Highlight Box: Employee Retirement Income Security Act

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates how private-sector employer-sponsored health and other benefits are administered. ERISA was enacted to allow multistate employers to offer a uniform package of benefits to all their workers, protect employee benefits from loss or abuse, and encourage employers to offer benefits. Among its provisions are rules about benefits and coverage standards, the information employer plans must provide, a fiduciary standard for plan administrators, appeal rights for plan beneficiaries, and access to the courts when a provision of the act is violated.

The ACA attempts to encourage employers to offer health coverage to employees but allows the employer to pay a fee rather than offer coverage. This "pay or play" provision avoids running afoul of ERISA because it allows individual self-insured employers to determine whether and how to offer coverage to employees.[10]

In general, ERISA preempts states' ability to establish laws that apply to self-insured employer coverage, which has limited state-based health reform efforts (Monahan, 2007; Jacobson, 2009; Supreme Court of the United States, 2016; Brown and King, 2016).[11] ERISA does have an exception to this preemption rule, a "savings clause" that preserves state regulatory authority over the business of insurance. Most large employers self-insure their health plans, meaning that they are not technically purchasing health insurance and their plans are, therefore, exempt from state regulation.

Hawaii is the only state with an ERISA exemption, which it received in 1983 in support of the state's Prepaid Health Care Act of 1974 (PHCA). Congress passed this exemption in large part because the PHCA was passed prior to the passage of ERISA and after significant lobbying by Hawaii's congressional delegation. While there is no evidence that this is likely in the near future, it is possible for Congress to enact legislation allowing ERISA waivers that support state health reform experiments.

The boundaries of the ERISA preemption language are vague, meaning that most of the limitations imposed by the law have been identified by court decisions. Prior to the passage of the ACA, some legal experts speculated that Massachusetts' "pay or play" requirement under that state's health reform law would be challenged under ERISA. However, this challenge was

[10] A self-insured (also called a "self-funded") business has chosen to assume the financial risk for providing health coverage to employees. The employer pays for employees' care rather than paying an insurance carrier a monthly per member fee to pay for all care incurred, although employers often hire an insurer to perform the administrative functions associated with health coverage (e.g., managing provider network contracts and conducting utilization review).

[11] This occurred most recently in the Supreme Court ruling in *Gobeille v. Liberty Mutual Insurance Co.* The Court ruled that ERISA preempts Vermont's ability to require self-insured employer plans to report data to the state's All Payer Claims Database. The ruling has been seen as undermining state efforts to evaluate and control rising health care costs (Brown and King, 2016; Jacobson, 2009).

not made, and this provision was implemented successfully. Maryland passed a Fair Share Act, which required any employer with at least 10,000 employees to spend at least 8 percent of its total payroll on employees' health care or health care costs.[12] If this standard was not met, the employer would have to pay the difference between its spending and the 8 percent requirement into the state Medicaid fund. The law was successfully challenged on the basis that it interfered with plan administration by forcing the employer to restructure its plan to offer a state-imposed minimum level of health benefits.[13]

An ordinance in San Francisco requires employers with 20 or more full-time employees (50 or more full-time equivalents for nonprofits) to make minimum health care expenditures for employees. Health care expenditures are either direct contributions to employees, reimbursement for health services, or payment to the city to be used to pay for employee care. When this law was challenged, the court ruled that ERISA did not preempt the ordinance. Rather than forcing employers to spend their health care dollars on a particular set of benefits, the law only required that the money be spent on health care; further, the law applies both to employers subject to ERISA and those that are not.

There have been no ERISA preemption cases regarding a state universal health care system with tax financing, making it difficult to remark on the chances of a legal challenge or its outcome. Employers would likely argue that offering state-funded comprehensive health benefits to residents of Oregon would, in effect, compel them to discontinue their current plans and offer a different benefit package to employees who are residents of the state (Hsiao et al., 2011). However, taxation and health care financing are generally seen as areas of state authority, which could deflect an ERISA preemption challenge. The uncertainty is one reason health reform proponents have encouraged Congress to allow elements of ERISA to be waived by states implementing reforms that expand health insurance access.

Opportunities and Challenges for Each Option

Single Payer

A Single Payer option in Oregon would most likely raise an ERISA challenge from large, self-insured employers, and seeking an exemption of ERISA for Single Payer would require federal legislation. Without such an exemption, large employers and those that self-insure could argue that a payroll tax–financed single-payer program would place pressure on employers to drop coverage or effectively pay twice by providing coverage and paying a tax. The size of the tax is part of the argument. Massachusetts implemented an employer pay-or-play requirement, but with a "pay" requirement that was modest enough ($295 per employee) to allow employers offering ERISA plans to continue to decide whether or not to offer coverage. Maryland, in

[12] The law only affected one employer, Walmart.

[13] A similar law in Suffolk County, New York, was struck down on the same grounds.

contrast, enacted a much more stringent pay-or-play requirement for very large firms, which was challenged under ERISA and struck down (Monahan, 2007). Another potential issue is that a requirement for employers to pass on to employees some of the savings associated with no longer providing employee health coverage (via higher wages) could be challenged as forcing employers' hands.

The counterargument to a challenge is that ERISA does not preempt the state's traditional authority over taxation and health care financing. If the impact on employer plans is seen as indirect, ERISA would not be grounds for a challenge. As the details of ERISA have mostly been defined through court decisions, there is a relative lack of clarity in this area because, to date, there have not been any cases focused on a state tax-financed universal health system.

Health Care Ingenuity Plan

As with Single Payer, HCIP would, in effect, compel all employers to give up or significantly modify their current health benefits, which would likely be the basis for a challenge by multi-state employers.

Public Option

ERISA does not affect the Public Option, which only affects the nongroup and small-group fully insured markets.

State Law and Regulations

Regulation of Health Insurance in Oregon

Oregon's health insurance market is broken out into individual market coverage, small-group coverage, large-group coverage, and coverage for associations and trusts. These differences are important not only because individuals and small group plans currently are subject to more oversight than are large groups, self-insured plans, and associations, but also because the groups are rated for risk separately. Table 6.4 provides an overview of coverage offered through different types of commercial insurance in Oregon.