require employers to offer worker health coverage
- Establish a broad-based universal coverage program funded partly by employer assessments for which the employer's workers are eligible
- Remain neutral regarding whether employers offer health coverage or pay assessment
- Impose no conditions on employer coverage to qualify for credit against assessment

Designing Employer Assessments to Avoid ERISA Preemption (cont)

- Consider allowing an array of spending options beyond health insurance to qualify for credit
- Minimize administrative burdens on ERISA plans
- Minimize statutory references to ERISA plans