Public Health Law

Office for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention

Selected Issues regarding ERISA, Health Benefit Plans, and State Laws that Address Health System Transformation

This issue brief is a summary of responses to technical assistance requests received by the Public Health Law Program regarding the Employee Retirement Income Security Act of 1974 (ERISA) and its relationship to health benefit plans and state laws that address health system transformation.

ERISA was passed to protect employees by providing minimum standards for employee benefits and granting access to courts to enforce the terms of the employee benefit programs.[1] ERISA was also intended to unify the standards and rules for employee benefit programs in order to encourage employers to offer benefits.[2] While ERISA regulates retirement benefits and pensions, this issue brief addresses only its relationship to health benefit plans and state laws that address health system transformation.[3]

ERISA and Health Benefit Plans

Health benefit plans subject to ERISA's provisions are broadly defined as any fund intended to provide "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment."[4] A health benefit plan is covered by ERISA only if it is "established or maintained by an employer or by an employee organization."[5] Public health insurance programs, which are programs administered by or through public agencies, are not within ERISA's scope because they are not provided or administered by an employer. Additionally, health benefit plans provided by the government as an employer are not subject to ERISA.[6] ERISA does not preclude additional federal regulation of health benefit plans that fall under its scope or federal coverage mandates for the plans.

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[1] *See* Richard Rouco, *Available Remedies Under ERISA Section 502(A)*, 45 ALA. L. REV. 631, 631–32 (1994).
[2] *See N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995) ("The basic thrust of the pre-emption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.").
[3] *See* Christopher J. Frankenfield, *The Relationship Between ERISA, State and Local Health Care Experimentation, and the Passage of National Health Care Reform*, 13 J. HEALTH CARE L. & POL'Y 423, 426 (2010).
[4] 29 U.S.C. § 1002(1) (2012). ERISA does not cover all employee benefits. It specifically excludes, for example, worker's compensation plans when the benefit offered is intended to cover only the employer's duty to provide worker's compensation. 29 U.S.C. § 1003(b)(3) (2012).
[5] 29 U.S.C. § 1002(1) (2012).
[6] 29 U.S.C. § 1003(a)(1) (2012).

ERISA Preemption

When a health benefit plan falls under ERISA's scope (an ERISA plan), the plan may be immune from state regulation. A state law is "preempted" and unenforceable when it is inconsistent with a federal law due to the Supremacy Clause of the Constitution, which states that federal law is enforceable over inconsistent state law.[7] ERISA preempts any state laws "related to" an ERISA plan and may preempt a state law "if it has a connection with or reference to [an ERISA] plan."[8] Further, ERISA preempts state laws that are consistent with the ERISA requirements because ERISA is meant to be the sole comprehensive regulation of employee benefits.[9]

ERISA preemption is limited by an exception permitting states to enforce general insurance, banking, or securities regulation against employee benefit plans.[10] A regulation is considered an insurance regulation if it is "specifically directed towards entities engaged in insurance" and if it "substantially affect[s] the risk pooling arrangement between the insurer and the insured."[11] This test generally allows states to mandate certain procedures or minimum standards for health benefit plans. States do not have the power to enforce laws regulating insurance against self-insured health benefit plans, a subset of ERISA plans where the employer bears the risk of higher costs.[12] This exception provides protection from liability or penalty, known as a safe harbor, from state insurance regulation to encourage self-insurance by corporations.

Lastly, the Supreme Court has held that ERISA's provisions on remedies create a comprehensive set of remedies that preempt any state remedies against an ERISA plan.[13] ERISA gives a right of action to an insuree against an insurer, but generally limits recovery to the value of benefits provided in the plan or a ruling specifying what is actually covered under the plan.[14]

ERISA and Health System Transformation

The relationship between ERISA and state laws that address health system transformation will depend on the specific state initiative. Many new health system transformation models focus on public health insurance and public health programs and may not be affected by ERISA because it applies only to employer-provided benefit programs. Additionally, many state regulations, such as "any willing provider" laws, which require an insurance company to cover any provider who will acquiesce to the insurance's terms, are considered insurance regulations that are not subject to ERISA preemption. However, some ERISA issues have arisen from health system transformation initiatives. One increasingly common conflict between ERISA and state laws is related to the requirement that certain employers

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[7] BLACK'S LAW DICTIONARY (9th ed. 2009); see also U.S. Const. Art. VI, cl. 2.
[8] *See* 29 U.S.C. § 1144(a); see also *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 129 (1992).
[9] *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). The Supreme Court has limited this potentially expansive preemption of state law by noting that courts must presume that ERISA is not intended to supplant police powers unless explicitly stated. *N.Y. State Conference of Blue Cross & Blue Shield Plans*, 514 U.S. at 655.
[10] 29 U.S.C. § 1144(b)(2)(A) (2012).
[11] *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003).
[12] 29 U.S.C. § 1144(b)(2)(B) (2012).
[13] *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53–54 (1987). *See also* 29 U.S.C. § 1132.
[14] *See* 29 U.S.C. § 1132(a)(1)(B) (2012).

either offer health insurance to employees or be subject to a fine or tax.[15] These laws potentially violate ERISA because they often require employers to offer a unique, qualifying benefit program in the state and thus prevent uniform administration of benefit programs in all fifty states.

Courts have interpreted these requirements differently. For example, a 2006 Maryland law required all employers with more than 10,000 employees pay eight percent of their payroll on employee health insurance or pay a penalty to the state fund equal to the difference between eight percent of employee payroll and actual money spent on employee health insurance.[16] The Fourth Circuit Court of Appeals found that the Maryland law violated ERISA because it would require companies to structure benefit plans differently in Maryland than in other states.[17] The state argued that companies could uniformly administer ERISA plans by providing other health benefits to employees or by paying the state. The court rejected this argument because the statute still directly mandated employers to provide certain coverage and the alternative spending would place a large burden on corporations to keep up with differences in state laws on health benefits.[18]

The Ninth Circuit Court of Appeals, however, found that a similar employer mandate in San Francisco did not fall under ERISA preemption. The 2006 Healthy San Francisco program enrolled participants for "a medical home, a primary care provider, and access to specialty care, urgent and emergency care, mental health care, substance abuse services, laboratory, inpatient hospitalization, radiology, and pharmaceuticals."[19] San Francisco funded part of the program by requiring employers with more than twenty employees to pay a fee if they did not provide health insurance to their employees and meet minimum spending requirements.[20] In contrast to the Maryland law, the Ninth Circuit found that the law was designed to provide health care to low-income residents, traditionally a state function.[21] Second, payments to the city to run Healthy San Francisco did not constitute a "plan" provided by an employer, because the employer makes a payment only to a government program that administers the health program rather than running a health program themselves.[22] Third, the Ninth Circuit disagreed with the Fourth Circuit that penalty payments made in lieu of providing ERISA coverage are connected to an ERISA plan because these payments require no administration.[23]

The split between the Ninth Circuit and the Fourth Circuit suggests that courts will distinguish between states that create public health programs while mandating that employers provide an alternate plan or contribute to the program, and states that mandate that employers provide certain coverage or pay a penalty for failing to provide that coverage.

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[15] *See* MD. CODE ANN., LAB. & EMPL. § 8.5-104(b) (West 2013), preempted by 29 U.S.C. § 1144(a) (2012). The Affordable Care Act contains a mandate for large employers to provide health insurance to their employees, but this is not preempted by ERISA because it is federal law. *See* 26 U.S.C. § 4980H (2012).
[16] *Frankenfield*, *supra* note 3 at 435.
[17] *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 191 (4th Cir. 2007).
[18] *Id.* at 194–97.
[19] *Frankenfield*, *supra* note 3 at 441.
[20] *Id.* at 443.
[21] *Golden Gate Rest. Ass'n v. City and County of San Francisco*, 546 F.3d 639, 647–48 (9th Cir. 2008).
[22] *Id.* at 652–53.
[23] *Id.*

Conclusion

This issue brief is summary of potential issues related to ERISA and its relationship to health benefit plans and state laws that address health system transformation. This issue brief is not intended to be a comprehensive discussion of all potential ERISA issues that may arise in health system transformation.

Resources Available

For additional information on this issue, please email phlawprogram@cdc.gov.

This document was developed by Molly R. Berkery, J.D., M.P.H., ORISE Legal Fellow and Dennis O. Vann, Legal Intern with the Public Health Law Program (PHLP) within the Centers for Disease Control and Prevention's Office for State, Tribal, Local and Territorial Support. *PHLP provides technical assistance and public health law resources to advance the use of law as a public health tool. PHLP cannot provide legal advice on any issue and cannot represent any individual or entity in any matter. PHLP recommends seeking the advice of an attorney or other qualified professional with questions regarding the application of law to a specific circumstance.*

This issue brief includes laws enacted through 2013.