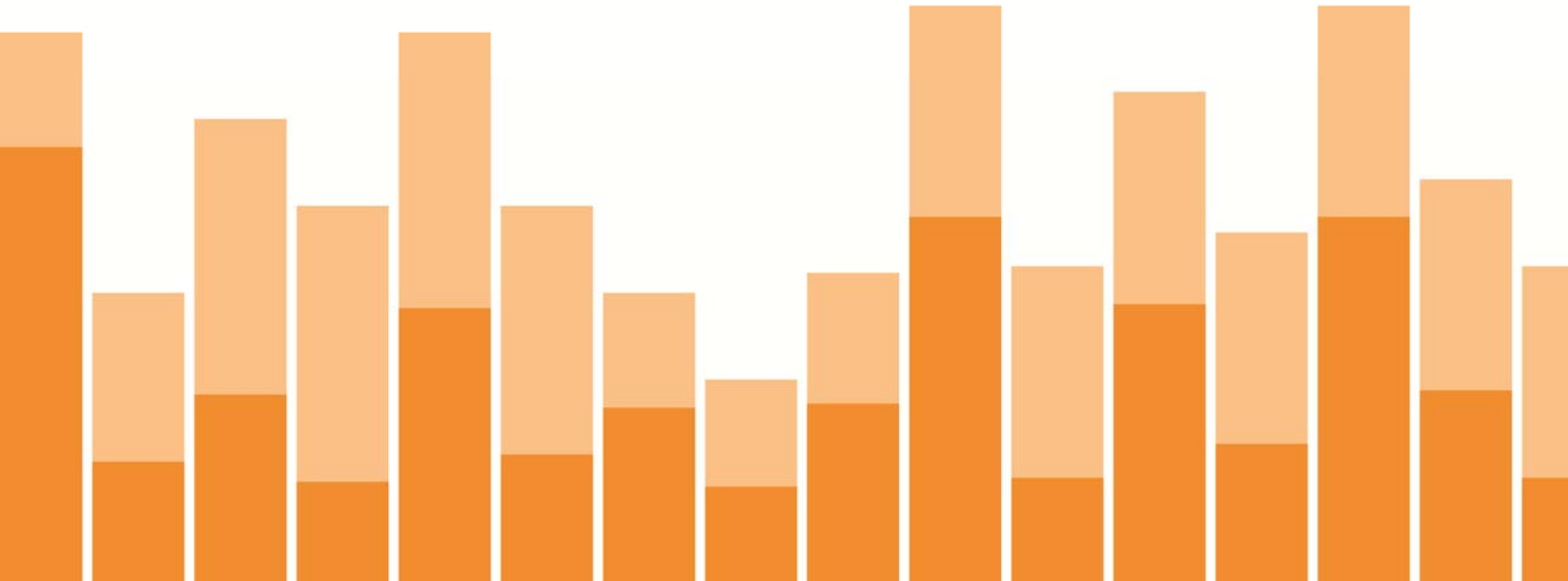
AMERICAN HEALTH POLICY INSTITUTE

2017

The Need to Strengthen ERISA Preemption

Vanessa Scott
Partner, Eversheds Sutherland



American Health Policy Institute (AHPI) is a non-partisan 501(c)(3) think tank, established to examine the impact of health policy on large employers, and to explore and propose policies that will help bolster the ability of large employers to provide quality, affordable health care to employees and their dependents. The Affordable Care Act has catalyzed a national debate about the future of health care in the United States, and AHPI serves to provide thought leadership grounded in the practical experience of America's largest employers. To learn more, visit americanhealthpolicy.org.

Vanessa Scott is a partner in Eversheds Sutherland's Washington, DC tax practice, where she specializes in ERISA and employee benefits matters. Ms. Scott advises domestic and international clients on a wide range of regulatory and compliance matters relating to ERISA-governed benefits and retirement plans and services. She is nationally recognized for her Patient Protection and Affordable Care Act (ACA) expertise, and is also a sought-after speaker on the Department of Labor's (DOL) re-proposal on the definition of investment advice fiduciary.

Ms. Scott is frequently quoted in the trade press and national publications, and has been named to *Best Lawyers in America* for ERISA and Employee Benefits. She also serves as Eversheds Sutherland's US Chief Diversity & Inclusion Officer, and is an adjunct professor of law at the Georgetown University Law Center. She attended Duke University and Vanderbilt University School of Law, and she holds an LLM in Taxation from the Georgetown University Law Center.

Contents

Introduction

The Employee Retirement Income Security Act of 1974 (ERISA) created preemption principles that are integral to the robust operation of self-insured employer-sponsored health plans.[1] Without ERISA, multi-state self-insured employer-sponsored plans would find it nearly impossible to operate under a variety of cumbersome and potentially conflicting state-based rules. Yet recent developments in Washington are raising concerns about ERISA's potential to maintain uniform operating rules across multiple states.

The latest series of challenges began in 2010, with the passage of the Affordable Care Act, which poses significant hurdles to the uniform administration of employer-sponsored health plans, creating administrative burdens that subvert certain bedrock preemption protections under ERISA. But Republican reform efforts present ERISA challenges as well. Although the GOP effort to repeal and replace the ACA is stalled in Congress, the employer-sponsored health system may see significant policy changes as the Trump Administration implements Executive Order 13765 to provide more state flexibility.[2] Moreover, key policymakers and stakeholders have signaled a preference for a state-driven health care delivery solution instead of the heavily regulated federal regime created by the ACA. In this challenging environment, any ACA reforms should remedy its current indifference to the vital role that ERISA plays in enabling multi-state employers to offer uniform low-cost health care benefits to employees and their dependents no matter where they live or work. Increasing state flexibility and innovation should not disrupt ERISA, which is essential to the continued success of the employer-based system.

I. The Significance of ERISA Preemption

Before ERISA, multi-state employers were subject to different state laws, which prevented the uniform administration of health care benefits, increased the cost of those benefits, and blunted the ability of large employers to improve the efficiency of the U.S. health system. In order to address this problem and to encourage employers to provide health care benefits,[3] Congress crafted ERISA to supersede or preempt any and all state laws as they relate to any employee benefit plan as defined under the law.[4] In addition, ERISA prohibits states from regulating benefit plans as insurance in an effort to circumvent ERISA preemption.[5] These provisions generally protect self-insured employer-sponsored health care plans from state laws that would otherwise mandate benefit requirements or impose administrative burdens, bind employers particular plan designs, or preclude employers from implementing uniform plan administrative practices across states. As a result, ERISA preemption significantly reduces costs for self-insured health care plan sponsors, participants, and beneficiaries.

ERISA's preemption provisions allow plan sponsors to seek lower-cost, nationwide pricing for health care services, allowing for uniformity of benefits design and equity across an employer's workforce. It also enables large employers to drive innovation in benefit and plan design, foster new health care cost controls, and improve the quality of care. These innovations have included consumer directed benefit designs, payment reform, provider transparency initiatives, and wellness programs. Any weakening of the foundation provided by ERISA preemption not only increases the cost and complexity of health benefits for employees and employers, but also frustrates further health care market innovation.

II. ERISA Preemption and the Affordable Care Act

The legislative history of ERISA makes clear that Congress intended ERISA's preemption provisions to be very broad. For the first 20 years after the law was enacted, courts applied ERISA's preemption mandate "literally and capaciously" to preempt a wide variety of state laws.[6] However, since 1995, the courts have significantly narrowed preemption protections. For example, in 1995 the Supreme Court held that ERISA did not preempt a state law imposing cost burdens on a health plan if those burdens only ''indirectly affect what an ERISA or other plan can afford or get for its money,"[7] and in 1997, the high court held that ERISA did not preempt a New York State tax imposed on the gross patient receipts of operators of medical facilities, including those operated by ERISA plans.[8] Then in 2016, the Sixth Circuit Court of Appeals held in *Self-Insurance Institute of America v. Snyder* that ERISA does not preempt a one percent Michigan State tax on the benefits paid by ERISA health care plans.[9]

Despite the Supreme Court's comparatively broad reading of the ERISA preemption in *Gobeille v. Liberty Mutual Insurance Co.* in 2016, prior court decisions have narrowed preemption in an manner that could threaten the long-term stability of employer-provided health care benefits should state taxes and fees on ERISA plans continue to proliferate.[10] In fact, the Sixth Circuit Court of Appeals decision in *Snyder* may provide a means by which state laws with incidental reporting and record-keeping requirements can continue to operate unimpeded by ERISA.[11]

ACA also threatens fundamental ERISA preemption protections. For instance, ACA regulations require self-insured plans to defer to states for determining key compliance aspects of the law, such as the definition of essential health benefits protected from annual and lifetime benefit limits.[12] Further, certain states have construed federal agency regulations interpreting section 1311 of the ACA to allow states to impose taxes on self-insured health plan claims to help pay for state health insurance exchanges.[13] The ACA also authorizes states to apply for federal innovation waivers that endow states with the flexibility to pursue their own strategies for providing comprehensive and affordable health care.[14] Although the U.S. Department of Health and Human Services (HHS) issued a final rule in 2012 establishing the procedural framework for states seeking such waivers, the substantive rules governing the scope and subject matter of state waivers were never issued.[15] However, in response to public comments, HHS clarified that "no federal laws or requirements may be waived that are not within the Secretaries' authority." While this suggests there may be certain limits on state innovation waivers, states remain at liberty to adopt requirements that may unintentionally, but dramatically, erode the ERISA preemption and impact self-insured plans should policymakers remain indifferent to its significance. For example, the Secretary for the Massachusetts Department of Health and Human Services has asked HHS for a waiver to create an alternative to the ACA employer mandate and penalties, and to allow the state "to develop creative ways for employers to offer coverage to their employees," including tailoring the use of Health Reimbursement Arrangements and Section 125 cafeteria plans.[16]

III. The Impact of State Taxes and Fees on Self-Insured Plans on ERISA Preemption Protections

State taxes and fees on self-insured plans made subject to ERISA are one of the most impending threats to ERISA preemption. States have used such assessments to fund a variety of state health programs. These include the Alaska Vaccine Assessment Program, Kentucky's ACA exchange fee, the Maryland Health Care Commission Fund, the Massachusetts Vaccine Purchase Trust Fund, the Oregon Transitional Reinsurance Pool, the Rhode Island Childhood Immunization Program, and the Vermont Immunization Program. Further, Michigan enacted a one percent tax on the health care claims paid by all employer-sponsored plans in the state, including self-insured plans. Almost a dozen other states are considering similar taxes to fund their health care programs. The more states are empowered to impose burdensome tax and reporting requirements on employers, the more they will do so. This slippery slope represents a serious threat to the viability of self-insured health care benefit plans, and thus to the purposes of ERISA preemption.

Large employers are concerned about the proliferation state taxes and fees on their multi-state operations. Forty-two percent of large employers say the erosion of the ERISA preemption would motivate their company to consider a significantly different approach to health care.[17] Ninety-one percent of large employers say that if Congress opens the door to health care reform being addressed on a state-by-state basis, the substantial variances that are likely to arise among the states would create considerable administrative problems for multi-state employers,[18] and 86 percent say the most important regulatory action the Trump Administration could take would be to protect ERISA preemption as state innovation waivers are implemented.[19]

IV. ERISA Preemption and Congressional Health Care Reform

Key stakeholders involved with current health care reform efforts favor a state-driven solution that would enable states to tailor individualized health care regulatory schemes, but may not recognize the importance of maintaining preemption protections. Preference for this state-by-state reform approach began as a groundswell among several Republican governors who met just prior to President Trump's inauguration to voice their support for state flexibility as a key priority in the health care reform debate.[20] This support was echoed in President Trump's Executive Order 13765, which directed the executive agencies to "…prepare to afford the States more flexibility and control to create a more free and open healthcare market."[21] Following suit, a February 2017 white paper outlining the House Republican health care reform plan foreshadowed legislation that would empower states to modernize their health care programs and allow each jurisdiction to "best take care of their unique patient populations."[22] The American Health Care Act (H.R. 1628), as passed by the U.S. House of Representatives on May 4, 2017, effects this state-by-state approach by providing states with the flexibility to allow each state to craft their health care programs as they see fit, including mandates that could impact employer-sponsored plans. In the Senate, the Better Care Reconciliation Act of 2017 would also provide "states additional flexibility to use waivers" in the ACA to free their health insurance markets from costly regulations.[23] Importantly, neither legislation explicitly protects the ERISA preemption for self-insured plans, and thereby runs the risk of unintentionally weakening ERISA protection for multi-state, self-insured health plans.

V. The Impact of a State-by-State Replacement Solution on ERISA-Governed Health Plans

While the flexibility offered by a state-by-state approach to health care reform may be preferable to many, this solution could threaten self-insured employer-sponsored health plans if ERISA preemption is ignored. Adopting a state-by-state approach resurrects various practical concerns rooted in the preemption threats posed by the ACA, and could create new threats as well, including: (1) laws and regulations that could allow states to collect health care claims data and fees from self-insured plans; (2) state compliance schemes that potentially compromise the consistent administration of large employer-sponsored health plans; and (3) ACA alternative approaches that prioritize flexibility over preemption protections in the name of state health care innovation.

A. Health Care Reform Should Protect Self-Insured ERISA Plans from State Efforts to Collect Claims Data and Impose Taxes and Fees on Health Plans

If federal legislative efforts encourage states to pursue individualized health care reform, states will inevitably seek to gather claims information from large employers and the plans they sponsor. In fact, as many as 17 states are currently pressing employer-sponsored plans for demographic and claims information through mandatory all-payer state claims databases and/or are imposing fees relating to such claims.[24] Although a recent Supreme Court decision held that state demands for plan-level data are currently applicable only to fully-insured employer health care plans,[25] federal health care reform efforts that favor state-level reforms may allow states to again sweep self-insured plan data into the purview of state regulation. Moreover, the Sixth Circuit Court of Appeals decision in *Self-Insurance Institute of America v. Snyder*, which explicitly attempts to narrow ERISA preemption in such cases, may provide the means by which state reporting and record-keeping requirements can circumvent ERISA preemption.[26]

More importantly, under current case law, it remains unclear whether ERISA preempts state taxes on the benefits paid by ERISA health care plans in all cases. The uncertainty surrounding the courts' treatment of state taxes and fees on self-insured plans threatens the long-term stability of employer-provided health care plans. The proliferation of such taxes and fees on ERISA plans, even if coming as part of understandable health care reform efforts to empower greater state flexibility, could destabilize the employer sponsored health care system. Clear standards supporting ERISA preemption are therefore necessary in order to prevent multiple jurisdictions from imposing differing, or even parallel, regulations, creating wasteful administrative costs and threatening to subject self-insured plans to wide-ranging liability. Failure to preempt state taxes and fees could subject self-insured health plans to 50 or more potentially conflicting and burdensome assessments, and are likely to create serious administrative problems. If each State is free to go its own way, each independently assessing taxes and fees on self-insured plans, the result could well be an unnecessary, duplicative, and conflicting maze of reporting requirements, any of which can mean increased confusion and increased cost.

B. Health Care Reform May Expose Employer-Sponsored Health Plans to Inconsistent Compliance Regimes

A state-by-state approach to health reform may also obligate large employers to comply with as many as 50 different regulatory regimes for plan administration. For large employers that operate in multiple states, this may mean different notice and reporting obligations for employees in different states. As noted in the recent Supreme Court decision in *Gobeille v. Liberty Mutual*, state-specific regulations, even with minimal individual impact, create burdens through the mere "possibility of a body of disuniform [sic] state reporting laws" when considered in the aggregate.[27]

Even beyond reporting requirements, each state could have the flexibility to create its own regulations regarding preexisting conditions, mandatory benefits, and the valuation of coverage provided.[28] For instance, in its current form the House-passed American Health Care Act would allow each state to choose whether to use block grant funds to mandate preventive health services as a key component of its health care market requirements. The bill does not explicitly limit state intervention to the individual or "small group" market, meaning that states would be free to mandate benefit changes to employer-sponsored plans as well. Not only could this approach lead to the inconsistent administration of employer-sponsored health coverage, but as state funding priorities shift and benefit mandates change, employers may be required to constantly revise and update plan offerings in order to remain in compliance in various jurisdictions. If ACA reforms prioritize state flexibility over ERISA preemption protection, large self-insured plans could be forced to spend considerable resources to comply with changing, and perhaps conflicting, health care regulatory and benefit requirements for their covered population.

C. Prioritizing State Flexibility Could Weaken ERISA Preemption and Expose Self-Insured Health Plans to Coverage Mandates

Large employers remain concerned that the current preference for a state-by-state ACA solution may signal a general erosion of ERISA preemption as a valid exercise of Congressional power. As perhaps the most significant threat to the employer-sponsored plan structure, this erosion of preemption exposes employers to state-based employee coverage mandates akin to the "pay-or-play" laws enacted by states over a decade ago.[29] These initiatives were implemented by states in an effort to respond to a federal failure to execute a broad-based healthcare solution. Although state coverage mandates were eventually struck down by federal courts, with strong Congressional support for state flexibility, and the courts' recognition of the "wide latitude enjoyed by states to regulate healthcare providers,"[30] a state-by-state ACA replacement approach exposes employers to pay-or-play once again.

Congress and the current Administration cannot sacrifice strong support for ERISA preemption while it attempts to maximize state health care coverage innovation. The Supreme Court has upheld a presumption *against* ERISA preemption of state laws absent a clear indication of Congressional intent, so that state laws can be given the fullest effect possible.[31] The Court has also held that matters of health and safety have traditionally been regulated by states, further supporting the presumption against preemption of such state health care laws that only impact plans economically.[32] Unless Congress clearly states its intent to preserve ERISA preemption, states will use this latitude to place direct cost burdens on self-insured plans under a traditional ERISA preemption analysis.

In addition, Congress has never clearly exercised its preemption authority on a number of state law issues that indirectly impact self-insured plans. For instance, states are still permitted to regulate third-party administrators that provide services to self-insured plans. States may also regulate insurers that provide health care stop-loss insurance to self-insured plans. If ACA reforms do not clearly prohibit states from regulating in these areas, states will continue to indirectly mandate such changes to self-insured plans, quietly and indirectly eroding ERISA's fundamental preemption principles.

As noted by the Supreme Court in *Gobeille*, ERISA preemption is necessary to prevent states from imposing "novel, inconsistent, and burdensome"[33] requirements on employer-sponsored health plans. A patchwork of state ACA legislative and regulatory alternatives that would impact the administration of employer-sponsored plans is wholly inconsistent with the framework of ERISA.

Conclusion

While health care reforms should offer states greater flexibility to free their individual and small group health insurance markets from costly ACA regulations, those reforms should not place new mandates or burdens on health plans governed under ERISA. Congress should not adopt or amplify the ACA's indifferent approach to ERISA preemption in the interest of state flexibility and innovation. While states should still have broad authority to regulate health care providers and health care insurers, ACA reforms must clearly and explicitly prohibit approaches that permit state regulation of ERISA plan benefits, force plans to provide sensitive claims data, or impose new state-mandated taxes and fees. Health care reform is clearly needed, but it should not disrupt the uniform administration of ERISA on a nationwide basis through mandates or other requirements, nor should it prioritize flexibility over preemption. Instead, ACA reforms must explicitly direct states to use innovation to develop workable, low-cost alternatives to the ACA that do not damage the employer-sponsored health care system.

Endnotes

[1] ERISA preemption does not apply to fully-insured employer health care plans.

[2] Executive Order 13765, Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, (Jan. 20, 2017) available at https://www.gpo.gov/fdsys/pkg/FR-2017-01-24/pdf/2017-01799.pdf. Also see: Executive Orders 13771 and 13777.

[3] Tumber, Marea B. (2015) "The ACA's 2017 State Innovation Waiver: Is ERISA a Roadblock to Meaningful Healthcare Reform?," University of Massachusetts Law Review: Vol. 10: Iss. 2, Article 5.

[4] ERISA §514(a), 29 U.S.C. §1144(a).

[5] ERISA §514(b)(2)(B), 29 U.S.C. §1144(b)(2)(B).

[6] Peter Schmidt, "ERISA and Health Plans," Employee Benefit Research Institute, November 1995. Edward Zelinksy, "ERISA Preemption After Gobeille v. Liberty Mutual: Completing the Retrenchment of Shaw," Benjamin N. Cardozo School of Law, January 12, 2017.

[7] New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U. S. 645, 650 (1995).

[8] De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806 (1997). The Court found no showing that the cost of the tax mandated any particular choice of benefits or benefit providers.

[9]2016 U.S. App. LEXIS 12142 (6th Cr. July 1, 2016).

[10] Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936, 947 (2016). In writing for the majority, Justice Kennedy noted: "Differing, or even parallel, regulations from multiple jurisdictions could create wasteful administrative costs and threaten to subject plans to wide-ranging liability…. Pre-emption is necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans."

[11] Self-Insurance Institute of America Inc. v. Snyder: Sixth Circuit Holds that ERISA Does Not Preempt Michigan Medicaid Tax Law, 130 HARV. L. REV. 1512 (2017).

[12] 78 Fed. Reg. 12834, 12835 (Feb. 25, 2013).

[13] Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight, Frequently Asked Questions (FAQ), CCIIO Question and Answer Regarding Assessment Fees, (July 10, 2013).

[14] Pub. L. No. 111-148, § 1332.

[15] 77 Fed. Reg. 11711 (Feb. 27, 2012).

[16] Marylou Sudders, Massachusetts Secretary of Health and Human Services, Letter to Seema Verma, March 22, 2017, available at: https://www.scribd.com/document/343231298/Administrator-Verma-Letter-3-22-2017-Final#download.

[17] HR Policy Association, Annual CHRO Survey, 2013.

[18] HR Policy Association, Annual CHRO Survey, 2010.

[19] HR Policy Association, CHRO Survey, January 2017.

[20] Michael Petruzzelli, *Governors Join Discussion on Health Care Repeal and Replace*, (Jan. 19, 2017) available at https://www.thenationalcouncil.org/capitol-connector/2017/01/governors-join-discussion-health-care-repeal-replace/.

[21] Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, (Jan. 20, 2017) available at https://www.gpo.gov/fdsys/pkg/FR-2017-01-24/pdf/2017-01799.pdf.

[22] OBAMACARE REPEAL AND REPLACE POLICY BRIEF AND RESOURCES, pgs. 7,16, available at https://www.documentcloud.org/documents/3462817-House-GOP-Health-Care-Policy-Memo.html.

[23] Discussion Draft – Senate Republican Health Care Bill, available at https//www.budget.senate.gov/bettercare.

[24] *Gobeille v. Liberty Mutual Ins. Co.,* 136 S. Ct. 936 (2016).

[25] *Id*. at 941.

[26] Self-Insurance Institute of America Inc. v. Snyder: Sixth Circuit Holds that ERISA Does Not Preempt Michigan Medicaid Tax Law, 130 HARV. L. REV. 1512 (2017).

[27] *Gobeille*, 136 S. Ct. 936 at 945.

[28] Under ERISA's savings clause, states may currently regulate these provisions in fully-insured plans.

[29] M. Babaro, WAL-MART IN THEIR SIGHTS, STATES PRESS FOR HEALTH BENEFITS, NY TIMES (2006) available at http://www.nytimes.com/2006/01/05/business/walmart-in-their-sights-states-press-for-health-benefits.html.

[30] See *DeBuono v. NYSA – ILA Med*., 520 U.S. 806, 815-816 (1977).

[31] *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers* 514 U.S. 645, 653-58 (1995).

[32] *DeBuono*, 520 U.S. at 803.

[33] *Gobeille*, 136 S.Ct. 936 at 945.