

# FYI<sup>®</sup> In-Depth

## For Your Information<sup>®</sup>

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## ERISA@40: ERISA Preemption and the ACA

This is the second in a multi-part series of articles to be published over the next several months celebrating the 40<sup>th</sup> birthday of the Employee Retirement Income Security Act. ERISA was signed into law by President Gerald Ford on September 2, 1974 — Labor Day. This landmark law regulates many aspects of employer-sponsored retirement and welfare benefit plans. The series looks back to explore how the employer-sponsored employee benefits industry has evolved, highlights lessons learned, and looks forward to what employers may expect in the future.

A sweeping preemption provision that constricted the ability of states and localities to regulate employer-sponsored benefit plans was a major feature of ERISA as enacted, designed to create administrative uniformity for employers who sponsor benefit plans covering employees nationwide. As noted in our first article in this series, preemption helped build support for ERISA within the business community. This article discusses the reach of ERISA preemption as it concerns pre-ACA health care reform laws designed to expand employer-provided health coverage, the status of those laws in the wake of the ACA, and the role and motivation of states and localities in regulating employer-sponsored coverage in a post-ACA world.

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### Background

A key congressional goal in passing ERISA was to streamline the administration of private-sector employee benefit plans throughout the United States and thereby free employers operating nationwide from the need to comply with various state and local requirements. Accordingly, Congress included a broad preemption provision declaring that ERISA supersedes any and all state laws “insofar as they relate to any employee benefit plan.” Additionally, courts have held that ERISA, a federal statute, trumps any state or local laws that “conflict with” ERISA’s substantive provisions. So, with some important exceptions — most notably, the “insurance savings clause,”

#### Then and Now

In 1974 when ERISA was enacted, the price of a first-class postage stamp was raised from 8 cents to 10 cents.

In 2014, the price of a first-class postage stamp jumped from 46 cents to 49 cents.

which “saves” from preemption laws regulating insurance, banking, or securities — ERISA’s reach is sweeping when it comes to state and local laws that regulate employer-sponsored benefit plans.

With the backdrop of failed health care reform initiatives in the 1990s, skyrocketing costs of health insurance and numbers of uninsured individuals, and a perceived lack of political will for Congress to act on these issues, a number of states and localities attempted to expand coverage in their jurisdictions by regulating employer-sponsored health coverage at the state or local level. Several of these laws, often referred to as “employer fair share” laws or “play or pay” mandates, triggered ERISA preemption challenges that enjoyed some — but, surprisingly to many, not universal — success. The ERISA preemption status of these laws was very much in flux when the Affordable Care Act (ACA) was enacted in 2010.



Among the most significant aspects of the ACA are the employer shared responsibility requirements, commonly known as the “employer mandate.” Pursuant to these requirements, beginning in 2015, large employers must either offer full-time employees (generally, employees who average at least 30 hours of service per week in a given calendar month) and their dependents health coverage that is affordable and provides minimum value or make an “assessable payment” to the IRS if at least one full-time employee enrolls in marketplace coverage and receives a premium subsidy. (See our [February 11, 2014](#) *For Your Information* publication for more information on the employer shared responsibility requirements.)

The ACA also required each state to establish a health insurance marketplace (also known as an exchange) in order to facilitate the purchase of individual health insurance; states that failed to do so by the January 1, 2014 deadline participate in the federally facilitated marketplace established by the federal government. (See our [December 19, 2013](#) *For Your Information* for more on ACA marketplaces.)

## Pre-ACA State and Local Laws Regulating Employer-Sponsored Coverage

Prior to the ACA, the following states and localities had enacted laws regulating employer-sponsored health coverage. As discussed below, some of these laws were challenged as preempted by ERISA.

*Hawaii:* Hawaii was the first jurisdiction to impose an “employer mandate” requiring nearly all employers to provide health benefits to at least some categories of their workers when it enacted the Prepaid Health Care Act (PHCA) in 1974, the same year ERISA passed. Under the PHCA, employers must offer coverage that satisfies state-prescribed standards to employees who work a minimum of 20 hours a week and meet certain wage requirements; this law also limits the amount an employee may be required to contribute to premium costs. In 1976, a Hawaiian employer challenged the PHCA on ERISA preemption grounds, and the Ninth Circuit Court of Appeals ultimately agreed that the law “relates to” employee benefit plans within the meaning of ERISA’s preemption provision. However, in 1983, Congress granted an express ERISA preemption waiver specifically for the PHCA —thereby mooting the preemption question.

*Suffolk County, New York:* Initially enacted in 2005 and then amended in 2006, the Suffolk County Fair Share for Health Care Act (FSHCA) required large retail employers to pay a “public health cost rate” for each of an employer’s Suffolk County-based employees. Non-compliant employers were subject to a civil monetary penalty. A

trade association called Retail Industry Leaders Association (RILA) sued on preemption grounds, and the federal district court agreed that ERISA preempted the FSHCA. Suffolk County did not appeal the district court's ruling.

*San Francisco, California:* In 2006, the City of San Francisco enacted "Healthy San Francisco," an ordinance generally requiring employers with 20 or more employees to make certain health care expenditures for some of their employees working in San Francisco by purchasing health insurance coverage and/or making specified payments to the City of San Francisco. In 2009, the Ninth Circuit Court of Appeals rejected a preemption challenge to Healthy San Francisco brought by a trade association, thereby allowing the law to go into effect. The trade association appealed this ruling but the US Supreme Court declined to review the case. (See our [March 31, 2009 For Your Information](#).)

*Massachusetts:* In 2006, Massachusetts enacted a sweeping health care reform law. In addition to instituting an individual requirement that all Massachusetts residents have coverage satisfying certain minimum creditable coverage (MMC) standards or pay a penalty, this law required employers with 11 or more full-time employees to either offer a group health plan to which the employer makes "fair and reasonable" premium contributions or pay an annual "fair share" contribution to a state trust fund. This law, called the Massachusetts Fair Share Employer Contribution, was not challenged on preemption grounds and ultimately became the model for the ACA. (See our [October 9, 2008 For Your Information](#).)

*Vermont:* Also in 2006, Vermont enacted a law requiring employers to pay an assessment on behalf of each of their "uncovered" full-time employee equivalents. This law defined an "uncovered employee" as an employee to whom the employer does not offer to pay for any part of the cost of health coverage, even if the employee has health coverage elsewhere. (See our [June 1, 2007 For Your Information](#).) Like the Massachusetts law, the Vermont law was not challenged on preemption grounds.

*Maryland:* Again, in 2006, the Maryland legislature passed the Maryland Fair Share Health Care Act (FSHCA), which required an employer with 10,000 or more employees to pay the state the difference between 8% of the employer's payroll (6% for nonprofit employers) and the amount the employer spent on health care coverage for its employees. At the time, only four Maryland employers had 10,000 or more employees, and the law's payment provision applied to only one Maryland employer — Wal-Mart. RILA filed a lawsuit in Maryland, and the Fourth Circuit Court of Appeals struck down the FSHCA as preempted by ERISA. Maryland did not appeal this ruling.

## Status of Pre-ACA Laws in the Post-ACA World

The current status of the pre-ACA health care reform laws directed at employer-sponsored coverage discussed above is as follows:

*Hawaii:* In passing the ACA, Congress included a reference to the PHCA, stating that the ACA should not be construed to "modify or limit the application of" the preemption exemption. Employers must still comply with the PHCA's provisions.

*Suffolk County, New York:* After the district court's finding that ERISA preempted this law and the county's failure to appeal that ruling, the law was not enforced.

*San Francisco, California:* Healthy San Francisco remains effective, but the ACA affects some employer compliance obligations. The city's Office of Labor Standards Enforcement has provided post-ACA guidance to help employers understand how Healthy San Francisco and the ACA work together. For example, Healthy San

Francisco permits contributions to a health reimbursement arrangement (HRA) to satisfy the employer health care spending requirement, but the ACA generally prohibits most stand-alone HRAs. To address this conflict, recent city guidance explains that excepted benefit coverage and excepted benefit HRAs may be used to satisfy the expenditure requirements. (See our [February 26, 2014 For Your Information.](#))

*Massachusetts:* In July 2013, Massachusetts repealed the Fair Share Employer Contribution, as well as additional employer requirements and implementing regulations. However, the requirement that Massachusetts residents have MMC or pay a penalty remains in effect. While employer-sponsored coverage can constitute MMC, satisfaction of ACA requirements does not ensure compliance with MMC requirements — meaning that employees, retirees, and dependents enrolled in an employer-sponsored plan that does not meet the MMC requirements may be subject to tax penalties. (See our [July 10, 2014 For Your Information.](#))

*Vermont:* The Vermont law is still in effect — although there is active legislation to repeal it. Some employers could be subject to both the Vermont and the ACA assessment, due to differences between the two laws. For example, the Vermont assessment applies to all employers (regardless of how many employees they employ), whereas the ACA assessment applies only to employers with more than 50 full-time employees. Additionally, the formula for determining the assessment is different under the two laws.

*Maryland:* After the court of appeals' finding that ERISA preempted this law and the state's failure to appeal that ruling, the law was not enforced.

## Role Left for State and Local Laws Designed to Expand Employer-Sponsored Coverage?

As noted above, there was considerable uncertainty before enactment of the ACA about the ability of state and local laws designed to expand employer-sponsored coverage to withstand ERISA preemption challenges. Indeed, in response to the preemption litigation concerning Healthy San Francisco, the DOL had planned to issue a proposed regulation to “clarify the circumstances under which health care arrangements established or maintained by state or local governments for the benefit of non-governmental employees do not constitute an employee welfare plan” covered by ERISA. The DOL ultimately abandoned this plan, though, given that the ACA was pending in Congress, and, according to the DOL’s “friend of the court” brief urging the Supreme Court not to hear the Healthy San Francisco case on appeal, would “significantly [reduce] the importance of the question whether and when such requirements are preempted by ERISA.”

The ACA, for its part, provides that “nothing in this title shall be construed to preempt any state law that does not prevent the application of the provisions of this title” — but no court or regulatory authority has, to date, interpreted what this provision means for any possible state and local laws designed to expand employer coverage. On the one hand, the provision is generally understood to mean that a state can impose requirements that are more expansive than the ACA’s requirements so long as the state-imposed requirements do not prevent the implementation of the ACA. On the other hand, a state requirement that is more expansive than the ACA’s requirements could nevertheless inhibit the uniform administration of the ACA nationwide and be preempted by ERISA on that basis.

Here is one example of this tension. California enacted (and just recent repealed) a post-ACA “waiting period” rule that prevented insured group health plans from imposing a waiting period that exceeds 60 days on individuals who are otherwise eligible for group health coverage. (See our [November 11, 2013 For Your Information.](#)) This rule was more restrictive than the ACA’s prohibition on waiting periods of longer than 90 days (See our [July 3, 2014](#) and

[April 2, 2014](#) *For Your Information* publications), and, as drafted, was presumably “saved” from ERISA preemption by virtue of the insurance savings clause. But what if California sought to impose this requirement on self-funded plans as well, in which case the law would not be protected from ERISA preemption by the insurance savings clause? Would the ACA’s allowance for laws that do not prevent the application of its provisions trump ERISA preemption in this situation? While such a law would be more stringent than the ACA’s 90-day limit, it would also create administrative problems for employers maintaining ERISA plans in multiple jurisdictions, including, but not limited to, California — and, in that sense, could be seen as conflicting with ERISA’s substantive provisions. The same questions appear applicable to the Healthy San Francisco law and the Vermont employer assessment law, neither of which has faced a post-ACA preemption challenge. Thus, it is not clear whether ERISA preemption would prevail in these circumstances.

This uncertainty, however, may be of little relevance. Since the ACA’s passage, states and localities have not enacted legislation attempting to impose more stringent requirements on self-funded plans. Is this surprising, given that, from a fiscal perspective, states can lower their marketplace-related expenditures if more of their residents are covered by employer-sponsored plans? Maybe not. Considering the availability of individual coverage through state marketplaces and the resources many states have dedicated toward developing and enhancing their marketplace offerings, states and localities may have little motivation to push legislation expanding employer coverage. The vestigial remains of still effective (or partially effective) state and local fair share and pay-to-play laws may serve as the only examples of states’ and localities’ inroads into what is now clear ACA territory.

## In Closing

Had Congress not enacted the ACA, other states and localities may well have passed various types of employer fair share/pay-to-play laws, and, ultimately, the Supreme Court may have weighed in on the ERISA preemption question. But now, in our post-ACA world, these questions seem to have sailed into ERISA preemption history.

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