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SPECIAL REPORT

STATE LAWS IMPACTING EMPLOYEE BENEFIT PLAN

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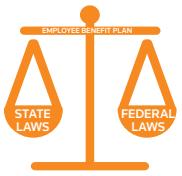


In addition to the steady stream of changes brought by health care reform at the federal level, states continue to weigh in on issues relating to employee benefits. An increasing number of these state laws overlap with existing federal laws and regulations. Employers and advisors must be aware of the jurisdictions they are in, track the laws and comply with requirements that do not always align. From state to state, definitions and rules may be interpreted differently, different reporting timeframes may apply and varying state-law damages and remedies may be available to plan participants. Many employer plan sponsors and third-party administrators (TPAs) operate in multiple states. And — because ERISA does not preempt every state law that may impact benefits — these entities are often subject to a patchwork of multistate and federal laws and must manage the increased burden and cost of tracking and complying with overlapping requirements.

Three benefits-related hot button issues for states are discussed in this report as examples of the interaction between state and federal law and the impact on employee benefit plans.

What Is ERISA Preemption?

The "supremacy clause" of the U.S. Constitution allows federal law to supersede, or "preempt," state law. Under ERISA's preemption provision, all state laws that relate to ERISA plans are preempted. Nevertheless, even under this provision, certain state laws that have an indirect impact on ERISA plans are expressly "saved" from preemption by the preemption provision's "savings clause." ERISA's broad savings clause creates an exception that reclaims a large amount of ground from the general preemption rule. State laws "saved" or excepted from preemption include, most notably, state insurance laws regulating the insurance companies through which many ERISA plans or plan sponsors provide benefits. However, the preemption provision's "deemer clause" goes on to limit the application of such "saved" state insurance laws by expressly prohibiting their direct application to ERISA plans. Thus, whether a state law mandating benefits is preempted by ERISA will depend on factors such as the law's intended target and its actual impact.

State Leave Laws

States and municipalities are adopting leave laws in record numbers. These laws fit into two general categories: (1) laws requiring paid sick leave and (2) laws requiring unpaid or paid family leave (including parental and maternity leave). They vary widely on details such as what employers and employees are covered, when employees begin to accrue leave, the rate at which it is accrued, service requirements before leave can be accrued, the maximum amount of leave, carryover allowances and notice requirements.

Mandates under state leave laws are likely to overlap but not easily harmonize with obligations under the Family and Medical Leave Act (FMLA), other federal laws, applicable local laws and an employer's own voluntary leave programs.

Snapshot: New York Paid Family Leave Law

- Enacted April 4, 2016
- Benefits funded through nominal employee payroll deduction
- Employees eligible for partially paid family leave after 26 weeks of employment
  - To care for a child within 12 months of birth or placement for adoption or foster care
  - To care for a child, parent, grandchild, grandparent, spouse or domestic partner with a serious health condition (as defined by the FMLA)
  - To address "qualifying exigencies" (as defined by the FMLA) when a spouse, domestic partner, child or parent is called to active military service
- Phased in starting in 2018 at 50% of employee's average weekly wage (capped at 50% of statewide average weekly wage) for up to 8 weeks
- Fully implemented in 2021 at 67% of employee's average weekly wage (capped at 67% of statewide average weekly wage) for up to 12 weeks

Interaction With FMLA. The FMLA does not supersede any state law that provides greater family or medical leave rights than those provided by the FMLA. Thus, employers must comply with both the FMLA and applicable state leave laws to the extent that they are otherwise subject to these laws.

Interaction With ERISA. State paid leave laws generally have been found not to be subject to ERISA preemption because they relate to payroll practices that are not considered welfare benefit plans under ERISA. But what if a mandate imposed under a state law relates to benefits provided under an ERISA plan? (For example, a state law might give employees the right to substitute paid sick leave for unpaid time off if the employee is caring for a child or other family member, but the employer might be providing sick pay through an ERISA plan that does not make sick pay available in such situations.) The DOL has concluded that ERISA does not preempt the state law because doing so would "impair" the FMLA, which expressly encourages more generous state family leave laws.

Overlapping Local Laws
Many municipalities also have paid sick leave and family leave requirements that must be considered along with state and federal obligations when drafting employer leave policies.

What Is the FMLA?
The federal Family and Medical Leave Act of 1993 (FMLA) generally requires covered employers to permit eligible employees to take up to 12 workweeks of unpaid, job-protected leave during any 12-month period:

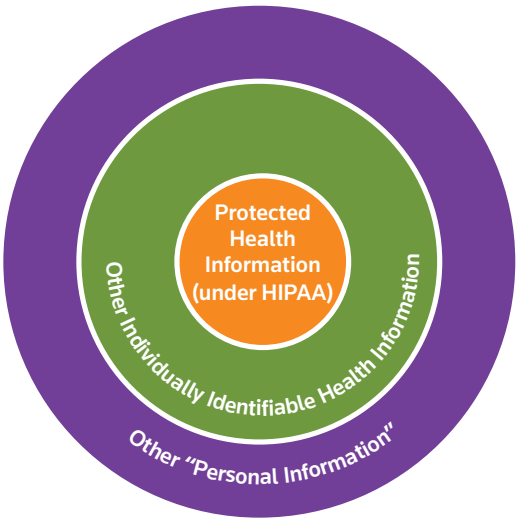
- Following the birth of a child or the placement of a child for adoption or foster care
- To care for an immediate family member who has a serious health condition
- Because of their own serious health condition
- For a "qualifying exigency" arising because a spouse, son, daughter or parent is on covered active duty in the Armed Forces

In addition, an eligible employee who is the spouse, son, daughter, parent or next of kin of a "covered servicemember" is entitled to up to 26 workweeks of leave during a single 12-month period to care for the servicemember with a serious injury or illness.

State Laws Requiring Security Breach Notification

In addition to federal requirements under HIPAA, almost all states have enacted legislation requiring covered entities to notify affected individuals of security breaches of personally identifiable health information. The laws vary in terms of who must comply with the law; what information is protected; what constitutes a breach and when, how and to whom notice must be provided.

State laws may protect personal information that goes beyond HIPAA's "protected health information."



What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is far-reaching legislation designed to improve the portability of health coverage, standardize health care transactions, impose privacy and security requirements and make other changes to the health care delivery system. The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted in 2009, made substantial changes to the parts of HIPAA that address the security and privacy of health information. This included a new requirement to notify affected individuals, HHS and, in certain circumstances, the media, in the event of a "breach" of unsecured protected health information.

Snapshot: Oregon Breach Notification Law.

Oregon's breach notification law applies to any person who, in the course of the person's business, "owns, maintains or otherwise possesses data that includes a consumer's personal information." "Personal information" generally includes an Oregon resident's first name and last name in combination with various data elements, including a Social Security number or financial account number. Many group health plans collect such personal information. Under the Oregon law, a person in possession of personal information who discovers a security breach must provide notice to any consumer whose personal information was included in the information that was breached. For breaches affecting more than 250 consumers, notification must also be provided to the state Attorney General and, for breaches affecting more than 1,000 consumers, to all consumer reporting agencies that compile and maintain reports on consumers.

Interaction With HIPAA and ERISA. HIPAA preempts a state breach notification law only if the law is "contrary" to HIPAA (i.e., it would be impossible to comply with both state and federal requirements or the state law would "stand as an obstacle to the accomplishment and execution of the full purposes and objectives" of the federal law). Entities will need to analyze relevant state breach notification laws to determine whether HIPAA preemption may apply. But, in general, it should be possible to comply with both federal and state requirements, making HIPAA preemption unlikely. For example, if a state breach notification law requires notification to be sent to the individual within five days following the detection of a breach, a covered entity that sends that notice within five days to comply with the state law will also be in compliance with HIPAA regulations (which require notice to be sent without unreasonable delay and in no case later than 60 calendar days after the discovery of a breach). ERISA preemption is also an issue, and, as with other state-law provisions generally, ERISA may preempt more restrictive state laws to the extent they impact the administration of an ERISA-covered plan.

State Laws Regulating Third-Party Administrators (TPAs)

Employee benefit plan sponsors may engage TPAs to perform services such as recordkeeping, claims adjudication and reimbursement. They also often provide standardized plan documents, prepare enrollment materials, perform nondiscrimination tests and prepare Form 5500s. Most states have laws regulating TPAs. For example, many states have adopted laws that require TPAs to be licensed by the state. State licensing laws may require:

- Audited or certified financials
- Surety bonds and E&O policies
- No commingling of assets
- Business plans and operating agreements
- Payment of fees
- Fingerprints and background checks
- Affidavits of key personnel and owners' backgrounds
- Written administrative services agreements

Some states impose additional requirements such as corporate registration, annual reporting and adherence with recordkeeping and claims-payment laws. And federal regulations may apply to TPAs providing certain services in connection with plans offered under the health insurance Exchange.

TPAs often operate in, and are subject to regulation by, more than one state. And the requirements may vary based on whether the TPA is resident or nonresident in the state.

Who is a TPA?

- Some states do not define TPA
- Many states use the National Association of Insurance Commissioners (NAIC) definition (or a variation)
  - NAIC: "Person who directly or indirectly underwrites, collects charges, collateral or premiums from or adjusts or settles claims on residents of the state in connection with life, annuity or health coverage offered or provided by an insurer"
- Claims adjudication catches most TPAs
- Premium collection (e.g., consolidated billing) may pull in cafeteria plan TPA

Who Is Not a TPA?

- NAIC exceptions include:
  - Insurer administering insurance coverage for policyholders
  - Administrator of a bona fide employee benefit plan established by an employer for which state insurance laws are preempted by ERISA
  - Business entity affiliated with a licensed insurer while acting as a TPA for the direct and assumed insurance business of an affiliated insurer
- States may have other exceptions or nonenforcement positions

Interaction With ERISA. Some states do not enforce their TPA requirements with respect to organizations servicing only ERISA-covered plans. However, such nonenforcement may be of limited value because most TPAs service both ERISA and non-ERISA covered entities and, therefore, do not qualify. Other states may enforce their TPA requirements regardless of the type of plan serviced, making ERISA preemption an issue. Whether ERISA preempts the state law usually depends on how much the law burdens the administration of employee benefit plans.

Snapshot: Kentucky Laws Regulating TPAs.

TPAs in Kentucky are impacted by a complex interplay of state-law requirements. Kentucky's TPA licensing statute requires that all TPAs be age 21, competent, trustworthy, reliable and financially responsible, have a good reputation and an acceptable level of education and not have had a license terminated for cause. A federal trial court has concluded that the licensing statute is not ERISA-preempted because it focuses on the TPA's conduct and does not relate to ERISA plans any more than licensing statutes for other professionals (such as attorneys and physicians) who may, in the course of their business, service ERISA plans. Kentucky law also requires (among other things) written TPA agreements, accessible recordkeeping, advertising restrictions and establishment of fiduciary accounts for funds collected. In addition, TPA compensation cannot be based on premiums collected or claims processed.

State regulatory efforts that go beyond regulating TPA conduct arguably impact the operations of the ERISA plan being served. For example, a state may require funds handled by the TPA to be held in trust (similar to the Kentucky requirement discussed above) or require that certain provisions be included in the administrative services agreement between the TPA and the TPA's client (e.g., the ERISA plan). Whether state statutes of this type are preempted with respect to ERISA plans is an open issue.