Background

One of the major problems facing the country today is the growing number of individual who do not have health care coverage. In his State of the Union Address, President Bush, recognizing this ever-growing problem called for a revision of the tax code to help solve the problem. Under his proposal, anyone who purchases health insurance, either through an employer or individually, would not pay income or payroll tax on their first $7,500 of compensation ($15,000 for family insurance). The idea is to give the same tax breaks to all individuals who purchase insurance and encourage the purchase of less expensive health care coverage.

However, the president's proposal was met with the less than enthusiastic response, particularly by the Democrats. In fact, House Ways and Means Health Subcommittee Chair Pete Stark (D-Calif.) went so far as to say that the President's call for an elimination of the income tax exemption for employer-provided health care, together with proposed cuts in Medicare and Medicaid support, was tantamount to "declaring war" on health care and vowed that the President's proposal would never get past his committee.

The President had said that his proposal would tax only the best health care plans and this would mean that executives would be paying taxes on their own plans. Unfortunately, this proposal would effectively result in the taxation of health care coverage for both executives and union employees with superior plans, creating an odd alliance against the proposal. Others who object to the proposal say it will be the first step in eliminating the current U.S. system of

employer-provided health care coverage without instituting a new delivery system for health care.

One problem with the President's proposal is that Republicans and Democrats are looking to different mechanisms to encourage, or require, more individuals to be covered under by health insurance. As illustrated by the President's State of The Union message, Republicans are attempting to use tax incentives to encourage individuals to obtain health care coverage whereas the Democrats, in general terms, are looking toward government entitlements which can be combined with employer, and in the case of Massachusetts, individual penalties and mandates.

So, with the near certainly of a failure for the President's proposal, some state legislatures have decided to take action on their own to provide health care services. Some states are being less ambitious, with New York Governor Spitzer proposing to cover 500,000 uninsured children. Virginia, Florida and Missouri have bills which would provide assistance in the form of tax rebates or credits to small businesses that offer health care and Mississippi would require businesses to establish medical savings accounts for their employees if the employers do no provide other forms of health care coverage. Maryland has a bill that would fund coverage for the uninsured through a doubling of its cigarette tax. Montana took the easy way out by simply urging the U.S. Congress to do something to address the problem.

However, the most notable attempts to achieve additional or near-universal health care was enacted by and Massachusetts.

Although Massachusetts has already had to delay the implementation of many section of its own law and, as will be discussed later, the law faces serious preemption threats, other states, such as California and New Jersey are looking to the Massachusetts model for their own states, as the emphasis for the coming year would also seem to be on universal (or at least greater) health care coverage. Most notably, Governor Schwarzenegger has proposed a law similar to the Massachusetts law that would be funded though employer penalties as well as a doctors' and hospitals' tax. As in Massachusetts, individuals who don't purchase health care would have a loss of their individual state income tax exemption.

This article will examine the various aspects of the Massachusetts Health Care Reform law to analyze whether they can survive an ERISA preemption challenge. In particular, we will examine the recent decisions by the Fourth Circuit Court of Appeals which has declared a Maryland law, which has some of the same aspects as the Massachusetts Health Care Law to be preempted by ERISA. Such as challenge is sure to come for Massachusetts as well. (In fact, many challenges await the Massachusetts law since insurers, employers and individuals will all find fault with various aspects of the law. If a law such as the Massachusetts Health Care Reform cannot survive a preemption challenge, then other states may cease to attempt to provide universal coverage and we may be faced with even more decades of deadlock as Republicans and Democrats continue to seek diametrically opposed approaches to the health care problem.

The Massachusetts Health Care Law imposes a variety of mandates and penalties on employers, insurers, and individuals. Therefore, before examining the pre-emption issue, it is necessary to briefly review the Massachusetts Health Care Law itself.

In April 2006, Massachusetts enacted legislation requiring most state residents to carry health insurance either through their employers or individually. The objective of the law was to cover the state's 500,000 uninsured residents. The authors of the law were well aware that no state law could directly dictate the terms and conditions of an ERISA-covered plan so they attempted an to avoid this problem through a series of penalties for employers and residents of Massachusetts and several mandates on Massachusetts insurers and HMOs. These provisions can be examined separately, based on the entities effected. They are as follows:

Employer Obligations

Premium Conversion Plan. By July 1, 2007, all employers doing business in Massachusetts must adopt and maintain a premium conversion (also known as a Code Section 125 or cafeteria) plan that allows employees to pay their share of health care premiums with pre-tax dollars. Such premium conversion plans must also allow employees who obtain health care through the Commonwealth's newly-created Health Insurance Connector Plan (the "Connector") to pay their Connector premiums with pre-tax contributions. Employers will be required to file a copy of their premium conversion plans with the Commonwealth when regulations are issued.

Employer's Fair Share Contribution. Massachusetts employers with more than 10 employees that fail to make a "fair and reasonable" contribution toward the cost of health coverage must pay an annual "Fair Share Contribution" not to exceed $295 per employee. To be exempt from the requirement to pay a Fair Share Contribution, the employer must pass one of the following two tests:

- *25% Test*. The employer must cover under its health insurance plan at least 25% of its employees employed at Massachusetts locations who work at least 35 hours per week, whether or not they are Massachusetts residents for the period from October 1 through September 30 of each year.

- *33% Test*. An employer that fails the 25% test must pay at least 33% of the premium cost for all of its Massachusetts employees who are regularly scheduled to work at least 35 hours per week and who work at least 90 days during the period October 1, 2006 through September 30, 2007.

Free Rider Surcharge. Effective July 1, 2007, in addition to the Fair Share Contribution, an employer with more than 10 employees that does not provide the required health care, or does not conform to the premium conversion plan rules, can be assessed a "free rider surcharge" if five or more of its employees or their dependents use free health care during a year or if one employee or his or her dependents uses state-funded care more than three times in a year. Final regulations, issued on December 22, 2006, have recently been repealed due to changes in the law. However, the repealed regulations do provide some insight regarding how the Division will

implement the Free Rider Surcharge. In accordance with the repealed regulations, the surcharge ranged from 10% to 55% of the Commonwealth's costs for these services. However, the first $50,000 of health care provided to the employer's employees would have been exempt from the surcharge

Creditable Coverage Certificates. Effective January 1, 2008, employers (and insurers) must issue certificates of creditable coverage similar to those required by the portability provisions of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Failure to provide the certificates could result in penalties of $50 per individual up to $50,000 per year.

Insurers' Obligations

Dependent Coverage. Effective January 1, 2007, group health insurance policies and contracts (but not self-insured plans) are required to cover dependent children for the first two years after they can no longer be claimed as dependents for federal income tax purposes or until they reach the age of 26, whichever occurs first. Presumably, for purposes of the first rule, the two-year period will begin on the first day of the calendar year following the last year that the employee claims the child as a dependent on IRS Form 1040. There does not appear to be any requirement that the employer continue to make contributions for dependents who are no longer covered under the plan. Thus, the former dependent child may have to pay the entire cost of coverage. The new Massachusetts dependent coverage requirement is in addition to and independent of the COBRA continuation coverage requirement.

Nondiscrimination Rule. Effective July 1, 2007, a group health insurance policy or contract (including HMOs but excluding stand-alone dental plan arrangements) cannot be issued in Massachusetts if the employer contributes a smaller percentage of the insurance premium for one employee than for another employee who receives an equal or greater salary. To date, Massachusetts has not issued any regulations or guidance on how this provision should be interpreted.

Individuals' Obligations

The law requires all residents of the Commonwealth to have health insurance, either acquired through their employer or purchased on their own, by July 1, 2007. Those individuals who do not obtain insurance through their employer may purchase it through the Connector, which will have the task of connecting individuals and small groups with insurers. These individuals and groups may be combined by the Connector in an effort to reduce costs.

The law requires all residents of the Commonwealth to have health insurance that meets a minimum "creditable coverage" standard as established by the Connector, acquired through their employer or purchased on their own, by July 1, 2007. Those individuals who do not obtain insurance through their employer may purchase it through the Connector, which will have the task of connecting individuals and small groups with insurers. These individuals and groups may be combined by the Connector in an effort to reduce costs.

Individuals may receive a subsidy for heath insurance coverage. Those who are under the federal poverty level will receive health coverage at no cost, while those who earn up to 300% of the poverty level will have subsidized coverage. For 2007, 300% of the federal poverty rate is approximately $29,400 for an individual and $60,000 for a family of four.

On their 2007 state income tax returns, individuals will have to affirm that they have health insurance coverage. This health insurance can be obtain by the individual on his own or through an employer, as an employee spouse or dependent Those that do not have health insurance that meets the minimum required standards established by the Connector can lose their state personal income tax exemption. If uninsured in subsequent years, penalties will be assessed based on the cost of individual coverage.

ERISA Preemption

Having examined the relevant provisions of the Massachusetts Health Care Reform Act, it is necessary to examine the Employee Retirement Income Security Act (ERISA) to determine which provisions are vulnerable to preemption.

The basic rule under ERISA section 514 is that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. However, in one significant exception, ERISA provides that "nothing...shall be construed to exempt or relieve any

person from any law of any State which regulates insurance...." The effect of these provisions has been debated and litigated almost since day ERISA was enacted.

One of the first significant cases involving ERISA preemption was the U.S. Supreme Court decision *Shaw v. Delta Airlines*. This case involved a New York State Human Rights Law which prohibited employers from treating pregnancy differently from other nonoccupational disabilities. (In 1976 the Supreme Court had ruled that discrimination based on pregnancy was not discrimination under Title VII of the Civil Right Act *General Electric Co. v. Gilbert*. Congress later overturned this decision by passing the Pregnancy Discrimination Act which required employers to treat pregnancy as they would any other medical condition.)

Although the Court was sympathetic with the New York State objectives, it took an expansive view of ERISA preemption. In its decision it noted that "ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries." As a comprehensive law, ERISA cannot be interpreted to preempt only state laws dealing with matters specifically covered by ERISA, such as reporting, disclosure and fiduciary responsibility. Rather, any law which relates to employee benefit plans would be preempted. Therefore, the Court ruled that the New York state law would be subject to ERISA preemption

However, after the decision in *Delta,* the Court's position on ERISA preemption has been substantially eroded. For example, the Supreme Court ruled in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, that ERISA does not preempt a New York State law that imposes indirect costs on employee benefit plans.

Under a New York hospital rate setting program, hospitals charged patients differently based on the type of health plan coverage they have. A 13% surcharge, retained by the hospital, is added to bills covered by commercial insurers and self-funded health plans, while an additional 11% surcharge is collected and passed onto the state. A separate surcharge of up to 9% could be added to some HMO bills. Blue Cross/Blue Shield plans were not surcharged. An insurer sued the state claiming these surcharges were preempted by ERISA because they significantly affect employee benefit plans.

Two lower courts agreed with the insurer, saying that these surcharges relate to employee benefit plans because they imposed a significant economic burden on ERISA plans. The Court reviewed the objectives of ERISA to determine what state laws Congress intended ERISA to preempt. It said the basic thrust of ERISA preemption was "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."

There was no evidence that the surcharges were driving every insurance consumer to the Blues, only that they had an indirect economic influence on choices made by consumers, including ERISA plans. These surcharges did not force plan administrators to choose the Blues or totally exclude insurers or HMOs from offering other programs. Plan administrators may still shop for the best price they can get and may still provide a uniform benefits package to all employees.

The Court said that nothing in ERISA or its legislative history shows that Congress intended to preempt general health care regulation which it said "historically has been a matter of

local concern." State laws mandating rate differentials are not preempted because of their indirect effect on plans. The surcharges only indirectly affect the relative prices of insurance policies and do not force ERISA plans to adopt coverage or effectively restrict their choices of insurers. The Court ruled that ERISA did not preempt New York's surcharges on commercial insurers and HMOs and sent the case back to the lower court to consider its affect on self-funded plans.

The decision is significant because it eliminated ERISA as a barrier to state health care reform initiatives aimed at controlling costs and allocating costs incurred by uninsured individuals. The Supreme Court, in rejecting preemption, concluded that the charge differentials enacted by NY did not "relate to" any ERISA plan. The Court cautioned against applying the "relate to" language of ERISA Section 514(a) too broadly, and looked to the objectives of ERISA in determining whether preemption was appropriate. It concluded that preemption is only appropriate when state law imposes direct administrative burdens on, or attempts to regulate the substantive terms of ERISA plans. The Court rejected the argument that the higher costs resulting from the initiatives impose severe restrictions on the choices available to ERISA plans.

In *NYSA-ILA Medical & Clinical Servs. v. Axelrod*, the Second Circuit had held that ERISA preempted the application of a state tax on the income of medical centers because the tax was not of general application, but targeted the health care industry, which is within the realm where ERISA welfare plans operate. The Supreme Court, however, continuing its trend of easing the extent of ERISA preemption, reversed the Second Circuit finding that the Second Circuit relied on an "expansive and literal interpretation of "relates to." The Court reasoned that the state law in question operated in a field historically within the police powers of the state, and

was not intended by Congress to be superseded by federal law. The Court found the state tax to be a statute of general applicability that, while imposing some administrative burdens on ERISA plans, did not "relate to" them within the meaning of ERISA. The Court also rejected the argument that a direct impact must be viewed differently from an indirect impact. The state tax had a direct impact on a welfare fund only because the fund provided benefits through health care facilities which it owned. The Court noted that most health care facilities are not operated by ERISA plans.

Another theory that helped certain state laws to avoid preemption was based on the theory that if a law governs an area historically within state powers and, therefore, is not preempted by ERISA. (*California Division of Labor Standards Enforcement v. Dillingham Construction);*

A company contracted with the state to install electronic equipment at a state prison. The company employed several apprentices from an apprenticeship program not approved by the state and paid the apprentices less than the prevailing wage. The state charged the contractor with violating the state's prevailing wage law since the apprenticeship program was not state approved. The contractor sued the state, saying the apprenticeship program was an employee benefit plan under ERISA and that ERISA preempted the state law.

The state prevailing wage law allows only state-approved apprenticeship programs to pay apprentices less than the prevailing wage while unapproved programs must pay the prevailing wage. The Court said that historic state powers are not preempted by federal law unless clearly

specified by Congress. In its ruling, the Court cited the *Travelers* case in which the New York hospital surcharge law was found not to be preempted by ERISA.

Apprentice wages on state projects, just like hospital charges, have long been regulated by the states. The state law does not require contractors to hire apprentices from state approved programs, nor does it require apprenticeship programs to receive state-approval to operate. As with the New York hospital surcharges, the California prevailing wage law affects the incentives but does not dictate the choices for ERISA plans or affect reporting, disclosure or fiduciary responsiblity. It is no different from other state laws covering areas of traditional state regulation. The Court ruled the state law is not preempted by ERISA.

After this brief examination of the history of ERISA preemption it is time to examine the various requirements of the Massachusetts Health Care Reform Law to see if they are vulnerable to preemption. It is unlikely that there will be any sweeping ruling on ERISA preemption of the entire act since the law is complicated and requires a separate examination of each mandate or penalty imposed, with an eye towards the affected parties and the past history and rulings on ERISA preemption.

One of the most simple mandates imposed on employers Massachusetts Health Care Reform Act, as discussed above, is that each employer is required to maintain a premium conversion plan and that the employees of that employer must be allowed to made pre-tax contribution, through the premium conversion plan, to either the employer's own plan or a plan established by the Connector. At first glace, this mandate would appear to be exempt from

ERISA preemption, since premium conversion plans are not covered by ERISA. However, a closer look at the only ruling by the U.S. Department of Labor (DOL) on this matter shows that even here pre-emption problems can arise. And, given the distaste that many employers have towards government intervention, it is likely that even on a simple matter such as this, preemption litigation is a possibility.

The DOL ruling was issued in Advisory Opinion 96-16. The premium conversion plan document at issue in the Advisory Opinion was separate from the employer's group health plan document. DOL ruled that the pre-tax plan is merely "a method by which employees may receive tax-favored treatment of contributions that are required" under the health plan and does not, by itself, provide ERISA-covered benefits.

However, DOL then went on to say that the premium conversion plan is a mechanism for funding the group medical plan and, therefore, it is part of the group health plan. As such, salary reduction contributions to the premium conversion plan are "plan assets" under ERISA and those who exercise discretion or control over the assets are ERISA fiduciaries.

This leaves open the question of whether even this part of the Massachusetts Health Care Act relates to ERISA-covered plans. If the premium conversion plan is a “mechanism” used by the group medical plan to fund the plan, it could be said that the Massachusetts law interferes with the administrator of employee benefit plans. Furthermore, if the employee contributions are, as stated in the DOL Advisory Opinion, plan assets, wouldn’t the state-imposed choice of contributing the pre-tax contributions to either an ERISA-covered plan or the state-sponsored

Connector plan create a state requirement that goes to the very heart of ERISA's rules for the treatment of plan assets?

In support of the preemption determination it would help to look at the Supreme Court's decision in case of *Egelhoff v. Egelhoff*. The basic ruling in this case was that ERISA preempts a state statute dealing with beneficiary designations under employee benefit plans. However, the rationale of the decision in case be applied to this portion of the Massachusetts law as well.

In *Egelhoff*, a state statute provides that certain beneficiary designations, including those for pensions and life insurance, are automatically revoked upon divorce. An employee died without a will two months after divorcing his second wife. However, the second wife remained the designated beneficiary under both his pension and life insurance plans. His children, from his first marriage, claimed that the state beneficiary designation statute nullified the second wife's claim to the benefits and, therefore, they were entitled to the benefits. The second wife claimed the state statute was preempted by ERISA.

The Court found that the state statute had an "impermissible connection" with ERISA plans because it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status" and "interferes with nationally uniform plan administration." Further, the Court found that "[t]he statute… implicates an area of core ERISA concern. In particular, it runs counter to ERISA's commands that a plan shall 'specify the basis on which payments are made to and from the plan'." Therefore the statute was preempted by ERISA, and the second wife, as

the named beneficiary under the plans, was entitled to both the life insurance and pension plan proceeds, even though she had been divorced from the employee prior to his death.

Similar logic can be applied to the Massachusetts mandated requirement that, not only must every employer have a premium conversion plan to permit employee pre-tax contributions to its health care plan, but also that the cafeteria plan be written and maintained so that employees also have a choice between making pretax contributions to the employer's plan and making pre-tax contributions to the Connector plan. As noted earlier, DOL has said that the premium conversion plan can be a part of the employer's ERISA-covered health plan. If this is the case, then surely a mandate on premium conversion plans such as the one imposed by the Massachusetts Health Care Reform Act would "bind ERISA plan administrators" and interfere with nationally uniform plan administration. It would also violate ERISA by specifying the basis by which payments are made to the plan.

So, even this most simple of the Health Care Reform Mandates could be ripe for ERISA preemption.

Play or Pay: The Maryland Case

As noted previously, the Massachusetts Health Care Act imposes series of penalties on employers who do not comply with the state law and maintain an employer-provided health care plan that covers a specified percentage of employees. These penalties include the Fair Share contribution and the Free Rider Surcharge.

In early 2006, Maryland enacted a law with similar, if far more extreme, penalties called the Fair Share Health Care Fund Act. The law required employers with 10,000 or more employees in Maryland to spend at least 8% of their total payroll on employee's health insurance or pay the difference between 8% and what was actually spent, to the state. Laws such as this have become to be known as "play or pay" laws. In other words, the employers must either provide the health care coverage "prescribed" by the state or pay the penalty through an excise tax payable to the state. The rationale behind this type of law is that if an employer is given such a limited choice, it will choose the path that is more favorable to its corporate image and provide the benefit to its employees rather than turn the money over to a state fund.

However, there was a third option available to Maryland employers. They sued the state and in *Retail Industry Leaders Association v. Fielder* the lower court noted that the Maryland law was, in fact, directed against only one employer. Maryland only had three employers with 10,000 or more employees and two of those already met the 8% standard. However, regardless of whether this would, in and of itself have been a reason to invalidate the law, the district court ruled that the law was preempted by ERISA, saying that because the law effectively requires Maryland employers to restructure their employee health insurance plans, it conflicts with ERISA's goal of permitting uniform nationwide administration of these plans. The District Court concluded, therefore, that the Maryland Act is preempted by ERISA.

The case was appealed to the US Court of Appeals for the Fourth Circuit, which upheld the ruling. In a decision, which was based on many of the Supreme Court's earlier preemption

rulings, the Appeals Court noted that "ERISA established comprehensive federal regulation of employers' provision of benefit to their employees. It does not mandate that employers provide specific employee benefits but leaves them free, 'for any reason at any time, to adopt, modify or terminate welfare plans'." (Curtiss-Wright Corp v. Schoonejongen, 514 U.S. 73,78 (1995); Instead ERISA regulated the employee benefit plans that an employer chooses to establish setting "various uniform standards including rules concerning reporting, disclosure and fiduciary responsibility." Shaw v Delta Air Lines Inc. 463 U.S. 85, 91 (1983).

The court went on to say that "the primary objective of ERISA was to "provide a uniform regulatory regime over employee benefit plans" Aetna Health Inc. v. Davila 542 U.S. 200, 208 (2004)...To accomplish this objective, §514(a) of ERISA broadly preempted "any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan.... This preemption provision aims "to minimize the administrative and financial burden of complying with conflicting directives amount States or between States and the Federal Government and to reduce "the tailoring of plans and employer conduction to the peculiaries of the law of each jurisdiction" Ingersoll-Rand Co. v. McClendon.

The Appeals Court then said it must look to the objectives of any particular statute as well as the effect the state law has on ERISA plans. In what to be a death blow to play-or-pay schemes the Court cited *Egelhoff v. Englhoff,* noting that a law that regulates the structure or administrator of an ERISA plan will not be saved from preemption merely because there is a method of opting out of its requirement.

It concluded by saying that a state law has an impermissible connection with an ERISA plan "if it directly regulates or effectively mandates some element of the structure or administration of employers' ERISA plans". On the other hand a state law that only creates an indirect economic incentives that affect but do not bind the choices of employers or their ERISA plans is generally not preempted.

Applying these criteria to the Maryland Fair Share Act, this court found that while an employer that failed the 8% test could pay the difference to the state. any reasonable employer would spend the money on its own employees. Consequently, the state of Maryland had created a situation where the only rational choice an employer would have would be to increase its health care benefits to the its own employees.

For this reason the court ruled that the Maryland Fair Share Act directly regulates the structuring of employers' ERISA-covered employee benefit health plan and is, therefore, preempted by ERISA.

While there is a good chance that the decision on the Maryland Fair Share Act will be appealed to the U.S. Supreme Court, it would appear that the decision is based on solid legal ground. While the state attempted to make an end run around ERISA, it is clear that if each state has the ability to impose its own standards on multi-state employee benefit plans though the use of assessments, excise taxes or other penalties, the goal of uniform administration of employee benefit plans would quickly lose all meaning and states could easily go from simply assessments on group health care plans to the enactment on mini-ERISAs, each with separate funding,

reporting and administrative requirements. All that state laws would require to avoid ERISA preemption would be some sort of "out" through the payment of some fee or excise tax.

It could be argued that he relative amounts of the Massachusetts and Maryland penalties for non-compliance would be a significant difference between the two laws. In Maryland, a refusal to provide any health care benefit could result in an employer being penalizing a quite significant 8% of payroll, whereas the Massachusetts penalty, seems at first to be merely $295 per employee through the Fair Share Contribution. However, even if only this small amount is taken into account, the rationale behind the Fourth Circuit's ruling would remain the same. An employer cannot be coerced into providing a particular type of employee benefit, or any benefits at all, though means of an excise tax or other penalty. It is unlikely that a court that has taken this position would look to the amount of the penalty to determine whether it is subject to ERISA preemption.

However, should a court look to see if the penalty is _____ large or coercive, it must be remembered that the Massachusetts law contains a wild card in the form of the Free Rider Surcharge. Basically, this provision says that an employer is taking a chance when it does not offer health care to its employees. If the employer is willing to gamble, it may get away with the $295 Fair Share Contribution and nothing more. But if it is unlucky, and many of its employees use state-sponsored health care during the year, it could be a substantial penalty through the Free Rider Surcharge. While many employers will survive with a penalty that is far less than the 8% required in Maryland, the unknown factors in the Massachusetts law could serve as a far more daunting prospect than even the high penalties imposed by Maryland.

And, finally, there is the breath of coverage of the Massachusetts law versus the law in Maryland. The Maryland law was clearly aimed at one very large employer. Therefore this was an employer that would have the resources to introduce and administer the state-approved benefit plans. However, in Massachusetts, the law applies to all employers with more than 10 employees. For such small employers, the expense of administering and complying with a state benefit law could be even more burdensome than the penalties the Massachusetts law seeks to impose.

So, while the Massachusetts law may appear to have different provisions and different penalties than the law in Maryland, it is quite likely that if the Maryland law fails to survive a preemption challenge the employer penalty provisions in the Massachusetts law, may also be doomed to failure.

Insurer's Obligation

At noted earlier, in a notable exception to ERISA preemption the law provides that nothing...shall be construed to exempt or relieve any person from any law of any State which regulates insurance...." This so-called savings clause has often allowed states to perform and "end run" around ERISA, by requiring insurance companies, HMOs, other entities such as Blue Cross/Blue Shield to provide certain specified types of benefits, accept specified health care providers and cover individual, who have specified conditions (e.g. disabled dependents) or who have attained a certain age. The states have also enacted continuation laws that either preceded

or supplement COBRA continuation coverage. For ERISA-covered plans, only self-funded plans would be exempt from the state insurance mandate rules.

Early on, the Supreme Court recognized that ERISA would not preempt these state laws mandating specified benefits. In the case of *Metropolitan Life Insurance Company v. Massachusetts*, the Court examined a Massachusetts law which required insurance contracts providing hospital and surgical benefits to also provide coverage for 60 days per year in a metal hospital and treat confinement in a general hospital for mental and nervous conditions on the same basis as any other illness.

The insurer argued that the Massachusetts law was, in reality a health law and not a traditional insurance law that Congress intended to save from ERISA preemption. The Court, however, rejected the argument, saying that mandatory benefit laws are historically and conceptually tradition insurance laws.

The Court acknowledge that insured multistate plans could face conflicting state insurance regulations. However, Congress created the distinction between insured and self-insured plans and had chosen not to alter it. According to the Court, arguments as to the wisdom of indirect state regulation of employee benefit plans must be directed at Congress.

Nevertheless, even after the Metropolitan case there has been a continual battle over which laws are saved from preemption as laws that regulate the business of insurance and which laws are merely attempts by the states to impermissibly dictate to ERISA-covered plans.

In *Ward v Unum* the U.S. Supreme Court ruled that California's "notice-prejudice" rule is not preempted by ERISA. Therefore, an insurer must prove it was actually harmed by an employee's late submission of an LTD claim before it can deny the claim as untimely

In this case, an employer's CEO became disabled. Almost two years later, he discovered a booklet in his safety deposit box describing LTD benefits. However, when he applied for benefits, the insurer denied his claim as untimely since the policy required claims to be submitted within 15 months of becoming disabled. The CEO sued the plan and the insurer for benefits, arguing that, under California's "notice-prejudice" law, an insurer must prove it suffered "actual prejudice" as a result of the untimely notice before denying the claim. The insurer said ERISA preempts the state law.

To determine whether a law is an insurance law, and therefore exempt from preemption, the Court used a two-part analysis. First, it looked to see what a "common sense view" of ERISA indicates. Second, it looked at federal case law interpreting the phrase "business of insurance" under the McCarran-Ferguson Act.

The Supreme Court determined this law was specifically aimed at the insurance industry. Therefore, it met the common sense understanding that it regulates insurance.

Under the McCarran-Ferguson Act, three criteria are used to determine whether a law relates to the business of insurance. The law must transfer or spread risk, be an integral part of

the policy relationship, and be limited to the insurance industry. However, the Court said all three factors need not be satisfied for a state law to survive ERISA preemption. Rather, these three factors are only "considerations to be weighed in determining whether a state law regulates insurance." The Court said the state law did not clearly relate to risk spreading. However, it definitely controls the terms of the insurance relationship and is limited by its terms to "persons who provide life insurance, health insurance and annuities." Therefore, the Court concluded that ERISA did not preempt the California law.

In a similar ruling, *Rush Prudential HMO, Inc. v Moran, the Supreme Curt decided that a* state law requiring disputed HMO claims to be submitted for independent, binding, external review is an insurance law and, therefore, is not preempted by ERISA.

After an HMO denied surgery for an employee's spouse, she requested a binding review as allowed under Illinois state law. The HMO said the spouse's coverage was provided under an employee benefit plan and that ERISA preempted the state law because the law related to an employee benefit plan. The spouse responded that insurance laws are not preempted and that this law regulated insurance.

The Court agreed with the spouse. In order to survive preemption, the state law had to be directed at the insurance industry. The law met that test because HMOs are risk-bearing organizations that also operate as health care providers. "The defining feature of an HMO is receipt of a fixed fee for each patient....The HMO thus assumes the financial risk of providing

the benefits promised [and] HMOs actually underwrite and spread risk among their participants." Therefore, HMOs are properly viewed as insurers.

Applying the McCarran-Ferguson Act criteria the court again decided two of the criteria had been met. Since HMOs are to be viewed as insurers, the law is limited to the insurance industry. Also, the independent review requirement is an integral part of the policy relationship between the insurer and the insured. Therefore, because the Illinois law did not unreasonably interfere with Congress' intention to provide a uniform federal set of rights and obligations under ERISA, the law was not preempted.

While it still treats HMOs in the same manner as insurers, the Court later dropped the McCarran Ferguson Act criteria altogether and in *Kentucky Association of Health Plans, Inc. v. Miller,* it adopted new standards to determine that Kentucky's "any willing provider" (AWP) laws are saved from ERISA preemption because they are state laws that regulate the business of insurance.

The Kentucky legislature passed two laws requiring HMOs to include physicians and other health care providers in their networks as long as the providers are willing to accept the contract provisions. The Kentucky Association of Health Plans sued the state, claiming the laws are preempted by ERISA.

The HMOs argued the AWP laws are not saved from ERISA preemption because they are not specifically aimed at the insurance industry but affect health care providers as well. They

also argued that the laws do not control the actual terms of insurance policies but focused on the relationship between insurers and providers.

The Court, however, disagreed. It said that the laws are aimed at insurers and HMOs by setting down conditions under which insurance may be sold. Providers are affected only as a consequence of the insurance laws. "We emphasize that conditions on the right to engage in the business of insurance must also substantially affect the risk pooling arrangement between the insurer and insured to be covered by ERISA's savings clause. Otherwise, any state law aimed at insurance companies could be deemed a law that 'regulates insurance' contrary to our interpretation ...in *Rush Prudential*… By expanding the number of providers in a network, AWP laws alter the scope of permissible bargains between insured and insured in a manner similar to the mandated-benefit laws we upheld in *Metropolitan Life*, the notice-prejudice rule we sustained in *UNUM* and the independent-review provisions we approved in *Rush Prudential* also substantially affect the type of risk pooling arrangements that insurers may offer."

The Court ruled that the laws are saved from ERISA preemption because they are laws regulating the business of insurance. In so doing, the Court set down a new, two-factor test to determine whether a state law is saved from ERISA preemption, replacing the three-factor McCarran-Ferguson test. Under the new rules, the law must be specifically directed toward entities engaged in insurance, and second, the law must substantially affect the risk pooling arrangement between the insurer and insured. The Court said the Kentucky laws satisfied both of these requirements.

Applying these rules cases to the Massachusetts Health Care Reform Act, it immediately becomes clear that the state is well within its rights to require continued coverage of dependents until they reach the age of 26 as well as to former dependents for a prescribed number of years. The law is specifically directed at insurers, HMOs and Blue Cross Blue Shield organizations. In addition, the required increase in the number of covered individuals through the expansion of the covered group to include certain dependants and former dependants would, in all likelihood, be viewed as substantially affecting the risk pooling arrangement between the insurer and the insured.

The nondiscrimination requirements, however, may be a different matter. Under the Act, a group health insurance policy or contract cannot be issued in Massachusetts if the employer contributes a smaller percentage of the insurance premium for one employee than for another employee who receives an equal or greater salary. The claim is that this provision of the law is specifically directed toward entities engaged in insurance so the Massachusetts law would meet this part of the Supreme Court's two-pronged test.

However, it could be argued that the rule, in fact, is not directed at the insurer but rather at the employer. And rather, than directly dictating to the employer the terms of the contributions that must be made to an ERISA-covered group health care plan (which would obviously be preempted by ERISA), it could be argued that the state is simply attempting another end run around ERISA and ERISA preemption by creating a set of circumstances under which an employer, particularly a smaller employer, cannot establish a health care plan for its employees unless it meets these non-discrimination rules In other words, unless an employer has

the size and the means to establish a self funded health care plan for its employees, it will have to follow the dictates of the state and select an insurance or similar contract that would only offer health care coverage if the employer agrees, though its contractual relationship with the insurer, to abide by the state's nondiscrimination rules

The second part of the Supreme Court's test in *Kentucky* which says that, the law must substantially affect the risk pooling arrangement between the insurer and the insured may also be used to challenge the Massachusetts Act. Unlike the facts in question in that case, it is not clear that the Massachusetts Act nondiscrimination rules would effect the risk pooling arrangement for the insurer. It could be argued that the Massachusetts nondiscrimination rules, ostensibly directed at insurers, do not, in fact, have any effect on the risk pooling arrangement. In other words, however, laudable the Massachusetts nondiscrimination rules may be, the do not affect the nature of the employee's coverage, the class of individuals who will be covered under the insurance contract or the service providers who will provide the health care coverage.

Naturally, it could be argued that a greater number of lower paid employees would participate in the employee's plan if they did not have to pay more than the more highly compensated employee. However, it would appear that, in order to defend this portion of the law from preemption, the defense would have to go even further and demonstrate to a court's satisfaction that this proposition would be true not only when comparing high paid to low paid employees, but also when a comparison is made between employees at every level of compensation. The proving such a proposition to a court of law might well be impossible.

Individual's obligations

Stated most simply, ERISA covers only employee benefit plans. As maintained previously, the Massachusetts Health Care Reform Act has mandates and penalties for employers, insurers and individuals. However, it is possible that even the penalties imposed on individuals and seemingly unrelated to employee benefit plans may be seen to rule afoul of the ERISA preemption rules.

To encourage universal health care coverage, The Massachusetts Health Care Reform Act says that all individuals living within the state must have health care coverage provided by their employer or purchased by the individuals. However, this health care coverage must meet certain minim standards. The Connector has the responsibility, among other things, to establish the minimum requirements for health care coverage. Those individuals who do not have health insurance that meets this minimum health care standards established by the Connector can lose their state personal income tax exemption.

While this provision is directed at the individual, it can have, and no doubt is designed to have, serious repercussions on an employer who is providing employee health care coverage to its employees. As noted above, the standards that an employer must meet to avoid the Fair Share and Free Rider penalties are based on whether the employer has a mere 25% of its employees participating in the plan or, failing that test, whether the employer pays 33% of the total cost of coverage.

Any attempt by the state to dictate the type or amount of coverage provided in ERISA-covered employee benefit plan would be quickly and easily preempted. However, it could be argued that, just as with the state law insurance provisions, Massachusetts has attempted yet another end run around ERISA preemption by placing the coverage burden on the individual rather than the insurer. For example, it is possible that under the Act, if an employer offers its employees an employee benefit health plan that does not meet the criteria established by the Connector but meets the percentage tests stated above, its employees would not be protected against the tax penalties by accepting coverage under the employer's plan. Rather, these individuals, even if covered under their employer's plan, would have to seek out additional coverage, their through the Connector or in the open market, to avoid losing their individual state income tax exemption. Needless to say, if an employer did establish a plan that does not meet the minimum standards established by Connector the effect on employee morale would be nothing short of disastrous.

In Retail Industry Leaders Association the court was faced with a similar situation where the state of Maryland did not dictate the amount to be spent on employee health care benefits but, rather gave the employer a choice of meeting the state standard for its health care coverage or simply paying a penalty to the state. In preempting the state law the court noted that "The Maryland General Assembly intended the Act to have precisely this effect. For these reasons, the amount that the Act prescribes for payment to the State is actually a fee or a penalty that gives the employer an irresistible incentive to provide its employees with a greater level of health benefits."

If this ruling holds up in the U.S. Supreme Court, there would be no reason why the "irresistible incentive" to provide Massachusetts employees at least the state specified level of health benefits would be treated any differently and event his provision of the Massachusetts Act, which is purportedly directed at individuals, will also be preempted.

An Alternative Solution?

As has been illustrated the Massachusetts law is a comprehensive law that attempt to provide near universal health care coverage for residents of the state. But practically each mandate under the law is subject to a preemption challenge and if key portions of the law fall to preemption, there will be no opportunity to see if Massachusetts found a solution to the health care coverage problem facing this nation.

But even if the law is doomed by preemption, there may be another solution. The little known Hawaii Prepaid Health Care Act (PHCA), which was conceived of before ERISA, mandates employers to provide prepaid health insurance coverage for employees who work at least 20 hours per weeks. Certain standards were set by the state for the required coverage with an emphasis on preventative care.

However, when ERISA was enacted, it appeared that the PHCA was doomed. The state first tried litigation to preserve the PHCA. However in *Standard Oil Company of California v. Agslaud,* the Court of Appeals for the Ninth Circuit systematically rejected the state's arguments that state mandated plans are exempt from ERISA's coverage that the Hawaii Act is an ERISA exempt disability insurance law, that ERISA is arbitrary and violates the U.S. Constitution Fifth

Amendment right to due process, and that ERISA's preemption language is too broad enough to encompass the Hawaii Act. It ruled that the entire law was preempted by ERISA.

The state then looked to Washington for assistance. In 1982, an amendment to ERISA was enacted specifically saying that the PHCA was exempted from ERISA preemption. Unlike the current situation, other states did not follow the example set by Hawaii and this exception to ERISA preemption has languished in relative obscurity.

However, with the number of uninsured individuals growing each year and any measures in Washington for meaningful health care reform seemingly remain stagnated, perhaps the time has come to allow the states to have a chance to see if they can help solve the problem. ERISA was enacted, in part, to assure the uniform treatment of employee benefit plans throughout the nation. But, as has been noted by Justice Brandeis, if states are given the freedom to act, this may lead to "one of the happy incidents of the federal system [when] a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." The Health Care Reform Act in Massachusetts raises many questions, and it remains to be seen whether this law can meet its goal of increasing health care coverage for the citizens of the state. But it will be impossible to know if this is a viable approach towards casing the health care crisis if critical portions of the law are preempted by ERISA. Perhaps it is time to allow states to experiment with new approaches to health care. But for this experimentation to take place, another legislative exception to the ERISA preemption rules may be required.