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New California Legislation Requires Employers with 50 or More Employees to Provide or Pay for Health Care Coverage for Employees, While Employers with at Least 200 Employees Must Also Cover Their Employees' Dependents.

CALIFORNIA ENACTS "PAY OR PLAY" EMPLOYER-FINANCED HEALTH CARE

By Nancy L. Ober

On the eve of his recall as Governor of California, Gray Davis signed into law landmark legislation that requires that employers of 50 or more employees to either directly provide health insurance meeting minimum specifications for their employees (and employees' dependents if the employer has 200 or more employees) or pay into a State pool to purchase coverage. (Employers with 20 to 49 employees need not comply until a tax credit is enacted, and employers of fewer than 20 employees are exempt.) It is estimated that SB 2, the Health Insurance Act of 2003, will require employers to pay the cost of health insurance for 1 million currently uninsured California workers.

Among the many questions left unanswered by the new law is how much it will cost employers. Even employers that currently offer health insurance may have to increase coverage in order to qualify for exemption from the State pool. Assuming that the legislation survives anticipated legal challenges – including lawsuits and a possible referendum to overturn it – it will begin taking effect in 2006.

WHY THIS BILL?

In enacting SB 2, the Legislature found that most Californians who have health insurance receive coverage through their employment, that 80% of the State's uninsured population (in excess of 3.6 million in 2001 who had no coverage at any time, and 6 million who lacked coverage some of the time) are workers or their families, and that most of these uninsured workers work for employers who do not offer health benefits. The Legislature found that persons without health insurance are more likely to be in poor health and to have chronic conditions than those with coverage, that medical debt is a leading cause of personal bankruptcy, and that uninsured workers receive care through "safety net providers" such as county hospitals and community clinics for which the State and other employers foot the bill. The Legislature also found that insuring more workers and their families would help control the cost of health care. Among the backers of the bill were the California Labor Federation and the California Medical Association.

SB 2 becomes effective January 1, 2006, for employers with 200 or more employees and January 1, 2007 for employers with 50 to 199 employees.

"PAY": HOW DOES THE STATE HEALTH PURCHASING PROGRAM WORK?

Administration and Eligibility: SB 2 charges an existing State agency, the Managed Risk Medical Insurance Board (which administers the Healthy Families Program for low-income workers), with administering a new State program to purchase health insurance coverage for uninsured workers. The Board is to negotiate contracts with health care service plans (HMOs) and health insurers for a benefits package that meets State minimum requirements and is not tied to employment with an individual employer. To be eligible for coverage, a worker (or "enrollee") must work at least 100 hours

per month for any individual employer and must have worked for that employer for three months. Sole proprietors and partners of a partnership who have worked at least three months in the business are also eligible. Large employers (with at least 200 employees) must cover the enrollee's dependents, including spouse or domestic partner and minor children. An "employer" for purposes of SB 2 includes all members of a controlled group of corporations, as defined in section 1563(a) of the Internal Revenue Code, except that 50% (rather than 80%) common ownership is required.

Funding: The State program is to be funded entirely by employer fees and enrollee contributions to be paid into a new State Health Purchasing Fund, with employers paying 80% of the cost. The Board is to set the aggregate employer fee on the basis of the total amount necessary to pay for health care for all enrollees (and, if applicable, their dependents) and the cost of administering the program. Each employer's fee is to be determined by the number of potential enrollees (and in the case of a large employer, dependents) in the employer's own workforce on a specified date. The Board may also consider "other factors" in setting the fee. The Employment Development Department is to collect the fee and to provide notice to all employers of the estimated fee for each budget year.

The enrollee's contribution may not exceed 20% of the employer fee. For some enrollees, however, the contribution may not exceed 5% of wages: this limit applies if the enrollee's wages are less than 200% of the federal poverty guidelines for a family of three and the enrollee is contributing for family coverage, or if the enrollee's wages are less than 200% of the federal poverty guidelines for an individual, and the enrollee is contributing for individual coverage. The employer is responsible for collecting enrollee contributions and remitting them to the EDD.

Benefits: The health benefits package to be provided to enrollees (and dependents, if applicable), is equivalent to coverage under a health care service plan or a group health insurance policy that meets the requirements for employer opt-out, described below. Benefits are to be provided through health care service plans (HMOs) and health insurance. The Board may contract for coverage only with health care service plans and insurers that demonstrate compliance with new insurance market reform measures contained in the bill.

The Board is authorized to establish required enrollee and dependent deductibles, coinsurance or copayment levels for specific benefits, including total annual out-of-pocket costs. No other out-of-pocket costs may be charged to enrollees and dependents. In setting the permitted deductibles, the Board is required to consider the impact of such costs in potentially deterring enrollees and dependents from receiving timely medical care, and on the ability of employers to pay the fee.

"PLAY": HOW MAY EMPLOYERS OPT OUT?

SB 2 permits an employer to receive a credit against the fee that it would otherwise pay to participate in the State pool by providing to the EDD proof that it covers eligible enrollees (and their dependents, if applicable) with one of the following types of coverage:

1. Health care coverage meeting the minimum requirements for health care service plan (HMO) contracts under the Health & Safety Code. Such plans are required to provide basic health care services including physician, hospital, laboratory, home health, preventive, emergency, and hospice care.
2. A group insurance policy that covers hospital, surgical and medical care expenses, if the maximum out-of-pocket costs for insureds do not exceed the maximum out-of-pocket costs for enrollees of health care service plans providing benefits under a preferred provider organization policy. Limited policies—such as Medicare supplement, vision-only, dental-only, hospital indemnity, accident-only, and specified disease insurance—do not qualify.
3. Any Taft-Hartley health and welfare fund or lawful collective bargaining agreement that provides for health and welfare coverage for a collective bargaining unit or other employees.
4. Any employer-sponsored group health plan meeting the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), provided that it meets the minimum requirements in 1 or 2 above.
5. A multiple employer welfare arrangement, provided that its benefits do not change after January 1, 2004, or that it meets the minimum requirements in 1 or 2 above.
6. Coverage provided under the Public Employees' Medical and Hospital Care Act, provided that it meets the minimum requirements in 1 or 2 above, or as otherwise collectively bargained.
7. Health coverage provided by the University of California to students of the University of California who are also employed by the University of California.

Nothing in the bill is to preclude an employer from providing additional benefits or coverage.

WHAT ARE THE PENALTIES FOR VIOLATION?

If the employer fails to pay the required employer fee under the State program, it is liable for a penalty of 200% of the amount of the fee, plus interest. If the employer fails to collect or transmit the employee contribution in a timely manner, the employer is liable for a penalty of 200% of the amount that the employer failed to collect or transmit, and the employee is relieved of all liability for that failure, and that failure cannot affect the employee's coverage.

SB 2 makes it unlawful for an employer to designate an employee as an independent contractor or temporary employee, reduce an employee's hours of work or terminate and rehire an employee if a purpose is to avoid the employer's obligations. An employer who violates these provisions is liable to the Fund for 200% of the amount of the fee that would otherwise have been paid by the employer for coverage for the enrollee (and, if applicable, dependents). SB 2 also prohibits an employer from requesting or seeking to obtain information concerning the employee, dependent or other family member's income or other eligibility requirements for public health benefit programs, other than information about the employee's employment status that is otherwise known to the employer and consistent with existing State and federal law and regulation. Public health benefit programs for this purpose include MediCal, the Healthy Families Program, the Major Risk Medical Insurance Program, and the Access for Infants and Mothers Program. The EDD is to adopt regulations to ensure that employers abide by these provisions.

HOW IS EMPLOYER-PROVIDED COVERAGE COORDINATED WITH PUBLIC PROGRAMS?

The Board is responsible for administering enrollment in the State program, using information from employers to identify potential enrollees. While employers are precluded from asking employees for financial information to determine eligibility for public programs, the enrollment form to be used by the Board will permit enrollees to provide, on a voluntary basis, information necessary to determine enrollee eligibility for public programs such as MediCal or Healthy Families. Enrollees or dependents who choose to provide financial information and who qualify for MediCal or for the Healthy Families Program will be enrolled in those programs and charged the enrollee's or dependent's share of costs, copays, coinsurance or deductibles in accordance with the requirements of those programs. The Board is to provide the State's share of the cost of such coverage out of special deposit funds in the State Health Purchasing Fund created by SB 2.

WHAT DOES THIS LAW REQUIRE OF INSURERS?

SB 2 also includes provisions for "insurance market reform." The Board may not contract with any HMO or health insurer that does not comply with these provisions. Effective January 1, 2006, health care service plan (HMO) contracts and health insurance policies sold to employers with 20 or more employees must require the employer to be responsible for 80% of the cost of coverage (not to exceed 5% of wages in the case of an enrollee whose wages are less than 200% of the federal poverty guidelines). A "medium" employer (20 to 199 employees) may require the enrollee to pay more than 20% of the cost of coverage, however, if the coverage includes dependents, the employer contributes over 80% of the cost of coverage for the individual enrollee, and the coverage includes prescription drugs. If the employer chooses to purchase more than one means of coverage for potential enrollees, and, if applicable, their dependents, the employer may require a higher level of contribution from potential enrollees, as long as one means of coverage meets these limits on enrollee contributions.

Health care coverage may include additional out-of-pocket expenses, such as copayments, coinsurance or deductibles. However, in reviewing and approving HMO contracts or health insurance policies containing such out-of-pocket costs, the Department of Managed Care (in the case of health care service plans) or the Department of Insurance is to consider those out-of-pocket expenses permitted by the Board under the State program.

Effective January 1, 2006, health plans and insurers are also required to make available to small and medium employers with 2 to 50 employees coverage consistent with the current requirements for plans offered in the small employer market. These requirements include offering all of the plan's contracts to all employers, guaranteed renewal, use of risk adjustment factors, and restriction of risk categories to age, geographic region and family composition.

ARE THERE ANY PROVISIONS FOR COST CONTAINMENT?

A companion bill to SB 2, AB 1528, requires the Governor to convene the California Health Care Quality Improvement and Cost Containment Commission composed of 27 members knowledgeable about the health care system and health care spending to make recommendations to the Legislature and the Governor before January 1, 2005 on health care quality improvement and cost containment. This commission is to be composed of representatives of the business community, organized labor, consumers,

health care practitioners, the health insurance industry, and other groups. SB 2 requires the Managed Risk Medical Insurance Board to consider the findings of this cost containment commission and to develop and utilize appropriate cost containment measures to maximize the cost effectiveness of health care coverage.

WHAT DOES SB 2 MEAN FOR EMPLOYERS?

Between now and 2006 employers need to assess whether and how SB 2 will affect them and take appropriate action.

- **Review existing health programs for employees.** Employers that already offer health insurance cannot assume that they are not affected. Health care plans and policies should be reviewed to determine whether eligibility, waiting periods, and the enrollee's share of the cost, as well as offered benefits, meet the requirements of SB 2. Otherwise, participation in the State pool may not be waived.
- **Consider a legal challenge.** Employers that do not offer health care coverage may wish to consider joining with industry groups planning a legal challenge to SB 2. One potential basis for challenge is federal preemption under ERISA. Health benefits are subject to ERISA, and ERISA preempts state regulation of employer-sponsored health plans. It could be argued that SB 2 violates ERISA by mandating the types of benefits that an employer's health plan must provide in order to opt out of the State pool. Another possible ERISA preemption argument is that the State pool funded by employer fees is in effect an employer-sponsored program subject to ERISA preemption.
- **Explore the cost of "pay" versus "play."** Estimates of the cost of implementing SB 2 vary wildly, from just over $1 billion – a figure cited by proponents – to over $11 billion, as claimed by some opponents. The actual cost will depend upon the rates that the State has to pay HMOs and insurers to provide coverage and the rate structure. If rates for the pool are set statewide, it may be cheaper for an employer to provide insurance directly, under a policy that is rated on a regional basis and reflects differences in the cost of living. Employers need to investigate the cost of available coverage for their specific operations and location.
- **Manage the workforce.** By some estimates, over 70% of the employers in the State employ fewer than 20 employees and are exempt from compliance. Employers with at least 20 but fewer than 50 employees do not have to comply until a tax credit is enacted. Employers with fewer than 200 employees are not required to provide dependent coverage. Employers that are close to these thresholds may avoid some or all SB 2 requirements by managing their employee numbers, keeping in mind that SB 2 prohibits reclassifying or terminating and then rehiring workers to avoid compliance.
- **Review compensation.** Subject to minimum wage requirements, employers should be able to consider new mandated health coverage as additional compensation in determining appropriate compensation levels for their employees.
- **Join in health care cost containment efforts.** The AB 1528-mandated cost containment commission, which must include representatives of business, provides one forum for influencing efforts to contain health care costs. Both critics and supporters of SB 2 point to huge insurance and provider expenditures on marketing and administration, as well as a health care delivery system that puts insufficient emphasis on prevention, as problems that must be dealt with if spiraling health care costs are to be controlled.

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