MEMORANDUM

To:	Oregon Joint Task Force on Universal Health Care
From:	Elizabeth Y. McCuskey & Erin C. Fuse Brown
CC:	Oliver Droppers Daniel Dietz
Date:	July 25, 2022
Re:	Analysis of ERISA Preemption Issues for Universal Health Plan Proposal (June 2022) – Oregon Services PO Numbers 174361 & 174397

This memorandum analyzes the Oregon Joint Task Force on Universal Health Care's (the "Task Force") June 2022 Universal Health Plan Proposal (the "Proposal") in light of potential preemption by the federal Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1144(a). Pursuant to the Statement of Work for the PO Numbers referenced above, this memorandum covers revenue mechanism design options, while focusing on ERISA preemption analysis for the design choices reflected in the Proposal.

In addition to the materials discussed during our live presentations to the Task Force on January 6, 2021 and February 4, 2022, the Task Force has provided us with the following documents:

- Universal Health Plan Proposal – June 2022
- Universal Health Plan – Questions and Answers
- Summary of Policy Decisions
- Task Force Meeting Slides – May 19, 2022.

The analysis in this memo proceeds as follows:

SUMMARY

To finance and maintain universal health plans, states must grapple with the existence of employer-sponsored insurance and ERISA's broad preemption of state regulation that "relates to" employer-sponsored benefits. The Proposal's funding mechanism of a payroll tax on employers, keyed to wages, is likely to avoid the kind of connection to employers' benefit choices that would trigger ERISA preemption. The Proposal preserves employers' ability to offer benefits outside the Universal Health Plan, which further severs the Proposal from any preempted "relation to" employers' benefit decisions.

ERISA PREEMPTION ISSUES & DESIGN OPTIONS FOR STATE SINGLE-PAYER PLANS

The Task Force's goal of designing a publicly-funded universal health plan for all Oregon residents requires consideration of mechanisms to consolidate the existing sources of health care funding into one publicly-funded program. The major source of private health care coverage is employer-sponsored health benefits, which currently cover nearly half of the people in Oregon.[1]

Employer-sponsored benefits are largely governed by federal law through the Employee Retirement Security Act of 1974 (ERISA).[2] ERISA supplies some rules that private employer-sponsored plans must follow, but ERISA does not apply to governmental employers or churches as employers.[3] Most notably, however, ERISA preempts state regulation that "relates to" private employer-sponsored benefits.[4] The Supreme Court has held that state laws impermissibly "relate to" employee benefit plans by making "reference to" those plans,[5] when they "act immediately and exclusively upon ERISA plans," or make "the existence of ERISA plans essential to the law's operation."[6] State laws also may "relate to" ERISA plans by having too strong a "connection with" them, such as when a state law "governs a central matter of plan administration," "interferes with nationally uniform plan administration,"[7] or indirectly "force[s] an [employer] plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers."[8] ERISA does, however, allow states to regulate insurance carriers that may sell plans to employers. But the preemption provision has been held to prohibit states from applying their insurance regulations to "self-funded" plans in which the employer assumes the financial risk of providing health benefits and typically uses a third-party contractor to administer the benefits.[9]

ERISA preemption is complex and opaque. A state seeking to consolidate employers' health care spending into a publicly-financed plan must therefore design the plan to avoid the preempted "relation to" employer-sponsored benefits. The Supreme Court recently offered some welcome clarity, holding that a state law with indirect economic effects on employer plans did not have a "connection with" those plans that would trigger ERISA preemption.[10] The Court reinforced that "ERISA does not pre-empt state [] regulations that merely increase costs or alter incentives for [employer] plans without forcing plans to adopt any particular scheme of substantive coverage."[11]

While a state-law mandate that employers provide certain benefits or cease providing benefits would almost certainly be preempted because it directly interferes in employers' benefit decisions, there are many other design options that do not directly interfere.

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[1] Oregon Health Authority, Health Insurance Coverage in Oregon, *Types of Health Insurance Coverage* (Jan. 2022) (survey data from 2021 show 47.2% of people covered by group plans, down from 49.3% before the COVID-19 pandemic).

[2] 29 U.S.C. § 1001 *et seq*.

[3] *See* 29 U.S.C. § 1002.

[4] 29 U.S.C. § 1141(a).

[5] New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995).

[6] Cal. Div. of Labor Standards Enf't v. Dillingham Contr., N.A., Inc., 519 U.S. 316, 325 (1997).

[7] Egelhoff v. Egelhoff, 532 U.S. 141, 148 (2001).

[8] *Travelers*, 514 U.S. at 668. *See* Shaw v. Delta Air Lines, 463 U.S. 85, 97–100 (1983) (laws effectively requiring employers to "pay employees specific benefits" are preempted).

[9] Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985); FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990).

[10] Rutledge v. Pharmaceutical Care Management Ass'n, 141 S.Ct. 474 (Dec. 2020).

[11] *Id.*

Primarily, those options include payroll taxes, provider restrictions, and assignment or secondary-payer provisions.[12]

States have wide latitude to levy taxes. In Oregon's Proposal, a combination of payroll and income taxes does most of the work of capturing employer expenditures, individual health spending, and providing incentives for both employers and employees to drop their employer-based coverage in favor of single-payer coverage. The payroll taxes are calculated as a percentage of wages, and therefore do not reference an employer's health benefit plan. Nor do they require employers to alter their employee benefit plans – they merely encourage a shift to the state's health plan. With a payroll tax, the employer is not forced to drop its coverage, and it does not have to change anything about the way it structures or administers its plan.

The Ninth Circuit Court of Appeals, which covers Oregon, has particularly strong precedent upholding states' ability to enforce payroll taxes to fund public health care programs. Ordinances passed by the cities of San Francisco and Seattle required employers to contribute to public programs that would cover their employees if the employers did not offer their own coverage. The Ninth Circuit held that these so-called "pay-or-play" laws created economic incentives for employers, but not to the point that they would effectively force the employer to start or stop offering particular benefits.[13] While these ordinances calculated the taxes on employers in part based on the employers' benefit choices, the Ninth Circuit held that the establishment of a public-program alternative preserved the employers' benefit choices enough to avoid preemption.[14]

The Supreme Court has upheld states' abilities to regulate medical providers, despite the indirect impact that those provider regulations might have on employer-sponsored health plans' costs and incentives.[15] That leaves states with the design option of using provider restrictions to move networks and covered employees into the publicly-funded system. A provider restriction tells providers that if they participate in the single-payer plan, they can only bill the single-payer plan at single-payer rates. They cannot bill the patient or other payers, which also eases the administrative burden on providers from negotiating with and billing multiple payers. A provider restriction creates additional incentives for employees to drop their employer-plans because it could shrink the network of participating providers in employer-based plans.

Similarly, a state could make its public plan the secondary payer and seek reimbursement from existing employer plans as primary payers, meaning they have the primary obligation to pay for covered services. These pay-and-recoup provisions enable those employers who wish to continue providing benefits to do so and allows the single-payer plan to capture some of that spending. If a patient covered by the public plan also has employer coverage, the public plan can pay providers for services and then seek reimbursement from the employer plan as a collateral source of coverage, such as an employer-based plan. Combining this sort of secondary-payer provision with a provider restriction may help states survive ERISA challenge because the combination gives the employer plan a more

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[12] For an extended analysis of these options, consider Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. Pa. L. Rev. 389 (2020).

[13] *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 546 F.3d 639, 642 (9th Cir. 2008); *ERISA Indus. Comm. v. City of Seattle*, 840 Fed. Appx. 248 (9th Cir. 2021).

[14] The preemption status of such pay-or-play provisions has not been settled at the Supreme Court level. The plaintiffs in the Seattle case have petitioned the Supreme Court to review the Ninth Circuit's decision but as of the date of this memo, the Court has not decided whether to hear the case. And the Fourth Circuit has held that a differently-designed pay-or-play tax in Maryland was preempted.

[15] *See Rutledge* and *Travelers*.

plausible way to continue to exist. If the provider cannot bill the employer plan, then the single payer will pay for the care, then turn around and seek reimbursement from the employer plan for an enrollee with dual coverage.

Our analysis is that each of those design options could survive ERISA preemption, though some are trickier than others. In the end, there are good arguments for why each of these provisions would survive an ERISA preemption challenge. However, ERISA cases are nothing if not unpredictable and inconsistent, so the result in any particular court is not guaranteed.

ERISA Preemption Issues in Universal Health Plan Proposal Provisions

Payroll Tax

The two most important ERISA preemption issues for payroll taxes are whether they are based on the private employers' benefits decisions, and whether the tax rate would be considered so "exorbitant" that it would in effect force the employer to make a particular choice about its benefits. The Proposal's plan to impose a payroll tax on employers to contribute to funding the Universal Health Plan seems to avoid both issues. By making the payroll tax progressively based on employee wages,[16] the Proposal's tax does not directly reference employers' benefit plans or make the tax contingent on them.

While there is no set threshold for when a tax becomes "exorbitant" for ERISA preemption purposes, the Supreme Court found that a 24% surcharge on commercial insurance claims to hospitals was not exorbitant.[17] The Ninth Circuit upheld a Seattle ordinance that required employers make a monthly expenditure of $420 per employee for health care,[18] and upheld a San Francisco ordinance that required employers contribute $1.17 to $1.76 per hour worked to cover employees' health care.[19] While the Supreme Court has left open the possibility that higher taxes could cross the threshold of "exorbitant," its most recent opinion in *Rutledge* suggests that the threshold would remain high and that the Court views such provisions with "indirect economic effects" on employer decisions as mostly not within the scope of preemption.

As of May 2022, the Task Force has considered marginal rates for the payroll tax of 7.25% for wages ≤$160K and 10.5% for wages above $160K.[20] Though payroll taxes may affect an employer's decision whether to offer its own supplementary health plan or change the financial incentives, the payroll taxes at this level do not force the employer's choice of substantive coverage or plan design. The existence of the Universal Health Plan as a meaningful alternative to employers offering their own private plans also weakens the ERISA preemption argument. The proposal would not require employers to spend any funds on health benefit plans at all, let alone dictate their covered benefits, funding levels, or plan administration.

The payroll tax will create some disuniformity for multi-state employers, but this is even less of a concern after *Rutledge*, which said, "Crucially, not every state law that affects an

[16] Proposal at page 4.

[17] *Travelers*, 514 U.S. 645.

[18] *ERISA Indus. Comm. v. City of Seattle*, 2020 WL 2307481, at *1 (W.D. Wash. May 8, 2020), *aff'd*, 840 F. App'x 248 (9th Cir. 2021).

[19] *Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 546 F.3d 639, 644 (9th Cir. 2008).

[20] Task Force Meeting Slides – May 19, 2022.

ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. That is especially so if a law merely affects costs."[21]

Thus a payroll tax can be imposed on a mandatory basis, as long as it is not at a rate high enough to force employers to drop or add coverage, and as long as it is not too directly based on the employers' benefits decisions. The household contribution to Plan funding via an income tax payment would not implicate ERISA preemption because it acts entirely on individuals, rather than employers or their insurers.[22] We understand the Proposal to apply the payroll tax to all employers, without exception.

Task force members have requested additional clarification about three aspects of the payroll tax and ERISA.

- First, on whether the payroll tax is employer-facing, employee-facing, or split between them—from an ERISA standpoint, it does not matter what share of the payroll tax is paid by the employer or employee, so long as the payroll tax does not reference or depend on the existence or amount of the employer's health benefit plan spending or cross the undefined threshold of exorbitance, discussed above. Nevertheless, the employee-share of a payroll tax, like a household income tax, would be subject to the federal cap on the deductibility of state and local taxes, which is beyond the scope of this project.
- Second, self-funded employer plans can be subject to the payroll tax to the same extent as fully insured employer plans. The ERISA analysis is the same for both types of plans.
- Third, *where* the payroll tax revenue is deposited (in a general fund vs. special fund for the universal health plan) does not meaningfully alter the ERISA analysis. To the extent that the tax is deposited in a special fund for the universal coverage plan, this may strengthen the case against ERISA preemption under the Ninth Circuit's precedents involving pay-or-play requirements in San Francisco and Seattle by offering employers the universal coverage plan as a legitimate choice and alternative to offering their own coverage.

Coverage Duplication

ERISA preemption cases have emphasized that state laws can avoid a preempted "connection with" employers' benefit plans by preserving meaningful choices for employers. The indirect economic effects on decision-making from a payroll tax is one way to avoid directly forcing employers' choices. Preserving employers' ability to decide whether or not to offer benefits is another way. So, a state law that expressly prohibited employers from offering health care benefits would almost certainly be preempted by ERISA because it directly references the employers' plans *and* directly targets the employer's decision about these benefits. But a law that preserves employers' ability to decide whether to offer benefits, but gives them economic incentives to drop coverage in favor of a public plan would likely avoid preemption.

Because ERISA allows states to enforce their regulations on insurers, a state law prohibiting *insurers* from offering plans that duplicate coverage from the state's public plan confidently avoids preemption. That, however, would leave employers able to self-fund plans that duplicate coverage and compete with the state plan. As the Proposal notes,

[21] *Rutledge*, 141 S. Ct. at 480.
[22] Though it is beyond the scope of this project, we note below that personal income taxes may implicate the federal SALT (State and Local Tax exemption) for higher-income taxpayers.

"Employers would no longer need to provide health benefits. But they would have the option to offer self-funded plans.[23] To avoid making a preempted "reference" to employer-sponsored benefits, it is recommended that the state law not expressly state the fact that employers would still be allowed to self-fund substitutive coverage.

The coverage duplication provisions that the Task Force considered in its January 2022 Outstanding Design Elements would allow *complementary* private coverage for those services and costs *not* covered by the Plan. This provision maintains an additional aspect of employers' choice about benefits by allowing them to offer complementary coverage as a benefit – either by purchasing it from an insurer or self-funding this coverage.

The Proposal thus preserves meaningful choice for employers along three lines: offer self-funded duplicative coverage, offer complementary coverage, offer no coverage and rely entirely on the Universal Health Plan.

Provider Participation & Reimbursement

The Supreme Court has held that state regulation of medical providers is largely outside the scope of ERISA preemption, even when that regulation influences the cost of services providers provide to employer plans.[24] The Court has not, however, considered whether a state law that deprives employer plans of a feasible provider network would effectively force the employer to drop its benefit plan.

The Proposal contemplates that the "Plan would pay providers directly" at rates set by region.[25] The Task Force's January 2022 Outstanding Design Elements described that the Plan would cover services from all providers licensed or authorized to practice in Oregon in good standing as "participating providers." If providers who participate in the state Plan are not permitted to continue contracting with (and being reimbursed by) self-funded employer-based plans, this may implicate ERISA if it is effectively forcing employers to drop their plans because there will be no providers to create a network for that plan.

If participating providers *are* allowed to continue contracting with (and being reimbursed by) employer plans, then a couple of policy-design questions about the status of complementary versus duplicative coverage (discussed in the previous section) would arise.

First, if participating providers provide services covered by the Plan to patients who also have employer-funded coverage, the Plan would need to rely on a mechanism to seek reimbursement from the employer-funded coverage as the primary payer. To the extent that substitutive employer-based coverage may continue to exist, the state may need to capture some the employers' expenditures on claims. It could also do so by designating the Plan as the *secondary payer*, so the primary obligation to pay falls on the substitutive form of coverage, and the Plan only must pay the difference to the provider if the amount paid by substitutive plan is less than the Plan's rate or pay for cost sharing (such as a deductible) that is not covered by the employer plan but is covered by the state Plan. A provision that makes the state Plan secondary to any other forms of substitutive coverage a beneficiary may have can also be paired with a *subrogation* provision that allows the Plan to assert the right of the beneficiary to reimbursement against the substitutive plan. This would allow the state Plan to pay for the services of a beneficiary, and then seek reimbursement via subrogation from the primary payer (the substitutive plan) that is

[23] Proposal at page 4.

[24] *Travelers*, 514 U.S. 645 (reaffirmed in *Rutledge*, 141 S. Ct. at 480).

[25] Proposal at page 2.

responsible for paying for the care. Because secondary payer and subrogation provisions preserve the employers' options of maintaining their own plans and do not interfere with such plans' beneficiary status or benefit choices, they should avoid ERISA preemption.

Second, providers may value the reduced administrative burden of participating only in the state Plan. To avoid ERISA preemption challenges, the state may want to allow participating providers to contract with ERISA plans, bill them, and accept higher rates from them. Yet some providers may voluntarily stop contracting with ERISA plans because they value the administrative benefits of only participating in the single-payer plan. Other providers may want to keep participating in ERISA plans (to be able to earn more), but then those providers would need to bear the administrative burdens of negotiating with these plans, billing, and then repaying any amounts previously paid by the single-payer plan for beneficiaries with dual-coverage.

Third, to mitigate legal challenges, provider participation in the Plan can be made optional but exclusive, where provider's voluntary participation in the state Plan means they cannot participate in other plans of coverage offered within the state. Note that this is slightly different than the Proposal's presumptive *enrollment* of all providers that are licensed and in good standing in the Plan. This alternative would make all licensed providers presumptively *eligible* to participate in the Plan, but if they choose to do so, they would have to agree not to participate in other substitutive plans. Presumptive provider enrollment plus a prohibition on contracting with other plans raises greater legal risks, whereas presumptive provider eligibility with voluntary enrollment conditioned upon exclusive participation in the state Plan would mitigate some of these risks. The tradeoff is that while large providers (such as hospitals) that depend on patient volume may need to participate in the Plan, smaller providers (such as certain physicians or specialists) may choose not to participate in the Plan in order to maintain a concierge practice of private-paying purchasers.

CONCLUSION

Oregon's 2022 Universal Health Plan Proposal contains several elements to consolidate employer and employee spending on health care into the Universal Health Plan: (1) a payroll tax levied on all employers; (2) restrictions on coverage duplication by state-regulated health insurers; and (3) regulation of participating provider reimbursement. These elements are structured in a way that will likely survive ERISA preemption, while still encouraging employers and employees to shift to the Universal Health Plan. Finally, we have offered thoughts on provider reimbursement and participation to allow the Universal Health Plan to survive ERISA challenges, draw maximum provider participation, and allow the state to recoup payments for services from substitutive forms of coverage that may persist after the Universal Health Plan is implemented. While beyond the scope of our work on this Project, we laud the Task Force's careful consideration of policy design to advance health care equity and access for Oregonians while navigating the complicated labyrinth of ERISA preemption.