Finance Technical Advisory Committee (FTAC) Meeting Summary

July 13, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the FTAC webpage.

Members present

Christine Eibner
David DiGiuseppe
Eddy Rauser
Ian Doyle
Kai Yeung
Pam MacEwan
Roger Gantz

Members absent

Esther Lucero
Robert Murray

Call to order

Pam MacEwan, FTC Liaison, called the meeting to order at 2:01 p.m.

Agenda items

Welcoming remarks

Pam MacEwan, FTAC Liaison, began with a land acknowledgement, welcomed FTAC members to the fourth meeting, and provided an overview of the agenda.

Meeting Summary review from the previous meeting

One revision was proposed to clarify language in the May 2023 meeting summary. Members present voted by consensus to adopt the meeting summary as amended.

Public comment

Roger Collier asked if costs doubling for some employers via a payroll tax could be deemed as "exorbitant" and in violation of the Employment Retirement Income Security Act of 1974 (ERISA). Roger Collier also asked how far out federal court processes to resolve ERISA preemption would be from Washington's passing of universal health care legislation.

Warren George, former member of Oregon's Task Force on Universal Health Care, encouraged further regional cooperation between Oregon and Washington and noted the benefits of a single-payer system.

Cris Currie, retired RN, remarked that ERISA is only an issue within the context of a single-payer system and encouraged FTAC to clarify with the Commission whether a single-payer health care system is their goal. His report on handling ERISA in a single-payer context is in the written public comments of the May meeting materials.

Marcia Steadman, Health Care for All Washington, noted that Washington's 2023-2025 operating budget allocated funding to support FTAC's work and expects to see a revised workplan and more robust meeting agendas. FTAC members were encouraged to follow Oregon's Task Force on Universal Health Care's example to address ERISA.

Presentation: Updates from the Commission's June meeting and goals of this meeting

Liz Arjun, Health Management and Associates (HMA)

FTAC heard updates from the Commission's June meeting, including the Commission's adoption of FTAC's guidance on Medicare eligibility, transitional solutions, and the Commission's ERISA questions for FTAC. This meeting focused on gathering information on ERISA in preparation for FTAC's discussion in September to develop recommendations for the Commission on ERISA eligibility options. FTAC member Roger Gantz suggested that the Commission coordinate with and leverage the resources of the Health Care Cost Transparency Board to examine ways to address rising health care costs and affordability for consumers.

Presentation: A brief history of ERISA and health care policy

Carmel Shachar, Asst. Clinical Professor of Law and Faculty Dir., Health Law and Policy Clinic, Harvard Law School

ERISA was not intended to be a health care statute but is one. ERISA, a federal statute, governs employer-sponsored health care plans or insurance plans where an employer covers the full financial risk of its employees' claims for health care benefits (known as self-funded). Regulation of ERISA plans is "exclusively a federal concern" and preempts "all state laws insofar as they…relate to any employee benefit plan" (one of the broadest preemption clauses ever written). Most Americans receive health care coverage through this type of health plan.

Prior to the 1990's, a state's statute was deemed in violation of ERISA preemption when it had a connection with or reference to an employer covered benefit plan. In *New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Co*., the state tried to make enrollment in Blue Cross Blue Shield (Blue) plans more attractive by imposing a 24 percent surcharge for hospital services for patients covered by anything other than a Blue plan compared to an 11 percent surcharge for Blue plans. The Supreme Court determined that ERISA did not apply because the law had an indirect economic impact on ERISA plans and did not mandate certain administrative structures or choices. ERISA statute refers to a fee/penalty becoming so "exorbitant" that it's no longer an indirect economic impact; however, there is no definition of "exorbitant."

In *Gobeille v. Liberty Mutual* (2016), the Courts made a more expansive preemptive decision (compared to Travelers). Liberty Mutual brought a case against Vermont that ERISA preempts reporting to the All-Payer Claims Database (APCD) because ERISA already has reporting requirements. In the Court's decision, and for the first time, potential *future* issues with uniformity were considered. Courts agreed with employers since the law governs a central matter of plan administration and interferes with nationally uniform plan administration.

Rutledge v. Pharmaceutical Care Mgmt. (2020) restored ERISA preemption jurisprudence of the 1990's and concerned Arkansas's regulation (Arkansas Act 900) of pharmaceutical benefit managers (PBMs) and drug pricing. PBMs argued that the state regulating what PBMs pay to pharmacies would be regulating ERISA plans since many

of the health plans for which PBMs administer fall under ERISA. The Supreme Court decided that Arkansas's law did not "refer to" ERISA because it applied to PBMs "whether or not they manage an ERISA plan." The majority opinion relied heavily on the Travelers case. Professor Shachar noted that Rutledge may be good news for states hoping to innovate but cautioned not to count on it being the last word on ERISA preemption.

The Gobeille decision shows that ERISA fixes are unlikely. Congress could carve health plans out of ERISA, though they've shown little interest in doing so. The Dept. of Labor (DOL) and the Dept. of Health and Human Services (HHS) could create ERISA carve outs. However, reporting to the APCD is a smaller issue than moving to universal health care and if there's no proactive attempt to smooth the APCD path, it's unlikely that Congress or those federal agencies will be a solution to the problem.

Two cases illustrate ERISA's impact on universal health care attempts. In Maryland's *Retail Industry Leaders Assoc. v. Fielder* (2007), the law targeted Walmart, requiring employers with more than 10,000 employees to spend at least eight percent of their payroll on health care, or else pay the difference between the employer's health care expenditures and the eight percent threshold into a state Medicaid fund (an example of "pay or play"). The only rational choice for Walmart was to spend the required amount on health care benefits. The Fourth Circuit struck down Maryland's "fair share law" because it mandated benefits and did not have an *in*direct economic impact.

In *Golden Gate Restaurant Association v. City and County of San Francisco* (2009), San Francisco issued a tax based on hours worked where employers had discretion about how to spend the expenditures. One option was to pay into a new health care program for low to moderate income residents. The Ninth Circuit reversed the District Court's findings that this program violated ERISA because the ordinance applied regardless of whether employers offered an ERISA plan. Golden Gate was distinguished from Fielder (Maryland) because employers had a "meaningful alternative" to increasing their current health plans and had total discretion about how to spend their mandated contributions. The Ninth Circuit continues to be friendly to this line of thinking, but other Circuits are closer to the Fourth Circuit's thinking on Fielder.

ERISA creates discontinuities within access to reproductive care post the Dobbs decision. Self-funded plans cannot be regulated by states and can likely cover abortion services and care even in states that ban abortions. However, employees would struggle to find providers and it's unknown whether ERISA is a shield against criminal liability. States also can't require employer plans to offer reproductive care. It is possible that a future presidential administration that was anti-abortion could have its DOL issue regulations that no ERISA covered plan could support access to abortion services which could cause issues for a state-based universal health care system.

FTAC member Christine Eibner asked why the Golden State case didn't reach the Supreme Court. It was clarified that the case wasn't pressing enough at the time to be resolved by the Supreme Court.

FTAC member Roger Gantz asked about states' abilities to regulate providers. It was clarified that mandating that providers only bill the universal plan could invite resistance (and potentially lawsuits) from providers, but the state could provide incentives to providers to bill only the universal plan. FTAC member David DiGiuseppe asked whether a state could develop a universal pricing reimbursement scheme that is outside the purview of ERISA. This could be successful if it's keyed to the provider side versus the insurer side. It could have indirect economic impacts on ERISA plans, but the state wouldn't be mandating specific benefits.

David DiGiuseppe asked to clarify that the clear pathways to addressing ERISA challenges are an act of Congress (highly unlikely), and a pay/play/meaningful alternative. Professor Shachar responded that in the latter, and

similar to Golden Gate, the universal plan would be the meaningful alternative where employers could design and offer their own benefits or pay into the universal plan for their employees to access health care.

FTAC member Eddy Rauser asked if Gobeille (APCD reporting) is a litmus test for ERISA being used as a shield against health care reform efforts. Eddy Rauser also asked whether Workers' Compensation is self-funded, and Pam MacEwan clarified that it is self-funded and does not fall under ERISA.

Presentation: ERISA issues in Washington

Commission member Jane Beyer, Senior Health Policy Advisory, Office of the Insurance Commissioner (OIC). Jane Beyer's presentation provided an understanding of what Washington state laws or policies have been tested or challenged, and what hasn't been challenged with regards to ERISA.

About one third of Washingtonians receive health coverage through a self-funded group health plan (SFGHP). The OIC regulates fully-insured small and large group health plans. OIC also has jurisdiction over health plans offered on the individual market. The Washington Legislature is the purchaser for the Uniform Medical Plan (UMP), a SFGHP for state employees that can be regulated by the state. Private SFGHPs are regulated by the DOL/Employee Benefits Services Administration (EBSA). State/local government SFGHPs are accountable to HHS/Centers for Medicare and Medicaid Services (CMS). Washington's future universal system would likely be regulated by an entity established by state law. OIC cannot regulate Taft-Hartley plans.

With regards to benefits, fully-insured health plans must provide benefits that are mandated by both federal and state law. Both private and state/local government SFGHPs must comply with federal laws including ERISA, the Mental Health Parity and Addiction Equity Act (MHPAEA), the Health Insurance Portability and Accountability Act (HIPAA), the Pregnancy Discrimination Act, Americans with Disabilities Act (ADA), Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), preventive services, and the No Surprises Act. The benefits for Washington's future universal system would be defined by state law, but the state-established regulatory entity would need to comply with federal laws that apply to all health plans.

For fully-insured health plans, "provider network adequacy" is defined in Washington state law, plus the Affordable Care Act (ACA) for qualified health plans (QHPs). For both private and state/local government SFGHPs, provider network adequacy is not directly regulated, though indirectly there is some network adequacy via federal laws, e.g., MHPAEA. Provider network adequacy must be defined in state law for the universal system.

The ACA and state law address eligibility for fully-insured health plans. For both private and state/local government SFGHPs, eligibility is set by the plan with certain federal laws such as HIPAA and the ADA playing an indirect role in eligibility. Eligibility for the universal system must be defined by the state.

ERISA was a prominent issue when the Washington Health Services Act (HSA) was enacted in 1993. The HSA included an employer mandate to offer coverage, starting with employers with more than 500 employees in 1995, and extending to all employers by 1997. Employers were required to purchase certified health plans or to enroll employees in the Basic Health Plan or health insurance purchasing cooperative established in the HSA. There was distinct treatment of Taft-Hartley trusts. The HSA directed the Governor to negotiate with Congress to obtain a statutory ERISA waiver. The employer mandate (and other provisions) was repealed in 1995 due to the 1994 election results. Washington did not have the opportunity to pursue an ERISA waiver with Congress.

The Washington Vaccine Association (WVA) (2010) has never brought an ERISA challenge despite SFGPHs being told how to administer benefits. Due to budget constraints in 2009, a group was created to develop a new funding mechanism for the state to continue purchasing and providing childhood vaccines. The WVA was created, where Washington universally purchases childhood vaccines for all children at volume discounted rates from the Centers for Disease Control (CDC) and delivers them to providers at no cost. Health insurers and TPAs of SFGHPs reimburse the WVA for vaccines administered to privately insured children via "dosage-based assessments." The WVA then transfers funds to the Washington Dept. of Health for bulk vaccine purchases. Payers are assessed at rates lower than reimbursing the costs of private purchase of vaccines which is a benefit to employers. All TPAs register with the WVA and there is no cost to patients.

The Partnership Access Line (PAL) has also never brought an ERISA challenge. PAL provides psychiatric consultations for certain providers caring for children and pregnant/postpartum individuals. PAL is insurance agnostic and was initially funded with Medicaid funds, despite some children being ineligible for Medicaid. The Washington Legislature developed an alternative funding mechanism. PAL is administered by the WAPAL Fund - a blend of Medicaid and assessment funding in proportion to the coverage source of people served. For privately insured children, there is quarterly covered-lives assessment on payers, including SFGHPs. The assessment per covered life for fiscal year 2024 is seven cents per-member per-month (PMPM).

Washington's behavioral health (BH) crisis system, also insurance agnostic, is largely funded by Medicaid, federal block grants, and state general funds. The 2023-2025 Operating Budget directs HCA, Medicaid managed care organizations (MCOs), BH administrative service organizations, carriers, self-insured organizations, and BH crisis providers to assess gaps in the current funding model and recommend options for addressing these gaps including, but not limited to, an alternative funding model, e.g., covered-lives assessment, for crisis services.

SB 5213 (did not pass, 2023) would've expanded regulation of PBMs to include contracts with SFGHPs and insurers regulated by OIC. Several states and Congress are examining PBMs' business practices. Some provisions in states' laws are also targeting plan design, e.g., consumer cost-sharing.

David DiGiuseppe asked whether the BH crisis assessment is likely to raise ERISA challenges. Jane Beyer noted that in both Travelers and Rutledge, the Courts allowed additional costs to be imposed on a plan, however it's a question of "how much is too much." By virtue of employers paying the BH assessment, they won't need to pay for those services. Like with the WVA and PAL, this benefits the employer.

David DiGiuseppe asked what an ERISA challenge looks like procedurally. A party files a case in federal district court to review and determine whether a state law violates federal law. The district court will determine whether to put a stay on implementation of the state law pending the court making its decision.

Roger Gantz asked to define "partially insured." Also known as a "level-funded" plan, risk is shared by both the employer (typically small employers) and their TPA and protected by stop-loss coverage. The "attachment point" is the predetermined amount at which the TPA will start to pay claims. OIC regulates how low the attachment can go.

Eddy Rauser asked what made the WVA successful. Jane Beyer replied that an entire legislative interim was spent with multiple stakeholders at the discussion table. Roger Gantz noted that the WVA is like a safe harbor test where the PMPM doesn't impair self-funded plans' ability to design their benefits.

Christine Eibner asked about the viability of taxing employers generally, if not specifically employers that currently offer health insurance. Hypothetically, a state could issue a general tax on all employers, put the revenue in a general fund, and use the fund for a given priority, which could be health care. Jane Beyer replied that that was Oregon's proposal, where it's in the employer's best interest to pay the tax and enroll employees in the universal plan.

Presentation: Next steps

Liz Arjun, HMA

At the Commission's August meeting, Pam MacEwan, FTAC Liaison, will share updates from this meeting. In September, FTAC will discuss and develop recommendations to the Commission on ERISA eligibility. HCA staff will send FTAC members informational materials in preparation of the September meeting.

Adjournment

Meeting adjourned at 3:58 p.m.

Next meeting

September 14, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.