



BENEFIT *Advisor*

In This Issue

In this first issue of the McGraw Wentworth Benefit Advisor for 2010, we will discuss state benefit mandates. The impact of state benefit law on employers and their health plans is a very confusing topic. This Advisor will provide a broad overview on how your organization should evaluate state benefit laws to determine their potential impact on your organization and your benefit plans.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGraw Wentworth website at www.mcgrawwentworth.com.

“State Mandated Benefits”

State mandated benefits, these three words can confuse even the brightest Human Resource professionals. Once a state issues a mandate, the immediate question is - does my plan have to comply with this mandate? What seems to be a simple question actually requires a complicated analysis of the law.

Many professionals would simply like to sweep state-mandated rules under the carpet and forget they exist. That may not, however, be the most prudent approach. This *Advisor* discusses the differences in various state mandates and their potential impact on your plan. This *Advisor* will:

- Provide a legislation overview of federal law and state law
- Discuss ERISA preemption
- Address state laws in general
- Address city mandates
- Overview Massachusetts Health Care Reform Act

Unfortunately, it is very difficult to make sense of state law and state mandates. This *Advisor* discusses the legislative landscape and clarifies its effect on employers.

Legislation Overview: Federal Law and State Law

Laws can affect many aspects of health plan coverage, such as eligibility for benefits, the actual benefits provided, the taxability of benefits, the confidentiality of specific information, job protection when an employee is

unable to work and so on. Laws can cover an endless list of topics, but remember we need them to prevent chaos and to protect everyone.



To properly evaluate a law, first determine whether it is a federal or a state law. Generally, federal laws regulate employers and their employer-sponsored health and welfare plans. They do not usually apply directly to insurance carriers. A notable exception is the HIPAA Privacy and Security Rules. Insurance carriers are considered covered entities under those rules.

State laws generally affect insurance carriers, and each state has a department of insurance to monitor those carriers. We discuss these laws in more detail in the section after next.

Since states only regulate insurance carriers, how your organization funds your plan matters. Fully insured plans must comply with state laws because insurance carriers must comply. Self-funded plans are usually exempt from state law because these plans do not involve insurers. We discuss the ERISA preemption in the next section.

Most employers are very familiar with federal laws regulating employee health and welfare plans. Following is a list of just a few:

- **ERISA:** Employee Retirement Income and Security Act
- **COBRA:** Consolidated Omnibus Budget Reconciliation Act
- **FMLA:** Family Medical Leave Act
- **HIPAA:** Health Insurance Portability and Accountability Act



and sample posters, forms, policies and so on. Most federal laws provide information on the people who drafted the laws, as well as how to contact them.

Complying with federal law has become easier over the years; conversely, it seems complying with state law has become more difficult.

ERISA Preemption

ERISA preemption is a fairly complicated topic. In general, ERISA expressly preempts (i.e., supersedes) state laws “relating to” employee benefit plans, except for causes of action occurring before 1975. State law means all statutes, decisions, rules and regulations of the state.

The clause in ERISA that discusses preemption is the “deemer” clause. The deemer clause says no self-funded employee benefit plan is deemed to be an insurance, banking or securities company. The deemer clause is basically how self-funded plans become preempted from state laws governing benefit plans, because state laws can only regulate the business of insurance.

Self-funded plans may still buy specific stop-loss insurance to protect against any substantial individual or

contract claims. Some plans buy aggregate stop-loss coverage to protect the plan as a whole against having a bad year. Buying stop-loss coverage does not mean your plan is insured. In general, stop-loss coverage is considered property or casualty coverage because it protects the employer from catastrophic health plan losses.

ERISA’s preemption provision is very broad. It not only supersedes state laws designed to affect benefit plans, it has also been used successfully in many types of law suits, including:

- Laws creating funding requirements for employee benefit plans.
- Laws regulating third-party administrators.
- No-fault insurance laws.
- Laws requiring health plans to cover specific benefits in specific states.
- Law requiring employers to notify employees of their right to continued life insurance coverage after they are laid off.

The ERISA savings clause allows states to regulate certain areas in some situations. Based on case law, states generally can:

- Tax and regulate traditional insurers performing traditional insurance functions.
- Regulate multiple employer welfare plans (MEWAs).
- Regulate hospital rates charged to insurers and others who pay for health care services.
- Provide remedies for injuries when a health plan controls medical care delivery.

NOTABLE THOUGHTS

**IF A WINDOW OF OPPORTUNITY APPEARS,
DON’T PULL DOWN THE SHADE.**

TOM PETERS

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ERISA does not supersede all state laws governing health care benefit plans. Some “tenuous, remote, or peripheral” state laws are so far removed from ERISA’s provisions such that ERISA does not apply to them. For example, ERISA did not supersede a participant’s medical malpractice claim against an HMO since the claim concerned quality of care received rather than a denial of benefits due. ERISA also did not supersede the federal statute requiring providers and HMOs to cover alternative treatments, since it affected providers but not ERISA plans. The list goes on, but it is important to verify with a legal professional which specific state laws are preempted by ERISA.

State Laws In General

State laws usually apply to insurance carriers offering insurance contracts issued in the state. Sometimes the laws apply to any carrier doing business in the state. In some cases, if a certain percentage of plan members are located in a given state, the carrier may have to comply with that state’s laws. It is notoriously difficult to obtain information on state mandates. In most states, the Department of Insurance websites are not intuitive. Mandates are sometimes so poorly written, it is difficult to see who is affected. Because insurance carriers shoulder the responsibility for complying with state mandates and must pay the penalties for non-compliance, your best source of information on state mandates is your insurance carrier’s legal department.

When you have a number of employees in different states, you may be required to have different benefits when state mandates apply. For example, some states have expanded COBRA laws. If you have

employees in a state with one of these laws and the carrier is required to comply, the expanded COBRA continuation applies only in that state. Fully insured plans with multi-state employee populations may need to supplement their plan descriptions to show benefits that differ from state to state.

Often ERISA does not preempt state laws that apply to employers. To determine how they should respond to a state law, employers must ask a key question - to whom does the law apply? For example, California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico have mandated disability benefits. Each state has different requirements on how to comply with these mandates. Employers can:

- Participate in a state fund. This option generally requires the employer to pay into the state fund based on the number of employees in the state affected.
- Self-fund the state disability benefit.
- Have the disability insurance carrier administer the state disability mandate.

Typically, state mandated disability income benefits are pretty limited. In fact, employer benefits frequently exceed state required coverage. The benefit period is also limited. The longest running plan offers 52 weeks of benefits, but most plans have a shorter duration. The benefits are generally funded through employee and employer contributions deducted from pay. If

your employees live in one of the six affected states, make sure you are complying with the plan. Do not assume your disability carrier is managing the process.

California is the only state that offers paid FMLA leave time. Employers withhold part of their employees’ pay to fund the state-mandated paid FMLA leave time. Other states have state leave laws similar to the Family Medical Leave Act or in many cases, more generous than the FMLA.

Employers are required to comply with all of these state laws.

One California law is particularly tricky. CA Senate Bill 1386 was originally

aimed at credit card issuers to protect personal data. It applies to any organization, in-state or out, that electronically maintains the personal information, including the social security number, of a California resident. The crux of the legislation is that the organization must follow certain protocols to protect this personal information and if the information is breached, the organization must notify anyone affected. Employers and their health plans must comply because they electronically maintain California residents’ personal information.



The whole situation surrounding state law is complex. The best way to track these laws is to develop a good information network:

- Join your local human resource organizations. If you have a multi-state presence, have your human resource colleagues join the human resource organizations in their states.
- Find out how your payroll vendor keeps track of state laws that affect payroll deductions. Ask the vendor to send you information on the laws in the states where you have employees.
- Join the Society for Human Resource Management.
- Sign up for e-newsletters from www.benefitslink.com, SHRM and www.plansponsor.com.



Keeping informed will help you comply with state mandates and laws that affect your plans and your organization.

City Mandates

It is fairly rare for a city to mandate benefits for employers that do business in the city. Several years ago, San Francisco passed the San Francisco Health Care Security Ordinance requiring employers to either regularly contribute a specified amount toward their employees' health care costs or pay into a city health care fund for San Francisco residents. Employers imme-

diately cried foul believing ERISA overrides the city ordinance. However, the Ninth Circuit Court has held that ERISA does not supersede the ordinance for the following reasons:

- The ordinance does not create an ERISA welfare benefit plan, because it is concerned primarily with benefit delivery as opposed to benefit plans themselves. It requires employers to make payments directly from their general assets instead of placing them into a separate fund. The court cited the lack of administrative obligations as the reason for the decision.
- The ordinance does not have an impermissible connection to welfare benefit plans. The ordinance does not regulate ERISA plan-provided benefits. Instead, it allows employers to structure their benefit plans as they see fit, and it imposes the same record-keeping burdens on employers without benefit plans as it does on those with benefit plans.

Employers have found it difficult to comply with this ordinance, especially if they have just one or two employees working in the city.

San Francisco is the only municipality that has enacted mandatory health care benefits. It is far more common to see a city ordinance requiring an organization to cover domestic partners. Typically, these ordinances bar a city from contracting with companies whose employee benefit plans discriminate against same-sex and sometimes even oppo-

site sex domestic partners. Organizations that want to win a contract in these cities must prove their health care plans cover domestic partners.

Fortunately more cities have not gone the route of San Francisco. Staying up to date on state law is difficult enough without having to monitor city laws as well.

Massachusetts Health Care Reform Act

Massachusetts passed a health care reform law two years ago aimed at creating universal coverage for all state residents. Employers that cover Massachusetts residents have become very familiar with this law over the last couple of years. This fairly complex law contains several key elements:

- **Individual "mandate":** Massachusetts state law requires all residents to have a certain level of health care coverage either through an employer group health plan or individual coverage purchased directly from an insurance carrier. Residents without adequate coverage must pay a penalty when they file their state income tax.

The individual mandate was expected to cut down the amount a health care system loses on charity care. If everyone in the state has a strong enough incentive to buy insurance, then these plans would cover a good portion of the health care costs.

This mandate, however, had some unintended consequences. First, the state realized fairly quickly that there were not enough primary care doctors in the state to provide health care for all residents. Many covered residents had to wait up to eight months for a preventive visit with their primary care doctor. Second, universal health coverage does not reduce cost. In fact, once residents were covered, they felt compelled to seek care. Massachusetts now has the highest estimated cost for employee health care coverage.

- **Employer “mandate”:** Massachusetts employers are not required to offer health care coverage to employees. However, if they do not cover employees, they must pay a state tax penalty. These penalties help offset the cost for employees’ individual coverage. Initially, the tax penalty was not too substantial, but as health care cost has ratcheted up, the state has increased the employers’ fine for failing to provide coverage.

Massachusetts employers must offer a Section 125 plan so that employees can pay for their coverage with pre-tax dollars. They also need to allow employees not eligible for group coverage to pay for their individual coverage pre-tax.

Employers must fulfill a number of reporting requirements if they have employees in Massachusetts. Many health insurance carriers are helping employers with these requirements.

- **Carrier regulations:** Massachusetts is one of the most highly regulated health care markets in the nation. Insurers needed to simplify their underwriting process so that residents could get individual health plan coverage.

The changes allow residents with pre-existing health conditions to buy insurance from an individual insurance carrier. Also, plans do not necessarily have to comply with all state mandated benefits for young adults.

- **MA “Connector”:** The state built an Internet-based tool called the Connector to help state residents buy the required health plan coverage.

The Connector works with a number of insurance carriers to help residents and even small businesses find the least expensive coverage.

Many of the health care reform measures being discussed in Congress adopt the provisions of the Massachusetts Health Reform Act. The act also helps low income individuals pay for coverage and care.

When the Massachusetts’ Health Care Reform Act initially passed, it was also challenged. Self-funded plans in the state believed they were ex-

empt because the law appeared to regulate insurance. However, that challenge was defeated. Because the law did not require employers to provide benefits, it was outside ERISA’s scope.

At first, complying with this law was a problem for employers; however, the state has improved the reporting process and in many cases, health plan administrators are helping employers to comply.

Concluding Thoughts

State mandates are a tough topic. One of the advantages of self-funding health plan benefits is that the plan is exempt from complying with many state mandates. For multi-state employers, ERISA preemption saves a lot of time and struggle, because it overrides so many state mandates for insurance carriers.

However, the ERISA preemption is not so broad that it absolves an employer from complying with all state laws. The trick is trying to determine whether you are required to comply or not. The best approach to keeping abreast with state law changes is to develop a good network of credible resources to keep you current. Both BLR and Ceridan offer reasonably priced state law resources if you have employees in a number of states. Finally, it makes sense to have a legal resource in each state where you have employees. You may not need legal opinions every day, but when situations do arise, a local attorney will likely be better versed in local law.

Good luck sorting through state mandates. If you have any questions, please contact your McGraw Wentworth Account Manager. **MW**



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