

Issues Paper #4:

Dr. Wm. Hsiao on ERISA's impact on state-based plans

CONSTRAINTS TO REFORM IN VERMONT

A. LEGAL CONSTRAINT: ERISA

Many policy experts cite ERISA as a barrier to comprehensive health care reform at the state level. To understand how ERISA might impact or limit our designs, we, with the help of staff from Vermont's Legislative Council, studied case law, published analyses and reports, and consulted leading national experts on this issue. Below we outline our analysis and that of other authorities on ERISA.

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA), which regulates employer benefit plans including health coverage, and "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"[24]. This phrase is commonly referred to as ERISA's "preemption clause." The objective of the preemption clause is to encourage employers to sponsor benefits plans for their employees and to allow employer-sponsored benefit plans to operate independent of potentially differing state laws. ERISA also contains provisions saving for the states the general authority to regulate in the areas of insurance, banking, and securities ("savings clause") and clarifying that states cannot simply deem employer benefit plans to be insurance plans for purposes of regulating them ("deemer clause") [24]. ERISA plans include both those that are "self-insured" and those whose benefits are offered through an insurance product.

Because states can regulate insurers, they can prescribe benefits and administrative features of insured plans but cannot regulate self-insured ERISA plans. Because the language of ERISA is confusing and the preemption and savings clauses appear largely contradictory, most of what is known about the limitations imposed by ERISA comes from court decisions. Even looking to the judiciary for guidance on ERISA does not make the law's prospective application clear, however, because opinions from the circuit courts of appeal are not uniform in their interpretation.

The U.S. Supreme Court has interpreted the term "relates to" to mean that ERISA preempts state laws that have "a connection with or reference to" an ERISA plan [25]. This means that state laws cannot specifically mention ERISA

plans, but it also means that states must be very careful in assessing the potential impact of proposed legislation on ERISA plans. Any law that seeks to influence benefits, administration, or structure under an ERISA plan, [26] imposes substantial costs on a plan, or requires employers to provide employees with specific benefits is likely to be preempted [25].

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, [27] the Supreme Court upheld a New York law imposing a hospital surcharge on all commercial insurers except Blue Cross & Blue Shield. In its ruling, the Court identified a general presumption against preemption in areas of traditional state regulation, such as health care, and held that the indirect influence of the surcharge was not sufficiently connected to ERISA plans so as to “bind plan administrators to any particular choice” and thus trigger ERISA’s preemption clause [27]. But the Court also hinted at the possibility that an “exorbitant” tax could reach a level at which consumers would effectively have no real choice and suggested that such a mandate might violate ERISA [27].

The 4th and 9th Circuits have weighed in on ERISA with respect to “pay or play” laws, which require employers to pay an assessment against which they can credit money spent on employee health care services or coverage. Each circuit has reached a different result. In *Retail Industry Leaders Association v. Fielder*, the Court of Appeals for the 4th Circuit struck down a Maryland law requiring very large employers to spend at least 8 percent of their total payroll on their employees’ health insurance costs or pay to the state the amount their spending fell short [28]. The only affected employer in the state was Wal-Mart, which had an ERISA plan. The court found that because Wal-Mart’s options were either to increase contributions to its own plan or to pay money to the state of Maryland, Wal-Mart effectively had no choice but to restructure its employees’ health benefit plans, and that lack of choice was an ERISA violation. The court held that “the choices given in the [Maryland law] . . . are not meaningful alternatives by which an employer can increase its healthcare spending to comply with the [law] without affecting its ERISA plans”[27].

In contrast, in *Golden Gate Restaurant Association v. City and County of San Francisco*, the Court of Appeals for the 9th Circuit upheld a San Francisco ordinance requiring employers either to make health care expenditures on behalf of their employees or to make payments directly to the city [29]. In relevant part, the court relied on the Supreme Court’s ruling in *Travelers* to hold that while an employer might choose to adopt or change an ERISA plan instead of making the required expenditures under the ordinance, the ordinance’s influence on such a decision is “entirely permissible”[29].

Vermont is in the 2nd Circuit, which means that the decisions in other circuits are not binding on Vermont, but also makes it difficult to ascertain the limits of what may be permitted in this state under ERISA. And given that most of the guidance on ERISA has come from court rulings, it is hard to determine how

the courts would treat an untested scenario, such as a single payer health care system.

ERISA is not necessarily a bar to a single payer health care system. While ERISA most likely would preempt a state's ability to enact a law prohibiting self-insured employer-sponsored benefit plans or requiring these plans to include particular benefits, states may be able to enact legislation that would create a universal state system through broad-based tax financing as an optional alternative to employer-sponsored benefit plan.¹ In addition, ERISA may not preempt a state's ability to largely align other aspects of the health care delivery system, such as claims payment rules, through a "single channel," which allows the state to replicate some of the beneficial features of a single payer system in an environment with multiple payer and benefit plans.

Patricia Butler, among the leading national experts on ERISA and its implications for state-based health initiatives, provided us with her opinion on the issue of a payroll tax-financed universal health care program.

"As outlined in more detail in a November 2006 monograph, universal publicly administered programs like single payer systems can raise ERISA preemption problems because they create incentives for employers sponsoring health coverage plans to terminate or modify their plans.[26] No courts have considered such state laws so it is not possible to predict precisely how a court would view such a challenge. States could defend this challenge with several credible arguments. For example, both taxation and health care financing are exercises of traditional state authority that a court should not presume Congress intended to preempt [27] (it should be kept in mind that when Congress enacted ERISA in 1974, the need for states to expand health care access seemed remote because serious discussions of a national health care program were under way [30]). Such a state law would not be directed at employer health plan administration – employers would be free to provide coverage to employees even if they also were paying the tax.² A payroll tax is not substantively different from other revenue sources that could be used to fund a single payer system such as income taxes or other assessments on individuals that would involve no employer role other than remitting the tax. Furthermore, the incidence of a payroll tax on employers actually falls on employees so its economic impacts are similar to those of an individual income tax"[31].

We also consulted Phyllis Borzi, Assistant Secretary of Labor for the Employee Benefits Security Administration and formerly an attorney and research professor at the George Washington Medical Center's School of Public Health and Health Services. She states the viability of tax-financing more forcefully, arguing that ERISA does not preempt broad tax-financed health programs. She confirmed this both in our conversation and in her published writing below:

"Clearly ERISA is not an impediment for states that choose to levy a fee or tax on all employers and to then use the funds to subsidize health care coverage

expansions. In such a situation, the regulated entity is the employer, not the employer plan”[32].

We also investigated potential ERISA issues in regard to a “single channel” system of health care administration. In this design, all billing and claims processing would be done through uniform mechanisms, regardless of payer. This would simplify the administration of health benefits for providers to achieve the uniformity in billing practices and claims processing found in a single payer system (see Section 4A), but would not dictate a defined benefits package for employers and insurers, as multiple plans and multiple benefit packages could still exist, as well as multiple payment levels. This can be achieved either by using one entity to process claims or through regulation requiring the use of the same billing and claims processing practices.

Requiring an ERISA plan to be administered in a specific way or through a single processor would most likely violate ERISA [32]. There have been no preemption cases that explicitly consider state claims adjudication standards; however, to the extent that the state law requires ERISA plans to define certain benefits in a particular way or administer the claims under certain standards, it is likely ERISA would preempt the law [33]. Because of this, any single channel system must allow ERISA plans to administer their own benefits. Very few employers, however, administer ERISA plans themselves. Most ERISA plans contract with an insurer or a third-party administrator for billing and claims processing services.

States have clear authority to regulate insurers under the “savings clause” and this regulatory authority should include the administration of claims and billing practices.”[24] Claims processing standards should be saved from preemption when applied to insurers, health maintenance organizations, and other insuring entities [33].

A state’s ability to regulate the practices of a third-party administrator (TPA) requires a more complex ERISA analysis. Because TPAs are not insurers when they administer claims rather than underwriting insurance risk, the savings clause does not apply to them [24]. Recent opinions of the Second Circuit Court of Appeals provide support that imposing a fee on a TPA does not “relate to” an ERISA plan [34]. The Second Circuit Court of Appeals held that ERISA did not preempt a hospital surcharge imposed on insurers administering self-insured ERISA health plans, even though the surcharge applied to that part of the insurer’s business. The Court of Appeals indicated that under *Travelers* the surcharge did not refer to ERISA plans nor did its economic influence directly impact upon plan activities [34]. In another recent decision, the Court of Appeals held that even when ERISA plans comprise a large percentage of a tax base, this was insufficient to trigger ERISA preemption of a state law taxing pensions [34].

These decisions, however, address fees or surcharges imposed on TPAs and do not address the issue of regulating the administrative practices of these entities. In order to ensure the state does not trigger ERISA preemption, the state's regulation of billing and claims processing should be designed to set standards for the TPAs. In addition, the law should be tailored so as to not directly impact on benefits offered by ERISA plans. In doing so, the state may defend an ERISA challenge by arguing that the ERISA plan itself is not the entity being regulated and is not significantly impacted by the regulation of the TPA [33]. However, certain claims payment rules, such as determination of medical necessity, do seem to directly determine benefits, which could make those individual rules more difficult to defend. Furthermore, there are claims payment standards established by ERISA, that any intermediary or regulation of claims processing would have to comply with [33].

ERISA, however, is clearly no bar to a state-wide rate setting system. According again to Pat Butler:

"The Supreme Court's 1995 Travelers Insurance case provides sound precedent to shield state rate-setting programs from ERISA preemption. Travelers upheld New York's hospital rate-setting program, which required hospitals to collect surcharges of 24 percent from commercial insurers but not Blue Cross or Blue Shield plans. Although the law imposed higher costs on private-sector employer-sponsored (i.e. ERISA) plans choosing to buy coverage from commercial insurers, the Court held that ERISA did not preempt the law because the law was not specifically directed at ERISA plans and its indirect economic influence did not "bind plan administrators" seeking insurance to choose Blue Cross or Blue Shield."

It is clear, Butler comments, that ERISA would not preempt a state rate-setting program that established rates for all providers – including hospitals, physicians and other providers - as long as it dictates what providers must *charge* rather than what payers must pay. "That this will require ERISA plans (both insured and self-insured) to pay those rates is what the Court approved in *Travelers* – the state law imposes costs on ERISA plans (that may differ across the country), but the Court noted that "cost-uniformity" is not an ERISA objective," she wrote to us. A fee-for-service payment system would be most closely analogous to the New York hospital rate-setting program at issue in *Travelers*.

Capitation payments have not been the subject of litigation and are somewhat more complex because the payments must inherently define the scope benefits provided by the accepting organization. But if those payments in no way determine the scope of benefits, and leave employers free to design benefits with insurers, they should not be treated any differently in the courts than fee for service rates.

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Risk adjustment mechanisms, for any kind of payment, should be easily defended against an ERISA challenge. The surcharge on hospital bills paid by commercial insurers in New York was in fact a risk-adjustment mechanism; Blues plans were insurers of last resort and required at that time to take all applicants. As such, their risk profile was often significantly worse than competing commercial plans and the surcharge was designed to give financial relief and lower premiums to encourage enrollment of a broader risk profile.

*Act 128 Health System Reform Design:
Achieving Affordable Universal Health Care in Vermont,
pp. 8-12*

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http://www.leg.state.vt.us/jfo/healthcare/FINAL%20REPORT%20Hsiao%20Final%20Report%20-%202017%20February%202011_3.pdf

¹ The 9th Circuit's ruling in *Golden Gate* suggests that Travelers may be read to permit laws and regulations to influence employer behavior without running afoul of ERISA. 10

² While addressing a different sort of publicly administered health program in San Francisco, the 9th Circuit Court of Appeals upheld the City's "pay or play" employer assessment against a preemption challenge, noting that the requirement was only that employers pay an assessment and the law did not directly affect ERISA plans. *Golden Gate Restaurant Association v. City and County of San Francisco*, 512 F. 3d 1112 (9th Cir. 2009).