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Pay-or-Play State Health Insurance Laws and ERISA Preemption

By Peter Marathas, Robert Rachal and Yolanda Montgomery, Proskauer Rose

Overview

According to some estimates, as many as 46 million Americans (nearly 16% of the total population) are uninsured.[1] The uninsured are not necessarily healthier than the rest of the population. They seek and receive medical care and treatment when necessary, and as available. Often, the only available source of health care for the uninsured are "free" clinics and hospital emergency rooms. The cost of these services are often passed on to the state, leading to strained or breaking budgets and increased Medicaid costs. While presidential candidates debate, and Congress struggles to find solutions, some states and municipalities have implemented, or are considering, their own initiatives to address this problem, often shifting the responsibility to health care companies doing business in their states.

Massachusetts passed a law in 2006 aimed at achieving universal (or nearly universal) coverage for the citizens of the Commonwealth. Similarly in 2006, San Francisco was the first city in the nation to pass an ordinance mandating employer health insurance payments and implementing low-cost health insurance. At least 15 states, including New York, Illinois and Maryland have comprehensive health care reforms bills or proposals under review for their 2007 – 2008 legislative sessions, or are currently studying the problem.[2] It is expected more states will follow. Many of these proposals include employer mandates or assessments — "pay or play" mandates — that require or will require employers to either provide group health insurance to all or substantially all of their workforce or pay the government a fee or an assessment. These laws and initiatives not only increase the cost for employers doing business in these states, they also increase the burdens imposed on human resource personnel — often requiring additional reporting and disclosure requirements.

As discussed below, while certain of these laws are subject to a preemption challenge under the Employee Retirement Income Security Act of 1974 ("ERISA"),[3] unless and until a preemption challenge is made, employers are well advised to monitor and understand these new laws and proposals and comply or prepare to comply with their requirements.

The Massachusetts law is indicative of the types of requirements that are or may be imposed upon employers by these state and municipality laws and ordinances.

Massachusetts Universal Health

In Massachusetts, *An Act Providing Access to Affordable, Quality, Accountable Health Care*[4] (the "Massachusetts Act") was signed into law on April 12, 2006, amidst great fanfare in Boston's historic Faneuil Hall. The Massachusetts Act is broadly based, including the full panoply of health insurance initiatives that are currently talked about by policy makers, pundits and political candidates.

The Massachusetts Act includes a first-in-the-nation individual mandate that requires all adult citizens of Massachusetts to be covered by creditable health insurance (effective as of January 1, 2007).[5]

Massachusetts residents must certify their insurance coverage status as of December 31 of each year on their state tax forms, by showing that they have: (1) creditable insurance, (2) waived health insurance due to sincerely held religious beliefs or (3) otherwise obtained a waiver from the coverage requirements. For 2007, Massachusetts residents who lack coverage (and do not have a waiver) will lose their personal exemption on

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their state taxes. In the future, Massachusetts residents will be fined based on a percentage of the monthly premium of the most affordable health plan available through the Connector, a state-subsidized health insurance program established under the Massachusetts Act. The fine will be first collected by offsetting amounts due on state tax returns, with surplus amounts collected from the taxpayer.

Employer mandates fall into four broad categories: (1) the employer fair-share contribution, (2) a 125 cafeteria plan requirement, (3) a free-rider surcharge and (4) certain reporting requirements.

The Employer Fair Share Contribution

While ERISA prohibits Massachusetts (and other states) from requiring employers to provide health insurance to their employees,[6] Massachusetts has established a fee — called a "fair share contribution" — that is imposed on employers who are not, in the eyes of the Commonwealth, doing their part to provide health insurance.[7] Under the Massachusetts Act, to avoid paying a "fair share contribution" of up to $295 per employee per year, employers with 11 or more full-time employees[8] must have either 25% or more of their full-time employees enrolled in their employer-sponsored group health plan, or pay for at least 33% of the premium cost of health insurance coverage.

Fortunately, the "take-up rates" (the percentage of employees who enroll in employer-sponsored health plans) typically exceed 25%. However, if the company does not contribute at least 33% of the premium cost, companies with 11 or more full-time employees in Massachusetts should annually check on their take-up rate to ensure that they are meeting the 25% minimum requirement.[9]

The 125 Plan Requirement

A 125 Plan is a tax-preferred employee benefit plan established under Section 125 of the Internal Revenue Code (the "Code").[10] Under a 125 Plan, employees are permitted to pay for health insurance premiums on a pre-tax basis, thus enabling them to pay for health insurance with tax-free dollars.

Effective July 1, 2007, employers with 11 or more full-time employees in Massachusetts that do not pay the full monthly cost of medical coverage for all employees must maintain a 125 Plan that meets both state and federal requirements. Enrollment in these plans was required as of September 1, 2007.[11]

The Massachusetts Act does not require employers to adopt or sponsor a full-fledged cafeteria plan with medical and dependent care reimbursement accounts; it simply requires employers to sponsor a so-called "premium only" feature,[12] under which employees may pay for their health insurance premiums on a pre-tax basis. Among its various requirements, the Massachusetts Act requires that employers permit their employees who are not otherwise eligible to participate in the employer-sponsored group health plan to pay for their Connector coverage on a pre-tax basis through the 125 Plan.

The Massachusetts Act originally required employers to file a copy of their 125 Plan document with the Connector by October 1, 2007. However, this rule was never implemented, and now employers simply must provide a copy of their 125 Plan upon the Connector's request.[13]

The Free Rider Surcharge

The free-rider surcharge penalizes employers with 11 or more full-time equivalent employees that do not provide health insurance or maintain a 125 Plan, and whose employees use at least $50,000 worth of state-funded health services per year. An employer who does not offer health insurance coverage or a 125 Plan will be assessed a surcharge if any employee (or dependent of an employee) receives free health care services four or more time in a single year, or the employees (or their dependents) of the employer collectively receive free health care service five or more times in one year.[14]

Surcharge amounts will range from 20 percent to 100 percent of the state's cost, depending on: (1) the number of employees, (2) the number of admissions and visits for each applicable employee, (3) the total state-funded health services provided to the applicable employees and (4) the percentage of employees for whom the employer provides health insurance.[15]

As noted, employers avoid the surcharge if they maintain a 125 Plan in accordance with the requirements discussed above.

Reporting Requirements

There are two main reporting requirements applicable to employers under the Massachusetts Act, the Health Insurance Responsibility Disclosure Form ("HIRD") and the 1099-HC reporting requirement.

There are two separate HIRD requirements — an employee HIRD requirement and an employer HIRD requirement. With respect to employees, employers are required to obtain an issued employee HIRD form from an employee who declines coverage under the employer-sponsored group health plan or, if he or she is not eligible for the plan, declines to

elect to pay for other coverage, such as Connector coverage, through the employer's 125 Plan.[16] Among other things, the employee HIRD form captures whether the employer sponsored a group health plan and whether the employee declined the coverage because he or she is covered under an alternative plan. If an employee refuses to sign the form, the employer must make note of its diligent efforts to obtain the signature. Employers must retain the document for three years and provide it upon request.

The employer HIRD "form" is not actually a separate, free-standing form. Rather, employers are required to complete a series of questions in their filing with the Massachusetts Division of Unemployment Assistance. Employers are required to certify whether they offer group health insurance, the percentage of premium they pay for various coverages (e.g., individual, family) and whether they sponsor a 125 Plan through which non-eligible employees may pay for alternative coverage.

The Massachusetts Act also requires employers and other health plan sponsors to provide, or contract with their third-party administrators or insurance carriers to provide, on or before January 31, form 1099-HC to Massachusetts employees, which details coverage information. The form is then submitted by the employee to the Massachusetts Department of Revenue along with the individual's tax return.

The 1099-HC reporting requirements are imposed upon employers by the Massachusetts Act. However, an employer insured under a contract with a Massachusetts-licensed carrier, Blue Cross, Blue Shield or an HMO, shifts the obligation to furnish the form 1099-HC to the carrier. Self-insured plans and out-of-state employers insuring Massachusetts employees and their dependents under contracts written in other states must either provide the form directly or contract with a third-party administrator or out-of-state carrier to provide the form.[17]

Not all proposed and implemented state and city health insurance initiatives are as complex as the Massachusetts Act, nor do they all impose as many administrative burdens and potential additional costs as the Massachusetts Act. However, as more and more states come "on line" with their version of the Massachusetts Act, employers with multi-state operations will be faced with an increasing challenge to ensure that they are in compliance with the various state requirements.

ERISA Preemption Challenges

State and local "pay or play" mandates may be legally infirm, subject to challenge as preempted by ERISA. ERISA has a very broad preemption provision, preempting all state laws that "relate to" an employee benefit plan.[18] Through over twenty opinions, the U.S. Supreme Court has struggled to define the scope of ERISA preemption. The rough line drawn is that regulation not impacting core concerns is not preempted,[19] but that regulation that seeks to directly regulate benefit plans or their administration is preempted.[20] Requiring employers to provide certain health benefits implicates a core concern[21]; as the U.S. Supreme Court has explained, "[t]he flexibility an employer enjoys to amend or eliminate its welfare plan is not an accident."[22]

The "pay or play" mandates would thus seem to run afoul of ERISA preemption under a common sense view of the issue, and the majority of courts to rule on this issue to date agree. In *Retail Industry Leaders Association v. Fielder*,[23] the U.S. Fourth Circuit Court of Appeals addressed whether the Maryland "Fair Share Health Care Fund Act" was preempted by ERISA. This act (which was targeted at Wal-Mart) required employers with 10,000 or more Maryland employees to spend at least 8% of their total payrolls on employees' health insurance costs, with any spending shortfall to be paid to the state. The Fourth Circuit concluded that no rational employer would pay money to the state instead of providing benefits to its employees, and that there was no practical non-ERISA alternative to meet the 8% spend mandate. The act would thus require covered employers in Maryland to restructure their health benefit plans to meet the minimum spend mandate, thereby conflicting with ERISA's goal of permitting uniform nationwide administration of these plans. Although it observed that Maryland's act sought to further noble goals, the Fourth Circuit held that this act was an attack on the "foundational policy of ERISA" permitting uniform nationwide administration of employee benefit plans, and was preempted.[24]

In *Retail Industry Leaders Association v. Suffolk County*,[25] a federal district court in New York addressed Suffolk County's Fair Share for Health Care Act. The Suffolk County act required covered employees to make minimum "employee health care expenditures" equivalent to the "public health care cost rate multiplied by the total number of hours worked" by their employees in Suffolk County. The stated purpose of the act was to protect smaller local employers from being undercut in compensation costs by larger "big box" retailers, who allegedly failed to provide as fulsome health care benefits as the smaller employers. In finding the Suffolk County act preempted, the court agreed with and followed the analysis used in *Fielder* to conclude that the only rational choice offered employers was to structure their ERISA plans so as to meet the minimum spend threshold.

The U.S. Ninth Circuit Court of Appeals appears to be in the minority with its opinion in *Golden Gate Restaurant Association v. City and County of San Francisco*.[26] In *Golden Gate*, the Ninth Circuit granted a stay permitting the City of San Francisco to implement its "pay or play" mandate, concluding there is a strong likelihood that the ordinance

imposing this mandate is not preempted. That ordinance imposes various minimum health care spend requirements on covered employers (defined to include businesses with more than twenty employees who engage in business within San Francisco), coupled with reporting requirements to prove these expenditures were made. The spend requirements can be met by making payments directly to the city. The Ninth Circuit concluded that, in its view, this ordinance did not mandate any benefits, reasoning that an employer could satisfy its minimum spend requirements by simply cutting a check to the city. The Ninth Circuit did not mention, much less seek to distinguish or refute, the earlier *Fielder* and *Suffolk County* rulings, which held that the only rational choice for an employer facing these "pay or play" mandates is to modify its benefits. Nor did the Ninth Circuit address that one of ERISA's core concerns is to provide employers flexibility in setting and modifying the level of health benefits provided nationwide, not in a balkanized city-by-city approach.

Conclusion

The financial and social pressures engendered from having a large number of Americans with little or no health insurance unlikely to abate in the near future. "Pay or play" mandates are increasingly being used by state and local governments as a tool to force employers to "solve" this problem. Employers will be increasingly unable to avoid these mandates and will have to make the "comply or challenge" decision discussed above. While the majority view would suggest these mandates may be legally infirm, *Golden Gate* illustrates these will be highly contested battles that may ultimately have to be resolved by the U.S. Supreme Court. While many of these laws may be ripe for preemption challenges under ERISA, until a law or ordinance is deemed to be preempted, employers will have to abide by these various state pay or play laws.

[1] *Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, Income, Poverty, and Health Insurance Coverage in the United States: 2004, U.S. Census Bureau, Current Population Reports: Consumer Income, P60–229, August 2005, at* http://www.census.gov/prod/2005pubs/p60-229.pdf (October 18, 2005).

[2] *See* National Conference of State Legislatures report at http://ncsl.org/programs/health/universalhealth2007.htm.

[3] 29 U.S.C. § 1001 *et seq.*

[4] Chapter 58 of the Acts of 2006.

[5] M.G.L. c. 176J.

[6] *See* 29 U.S.C. § 1144 (ERISA § 514).

[7] It appears that Massachusetts may be relying upon the holding in the United States Supreme Court decision in *New York Conference of Blue Cross Plans v. Travelers*, 514 U.S. 645 (1995), where the Supreme Court found that states may impose a tax on employers and their group health plans to fund uncompensated care programs in the state.

[8] Defined as employees working 35 or more hours per week. 114.5 CMR § 16.03(1)(a). There are certain exceptions for temporary and seasonal employees and others.

[9] As indicated above in Footnote 8, certain types of employees may be excluded from the denominator, to help employers who are close pass the test. These rules are complex and governed by regulation. Human resource personnel should actively work with ERISA counsel on these exclusions, particularly if their company's take-up rate is close to the 25% mark and they do not contribute at least 33% of premium cost.

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[12] This was clarified in Technical Corrections to the Massachusetts Act, Chapter 324 of the Act of 2006, *An Act Providing Access to Affordable, Quality, Accountable Health Care* ("TC") § 57.

[13] M.G.L. c. 151F, § 1, as amended.

[14] M.G.L. c. 118G, § 18B.

[15] 114.5 CMR § 17.04.

[16] 114.5 CMR § 18.04.

[17] M.G.L c. 175, § 11; M.G.L c. 176A, § 34; M.G.L c. 176B, § 22; M.G.L c. 176G, § 61.

[18] 29 U.S.C. § 1144(a).

[19] 29 U.S.C. § 1144(a).

[20] 29 U.S.C. § 1144(a).

[21] 29 U.S.C. § 1144(a).

[22] 29 U.S.C. § 1144(a).

[23] 475 F.3d 180 (4th Cir. 2007).

[24] *Id.* at 198. The U.S. Department of Labor's amicus brief also asserted that the Fair Share Health Care Fund Act should be preempted. The Department of Labor noted that the preemption analysis does not turn on whether the law is characterized as a tax, penalty or fee. Rather, Maryland's act had the prohibited effect of upsetting uniform national administration by, as a practical matter, mandating a minimum level of employee benefits.

[25] 497 F. Supp.2d 403 (E.D.N.Y 2007).

[26] 512 F.3d 1112 (9th Cir. 2008).

Peter Marathas is a partner in Proskauer's Boston office where he advises corporate, not-for-profit, governmental and individual clients on matters related to executive compensation and employee benefits. Mr. Marathas regularly provides assistance with matters effecting compensation of senior executives, including tax, securities law, accounting, ERISA and corporate governance issues. He works closely with clients' management teams, boards and compensation committees to develop and design appropriate executive compensation programs and to resolve legal issues confronting employers when implementing such programs.

Robert Rachal is a senior counsel in Proskauer's New Orleans office. His work focuses on complex ERISA litigation, and on advising fiduciaries to limit their exposure to lawsuits. For the past fifteen years, he has handled numerous class actions under ERISA, including claims challenging 401(k) or ESOP investments in employer stock, claims that fiduciaries paid too much in fees and expenses in 401(k) plans, claims against cash balance pension plans, claims that plans discriminated on the basis of sex or age, claims that plans illegally cut back benefits or engaged in prohibited transactions, claims that employers failed to properly fund plans, claims that insurers mishandled plan funds, and claims that fiduciaries breached their duties to inform of plan benefits.

Yolanda Montgomery is an associate in Proskauer's New Orleans office, where her practice focuses on ERISA litigation, ERISA substantive plan work, and employment litigation, representing employers.

Fredric C. Leffler
212.969.3570 – fleffler@proskauer.com

Peter J. Marathas Jr.
617.526.9704 – pmarathas@proskauer.com

Robert W. Rachal
504.310.4081 – rrachal@proskauer.com

Yolanda D. Montgomery
504.310.2075 – ymontgomery@proskauer.com