

Including Employer Financing in State Health Reform Initiatives: Implications of Recent Court Decisions

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Introduction

Several state and local governments have recently imposed assessments on employers to help fund health care access initiatives. Including employers in financing health care takes advantage of the historic role of employer-based health coverage while providing alternative health care options for uninsured workers via broadly shared financing. The federal Employee Retirement Income Security Act of 1974 (ERISA) can become an issue when state or local laws appear to affect whether and how employers offer worker health coverage. ERISA preempts laws that “relate to” private sector employer-sponsored benefit plans because the laws either refer to such plans or have an impermissible connection with them. In the last three years, federal courts of appeal have reached different conclusions about whether ERISA preempts employer “pay or play” laws in Maryland and California.

This Issue Brief discusses implications of these court cases for state health reform. After outlining the reasons states may want to include employers as a source of health

care financing, the paper discusses ERISA’s preemption principles, describes state and local laws that have imposed employer fees, and notes the key findings and conclusions from the court of appeals opinions. Based on principles drawn from these court decisions, the Brief then offers suggestions for how states can include employer assessments in financing health care programs while minimizing grounds for ERISA challenges, recommending that states: 1) not require employers to offer worker health coverage; 2) establish broad-based universal coverage programs funded partly with employer assessments for which paying employers’ workers are eligible; 3) remain neutral regarding whether employers offer health coverage or pay the assessments; 4) impose no conditions on employer coverage to qualify for a credit against the assessment; 5) consider allowing an array of spending options beyond traditional health insurance plans to qualify for a credit against the assessment; 6) minimize administrative impacts on ERISA plans in the state program; and 7) avoid references to ERISA plans when drafting legislation.



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Policy Framework

State health policymakers have several reasons to include employers as sources of financing health care access initiatives. Foremost is the fact that employers currently pay a large share of the nation's health care bill: the vast majority of Americans under age 65 (62 percent in 2007) receive health benefits through their own employers or that of a family member.¹ Substituting public revenues for these private sources would be difficult politically and fiscally – even when state economies are strong. And sharing financing across an array of payers such as individuals, employers and even health care providers² becomes more attractive when state revenues decline during economic downturns. Surveys indicate that the general public and employers support a continued role for employers to offer health coverage and share in its cost.³

Developing a public health care program funded in part by employer contributions can provide uninsured workers access to affordable coverage options. People working in large firms are much more likely than those in small firms to have health coverage.⁴ But even in larger firms some workers lack access to coverage because it is not offered to part-time or temporary employees or to workers during waiting periods; and, of course, some workers offered coverage cannot afford their share of the premium.⁵ Public programs often include children of employees who either have no workplace insurance or cannot afford to cover their dependents.

In recent years, the proportions of both employers offering health coverage and workers covered by employer-sponsored plans have declined, primarily among small firms.⁶ States have attempted to encourage more employers to offer and contribute to employee health benefits through voluntary initiatives such as tax credits and purchasing pools, as well as subsidies for lower income workers. Because these policies have not reversed the trend of declining health coverage, some states have enacted or considered mandatory approaches, such as assessments on non-insuring employers

or broad-based “pay or play” strategies. In a “pay or play” model, the state imposes an assessment on employers,⁷ which is waived if the employer pays for employee health coverage or is reduced by the amount of an employer's health care expenditure.

State and Local Access Initiatives that Include Employer Financing

About 20 years ago, two states enacted employer pay or play programs that were never implemented.⁸ More recently, a 2003 California pay or play law was signed into law but repealed by a public initiative the following year.⁹ Interest in this financing model resurfaced in recent years, with three states and three local governments adopting various types of pay or play laws in 2005 and 2006. In 2007, the California Assembly passed a pay or play law that had the approval of the governor, but the bill died in the state Senate. These laws are outlined below:

State Initiatives

Maryland: In January 2006, Maryland enacted the “Fair Share Act.” The law required for-profit employers of 10,000 or more workers that did not spend at least 8 percent of payroll on “health insurance costs” to pay the difference into a fund supporting the state's Medicaid program. The health care spending threshold for non-profit organizations was 6 percent of payroll. The law defined “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 were required annually to report to the state the number of workers and percentage of payroll spent on employee health care.

Wal-Mart, the only employer subject to the payment obligation by virtue of its size and health care spending level, was a member of an organization that challenged the law on preemption grounds. In July 2006, a federal district court held that ERISA preempted the law¹⁰ and this decision was upheld by the 4th Circuit Court of Appeals in early 2007.¹¹ This appellate decision is discussed below.

Massachusetts. In April 2006, Massachusetts adopted a comprehensive health care access law, requiring all state residents who can afford to buy health insurance to obtain coverage or face tax penalties.¹² The law merged the individual and small group health insurance markets and created the “Connector,” which links individuals and firms with 50 or fewer employees to approved health insurance products (but products for individuals and small groups can be bought in the merged insurance market, independent of the Connector). The Connector administers the Commonwealth Care Health Insurance Program, which subsidizes coverage for residents with lower and moderate incomes. The law also requires employers with 11 or more employees to establish tax code Section 125 plans that allow workers to purchase health insurance with pre-tax income and to pay the state an annual assessment of up to \$295 for each full-time equivalent employee if the employer does not offer and contribute a “fair and reasonable” amount toward employee health insurance premiums. This condition was originally defined by the state Division of Health Care Finance and Policy as being met if at least 25 percent of the employees were enrolled in an employer-sponsored plan or the employer paid at least 33 percent of the worker premium. The Division has recently amended the regulations to allow the assessment on employers with over 50 employees to be waived only if both the minimum enrollment and employer premium contributions are met or if at least 75 percent of their workers are enrolled in the company's health plan. Although portions of the Massachusetts law could raise ERISA issues, it has not yet been challenged in court.¹³

From the law's July 2006 implementation through March 2008, approximately 440,000 previously uninsured state residents have obtained insurance coverage: 57 percent through subsidized public programs, 36 percent from employer-sponsored insurance and 7 percent as individuals.¹⁴ In its first year of operation (October 2006 through September 2007), approximately 24,000 employers had 11

or more workers. Fewer than 1,000 of them (3.6 percent) were required to pay the assessment (totaling \$7.7 million) because they did not meet one or both waiver conditions.¹⁵ The proportion of the state's employers that offer insurance has grown slightly since 2001, in contrast with the national decline of employers offering coverage during that period.¹⁶ Employers report satisfaction with the program.¹⁷

Vermont. In 2006, Vermont enacted the Catamount Health Plan and Catamount Health Assistance Program to offer subsidized health products to uninsured Vermont residents (including subsidies for employer-sponsored coverage), emphasizing care for chronic conditions. The program is financed by tobacco taxes, income-based premiums paid by enrollees, and assessments paid by employers with more than six employees (declining to four employees as of July 2009) of \$365 per year per uncovered full-time equivalent worker (with exceptions for small employers). Uncovered 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 for but not enrolled in the employer's plan or covered under other public or private sector plans. Employers must report to the state the number of hours worked by uncovered employees and keep records related to the law's requirements. As with the Massachusetts law, the Vermont statute might raise some preemption issues but has not been challenged in court.¹⁸

In the first 12 months of the new program's operation (November 2007 through October 2008), Vermont subsidized premiums for 7,700 people, 15 percent of whom receive insurance through the workplace. In the first year employers were subject to the fee (May 2007 through April 2008), approximately 1,000 employers paid assessments totaling \$5.5 million.

California. In a special legislative session in late 2007, the California Assembly passed ABX1 X, which would have created a comprehensive health care access program: 1) requiring state residents (with certain hardship exemptions) to have insurance coverage; 2) providing public subsidies for health coverage for low and lower middle income residents (including Medicaid expansions); and 3) offering the opportunity for individuals and workers without employer coverage to buy insurance from a public pool. Financing for the entire program (including coverage under the purchasing pool) would have come from a combination of enrollee premiums, employer fees (ranging from 1 percent to 6.5 percent of payroll depending on employer revenues), hospital assessments, and county government contributions. Because the state's constitution limits the legislature's authority to impose new taxes, the revenue provisions were placed into a separate initiative to be submitted to the electorate in 2008.¹⁹ The program had the support of Governor Schwarzenegger but failed in the state Senate in early 2008.

Local Initiatives

New York City. 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 to be \$2.50 to \$3.00 per hour) for their workers or face fines and license revocations. The law defined health care expenditures as employer spending on health insurance, direct services, reimbursing employees for the cost of services, contributions to Health Savings Accounts (HSAs), and similar expenditures. The law was never implemented and was withdrawn after federal courts in Maryland and Suffolk County held that ERISA preempted similar laws.

Suffolk County. In October 2005, New York's Suffolk County passed an ordinance similar to the one in New York City 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 (if grocery sales

accounted for at least 20 percent of that total) to spend at least \$3.00 per hour on employee health care expenditures (defined similarly to spending under the New York City law). The law apparently would have applied primarily to large retailers, like Wal-Mart, that did not meet the expenditure threshold.²⁰ The local law was challenged on ERISA grounds and, in 2007, a federal district court held it preempted, basing its reasoning on that of the 4th Circuit and the similarities between the ordinance and the Maryland law.²¹

San Francisco. In August 2006, San Francisco created the Health Access Plan to provide health care to city residents through its public health department clinics and hospitals. The program is financed by individual contributions and employer assessments. For-profit employers with between 20 and 99 employees and non-profit employers with at least 50 employees must spend at least \$1.17 per hour on employee health care; for-profit employers with 100 or more workers must spend at least \$1.76 per hour. Spending can include an array of options such as payments to third parties like insurers, reimbursement for employee health spending, funding HSAs, or payments to the city. If an employer pays the city, its uninsured workers residing in the city are entitled to enroll in the Health Access Plan and nonresidents receive medical reimbursement accounts to purchase health care elsewhere.

The law was challenged in court on preemption grounds by the Golden Gate Restaurant Association. In late 2007, a federal district court held that ERISA preempts the city's ordinance. But the 9th Circuit Court of Appeals stayed that decision, pending the city's appeal,²² allowing the program to be implemented in early 2008. As discussed below and in Appendix A, the appellate court reversed the district court's decision in September 2008.²³ The Health Access Program has enrolled more than 27,000 uninsured workers in its first eight months of operation in 2008, representing one-third of the estimated number of uninsured San Franciscans.²⁴

ERISA's Preemption Provisions

ERISA was enacted to remedy fraud and mismanagement in private-sector employer pension plans.²⁵ It also applies to other employee benefit plans, such as health coverage, sponsored by private-sector unions or employers (other than churches). It does not apply to plans operated by public employers such as state or local governments. Private sector employee benefit plans, which include health coverage, are “ERISA plans,” regardless of whether they are offered through insurance or self-insured by the sponsor.²⁶ While regulating pension plans in considerable detail, ERISA imposes fewer regulations on employer-sponsored health plans.

Despite its limited standards for health plans, ERISA contains a broad preemption provision (the “preemption clause”) stating that federal law supersedes any state law that “relates to” ERISA plans, except those that regulate insurance, banking, and securities.²⁷ States cannot deem employer-sponsored plans themselves to be insurers. Consequently, states are prohibited from regulating employee health plans directly. They can, however, regulate the insurers with which an employer plan contracts, 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 34 years since ERISA was enacted. From 1974 through 1995, 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.”²⁸ The Court overturned state laws with any impact on or reference to an ERISA plan’s benefits, structure, or administration.²⁹ The Court did suggest that state laws with a “tenuous, remote, or peripheral” impact on ERISA plans would not relate to them,³⁰ though it has never applied that exception explicitly.

Following early Supreme Court precedent, lower federal courts invalidated Hawaii’s 1974 mandate that employers provide worker health coverage³¹ and California’s 1973 law setting benefit standards for employer-sponsored managed care plans, including self-insured plans.³² A 1983 amendment to ERISA authorized the Hawaii employer mandate.

In a ground-breaking development—the 1995 *Travelers Insurance* decision—the Supreme Court narrowed the reach of ERISA’s preemption clause by limiting the types of state law impacts on ERISA plans that cause preemption.³³ 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 limit their ability to design uniform interstate benefit plans – a primary objective of the preemption clause. The Court noted that “cost uniformity was almost certainly not an object of preemption.”³⁴ It also observed that a state law might impose cost burdens so exorbitant that they removed any actual choice and therefore could be preempted. The Court also stated that “acute, albeit indirect economic effects” could suffice to force an ERISA plan to “adopt a certain scheme of substantive coverage” and therefore might be preempted.³⁵ But in the Court’s view, the 24 percent hospital cost surcharge paid by commercial insurers was not high enough to cause ERISA to preempt the New York law.³⁶

The Court also has interpreted ERISA’s so-called insurance “savings clause,” which exempts state insurance regulation from preemption.³⁷ 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 health plans and enrollees directly conflict with ERISA and are preempted on that ground alone.³⁸

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 explicitly³⁹ or by requiring reference to an ERISA plan in order to comply with the state law,⁴⁰ or
- Has a connection with an ERISA plan by substantially affecting its benefits,⁴¹ administration,⁴² or structure.⁴³

Court of Appeals “Pay or Play” Law Decisions

4th Circuit Decision. In January 2007, the 4th Circuit Court of Appeals held that ERISA preempted the Maryland Fair Share Act.⁴⁴ This decision and its implications for state health policy were discussed in an earlier Issue Brief.⁴⁵ The Court of Appeals did not address the “reference to” test but looked only at whether the state law bore an impermissible “connection with” employer-sponsored health coverage. First, it held that the law was not a tax but a health benefits mandate because its purpose was to compel Wal-Mart to increase health care spending, citing the legislative sponsors’ statements about their objectives. The law was preempted because, unlike laws at issue in *Travelers* and related cases, it regulated health plan structure by obligating designated employers to provide “a certain level of benefits.” The Court held that the law created an “irresistible incentive” for the employer to expand its existing ERISA plan in order to spend the required funds on behalf of its own employees. The Court dismissed as impractical alternative spending options offered by the Maryland law (such as funding HSAs or operating employee clinics) and also applied an earlier Supreme Court case, *Egelhoff v. Egelhoff*, holding that ERISA preempted a state law allowing employers to opt out of a

state requirement.⁴⁶ Finally, the Court of Appeals held the law would conflict with laws enacted or under consideration at that time in several other states and localities. One of the three appellate judges dissented on the grounds that the state law was merely a spending requirement, not a benefits mandate, and did not interfere with uniform national employee benefits administration because its only direct requirement, record-keeping, was too insubstantial to constitute such interference. Legal analysts have disagreed over the soundness of the 4th Circuit's opinion and its application to other state laws.⁴⁷

9th Circuit Decision. In contrast, in September 2008, the 9th Circuit Court of Appeals upheld the San Francisco ordinance against a preemption challenge. The Court noted that funding health care for lower and moderate income people is a traditional area of state responsibility that, as noted by the Supreme Court in the *Travelers* case, should not be preempted without clear congressional intent to do so.

Then the Court of Appeals held that the ordinance does not relate to ERISA plans under either Supreme Court preemption test. The law is not connected with ERISA plans because its only employer obligation is to make a payment (not to maintain an ERISA plan or provide particular benefits), so, like the hospital surcharges at issue in the *Travelers* case, the law does not “bind plan administrators to a particular choice.” The Court also held that ERISA does not preempt a law with which employers can comply through means other than via an ERISA plan – using an ERISA plan to meet the law's requirements is the employer's choice but not required by the law. The Court further noted that record-keeping requirements were not connected with ERISA plans because they exist for all employers regardless of whether they offer ERISA plans. The Court held that the city's ordinance does not refer to ERISA plans because it does not act on ERISA plans – involving only employer spending and not benefits or plan administration. Furthermore, enforcement of the ordinance does not

depend on the existence of an ERISA plan, unlike the laws at issue in other Supreme Court cases, because it is effective even if no employers have ERISA plans.

Of particular interest to state health policy makers, the 9th Circuit distinguished the Maryland Fair Share law and reasoning of the 4th Circuit. Because Wal-Mart was the only employer actually subject to the Maryland law and its employees would not benefit from any payment the retailer would make to fund the state's Medicaid program, the 9th Circuit observed it was reasonable for the 4th Circuit to conclude that Wal-Mart faced an “irresistible incentive” to expand its existing ERISA plan and paying the state was not realistic. In San Francisco, however, the 9th Circuit noted, employees of “pay” employers could become eligible for the health access program or a health reimbursement account, a “tangible benefit” for employees and “meaningful alternative” for employers. The plaintiff restaurant association has requested a hearing before a full panel of the Court of Appeals, and other commentators have criticized the decision.⁴⁸

Reconciling the Decisions. The two Court of Appeals decisions involve different laws with different practical impacts, but they also represent different views of preemption analysis and so are not entirely compatible with one another. By targeting Wal-Mart in drafting their law, Maryland legislators made it easy for the 4th Circuit to characterize the law as a benefits mandate rather than a tax or other spending requirement. Had the case been before the 9th Circuit, that court might have concluded that ERISA preempted such a law directed only at one employer and whose payment would not have direct benefits to its employees. And because San Francisco's ordinance applied to a large number of employers whose assessments partly funded the Health Access Program, the city's ordinance might have overcome preemption under the 4th Circuit's reasoning.⁴⁹

But while the differences in legislative objectives, drafting, and practical impact make the decisions somewhat easy to reconcile, the Courts of Appeal appear to view ERISA preemption of pay or play laws differently. For example, although the 4th Circuit's decision focuses on the law's impact on Wal-Mart, it did observe that most employers would generally prefer to spend their own money on their own employees rather than pay a state assessment (while, of course, not discussing the impact of a public program for which employees of “pay” employers would be eligible, which was not at issue in Maryland). The 4th Circuit also views the potential for different employer assessment laws and record-keeping requirements across the country as undermining ERISA's objective of minimizing the burdens on multi-state employers of complying with varying state laws. In contrast, the 9th Circuit found no such burden on plans because it characterized the obligation as a spending requirement (akin to taxes that vary across states and localities) and noted that record-keeping responsibilities would exist regardless of whether an employer had an ERISA plan. The 4th Circuit did not consider whether the Maryland law met or failed the “reference to” preemption test, but the 9th Circuit took a fairly narrow view of how that test has been applied in the three Supreme Court cases where it has been used.

Finally, the two Courts of Appeal also read differently the relevance of the Supreme Court's recent preemption case law: 1) whether *Travelers* prohibits an employer assessment that can be waived or reduced for money the employer spends on employee health care; 2) whether the Supreme Court's decision in the *Egelhoff* case⁵⁰ compels preemption of a state law allowing plan administrators to opt out of a state requirement; and 3) whether the Supreme Court's decision in the *Dillingham Construction*⁵¹ case prohibits preemption of a law whose requirements can be satisfied by means other than an ERISA plan (even if an employer could also comply via an ERISA plan).

Implications for State Pay or Play

Laws. Technically, the two Courts of Appeals decisions are precedent only within their jurisdictions,⁵² but courts in other states will be guided by the reasoning in these cases. As discussed in an earlier Issue Brief,⁵³ the Massachusetts and Vermont employer fee laws raise some preemption issues, the former by conditioning the fee waiver on an employer paying a minimum share of the health insurance premium and the latter because, to determine if the fee must be paid, an employer arguably has to refer to the eligibility terms of its ERISA plan. The 4th Circuit's decision might not itself provide direct support for a preemption challenge to either law, however. First, those laws are much more comprehensive and affect a large proportion of employers. Furthermore, their assessments arguably are not so large as to create the “irresistible incentive” for employers to create or expand ERISA plans to avoid paying the fee.

Massachusetts: The 9th Circuit opinion could be cited by both supporters and opponents of the Massachusetts laws. Supporters might argue that the Massachusetts employer fee helps support a comprehensive program (in this case, funding CommonwealthCare and hospital uncompensated care). But opponents could assert that it affects an employer plan's structure by waiving the fee only if an employer pays at least one-third of the employee premium, which opponents might argue is inconsistent with the 9th Circuit's caution that it might find preemption if a law attempted to dictate ERISA plan benefits. Although the Massachusetts law does not dictate plan *benefits* per se, it arguably affects plan *structure* in violation of the Supreme Court's guidance that a state law has a connection with an ERISA plan if it affects the plan's benefits, *structure*, or administration. Even if the 9th Circuit's decision does not resolve preemption questions, however, Massachusetts could still defend its law on the ground that the small employer fee has such a “tenuous, remote, or peripheral” impact on ERISA plans that it does not relate to them.

Vermont: Vermont might be able to use the 9th Circuit's narrow reading of the “reference to” test to defend its law against a preemption challenge. Even though an employer's payment obligation depends on which of its employees, if any, do not enroll in an employer-sponsored plan, the law does not dictate how a plan must be structured nor is its enforcement dependent on the existence of an ERISA plan—if no plan exists, the employer pays the fee. The employer need not look at the terms of an ERISA plan to determine whether it is required to pay the fee; it need only determine which of its employees are uninsured under its own plan, another private plan, or public coverage.

California: Had the 2007 California pay or play proposal become law, it could have been defended against a preemption challenge under the reasoning of the 9th Circuit's decision. The bill that passed the state Assembly with the blessing of the governor in the special legislative session late in 2007 would have created a public purchasing pool through which uninsured Californians could purchase health coverage, funded by a combination of individual contributions, employer assessments, tobacco taxes, and hospital assessments. Employers would have been required to pay between 1 and 6.5 percent of payroll, according to their revenues and would receive a credit against the assessment for actual spending on employee health care (defined broadly and beyond spending under traditional ERISA plans). Because the program was even more comprehensive than that in San Francisco and the law offered employers alternative ways to meet the spending requirement, under the 9th Circuit's reasoning, it would likely have overcome an ERISA challenge.⁵⁴

Designing State Employer Assessments to Avoid ERISA Preemption

Although ERISA preemption remains a complication for state health care access initiatives financed with employer contributions, it is possible for state health policy makers to craft pay or play programs to

avoid similarities with the Maryland law that caused it to be preempted and take advantage of elements of the San Francisco ordinance that helped it overcome its preemption challenge.

- **Do not require employers to offer health coverage to their workers.** A direct employer mandate would be preempted under the line of precedent that persists after *Travelers*, which invalidated Hawaii's law (which the 9th Circuit distinguished from the San Francisco ordinance). Even if a law is drafted as a tax or other assessment, targeting only one or a few employers raises the potential argument (relied on by the 4th Circuit and likely to be supported by employers' statements in court documents) that the state's real object is to force those employers to create or expand ERISA plans.
- **Establish a broad-based universal coverage program funded in part with employer assessments for which paying employers' workers are eligible.** While the 4th Circuit might not agree, under the 9th Circuit's reasoning, a health reform law should overcome an ERISA challenge if the state's objective is to establish a broadly-financed public health coverage program but allow employers the choice to spend funds directly on their employees. Under the 9th Circuit's analysis, allowing the employees of “pay” employers to be eligible for the public program (perhaps upon individual payment of income-based premiums) constitutes a “tangible benefit” that provides a realistic choice between paying and playing.
- **Remain neutral regarding whether employers offer health coverage or pay the assessment.** If the state's objective is to assure universal or near-universal coverage, it should be explicitly neutral with respect to whether an employer pays the assessment or spends directly on employee health care. While courts typically examine statutory language and not evidence of legislative intent, the Maryland case illustrates

the importance of state health policy makers avoiding any characterization that their goal is to require employers to offer workplace health coverage. The justification for a credit against the assessment is to permit employers to spend on worker health care (to come within the broad language in *Travelers* to avoid “binding plan administrators to a particular choice”). The law’s sponsors should not express a preference for either paying or playing.

- **Impose no conditions on employer coverage to qualify for the credit against the assessment.** Despite a state’s concerns about whether a “play” employer’s health benefit, cost sharing, and premium contributions are adequate, it is dangerous to condition a credit on meeting qualifications that will directly affect an ERISA plan’s benefits or structure. Even the 9th Circuit, which characterized the city’s employer assessment as a spending requirement (contrasted with the 4th Circuit’s depiction of the Maryland law as a benefits mandate), noted that the city ordinance does not specify the benefits employers must offer. State health policy makers and employee advocates may worry that an unconditional spending requirement may result in meager benefits, especially in a costly workforce (for example, one with many older workers). Unfortunately, this policy concern remains a limitation to designing a pay or play law under ERISA constraints.
- **Consider allowing an array of spending options beyond traditional health insurance plans to qualify for the credit.** Both the Maryland and San Francisco laws permitted employers a broad array of spending options to qualify for the credit against the assessment beyond traditional third party health insurance (or a self-funded employer health plan). These choices included funding HSAs (HSAs are not ERISA plans⁵⁵), reimbursing employees for services they purchased individually (which might occur outside a formal ERISA plan), and direct provision of health care through worksite clinics (which can occur outside ERISA plans in certain circumstances).⁵⁶ The 4th Circuit did not find these options likely to make up the

difference between what Wal-Mart already spent on employee health care and the 8 percent of payroll requirement, and the 9th Circuit focused primarily on the option to pay the city without discussing other types of spending that might occur outside an ERISA plan. Allowing a broad set of options for employer spending, some of which could be offered outside an ERISA plan, might avoid preemption under reasoning in the *Dillingham Construction* case but also raises the potential that spending might satisfy all or most of the payment obligation while offering inadequate benefits and therefore presents a conundrum for policy makers.

- **Minimize administrative impacts on ERISA plans.** States cannot tax ERISA plans directly; the pay or play assessment must be imposed on employers. While a state pay or play law provides an incentive for the employer (in its capacity of ERISA plan sponsor) to evaluate whether it is preferable (from cost, management, and employee relations perspectives) to pay the tax or cover workers, such a burden should not compel preemption under the reasoning of *Travelers* and the 9th Circuit decision. Designing a pay or play program to be administered with other state tax laws (e.g., for remitting unemployment compensation taxes or withholding employee income taxes) can help overcome arguments that the state law imposes impermissible administrative burdens. The 9th Circuit also noted that the city’s record-keeping requirement did not specifically burden ERISA plans because it existed regardless of whether the employer spent funds through an ERISA plan or otherwise, but the 4th Circuit opined that that required record keeping on workplace health spending would burden interstate ERISA plan administration.
- **Minimize statutory references to ERISA plans.** Application of the Supreme Court’s “reference to” test has always been unclear. The Court reiterates this test in all its preemption cases but has applied it in only three. The 2nd Circuit Court of Appeal has held that a state law must operate directly on, or be premised on the existence of, an ERISA

plan rather than merely include the words “ERISA,” “employer-sponsored health plan” or similar terms.⁵⁷ The 9th Circuit took a similarly narrow view of this preemption test regarding the San Francisco ordinance. The 4th Circuit did not apply this test to the Maryland law. When possible, a state could minimize the risk of a preemption challenge by drafting a pay or play law without explicit reference to ERISA plans but rather refer to employer spending obligations and the credit allowed against them.

Another consideration in designing a pay or play law could be whether to include public employees along with private sector employees in a public purchasing arrangement. While recent state pay or play laws have not been drafted to include state or local government employees, in previous years some state reform proposals have considered allowing lower income people to participate in public employee purchasing arrangements. Partly financing such coverage with employer assessments might raise additional ERISA issues. Public employee benefit plans are excluded from the definition of ERISA plans, but allowing private employers to participate in them directly subjects the public plans to ERISA. In holding that the San Francisco Health Access Program was not an employer-sponsored plan (noting that city employees were not eligible for that program), the 9th Circuit dismissed this potential complication. But states should be aware that allowing private employers to contribute (on behalf of their employees) to a health coverage pool that includes public employees risks subjecting the public plan to ERISA requirements.

Congressional Proposals to Authorize States Relief from ERISA Preemption

States considering broadly-financed universal health coverage programs in past years have sought congressional relief. Hawaii’s employer health insurance mandate, invalidated by the courts, was granted a statutory exemption from ERISA preemption in 1983.⁵⁸ Bills were introduced in Congress in the early 1990s to: 1) authorize specific state initiatives (such as Washington State’s employer mandate and Oregon’s pay or play law⁵⁹); 2) allow general categories of state access initiatives (such as

financing universal access programs or high risk pools and maintaining hospital rate setting systems⁶⁰); and 3) provide a process by which federal agencies could waive ERISA provisions and award grants for a limited number of state demonstration health care access and cost control programs.⁶¹ None of these proposals was enacted.

The revival of state interest in health coverage expansions involving employer financing along with adverse court decisions have renewed interest by some members of Congress in offering states relief from ERISA constraints. A bill introduced (but not enacted) in 2005 would have allowed the Secretary of the Department of Health and Human Services (DHHS) to grant waivers of ERISA's preemption clause among other federal laws as part of a grant program for up to five states for health coverage reforms.⁶²

Three proposals were introduced in the most recent session of Congress in 2007 to facilitate state health care access and cost control initiatives. Two of these bills did not authorize ERISA relief, but one would have allowed states applying for health reform demonstration grants that would be approved by Congress after recommendation by a federal task force to seek "exceptions" to federal statutes, presumably including ERISA's preemption provisions.⁶³ Because the business community generally opposes such open-ended waiver authority,⁶⁴ it might be a more acceptable compromise between state and private sector interests for Congress to enact specific "safe harbors" from preemption. For example, states could be allowed to require all payers (including self-insured employer plans) to participate in data collection and quality improvement programs and to enact pay or play initiatives meeting specified standards to finance universal access programs.⁶⁵

Whether the upcoming Congress will consider such proposals will depend on how quickly it and the new administration are able to consider potential national health reform policy as well as the direction of such national policy.

Conclusion

The two recent federal Court of Appeals cases offer some guidance about how states can impose financial requirements on employers to help fund health care initiatives. But until the U.S. Supreme Court considers a state "pay or play" law or Congress amends ERISA to allow more state flexibility, the application of ERISA's preemption clause to such a health reform model remains uncertain. State policy makers should not be discouraged from designing health care access programs that include employer financing but should seek to minimize the application of the 4th Circuit decision and take advantage of more helpful analysis by the 9th Circuit as outlined in this Issue Brief.

About State Coverage Initiatives (SCI)

State Coverage Initiatives works with states to plan, execute, and maintain health insurance expansions, as well as to improve the availability and affordability of health care coverage. SCI's team of policy experts works with states to help expand coverage to working families, build on employer-based health insurance, and foster collaboration among stakeholders. SCI is a national program of the Robert Wood Johnson Foundation (RWJF) administered by AcademyHealth.

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The National Academy for State Health Policy is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. NASHP provides a forum for constructive, nonpartisan work across branches and agencies of state government on critical health policy issues facing states. NASHP is a nonprofit, nonpartisan organization dedicated to helping states achieve excellence in health policy and practice.

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About the Author

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Appendix A

The 9th Circuit Court of Appeals Decision in *Golden Gate Restaurant Association v. City and County of San Francisco*

In September 2008, the federal 9th Circuit Court of Appeals reversed a lower court decision.⁶⁶ The Court held that ERISA does not preempt San Francisco's "pay or play" law that requires large and medium-sized employers to spend a specified amount on employee health care or help to finance the city's "Health Access Plan" (HAP) that provides care to uninsured city residents. Uninsured city residents are eligible to enroll in HAP with premium and cost sharing contributions on an income-related basis; workers who are insured or who live outside the city whose employers have paid the assessment are entitled to establish medical reimbursement accounts with the city to pay for health care services.

The Ordinance. Employers are subject to the assessment on behalf of workers in the city who work at least ten hours per week and have worked for the employer for at least 90 days. For-profit employers with between 20 and 99 employees and non-profit employers with at least 50 employees must spend at least \$1.17 per hour on employee health care; for-profit employers with 100 or more workers must spend at least \$1.76 per hour.⁶⁷ The required "health care expenditures" include: contributions to a health savings account (HSA), reimbursement to covered employees for their purchase of health services, payments to a third party to provide health care services, direct employer health care delivery costs, and/or payment to the city to be used on behalf of covered employees' membership in the HAP or establishment of medical reimbursement accounts. The ordinance requires employers to maintain records of health care expenditures but does not specify the form in which such records should be kept.

Legal Analysis. The Court categorized employers into several groups according to whether they had ERISA plans, included all or only some employees in their plans,

and spent more or less than the required amount on health care. In all cases, however, the Court determined that the ordinance does not require employers to establish their own ERISA plans or alter existing plans because they can comply with the ordinance by paying the city or creating or amending ERISA plans. The Court also noted that the ordinance is not concerned with the nature or amount of health benefits an employer provides employees but only with the dollar amount of employer spending. The Court began its legal analysis by observing that Congress's purposes in enacting ERISA were to safeguard employees from the abuse and mismanagement of employer-funded employee benefits as well as to provide "a uniform regulatory regime over employee benefit plans." It then reiterated the Supreme Court's tenet that state and local laws are not to be preempted without clear evidence of congressional intent when they operate in a traditional field of state jurisdiction and found that the provision of health services to lower and moderate income people is such a conventional state activity. It then examined the preemption assertions of the plaintiff Golden Gate Restaurant Association and the U.S. Department of Labor, which participated on its side: 1) that the city HAP itself was an ERISA plan; and 2) that the ordinance "related to" employer-sponsored plans in violation of the preemption clause.

The HAP is not an ERISA Plan. The Court held that allowing employers to pay the city does not create employer-sponsored ERISA plans because an employer's only responsibility is to remit payment. The objective of ERISA is to avoid mismanagement of employee benefits funds, but San Francisco employers have no opportunity to manage funds they pay the city. And the minimal record-keeping requirements do not constitute discretionary activities. The HAP itself is not an ERISA plan because it is funded by multiple sources, including tax revenues, under half of HAP enrollees are workers whose employers have paid the assessment, the HAP was not "established or maintained" by an employer but by a government agency, and employers

have no control over who is eligible for the HAP or what benefits it provides.⁶⁸

The Ordinance Does Not Relate to ERISA Plans. In determining whether the city ordinance relates to employer-sponsored health plans, the Court first considered whether it had an impermissible "connection with" ERISA plans. Under the reasoning in *Travelers Insurance* (and in contrast to other preemption cases⁶⁹), the Court held that the ordinance does not "bind plan administrators to a particular choice." Its only obligation is payment – it does not require employers to adopt an ERISA plan or provide specific benefits under an existing ERISA plan. Although employers might be influenced by the ordinance to create or expand an ERISA plan rather than pay the city, that decision (similar to the surcharge at issue in *Travelers* that might influence an employer to purchase Blue Cross coverage) is the employer's choice, and that type of influence is less direct than the surcharges in *Travelers* and "entirely permissible." The Court also relied on a line of cases holding 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 affects employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."⁷⁰ Furthermore, the health expenditure record-keeping requirements exist regardless of whether an employer has an ERISA plan and are imposed on the employer, not the plan.⁷¹

The Court also held that the ordinance does not have an impermissible "reference to" ERISA plans, taking a fairly narrow view of the Supreme Court's second preemption test, because it does not act on ERISA plans at all. First, it involves only employer spending and does not attempt to dictate employer-sponsored benefits or plan administration. Furthermore, enforcement of the ordinance does not depend on the existence of ERISA plans (unlike the laws at issue in other Supreme Court cases⁷²) because it "can have its full force and effect even if no employer in the City

has an ERISA plan.” Rather the Court found the ordinance conceptually similar to prevailing wage laws that require an employer to pay a minimum total wage (minimum salary plus benefits) but allow employers to set the fringe benefits levels.⁷³

Distinguishing the 4th Circuit Case.

Finally, the Court of Appeals distinguished the decision of the 4th Circuit Maryland “Fair Share Act” case. Noting that Wal-Mart was the only employer affected by the Maryland law and that the payment to the state’s Medicaid program would not have benefited Wal-Mart employees, the Court observed that it was reasonable for the 4th Circuit to conclude that Wal-Mart faced an “irresistible incentive” to expand its existing ERISA health plan and had no true choice about whether to pay the state or alter its plan. The Court held that the city’s ordinance, however, “offers employers a meaningful alternative that allows them to preserve the existing structure or their ERISA plans.” Because the workers of employers paying the city are eligible for free or discounted enrollment in the HAP or medical reimbursement accounts, the “ordinance provides tangible benefits to employees when their employers choose to pay the city rather than to establish or alter ERISA plans.” In the Court’s view, this “meaningful alternative” belies the argument that the ordinance effectively mandates employers to create or amend ERISA plans in violation of the preemption clause.

Rehearing Sought. The Restaurant Association has petitioned the 9th Circuit for an “en banc” hearing before a larger panel of the Court of Appeals.

Endnotes

- 1 Fronstin, P. Issue Brief No. 321. *Sources of Health Insurance and Characteristics of the Uninsured: An Analysis of the March 2008 Current Population Survey*. September 2008. Washington, D.C. Employee Benefits Research Institute, www.ebri.org.
- 2 Courts have held that ERISA does not preempt state provider taxes and fees, *Boyle v. Anderson*, 68 F. 3d 1093 (8th Cir. 1995), cert den. 516 U.S. 1173 (1996), *Connecticut Hosp. Assoc. v. Wetman*, 66 F. 3d 413 (2d Cir. 1995), *New England Health Care Employee Union v. Mount Sinai Hospital*, 65 F. 3d 1024 (2d Cir. 1995).

- 3 Kaiser Family Foundation. *Kaiser Health Tracking Poll: Election 2008*. September 2008, www.kff.org; Harris Interactive. “The Public is Willing to Support Many Options to Expand Health Insurance Coverage But Not All.” Vol. 6, Issue 8, May 8, 2007, www.harrisinteractive.com/news/newsletters_wsjs.asp. *Survey of Health Insurance*. A recent survey reveals that over three-quarters of employers in Massachusetts agree that all employers bear some responsibility for providing worker health benefits, Gabel, J.R. et al. “After the Mandates: Massachusetts Employers continue to support Health Reform as More Firms Offer Coverage,” *Health Affairs* 27(6) p. W566, October 28, 2008. A recent survey of employers offering employee health coverage found that a majority (64 percent) believe the employer-based system should remain the primary means of offering health coverage, International Foundation of Employee Benefit Plans, “Health Care Cost Control: Industry Approaches and Attitudes,” reported in *BNA Pension & Benefits Reporter* 35(46):2592-2593, November 18, 2008.
- 4 Fronstin, P. *Sources of Health Insurance*.
- 5 Kaiser Family Foundation and Health Research & Educational Trust. *Employer Health Benefits 2008 Annual Survey*. www.kff.org.
- 6 Kaiser Family Foundation and Health Research & Educational Trust *Employer Health Benefits 2008*; Fronstin, P. *Sources of Health Insurance*.
- 7 The assessment may be called a fee, assessment, contribution or other term than a “tax,” for purposes of selling the concept or because state law limits states’ ability to impose taxes but allows other kinds of revenue measures.
- 8 In 1988, Massachusetts enacted the Health Security Act, which would have required employers of more than five employees to pay a payroll tax to finance a public health coverage program while providing a credit for the costs of any employee health benefits the employer actually funded up to the limit of the tax liability. The law was challenged on ERISA grounds but the case was never pursued and the law was repealed several years later without being implemented. In 1989, Oregon enacted an employer pay or play law that imposed a payroll tax on employers who did not provide employee and dependent coverage with minimum benefits and specified employer premium contributions. The law was not challenged in court and was repealed before implementation. ERISA implications of these laws are discussed in Butler, P.A. *Revisiting Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints*. May 2002. Portland, ME: National Academy for State Health Policy. www.nashp.org.
- 9 California’s Senate Bill (SB) 2 would have created a public health coverage program for workers in firms of 50 or more, funded by employee and employer premiums and fees. Employer fees would be waived if they offered coverage meeting state health insurance benefits standards or participated in Taft-Hartley or union plans. ERISA implications of this law are discussed in Butler, P.A. *ERISA Implications for SB 2: Full Report*. March 2004. Oakland, CA: California Health Care Foundation, www.chcf.org.
- 10 *Retail Industry Leaders Association v. Fielder*, 435 F. Supp. 2d 481 (D. Md. 2006).
- 11 *Retail Industry Leaders Association v. Fielder*, 475 F. 3d 180 (4th Cir. 2007).
- 12 McDonough, J.E., et al. 2008. “Massachusetts Health Reform Implementation: Major Progress and Future Challenges.” *Health Affairs* 27(4): W285-297.
- 13 ERISA issues raised by the Massachusetts law are discussed in detail in Butler, P.A. *ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland “Fair Share Act” Court Decision*. November 2006. Washington, D.C.: State Coverage Initiatives, www.statecoverage.org, and Portland, ME: National Academy for State Health Policy, www.nashp.org. Some analysts believe ERISA preempts the Massachusetts law (Schiffbauer, W.G. “ERISA Preempts Provisions of the Massachusetts ‘Pay or Play’ Health Care Reform Law.” *BNA Pension & Benefits Reporter* 33 (38): 2315-2318, September 26, 2006; Zelinsky, E.A. 2007. “The New Massachusetts Health Law: Preemption and Experimentation,” *William and Mary Law Review* 49 (1): 229-287), while others disagree (Monahan, A. B. 2007. “Pay or Play Laws, ERISA, Preemption, and Potential Lessons from Massachusetts,” *Kansas Law Review* 55(5):1203-1232).
- 14 Massachusetts Department of Health & Human Services, Division of Health Care Finance and Policy. *Health Care in Massachusetts: Key Indicators*. August 2008. www.mass.gov/dhcfp.
- 15 Massachusetts Department of Health & Human Services, Division of Health Care Finance and Policy. *Fair Share Contribution 2007 Results to Date*. October 2008. www.mass.gov/dhcfp.
- 16 *Ibid*.
- 17 Gabel, J.R. et al. 2008. “After The Mandates.”
- 18 These issues are discussed in Butler, *Implications for State Health Care Access Initiatives*.
- 19 Curtis, R. and E. Neuschler. “Affording Shared Responsibility for Universal Coverage: Insights from California,” *Health Affairs* (in process); Curtis, R. and E. Neuschler, “Designing Health Insurance Market Constructs for Shared Responsibility: Insights from California,” *Health Affairs* (in process)
- 20 The court record does not indicate how many food retailers would have had to pay the assessment, but the Memorandum in Support of Plaintiff’s Motion for Summary Judgment suggested a “handful” of firms would have been affected, while focusing on the impact the ordinance would have on Wal-Mart.
- 21 In *Retail Industry Leaders Association v. Suffolk County*, 497 F. Supp. 2d 403 (E.D. N.Y. 2007), the district court noted the “striking” similarity between the Maryland Fair Share Act and the county ordinance and therefore followed the 4th Circuit’s reasoning that the local law was preempted because it targeted Wal-Mart, it provided employers no rational choice but to structure ERISA plans to meet the spending threshold (noting that the alternative spending options were unrealistic), and therefore it would interfere with uniform national administration of employee benefit plans.
- 22 *Golden Gate Rest. Ass’n v. City and County of San Francisco*, 512 F. 3d. 1112 (9th Cir. 2008).

- 23 *Golden Gate Rest. Ass'n v. City and County of San Francisco*, No. 07-17370, CV-06-06997-JSW, 9th Circuit Ct of Appeals, September 30, 2008. This decision is discussed in Appendix A.
- 24 Lewis, C. "San Francisco Ruling Clarifies 'Pay or Play,'" *HealthLeaders-Interstudy: California Health Plan Analysis*. Fall 2008. 7(4): 11-13.
- 25 29 U.S.C. 1000 et seq. For a detailed discussion of ERISA and its preemption provisions, see Butler, P.A. 2000. *ERISA Preemption Manual for State Health Policy Makers*, published by the National Academy for State Health Policy (www.nashp.org) and State Coverage Initiatives at Academy Health (www.statecoverage.org).
- 26 A self-insured health plan is one where the employer, union, or Taft-Hartley Trust (rather than an insurer) bears the risk of loss; insurers often administer these plans, but they do not act as risk-bearing insurers and states cannot regulate the contents or structure of private sector employer-sponsored self-insured plans..
- 27 29 U.S.C. 1144(a).
- 28 *Shaw v. Delta Air Lines*, 463 U.S.85 (1983).
- 29 *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Alessi v. Raybestos-Manhattan*, 451 U.S. 504 (1981); *Mackey v. Lanier Collection Agency*, 486 U.S. 825 (1988); *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990); *FMC Corp v. Holliday*, 498 U.S. 52 (1990); *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992).
- 30 *Shaw v. Delta Air Lines*, note 28.
- 31 *Standard Oil v. Agsalud*, 442 F. Supp. 695 (N.D. Cal. 1977), *aff'd* 633 F. 2d 760 (9th Cir. 1980), *aff'd mem.* 454 U.S. 801 (1981).
- 32 *Hewlett-Packard v Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd*, 571 F. 2d 502 (9th Cir. 1978).
- 33 *New York Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).
- 34 514 U.S. at 662.
- 35 514 U.S. at 668.
- 36 514 U.S. at 664.
- 37 29 U.S.C. 1144(b)(2)(A). See *Kentucky Association of Health Plans v. Miller*, 538 U.S. 329 (2003).
- 38 *Pilot Life Ins. Co. v. Dedeaux*, 481 U.A. 41 (1987); *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004).
- 39 In *Mackey v. Lanier Collection Agency* the law referred to ERISA plans by exempting them from a garnishment law.
- 40 In *District of Columbia v. Greater Washington Board of Trade*, the D.C. ordinance imposed requirements on workers' compensation benefits (not subject to ERISA) 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. In *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 140 (1990), a state remedies law allowed workers to sue on the ground that they were fired to avoid funding their pensions; the Court said this law was therefore premised on the existence of an ERISA plan.
- 41 *Alessi v. Raybestos-Manhattan; Mackey v. Lanier Collection Agency; Ingersoll-Rand v. McClendon; Metropolitan Life Ins. v. Massachusetts*; and *District of Columbia v. Greater Washington Board of Trade*.
- 42 *FMC Corp. v. Holliday and District of Columbia v. Greater Washington Board of Trade*.
- 43 *Shaw v. Delta Air Lines* and *FMC Corp. v. Holliday*.
- 44 *Retail Industry Leaders Association v. Fielder*, 475 F. 3d. 180 (4th Cir. 2007).
- 45 Butler, P.A. *ERISA Update: Federal Court of Appeals Agrees ERISA Preempts Maryland's "Fair Share Act,"* February 2007, Washington, D.C.: State Coverage Initiatives, www.statecoverage.org, and Portland, ME: National Academy for State Health Policy, www.nashp.org.
- 46 In *Egelboff v. Egelboff*, 532 U.S. 141 (2001), the Supreme Court held that ERISA preempted a state law requiring plan administrators to pay benefits to state-designated beneficiaries of non-probate assets, including ERISA-governed life insurance policies, rather than the beneficiaries designated in plan documents unless the plan administrator specifically opted out of using the state-designated beneficiary.
- 47 For example, Zelinsky ("The New Massachusetts Health Law") agrees with the 4th Circuit's decision and argues that ERISA would preempt many provisions of the Massachusetts law, while Fisk and Oswald disagree with the 4th Circuit's decision in the Maryland case (Fisk, C.L. and Oswald, M.M., 2008. "Preemption and Civic Democracy in the Battle over Wal-Mart," *Minnesota Law Review* 92 (4): 1502-1538).
- 48 Schiffbauer, W.G. "Judicial Jabberwocky: ERISA through the Ninth Circuit Looking Glass in *Golden Gate Restaurant Association v. City and County of San Francisco*," *BNA Health Care Policy Report* 16(40): 1402-1406. October 13, 2008.
- 49 The Maryland District Court noted that it might have decided differently a challenge to a comprehensive health care access/financing program like the one in Massachusetts (435 F. Supp 481, 496, note 15), although the Court of Appeals did not reiterate this point in affirming the lower court's decision.
- 50 532 U.S. 141 (2001), discussed in endnote 46.
- 51 The case of *Cal. Div. of Labor Standards Enforcement v. Dillingham Construction, Inc.* 519 U.S. 316 (1997) involved a state law permitting employers to pay lower wages for employees in state-approved apprenticeship programs than in other apprenticeship programs. Apprenticeship programs can (but need not) be ERISA programs. The Supreme Court held that ERISA did not preempt the law because the category of apprenticeship programs includes ERISA plans but is broader than only ERISA plans and because the law could function regardless of whether an apprenticeship program was an ERISA plan.
- 52 The 4th Circuit covers Maryland, North Carolina, South Carolina, Virginia, and West Virginia. The 9th Circuit covers Arizona, California, Idaho, Montana, Nevada, Oregon, and Washington.
- 53 Butler, P. *ERISA Update*.
- 54 The Court's reasoning would have both shielded the employer "contribution" requirement from preemption and also avoided arguments that the state purchasing pool itself was an ERISA plan or employer contributions to it effectively mandated employers to create ERISA plans. In addition, the Court's reasoning might have avoided the need for the employer assessment (along with other financing sources) to be submitted to a popular vote, necessitated in order to impose "taxes" as opposed to "fees." The California Constitution requires a two-thirds vote of each house of the legislature to impose taxes (not possible to achieve in the case of this health reform proposal); but case law allows the state or localities to impose "fees" for programs that benefit the fee payer (see Curtis and Neuschler, "Affording Shared Responsibility"). Because the 9th Circuit held that the San Francisco Health Access Program (funded partly by employer contributions) directly benefited the workers of employers paying the assessments, the 9th Circuit's reasoning should have allowed the legislature to impose employer fees without running the risk of ERISA preemption.
- 55 The U.S. Department of Labor, which administers ERISA, does not consider HSAs to be ERISA plans, U.S. Department of Labor, Employee Benefits Security Administration, *Field Assistance Bulletin No. 2006-02*, October 27, 2006.
- 56 Federal regulations provide that worksite clinics are not ERISA plans if maintained to treat only minor injuries or illness, 29 C.F.R. 2510.3-1(c) (2).
- 57 In *NYS H.M.O. Conference v Curiale*, 64 F. 3d 794 (2d Cir. 1995), for example, the 2nd Circuit Court of Appeals noted that state laws must operate directly on ERISA plans to fail this test, suggesting this test is merely an alternative way to determine whether a state law has a "connection with" ERISA plans.
- 58 29 U.S.C. 1144(b)(5); this exemption does not allow any amendments to the 1974 Hawaii law and provides explicitly that it is not intended to exempt state tax laws involving employee benefit plans.

- 59 H.R. 2870, 103d Congress, 1st Session (1993) by Representative Kreidler regarding Washington and H.R. 3618, 103d Congress, 1st Session (1993) by Representative Wyden regarding Oregon.
- 60 S. 2589, 102d Congress, 2d Session (1992) by Senator Durenberger.
- 61 S. 3180, 102d Congress, 2d Session (1992) by Senators Leahy and Pryor.
- 62 H.R. 3891, 109th Congress, 1st Session.
- 63 S. 1169, 110th Congress, 1st Session would authorize only grants to states. S. 325, 110th Congress, 1st Session explicitly prohibited ERISA waivers. H.R. 506, 110th Congress, 1st Session, while otherwise similar to S. 325, allowed states to request exceptions to otherwise applicable federal law, which one of its sponsors indicated could include preemption waivers, Testimony of Rep. Tammy Baldwin before the House Education and Labor HELP Subcommittee, May 22 2007, <http://edlabor.house.gov/hearings/help052207.shtml>.
- 64 Testimony of Kevin Covert, American Benefits Council, before the House Education and Labor HELP Subcommittee, May 22 2007, <http://edlabor.house.gov/hearings/help052207.shtml>.
- 65 Weil, A. 2008 "How Far Can States Take Health Reform?" *Health Affairs* 27(1): 736-747.
- 66 *Golden Gate Rest. Ass'n v. City & County of San Francisco*, 535 F. Supp. 2d 968 (N.D. Cal. 2007).
- 67 Employers that fully or partially self-fund their health plans need not keep track of expenditures for each employee but are deemed to comply with the spending requirement if their preceding year's average spending rate per employee meets or exceeds the applicable spending requirement.
- 68 The Court also dismissed the DOL's argument that the Health Access Program was a "government-run program for private employers, which removed the exemption for public employee programs from ERISA (when private employers can join a public employee benefit plan, the plan is subject to ERISA). The Court noted that the Health Access Program was not available to city employees and the city was not claiming exemption from ERISA on this ground.
- 69 The Court distinguished *Standard Oil v. Agsalud* invalidating Hawaii's employer health plan mandate because it specified benefits the employer must offer; distinguished *Egelhoff v. Egelhoff*, because the state law at issue in that case substituted the state's designation of a life insurance beneficiary for that in the plan documents; and distinguished *Shaw v. Delta Air Lines* because the state law there limited the structure of employer plans (by prohibiting them from treating pregnancy differently from other physical conditions).
- 70 *Keystone Chapter, Associated Builders & Contractors, Inc. v. Foley*, 37 F. 3d 945, 960 (3d Cir. 1994).
- 71 See, *WSB Electric, Inc. v. Curry*, 88 F. 3d 788, 795 (9th Cir. 1996).
- 72 In *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 140 (1990), the Court held a state remedies law preempted because it was "premised on the existence of a [ERISA] pension plan;" in *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992), where the law required workers' compensation programs to conform to employer-covered health benefits (if any), compliance with the law was measured by reference to the level of benefits in an ERISA plan.
- 73 The Court cited *WSB Electric, Inc. v. Curry*.