



AMERICAN BENEFITS COUNCIL

EMPLOYER "PAY OR PLAY" REQUIREMENTS KEY STATE AND LOCAL HEALTH CARE REFORM INITIATIVES APRIL 2008

More than 132 million Americans have health benefits voluntarily provided by their employers under the federal framework established by the Employee Retirement Income Security Act of 1974 (ERISA). A core element of the federal policy embodied by the ERISA framework is that it encourages employers to provide health benefits coverage by allowing them to maintain uniform benefits on a nationwide basis. While ERISA permits states to regulate insurance, it preempts state or local laws that would regulate employer benefit plans.

The ability to uniformly cover employees and retirees – who often live and work in different states across the country -- is vital to employers' sponsorship of affordable health and retirement benefits. Requiring employers to modify their health benefit plans to comply with 50 state laws and potentially a much larger number of city or county laws vastly increases the complexity and administrative burden of providing benefits. State or local regulation substantially increases costs for employers and employees and significantly limits employers' ability to design benefit plans that meet the specific needs of their workforce.

Health care initiatives that require employers to "pay or play", by either paying an assessment to the state (or local government) or contributing to employee health coverage have been enacted or are under consideration in states, counties and cities. "Pay or play" and other similar mandates threaten employers' ability to uniformly administer their health benefit plans. The chart below compares key enacted and proposed state and local health care initiatives, the requirements they impose on employers and any legal challenges on ERISA preemption grounds.

Enacted Legislation - No ERISA Challenge

	General Description	Contribution and Benefits	Notice and Reporting	Penalties	Status / Comments
<p>Massachusetts</p> <p>Chapter 58-Massachusetts Health Care Reform Law</p>	<ul style="list-style-type: none"> • Generally applies to employers with 11 or more employees who are employed in Massachusetts. • Employer pay or play mandate. • Requires Section 125 cafeteria plan for all employees regardless of group health plan eligibility. • Individual mandate. • Connector program. • State health insurance purchasing pool. • Subsidies for low income. • Expands federal programs. • Insurance market reform. 	<p><u>Employer Fair Share Contribution Requirement</u></p> <p>Employer must satisfy either of two tests to show employer premiums are “fair and reasonable:”</p> <p>(1) at least 25% participation by full-time employees (35 + hours per week) in the employer's group health plan (participation test), or</p> <p>(2) the employer offers to contribute at least 33% of the premium cost of its health plan for all full-time employees employed for at least 90 days (contribution test).</p> <p>Failure to satisfy either of these tests results in an employer obligation to make a \$295 Fair Share Contribution per employee to the Commonwealth. (See Penalties).</p>	<p><u>Employers must file annual Fair Share Contribution</u> report with the number of full-time employees with health coverage, number of uninsured full-time employees, total hours worked by full-time employees and confirmation of a compliant cafeteria plan.</p> <p><u>Employer must file an annual Employer Health Insurance Responsibility Disclosure (HIRD) Form</u> with the Fair Share Contribution filing.</p> <p><u>Employer must collect and retain an Employee HIRD form from Massachusetts employees</u> who decline coverage under the employer’s health plan or Section 125 plan.</p> <p><u>Employer is required to provide a certificate of coverage form (1099-HC)</u> to employees by January 31 of each year, notifying them whether employer</p>	<p><u>Fair Share Contribution of \$295</u> If an employer does not make the required “fair share” premium contribution as required by law, it must pay \$295 to the Commonwealth per uninsured full time equivalent.</p> <p><u>Free Rider Surcharge</u> An employer may be subject to the Free Rider Surcharge if it did not offer a compliant Section 125 plan and its employees or their dependents received health care services costing at least \$50K and were paid with state uncompensated care funds.</p> <p><u>\$1,000 - 5,000 penalty for failure to file HIRD form.</u></p>	<p>Enacted April 12, 2006.</p> <p>Effective July 1, 2007.</p> <p><u>ERISA Issues</u></p> <p>Since the employer requirements mandated by the Massachusetts Health Care Reform law have not yet been challenged in court, it is difficult to predict with certainty whether they would survive an ERISA preemption challenge.</p> <p>Some commentators have opined, however, that the Massachusetts “pay or play” health care reform law includes provisions which contravene ERISA’s purpose and would likely be preempted by federal law because they “relate to” the benefit plan activities of an employer. These include mandates for:</p> <ul style="list-style-type: none"> • the provision of a group health plan; • a minimum employer contribution or a payment to the state; • the establishment of a Section 125 plan for all employees to make pretax

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		<p><u>Section 125 Plan Requirement</u> Employer must establish and maintain a Section 125 plan that allows employees (who work at least 64 hours per month (or 16 hours per week) to pay for health insurance coverage on a pre-tax basis. A “premium only” Section 125 plan is the minimum plan allowed under the Massachusetts law. (See Comments).</p> <p>Employers must allow their employees access to Commonwealth Choice (individual) coverage through their Section 125 plan on a voluntary basis. Commonwealth Choice offers a range of private plan options at varying levels of premiums, deductions and co-payments, including low premium, limited</p>	<p>coverage is creditable. The 1099-HC must be filed with the Department of Revenue annually, listing employees with creditable coverage.</p>		<p>contributions to a group health plan. (For further discussion, see <i>Hiding in Plain View: ERISA Preempts Provisions of Massachusetts ‘Play or Pay’ Health Care Reform Law</i>, William G. Schiffbauer, Esq., BNA’s Health Care Policy Report, September 18, 2006).</p> <p><u>State Mandates – “Cafeteria” Section 125 Plans</u></p> <p>A Section 125 cafeteria plan is a program offered by an employer that satisfies Section 125 of federal tax law that allows employees to pay health insurance premiums (premium conversion plans) and other qualified health expenses (flexible spending accounts) on a pre-tax basis.</p> <p>Although many employers, (particularly large, multi-state employers) voluntarily offer Section 125 cafeteria plans to their employees, Massachusetts is the first state to require that employers adopt a cafeteria plan.</p> <p>Other states that have enacted</p>

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		<p>benefit "Young Adult Plan" for 18-26 year olds.</p> <p>Failure to satisfy the state Section 125 plan requirement may subject an employer to the Free Rider Surcharge. (See Penalties).</p> <p><u>Benefit Requirements</u> Although employers are not required to offer specific health benefits, individuals are subject to a penalty if they do not have "minimum creditable coverage." In 2008, any legally sold health insurance coverage satisfies the standard. In 2009, a range of requirements for <u>"minimum creditable coverage"</u> go into effect regarding types of benefits and the use of deductibles, out of pocket maximums or treatment limitations.</p>			<p>Section 125 mandates include Rhode Island (Public Law 2007-125), Missouri (House Bill 818) and Connecticut (Public Act No. 07-185).</p> <p>State laws requiring Section 125 plans impose varying requirements regarding employee eligibility and whether employers must allow employees to purchase individual insurance policies. As a result, they create complex compliance obligations under state and federal law for multi-state employers.</p> <p><u>Impact of 2009 Benefit Mandate</u></p> <p>In 2009, individuals must have coverage that satisfies state minimum standards or lose their individual tax exemption and be subject to monetary penalties. Employers who offer coverage that does not satisfy the 2009 minimum standards risk the possibility of not having sufficient employee participation to satisfy the employer mandate.</p> <p><u>HSAs and "Minimum Creditable Coverage"</u></p>

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					Health savings accounts (HSAs) and the qualified high deductible health plans used with them will satisfy the state's standards for "minimum creditable coverage."
<p>Vermont</p> <p>Catamount Health</p>	<ul style="list-style-type: none"> • Generally applies to all employers with nine or more employees in 2008. • Employer play or pay mandate. • State health insurance purchasing pool. • Premium subsidies for low income. 	<p><u>Employer Health Care Contribution Fund</u></p> <p>Employers are required to calculate and report "Health Care Contributions" to the state.</p> <p>If the employer has 8 or fewer employees, no calculations will be required through June 30, 2008. The exemption drops to 6 employees on July 1, 2008, and to 4 employees on July 1, 2009.</p> <p>If the employer has more than the number of exempted employees, it must calculate and pay a Health Care Contribution to the state based on the number of "uncovered" full-time equivalents (FTE) using the following guidelines:</p> <p>+ Employers who do not offer a plan that pays some "portion" (not defined) of the cost of health care coverage (see Benefit Requirement below) of their workers must pay the health care contribution on <u>all</u> of their</p>	<p><u>Recordkeeping</u></p> <p>Calculation of health care contributions and record retention is required when employer employs more than the exempt FTEs.</p> <p><u>C- 101 Quarterly Reporting of insured employees.</u></p> <p>Employers must report the number of "uncovered" FTEs and the health care contributions due, even when they are zero.</p> <p><u>Health Care Contribution Calculations</u></p> <p>Employers are required to make available upon request the Health Care Contribution worksheet (or equivalent) used to calculate the employer Health Care Contribution.</p>	<p><u>Penalty</u></p> <p>Employer Health Care Premium Contribution equal to one dollar per day per total number of "full-time equivalents" to whom the employer does not offer health insurance.</p>	<p>Enacted May 2006.</p> <p>Final regulations for the Employer Health Care Contribution Fund became effective January 2007.</p> <p>The employer requirements of Catamount Health raises ERISA preemption concerns given the administrative burden imposed by the employer recordkeeping and reporting requirements on multi-state employers with employees in Vermont.</p> <p>Catamount Health's employer requirements have not been challenged in court, however, making it difficult to predict with certainty whether they would survive an ERISA preemption challenge.</p>

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		<p>employees.</p> <p>+ Employers who offer health coverage must pay for workers who are ineligible for the plan or workers who refuse the employer's coverage and do not have coverage from another source.</p> <p>The Health Care Contribution is equal to \$91.25 per quarter for each uncovered FTE in excess of the exemption (i.e., \$365 per year per uninsured full-time worker). (See above for exemptions for 2008 and 2009).</p> <p>Employers may not be required to report or make Contributions for seasonal or part time employees if those employees have coverage from a source other than Medicaid or the publicly funded Vermont Health Access Plan and the employer offers insurance to all its full time employees.</p> <p><u>Benefit Requirements</u></p> <p>"Employer coverage" must include hospital and physician services.</p>	<p><u>Declaration of Coverage</u> for employees who decline coverage must be renewed annually and retained in the employer's files for three years.</p>		<p><u>HSAs as "Employer Coverage"</u></p> <p>In order for an employer to offer a health savings account (HSA) as qualifying "employer coverage", the employer must offer the qualified high deductible health plan <u>and</u> contribute to the HSA.</p>

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<p>San Francisco</p> <p>San Francisco Health Care Security Ordinance (HCSO)</p>	<ul style="list-style-type: none"> Generally applies to employers who engage in business within San Francisco and who employ 20 or more employees and non-profit employers with 50 or more employees. Employer pay or pay mandate. Establishes the Health Access Program (HAP), “Healthy San Francisco” administered by the San Francisco Department of Public Health. 	<p><u>Minimum Employer Health Care Expenditures</u></p> <p>Covered employers must make quarterly minimum health expenditures for all employees employed at least 90 days and performing at least 10 or more hours per week within San Francisco. Capped at 172 hours paid per month.</p> <p>Certain employees are exempt from the spending requirement, including Managers earning more than \$76,851 in 2008, employees covered by TRICARE / Champus or Medicare and those who sign a Voluntary Waiver Form (See reporting requirement).</p> <p>The minimum employer health care expenditure is based on a per hour rate:</p> <ul style="list-style-type: none"> Large employer (100+) \$1.76/hr Medium employer (20-99) \$1.17/hr <p>The per hour employer expenditure rate increases to \$1.85/hour (100+ employees)</p>	<p><u>Employers must maintain records</u> of hours and health expenditures as required by the HCSO, including calculations of health care expenditures for each covered employee and documentation that such expenditures were made for each quarter of each year.</p> <p><u>Employers must allow the Office of Labor Standards Enforcement (OLSE) “reasonable access”</u> to records and cooperate with OLSE investigations and audits.</p> <p><u>Employers must file a Mandatory Annual Reporting Form</u> identifying per quarter the average number of employees per week, total number of covered employees, employees subject to exemption categories, total number of hours paid to all covered employees, total amount of health care</p>	<p>Penalty of 150% of amount owed for failure to make contribution.</p> <p>Revocation or suspension of business licenses.</p>	<p>Enacted July 2006.</p> <p>Effective date for the “employer spending requirement” is:</p> <ul style="list-style-type: none"> January 9, 2008 for all employers with 50 or more employees. April 9, 2008 for for-profit employers with 20-49 employees. <p><i>ERISA Preemption Litigation</i></p> <p><u>The HCSO’s employer spending requirement is preempted by ERISA</u> according to a federal district court ruling in <i>Golden Gate Restaurant Association v. City and County of San Francisco</i> (U.S. District Court for the Northern District of California, 12/26/07). The district court relied on the 4th Circuit decision in <i>RILA v. Fielder</i> in concluding that the HCSO spending requirements had an impermissible connection with ERISA plans by mandating employee health benefit structures and administration and interfering with employer autonomy over whether and how to provide employee health coverage.</p>

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		<p>and \$1.23 (20-99 employees) on January 1, 2009.</p> <p>A covered employer must perform certain required calculations for <u>each</u> of its covered employees to determine whether its health care expenditures meet or exceed the HCSO required minimums. The HCSO contains two exceptions to this requirement which allow calculation of an average hourly expenditure rate by:</p> <ul style="list-style-type: none"> • Covered Employers that provide <u>uniform coverage</u> (permits aggregation of expenditures for employees with the same type of coverage, for example HMO or PPO coverage), and • Covered employers with self-funded plans. <p><u>Benefit Requirements</u></p> <p>The HCSO provides a non-exclusive list of qualifying health care expenditures that can satisfy the minimum</p>	<p>expenditures made for all covered employees and total number of employees for each expenditure option.</p> <p><u>Employers must provide a Notice to employees of employer payment to city.</u></p> <p><u>Employers must retain Employee Voluntary Waiver Forms</u> verifying that an employee is receiving health care coverage from another employer (either as an employee, or through their spouse or domestic partner’s policy) <u>and</u> that s/he “voluntarily” waives the right to have her current employer make a health care expenditure for her benefit. Employees who sign waiver forms are exempt employees for the purposes of the HCSO.</p>		<p><u>An emergency stay of the lower court ruling</u> by a three-judge panel of the 9th Circuit allowed the employer spending requirement to go into effect. In granting the stay, the panel indicated that it believed the district court decision was flawed and the City had a strong likelihood of prevailing in its appeal on the merits. The panel reasoned that the HCSO, by providing a city payment option, did not require an employer to modify an ERISA-covered employer benefit plan. (U.S. Court of Appeals for the Ninth Circuit, 01/09/08).</p> <p><u>An emergency appeal</u> by Golden Gate Restaurant Association seeking a temporary stay of the HCSO was rejected by U.S. Supreme Court Justice Anthony M. Kennedy on February 21, 2008.</p> <p><u>Oral arguments in the City’s appeal to the 9th Circuit</u> were heard on April 17, 2008.</p> <p>The American Benefits Council submitted an <i>amicus curiae</i> (friend of the court) brief in support of the Golden Gate Restaurant Association. The</p>

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		<p>employer spending requirement, including:</p> <ul style="list-style-type: none"> + Direct reimbursement to employees for certain health care expenses; + Contributions to health savings accounts; + Payment to third parties for provision of health care services; + Costs incurred for the direct delivery of health care services; + Payments to the City for the purpose of being used on behalf of covered employees. <p>Employer payments to the City provide funding for HAP/ "Healthy San Francisco" and may also be used by the City to establish and maintain medical reimbursement accounts (MRAs) for the benefit of covered employees who are not residents of San Francisco or are otherwise ineligible for the "Healthy San Francisco" program.</p>			<p>amicus brief describes how the HCSO spending requirements interfere with the uniform administration of multi-state or national employee health benefit plans and force employers to make certain choices, exactly the sort of state or regulation ERISA was intended to preempt. The brief also underscores the serious policy concerns posed by this case – if the HCSO is allowed to stand, it will become a roadmap for use by other local and state jurisdictions in crafting similar legislation.</p> <p>The <u>U.S. Department of Labor</u> and several other employer organizations also submitted amicus briefs in support of Golden Gate Restaurant Association and the district court decision preempting the HCSO spending requirements.</p>

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<p>Maryland Fair Share Act</p>	<ul style="list-style-type: none"> Employer play or pay mandate. 	<p>Employers with more than 10,000 employees in Maryland must offer and contribute 8% of total payroll to health coverage or pay penalty to state.</p> <p>Applied to both full and part-time employees.</p>	<p>Required covered employers to make annual reports concerning number of employees in the state, health insurance expenditures and percentage of compensation spent on health insurance costs.</p>	<p>Pay shortfall below 8% of payroll to State.</p> <p>\$250 per day for failure to file report.</p> <p>\$250,000 for failure to pay penalty.</p>	<p>Enacted January 2006.</p> <p><u>The Maryland Fair Share Act is preempted by ERISA</u> according to a federal appeals court decision in <i>Retail Industry Leaders Association (RILA) v. Fielder</i> affirming a lower court ruling. (U.S. Court of Appeals for the Fourth Circuit, 01/17/07).</p> <p>The 4th Circuit reasoned that the Maryland law directly impacted plan design and contravened ERISA’s purpose of preserving plan uniformity.</p> <p>The State of Maryland did not seek an appeal to the U.S. Supreme Court.</p>
<p>Suffolk County New York Fair Share for Health Care Act</p>	<ul style="list-style-type: none"> Generally applied to large retailers selling groceries. Employer play or pay mandate. 	<p>Large retail employers selling groceries required to spend \$3 per employee per hour worked on health care expenditures.</p> <p>Includes full-time, part-time and seasonal employees.</p>	<p>Required employer reporting of certain payroll and health spending information to the Suffolk County Department of Labor.</p>	<p>Pay shortfall below amount owed to the State.</p> <p>Additional civil penalties.</p>	<p>Enacted September 2005.</p> <p><u>Suffolk County Fair Share Act is preempted by ERISA</u> according to federal district court ruling in <i>RILA v. Suffolk County</i>. (U.S. District Court for Eastern District of New York, 07/14/07).</p> <p>The district court relied on the 4th Circuit ruling in <i>RILA v. Fielder</i> in concluding that the Suffolk County Act had an impermissible connection with employee benefit plans.</p> <p>Suffolk County did not seek an appeal by the district court or the U.S. Court of Appeals for the Second Circuit.</p>

Proposed Legislation

	General Description	Contribution and Benefits	Notice and Reporting	Penalties	Status / Comments
<p>California</p> <p>ABX1 1 compromise proposal</p>	<ul style="list-style-type: none"> • Employer play or pay mandate. • Individual mandate. • State insurance purchasing pool. • Subsidies for low income. • Expands federal programs. • Insurance market reform. 	<p>Employer must offer and contribute 1-6.5% (sliding scale based on employer size) of Social Security payroll for health care for full and part-time employees or pay equivalent amount to state.</p>	<p>Unspecified. Employer reporting requirements would likely be determined through regulatory process.</p>	<p>Employers pay the shortfall below 2- 6.5 % of Social Security wages to state.</p>	<p>The state Senate failed to approve the proposal. Further consideration this year is unlikely.</p> <p>The pending 9th Circuit appeal of <i>Golden Gate v. City and County of San Francisco</i> (see above) is likely to affect current or future reform proposals in California and whether or how they utilize “pay or play” or other employer mandates.</p>
<p>Pennsylvania</p> <p>“Prescription for Pennsylvania”</p>	<ul style="list-style-type: none"> • Employer play or pay. • Individual mandate on university students. • State insurance purchasing pool. • Subsidies for low income. • Expands federal programs. • Insurance market reform. • All children eligible for state coverage on sliding scale. 	<p>Employer tax of 3% of payroll (3.5% after 2011) for failure to offer qualifying healthcare (also applies to churches & government employers).</p> <p>Equivalent tax credited back if employer offers "qualifying health coverage" to all employees working 90+ days and 30+ hrs/ week.</p> <p>Qualifying coverage determined by Departments of Labor and Industry and Insurance based on level of participation and out-of-pocket cost to employee.</p> <p>Coverage for dependents to age 30 for insured plans.</p>	<p>Employers are required to make a quarterly filing with the Pennsylvania Department of Labor and Industry.</p>	<p>Enforcement similar to enforcement under unemployment compensation law.</p>	<p>Reform proposal is pending consideration by the legislature.</p> <p>In December 2007, Governor Edward G. Rendell proposed a new funding option for the Cover All Pennsylvanians health care initiative (the part of “Prescription for Pennsylvania that provides health insurance for the uninsured). This new funding option would replace the originally proposed employer “fair share” assessment with new and increased tobacco taxes as well as a surplus from a state Health Care Retention Account which provides abatements for medical malpractice premiums.</p>