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A LITTLER MENDELSON REPORT

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An Analysis of Recent Developments & Trends

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Summary: State and local governments are regulating health care, incrementally adopting elements of President Clinton's failed plan along with other reform proposals to expand access to health insurance. This Insight focuses on what these governments are doing and how their laws affect employer-provided medical benefits.

Introduction

More than 10 years after President Clinton's health care plan failed to win Congressional approval and subsequent federal inaction, state legislatures and municipal governments across the country are stepping forward to regulate health care. One lesson of the failed Clinton plan is that wholesale change is not politically possible, in large part because there is no consensus on whether and how to create universal health care coverage. Governors, state legislatures and local governments have learned this lesson and are, instead, incrementally adopting elements of the Clinton plan along with numerous other reform proposals.

Filling their traditional role as policy laboratories, states and local governments are experimenting with a variety of ways to expand access to health insurance and to control the rapid increase of medical costs. With an estimated 46 million Americans without health insurance, states are implementing programs targeted to the particular segments of the population that are often uninsured or underinsured: the working poor, young adults, the self-employed, employees of small businesses, and part-time or temporary employees. Other more revolutionary approaches to reform, such as a single payer system, have been proposed in some states, but have so far not been adopted.

This Insight focuses on what states and local governments are doing and how their laws affect employer-provided medical benefits. Across the country, employers are increasingly being required to provide expensive medical benefits or pay a penalty if they fail to do so. With this heightened regulatory activity, business advocacy groups and individual employers have the opportunity to shape these new laws, or be shaped by them. In Massachusetts, several business groups were influential participants as the health care reform law was written, and this level of involvement offers a model for how employers in other states can help determine the impact of these new laws on their bottom line.

Nearly Universal Health Coverage: An Achievable Goal?

Three New England states have adopted health care reform plans that should lead to nearly universal health care coverage once they are fully implemented. The plans in Maine, Massachusetts, and Vermont seek to expand coverage within the structure of the existing health care system.

A. Maine: Dirigo Health Care Reform Act

Adopted in 2003, Maine's Dirigo Health Care Reform Act includes three interrelated approaches: (1) a health plan (DirigoChoice) offered by private insurers to small businesses, the self-employed, and uninsured individuals to achieve universal access; (2) new systems to control health care costs; and (3) initiatives to ensure high quality health care statewide.

The state's goal is for all residents to have access to health coverage by 2009. The act has been challenged on several grounds, including constitutionality. A state superior court judge recently upheld the law in its entirety.[1]

[1] *Maine Ass'n. of Health Plans v. State of Maine*, Nos. AP-05-090, 095, 096, **5-7 (Me. Super. Ct., Cumberland County Aug. 4, 2006) (Cole, J.)

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B. Massachusetts: Universal Coverage

The most widely publicized of these laws, Massachusetts's health care plan takes a multi-pronged approach. The law's underlying principle is that the government, employers, and individuals all share responsibility for contributing to the cost of expanded health insurance coverage.

The law includes a first-in-the-nation mandate that every individual have health insurance, if affordable health insurance plans are available. By making insurance coverage mandatory, Massachusetts seeks to ensure that all residents not only have *access* to insurance, but also have insurance *coverage*.

With respect to employers, all but the smallest will pay penalties if they do not offer subsidized insurance to their employees. To help small businesses and individuals obtain insurance, the law establishes a state agency to connect them to affordable health care plans and mandates market reforms to help private insurers develop affordable insurance products. For additional information regarding the Massachusetts health care plan, see Littler's ASAP, *Massachusetts is Poised to Implement Sweeping Health Insurance Legislation*.

C. Vermont: Catamount Health

Vermont's program, Catamount Health, adopted in May 2006, shortly after the Massachusetts plan, will provide affordable, comprehensive coverage for the uninsured. Insurers will be invited, but not required, to offer a standard plan similar to the typical insurance plan, with one notable exception: the plan must allow patients to receive free preventive care (such as mammograms) or recommended services for chronic illnesses (such as eye exams for people with diabetes).

Those without insurance and who are not eligible for adequate coverage through their employer are eligible to purchase Catamount Health, and anyone whose income falls under 300% of the federal poverty level will receive state financial assistance with their premiums.

People who are uninsured, but eligible for insurance through their employers, may receive state financial assistance. If the employer-offered insurance meets coverage standards, the state will help with the employee's share of the premiums and with the employee's deductibles for care related to chronic conditions.

Will Employers Be Required to Pay or Play?

Bills have been proposed in approximately 30 states that require employers either to provide health care coverage for workers or pay into a state fund that covers the costs of the uninsured.

Maryland's Fair Share Act is the most notable example of this approach. If upheld, the law will require employers with 10,000 or more employees in the state to spend 8% of the total wages paid in the state on health insurance costs or pay the state the difference between what it spends for health insurance and the 8% figure. For nonprofit employers, the benchmark is 6%.

However, the United States District Court for the District of Maryland ruled in July 2006 that ERISA preempts the law.[2] The state has appealed to the Fourth Circuit Court of Appeals, which will likely decide the case in 2007.

While similar in their approach, the so-called "pay or play" proposals vary widely in terms of how many employers would be affected in each state. Some bills are limited to retailers while others apply to all employers. Some target employers with as few as 100 employees while others target only large employers of 10,000 or more workers. Most bills require an employer to spend a percentage of payroll for health insurance (generally ranging from 8%-11%) or a flat amount per worker per hour (ranging from $2.50 to $4.17).

Other than Maryland, three jurisdictions have adopted a pay or play law. The California legislature approved a law in 2003 that required employers to provide health insurance or pay a fee to the state, but voters repealed the law in 2004. More recently, the California legislature adopted a new health care law nearly identical to the one in Maryland. However, Governor Schwarzenegger announced he would veto the bill stating that "[s]ocialized medicine is not the solution to [the] state's health care problems." He stated further that the 2006 bill uses the same one-sided approach tried in earlier law - The Health Insurance Act of 2003 - that was repealed in 2004. He said be opposed the bills because they placed nearly the entire burden on employers.

Laws in Suffolk County, New York and New York City target grocery retailers. In Suffolk County, certain grocery stores will be required to pay a penalty if they do not provide health benefits equal to the amount the public spends on providing care to an uninsured worker. New York City approved a pilot program in October 2005 for large grocery stores. The covered stores are required to pay approximately $2.50 to $3.00 for health care for each hour that their employees work. Employers will have flexibility in how they make the contributions and will be fined if they do not comply with the law.

[2] *Retail Indus. Leaders Ass'n v. Fielder*, 435 F. Supp. 2d 481 (D.Md. 2006).

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The Retail Industry Leaders Association, the plaintiff in the lawsuit challenging Maryland's Fair Share Act, has also filed a lawsuit challenging the legality of the Suffolk County law on the grounds of ERISA preemption.

If these laws are upheld, state legislatures will be emboldened, and employers should expect more states to adopt pay or play or similar-type health care coverage laws.

The Naming of Names

With states increasingly worried about the fiscal impact of providing health care to the working poor and uninsured, policymakers want taxpayers to know which employers are not providing insurance to their employees. The intent is to embarrass employers and put public pressure on them to offer health insurance or to make their health insurance more affordable to employees.

Six states have adopted laws that require a public report of the names of employers whose workers are enrolled in the state's Medicaid program or who otherwise receive their health care at the taxpayers' expense. Massachusetts took this approach in 2004. Hawaii and Illinois followed suit in 2005 as did Maine, New Jersey, and Washington in 2006. Similar bills are pending in at least 14 other states.

Targeted Expansion of Insurance Coverage

Some states are taking a cautious approach by expanding eligibility for existing insurance programs rather than creating new programs or mandates. For example, at least 11 states have changed the definition of "dependent" so it includes young adults who have graduated from college, grandchildren being supported by their grandparents, disabled adult children, or full-time students whose studies are interrupted by military service or illness. Numerous other states are considering similar bills.

Some states are allowing high deductible plans if they are paired with Health Savings Accounts (HSAs). HSAs, established by the U.S. Congress in December 2003, are tax-free financial accounts that are designed to help individuals save for future health care expenses. Nearly 30 states have passed HSA-related laws.

Will A Revolution Come?

Advocates and legislators in several states are seeking a more revolutionary approach to changing the health care system. The two leading proposals, the establishment of a constitutional right to adequate and affordable health care and the creation of a single payer system, much like Canada and other countries have enacted, have not been adopted — yet.

A. A Constitutional Right to Health Care

The U.S. Supreme Court has ruled that there is no fundamental right to health care and the federal government is not obligated to provide health care to its citizens.[3] Similarly, state constitutions do not guarantee this right, and, as a result, several states are considering a constitutional amendment establishing a right to health care. To date, these proposed amendments have not been put on the ballot for voter approval.

None of the proposed amendments would require the state to become a health care provider or insurer, nor require any individual physician or other health care provider to offer care. Rather, the state legislatures would be given the responsibility for developing a plan to assure access to needed medical care for all residents of the state.

B. Single Payer System

A more radical approach to health care reform is the establishment of a single payer system in which public and private health care plans are replaced with a single public entity that would oversee the delivery of health care services and the billing and payment for those services. Medical care would continue to be delivered by private physicians and other health care providers while a public fund would negotiate rates and pay providers for all health care bills.

The goal of a single payer system is the elimination of the duplicative administrative and overhead costs caused by a fragmented health care financing system. For example, studies have shown that health insurance companies spend up to 40% of every health care premium dollar on administration and marketing. With a single payer system, this money could be spent on health care instead.

With states taking incremental approaches to health care reform, none have adopted a single payer system.

Will ERISA Preempt These Initiatives?

This patchwork of regulations poses a particular problem for multistate employers that are faced with the challenge of complying with an array of requirements, some of which may ultimately be preempted by ERISA. Employers that decline to comply with state laws regulating health insurance because they believe the laws are invalid under ERISA risk becoming a test case.

The key question is whether these laws intrude on ERISA's comprehensive federal framework for the administration and regulation of employee benefit plans or whether they regulate employers and insurance, not the underlying ERISA plans. In Maryland, the district court judge struck down the state's Fair Share law, concluding that it was preempted by ERISA. The Court found that the Fair Share law interfered with a core

[3] *Harris v. McRae*, 448 U.S. 297, 318 (1980) (holding that medical care is not a fundamental right); *Maher v. Roe*, 432 U.S. 464, 469 (1977) (same).

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purpose of ERISA, *i.e.*, to provide employers with the ability to maintain a national, uniform administration of employee benefit plans and not be subject to different legal obligations from state to state, a core purpose the United States Supreme Court has repeatedly noted in recent ERISA opinions. However, the case could have gone the other way if the judge had concluded that the law simply regulated the amount employers spend for health care, whether through an ERISA plan or otherwise.

Now What?

State legislatures are well aware of ERISA's preemption rules and are drafting their laws to minimize the likelihood of a successful challenge. Employers should closely evaluate each new law and how it affects their employees - some provisions of the law may apply to them and some may not depending on whether the employer's benefit plan is an ERISA plan.

In light of these challenges, one member of the U.S. Senate is proposing a draconian approach that would end states' efforts to expand access to health care. Senator Michael Enzi (R-Wyoming) has proposed a plan to preempt "any and all" state regulation of medical insurance. The bill is unlikely to pass in its current form, but its progress bears watching.

This is bit like walking through a minefield. A cautious, step-by-step approach will allow an employer to assess how, if at all, it should revise its medical benefit plans as states experiment with ways to expand access to and control the costs of health care. This challenge will be especially difficult for companies that have employees in many different states. This is why employers should seriously consider becoming involved early in their respective state's legislative process so that they can have as much influence over the process as possible. If not, employers risk being forced to comply with state-based legislation that may not be as fair as it could have been to their bottom lines.

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