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ERISA Preemption and State Health Care Reform (Part 2)

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Application of ERISA preemption in the welfare plan arena

The Supreme Court has indicated that a state law "relate[s] to" plans and is therefore preempted by ERISA § 514(a) if it interferes with Congress's goal of avoiding "a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."¹ *Agsalud* makes clear, for

example, that a state law requiring employers to establish an employee benefit plan "relate[s] to" plans within the meaning of section 514(a) and is therefore preempted.² The Supreme Court later explained that the Hawaii law struck down in *Agsalud* interfered with uniform plan administration by requiring employers either to: "(1) integrat[e] a state-mandated ongoing benefit plan with an existing plan or (2) establish [] a separate plan to process and pay benefits under the plan required by the State."³ And "if Hawaii could demand the operation of a particular benefit plan, so could other States, which would require that the employer coordinate perhaps dozens of programs."⁴

The Supreme Court has likewise found state laws preempted where they sought to "mandate [] employee benefit structures or their administration."⁵ In *Shaw*, the Court held that ERISA § 514(a) preempted a New York law

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requiring employers to structure their employee benefit plans in a manner that provided the same benefits for pregnancy-related disabilities as for other disabilities.⁶ Multistate employers could only comply with the New York law by varying the benefits provided to their New York employees or by providing the same benefits required by New York to all of their employees nationwide. The New York law thus interfered with nationally uniform plan administration.

Similarly, the Court held in *Egelhoff* that ERISA § 514(a) preempted a state law that revoked, upon divorce, a former spouse's designation as beneficiary. The Court emphasized that this state law bound ERISA plan administrators to a particular choice of rules for determining beneficiary status. The statute required a plan administrator to pay benefits to the beneficiaries chosen by state law, rather than to those identified in the plan documents.⁷ By requiring administrators to familiarize themselves with potentially conflicting state laws to determine beneficiary status, the statute interfered with nationally uniform plan administration.⁸

Consistent with *Agsalud*, *Shaw*, and *Egelhoff*, courts have generally held that ERISA preempts state laws that require employers to establish a plan, state laws that require employers to provide a specific type of benefit, and state laws that interfere with core plan administration functions. In addition, the Supreme Court has held that ERISA § 514(a) preempts state laws that provide "alternative enforcement mechanisms" for violations of ERISA or the terms of a plan.⁹ In *Pilot Life*, for example, the Court held that section 514(a) preempted a state tort action seeking damages for an allegedly erroneous denial of benefits under an insured disability plan.¹⁰

At the same time, the states continue to have broad authority to regulate health care *providers*, even though such regulation may have an indirect economic impact on ERISA plans. In *Travelers*, the Court held that ERISA did not preempt a state law that required hospitals to collect surcharges from patients covered by commercial insurers, but not from patients covered by a Blue Cross & Blue Shield plan. The surcharge did not "relate to" plans because it did not require plan administrators to purchase any particular health insurance package. Instead, the law had only an indirect effect on the relative cost of the insurance packages available for purchase by plans, which was not enough to result in preemption. Although it upheld the surcharge law, the Court recognized that a state law might be preempted by section 514(a) if it produced "such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers."¹¹

The states also have broad authority to regulate insurers and insurance contracts under the insurance saving clause. In *Metropolitan Life*, the Court held that ERISA did not preempt a state law requiring insurers to provide

minimum mental health benefits in group policies sold to plans. Although this mandated benefit law "relate[d] to" plans, the Court held that it was nonetheless saved from ERISA preemption as insurance regulation under section 514(b)(2)(A).¹²

Similarly, in *Rush Prudential*, the Court held that ERISA did not preempt a state HMO law requiring independent physician review of medical necessity disputes. Although this HMO law "relate[d] to" plans, it too was saved from preemption as insurance regulation.¹³ The Court further held that this state HMO law did not run afoul of ERISA's "categorical preemption" of alternative remedies because it "provide[d] no new cause of action . . . and authorize[d] no new form of ultimate remedial relief."¹⁴ Likewise, in *Unum Life*, the Court concluded that a state "notice-prejudice" rule governing insurers "relate[d] to" plans, but was saved as insurance regulation.¹⁵ And in *Kentucky Association*, the Court held that a state "[a]ny [w]illing [p]rovider" law was saved as insurance regulation.¹⁶

The Supreme Court has also held, however, that the deemer clause exempts self-funded plans from state laws that purport to regulate insurance. Thus, in *FMC Corp.*, the Court held that a state anti-subrogation law fell within ERISA's insurance saving clause, but was nevertheless preempted by the deemer clause as applied to self-funded plans.¹⁷ Similarly, although a state "any willing provider" law may fall within the insurance saving clause, the law will be preempted by the deemer clause as applied to self-funded plans.¹⁸

The Impact of ERISA Preemption on State "Pay or Play" Laws

Numerous states have enacted or are considering the enactment of health care reform legislation to expand coverage to the uninsured and to address other health care quality and cost concerns.¹⁹ These initiatives include subsidized insurance, market reforms, connector/exchange authorities, individual mandates, employer "pay or play" requirements, and combining coverage expansions with quality and cost initiatives.²⁰ Few of these state health care reform initiatives have actually been challenged on ERISA preemption grounds. Indeed, most of these initiatives would likely fall outside the scope of preemption because they do not "relate to" ERISA plans.

State "pay or play" laws, however, are a notable exception.²¹ Not only is there a compelling argument that these laws "relate to" employee benefit plans, but there is simply no question that they fall outside the scope of the insurance saving clause. A key feature of these "pay or play" laws is that they purport to give employers a "choice" between either: (1) paying a certain level of health care benefits to their employees through employee benefit plans, or (2) paying any shortfall amount to the state or local government. Proponents of these "pay or play" laws argue that such

laws survive preemption because they do not *require* employers to establish employee benefit plans or to provide any specific level of benefits through their existing plans. According to “pay or play” proponents, employers are always free to comply by paying any shortfall amount to the state or local government.

“Pay or play” opponents argue, however, that these state laws are no different from mandated benefit laws because they require employers to provide a minimum level of health care benefits to their employees or pay a penalty to the state. Opponents argue that such laws deprive employers of their authority under ERISA to decide whether to establish employee benefit plans and to determine the level of benefits to be provided under such plans. They further argue that these laws interfere with nationally uniform plan administration by requiring multistate employers to provide a different level of plan benefits and to comply with different administrative and reporting requirements in different states.

In the first major challenge to a state “pay or play” law, the Fourth Circuit agreed with the arguments of “pay or play” opponents, holding in a 2-1 decision that Maryland’s Fair Share Health Care Fund Act (MFSA) was preempted by ERISA § 514(a).²² The MFSA required employers with 10,000 or more employees in Maryland to spend at least 8 percent of their total payroll on employees’ health insurance costs or pay the Maryland secretary of labor, licensing, and regulation the difference between what the employer spent for health insurance costs and an amount equal to 8 percent of the total wages paid to employees in the state.²³ Funds collected by the state were to be “used only to support the Maryland Medical Assistance Program, which consist[ed] of Maryland’s Medicaid and children’s health programs.”²⁴

The court explained that a state law is preempted by ERISA § 514(a) “if it directly regulates or effectively mandates some element of the structure or administration of employers’ ERISA plans.”²⁵ It held that the MFSA “effectively mandat[ed] that employers structure their employee healthcare plans to provide a certain level of benefits.”²⁶ Indeed, “[t]he only rational choice employers have under the [MFSA] is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold.”²⁷ And by requiring employers to “structure their recordkeeping and healthcare benefit spending” to comply with the MFSA, the law “disrupt[ed] employers’ uniform administration of

employee benefit plans on a nationwide basis.”²⁸

Another ERISA preemption challenge to a “pay or play” law enacted by the City of San Francisco is currently pending in the Ninth Circuit. In December 2007, a federal district court in California held that the employer spending requirement of San Francisco’s Health Care Security Ordinance (SFHCO) was preempted by ERISA § 514(a) and issued a permanent injunction against its enforcement. Two weeks later, a three-judge panel of the Ninth Circuit granted the city’s motion to stay the district court’s decision, thus allowing the city to enforce the SFHCO pending resolution of its appeal.²⁹ The Ninth Circuit’s decision to grant the stay technically was not a decision on the merits. Nevertheless, in granting the stay, the Ninth Circuit determined unanimously that the city had a “strong likelihood” of succeeding on its argument that the SFHCO is not preempted by ERISA § 514(a).³⁰

The SFHCO requires medium and large employers to make minimum health care expenditures on behalf of their employees based upon the size of the employer. For 2008, private employers with between 20 and 99 employees and nonprofit employers with 50 or more employees must make health care expenditures of \$1.17 per hour for each employee. Private employers with 100 or more employees must make health care expenditures of \$1.76 per hour for each employee. The SFHCO sets out a nonexclusive list of qualifying expenditures, which include contributions to HSAs, direct reimbursement to

employees for expenses incurred in the purchase of health care services, payments to third parties for health care services, or payments to the city to be used on behalf of covered employees. It also imposes recordkeeping and reporting requirements on employers, and penalizes them for noncompliance.

In concluding that the city had a “strong likelihood” of succeeding on the merits, the Ninth Circuit essentially accepted all of the arguments advanced by “pay or play” proponents. The court determined that the SFHCO was distinguishable from the state laws that were found preempted in *Shaw* and *Agsalud* because it did not *require* employers to establish an ERISA plan or provide specific benefits through an existing ERISA plan.³¹ Rather, the court emphasized that the SFHCO permits an employer to “fully discharge its expenditure obligations by making the required level of employee health care expenditures . . . in whole or in part to the City.”³² And unlike

Pay or play laws purport to provide choices.



the state law that was found preempted in *Egelhoff*, the court determined that the SFHCO did not “bind [] ERISA plan administrators to a particular choice of rules’ for determining plan eligibility or entitlement to particular benefits.”³³ Finally, the court concluded that the SFHCO’s recordkeeping and reporting requirements did not interfere with nationally uniform plan administration because they burdened only the employer, not any ERISA plan.³⁴

Although the Ninth Circuit conspicuously made no mention of the Fourth Circuit’s ruling, its reasoning appears to be in direct conflict with the Fourth Circuit’s holding that ERISA § 514(a) preempted the MFSA. Indeed, the SFHCO has at least one feature—not yet addressed by the Ninth Circuit—that arguably makes the SFHCO even more susceptible to an ERISA preemption challenge than the MFSA. The revenues generated by the MFSA would have gone into a pooled fund that benefited all Maryland Medicaid recipients—they were not specifically allocated to purchase medical coverage for a covered employer’s employees. Under the SFHCO, by contrast, an employer’s contributions to the city are actually allocated to purchase medical coverage for the contributing employer’s employees. The SFHCO thus in effect requires employers to establish ERISA plans that are administered and regulated by the city.³⁵

If the Ninth Circuit holds that the SFHCO is not preempted by ERISA § 514(a), the result will be a conflict between the Fourth and Ninth Circuits on an issue of national importance, and the case could well end up in the Supreme Court. The Ninth Circuit heard oral argument in the case on April 17, 2008.

Conclusion

The constraints imposed by ERISA’s preemption provision were essential to its enactment in 1974. The current controversy over state “pay or play” laws not only highlights these constraints, but also underscores the voluntary nature of our private, employer-sponsored system of providing pension and welfare benefits.

Regardless of the outcome of the controversy over “pay or play” laws, states will continue to have broad authority to enact a wide range of health care reforms that do not “relate to” ERISA plans. ERISA preemption becomes an issue where a state law effectively requires employers to establish plans, where it requires employers to provide a certain level of benefits or specific type of benefit, or where it otherwise mandates the structure or administration of plans. Even within the scope of ERISA preemption, states have broad authority under the insurance saving clause to regulate insured plans indirectly through laws regulating insurers or insurance contracts.

Conflict brews between 4th and 9th Circuits.

Endnotes

1. *Travelers*, 514 U.S. at 657.
2. *Agsalud*, 633 F.2d at 760.
3. *Fort Halifax Packing Co.*, 482 U.S. at 14.
4. *Id.* at 13.
5. *Travelers*, 514 U.S. at 658.
6. *Shaw*, 463 U.S. at 96-97.
7. *Egelhoff*, 532 U.S. at 147.
8. *Id.* at 148-50.
9. *Travelers*, 514 U.S. at 645.
10. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987).
11. *Travelers*, 514 U.S. at 668; see also *id.* at 664 (“there might be a point at which an exorbitant tax leaving consumers with a Hobson’s choice would be treated as imposing a substantive mandate”).
12. *Metropolitan Life Ins. Co.*, 471 U.S. at 727, 739-47.
13. *Rush Prudential HMO, Inc.*, 536 U.S. at 365-75.
14. *Id.* at 379-80. Two federal district courts have recently upheld state laws that prohibit “discretionary clauses” in insurance contracts sold to plans as a permissible regulation of insurance under ERISA § 514(b)(2)(A). *American Council of Life Insurers v. Ross*, No. 1:07-cv-631 (W.D. Mich., Feb. 29, 2008); *Standard Oil Co. v. Morrison*, No. 6:06-cv-00047-DWM (D. Mont., Feb. 27, 2008). Although the plaintiffs’ rights of appeal in these cases have not been exhausted, the decisions certainly reflect a growing trend in the lower courts to construe the scope of the insurance saving clause expansively.
15. *Unum Life Ins. Co. v. Ward*, 526 U.S. 358, 366-75 (1999).
16. *Ky. Ass’n of Health Plans v. Miller*, 538 U.S. 329, 333, 341-42 (2003).
17. *FMC Corp.*, 498 U.S. at 60-65.
18. See *Prudential Ins. Co. v. National Park Med. Ctr.*, 413 F.3d 897, 912-13 (8th Cir. 2005).
19. See J. McDonough, M. Miller and C. Barber, *A Progress Report on State Health Access Reform*, Health Affairs Web Exclusive at W105 (Jan. 29, 2008) (“In the past two years, lawmakers in at least thirty-nine states and the District of Columbia have enacted laws to address shortcomings in access, quality, and costs.”). See also Nat’l Conf. of State Legislatures, *2007 Comprehensive Health Care Reforms: Side-by-Side Comparisons* (updated July 2007) (chart showing features of comprehensive health care reforms that have been enacted or are under consideration), available at <http://www.ncsl.org/programs/health/2007Comprehensive1.htm>.
20. See Congressional Research Service Report for Congress, *Health Reform and the 110th Congress* at CRS-14 (Feb. 25, 2008); J. McDonough, M. Miller and C. Barber, *supra*, n.19, at W105-W108; Nat’l Conf. of State Legislatures,

supra, n.19.

21. See generally Nat'l Conf. of State Legislatures, *2006-2007 Fair Share Health Care Fund or "Pay or Play" Bills: Can States Mandate Employer Health Insurance Benefits?* ("Pay-or-play" refers to states using their tax authority to assess employers (pay) while giving them the option to avoid the fee by providing health care or coverage to their workers (play)."), available at <http://www.ncsl.org/programs/health/payorplay2006.htm>.

22. Retail Industry Leaders Ass'n v. Fielder, 475 F.3d 180, 183 (4th Cir. 2007). The secretary of labor submitted an *amicus curiae* brief in *Fielder*, arguing that the MFSA was preempted by ERISA § 514(a). Brief of the Secretary of Labor as Amicus Curiae Supporting Plaintiff-Appellee and Requesting Affirmance, *Retail Industry Leaders Ass'n v. Fielder*, No. 06-1840 (4th Cir. Nov. 6, 2006).

23. *Id.* at 184.

24. *Id.* at 185.

25. *Id.* at 192-93.

26. *Id.* at 194.

27. *Id.* at 193. See also Retail Industry Leaders Ass'n v. Suffolk County, 497 F. Supp. 2d 403 (E.D.N.Y. 2007) (holding that a similar "pay or play" law was preempted

by ERISA § 514(a) based upon the *Fielder* court's reasoning that "the only rational choice employers have under [the Act] is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold").

28. *Id.*

29. Golden Gate Restaurant Ass'n v. City and County of San Francisco, 512 F.3d 1112, 1114 (9th Cir. 2008).

30. *Id.* at 1119.

31. *Id.* at 1121.

32. *Id.*

33. *Id.* at 1122.

34. *Id.* at 1122-23.

35. See generally E. Zelinsky, *Golden Gate Restaurant Association: Employer Mandates and ERISA Preemption in the Ninth Circuit*, Cardozo Legal Studies Research Paper No. 219 at 4, 23-28, available at <http://ssrn.com/abstract=1090122>. Just as in *Fielder*, the secretary of labor filed an *amicus curiae* brief arguing that the SFHCO is preempted by ERISA § 514(a). Brief for the Secretary of Labor as Amicus Curiae Supporting Appellee and Requesting Affirmance, *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, Nos. 07-17360 & 07-17372 (9th Cir. March 27, 2008).