MEMORANDUM

To: Wayne Altman, MA Primary Care Alliance for Patients

From: Elizabeth Y. McCuskey & Erin C. Fuse Brown*

Date: May 2, 2025

Re: Analysis of ERISA Preemption Issues for An Act relative to Massachusetts primary care for you (H.D. 3661, Jan. 17, 2025)

This memorandum analyzes the legislation "An Act Relative to Massachusetts Primary Care for You" (H.D. 3661, "PC4YOU Bill" or "the Bill") in light of potential preemption by the federal Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1144(a). Pursuant to the Proposal for Consulting Services and its First Amendment, this memo provides our analysis of the PC4YOU Bill's interaction with ERISA, based on review of the PC4YOU Legislation, summary, and slides provided by MAPCAP.

The analysis in this memo proceeds as follows:

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SUMMARY

To finance and maintain universal health care financing programs, states must grapple with the existence of employer-sponsored insurance and ERISA's broad preemption of state regulation that "relates to" employer-sponsored benefits.[1] The PC4YOU Bill aims to promote broader patient access to primary care in Massachusetts by establishing a state-administered public fund, out of which participating primary care providers would receive reimbursement according to a prospective primary care payment model. Although not entirely explicit in the

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[1] *See* Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. Pa. L. Rev. 389 (2020).

Bill, we understand that the goal is to eliminate private-payer billing by providers who participate in the program and eliminate cost-sharing burdens for patients. Notably, however, the Bill does not specify whether and how self-funded employer-based plans ("self-funded ERISA plans")[2] may be subject to the prospective payment model operated by the Fund, and it is ambiguous how providers would bill for primary care services provided to enrollees of self-funded ERISA plans.

To increase statewide investment in primary care, the Bill also establishes overall primary care spending targets for various health care entities and subjects entities that fail to meet their targets to enforcement authority of the Commission. We assessed key provisions of the Bill for possible risks of ERISA preemption. Our conclusions are summarized as follows:

- **Overall structure.** The provisions establishing the public payer (the Primary Care Stabilization Fund, hereinafter the "Fund"), setting terms of provider participation for reimbursement, and implementing the prospective payment model are likely to avoid the kind of connection to employers' benefit choices that would trigger ERISA preemption, for the reasons discussed below.
- **Fund revenue.** We understand one goal of the Bill is to collect revenue for the Fund from all payers in Massachusetts. As written, however, the Bill does not appear to impose an assessment on ERISA plans. To include ERISA plans in the assessment without triggering ERISA preemption, the Bill could add "other employers" to the list of entities subject to the annual assessment in lines 417-421.
- **Provider participation and recoupment by the Fund.** There may be other provisions related to *provider participation* or the ability for the Fund to pay primary care providers and seek reimbursement from private payers (*pay-and-recoup*) that the Bill drafters may want to consider, as these may encourage greater provider participation in the Fund and enable to Fund to capture ERISA plan primary care spending for patients covered by ERISA plans. These provider participation and pay-and-recoup provisions can be structured to minimize risks of ERISA preemption. The Bill could, for example, add language assigning to the Fund any rights of payment the participating primary care providers' patients have through commercial insurance plans.
- **Cost-sharing restrictions.** The ACA's federal prohibition on insurance cost-sharing for "*preventive* services" already eliminates this practice for many screenings, counseling, and immunizations delivered by primary care providers. The Bill's provision further eliminating cost-sharing for all *primary care* services could be read as impermissibly altering employer self-funded plans' terms, triggering ERISA preemption. To the extent that provision is read simply to prohibit participating providers from collecting cost-sharing payments from insured patients, however, preemption might be avoided.
- **Primary care spending targets.** With the primary care spending targets, to the extent that employer self-funded plans would fit within the regulatory definition of a "health care entity," ERISA preemption may make the target difficult to enforce against these plans. The Bill could clarify that, for this provision "payer" includes only "carriers."

[2] PC4You Bill, Ch. 6D, Section 9B(l) (requiring "carriers" to comply with the prospective payment model); Ch. 29 of Gen. Laws, Section 2PPPPP (defining "carriers" to exclude ERISA plans).

STATE HEALTH REFORM AND ERISA PREEMPTION

The PC4YOU Legislation proposes a state-operated program of universal access to primary care. The Legislation would implement a prospective primary care payment model by establishing a Primary Care Stabilization Fund ("Fund"), administered by the Massachusetts Health Policy Commission, and funded by tax revenues. Primary care practices that elect to participate in the program would agree to take their reimbursement directly from the Fund and not to collect cost-sharing payments from commercially-insured patients.

It is unclear whether, as a condition of participating in the program, primary care providers would be restricted from billing other commercial payers. It is further unspecified whether the Fund would be empowered to recoup payment from commercial payers, including ERISA plans, for primary care services provided to commercially insured patients at participating practices, with commercial payers given credit for they had already contributed to the Fund.

Participating providers' reimbursement from the Fund, the prohibition from collecting cost-sharing payments from their patients, the Fund's assessment on "for-profit non-traditional healthcare corporations and entities," and a requirement that employer-sponsored plans meet primary care expenditure targets could implicate employer-sponsored plans in Massachusetts. Employer-sponsored plans are the main source of health insurance in Massachusetts, covering over half its population.[3] State-level reforms that implicate employer-sponsored plans should anticipate the need to navigate obstacles of preemption by federal law, chiefly the Employee Retirement Security Act of 1974 (ERISA).[4]

Employer-sponsored benefits are largely governed by federal law through ERISA. While ERISA supplies some rules that private employer-sponsored plans ("ERISA plans") must follow, ERISA does not apply to governmental employers or churches as employers.[5] Most notably, however, ERISA preempts state regulation that "relates to" employer-sponsored benefits.[6] The Supreme Court has held that state laws impermissibly "relate to" employee benefit plans by making "reference to" those plans,[7] when they "act immediately and exclusively upon ERISA plans," or make "the existence of ERISA plans essential to the law's operation."[8] 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," or "interferes with nationally uniform plan administration,"[9] or indirectly "force[s] an [employer] plan to adopt a certain scheme of substantive coverage or effectively restrict[s] its choice of insurers."[10]

Even if a state law "relates to" employer-sponsored plans, ERISA's "savings clause" expressly allows states to regulate insurance carriers – regulation of insurers is "saved" from preemption.

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[3] Massachusetts has the sixth highest rate of employer coverage in the nation: 54.6% in 2023. Kaiser Family Foundation, Health Insurance Coverage of the Total Population (2023).

[4] 29 U.S.C. § 1001 *et seq.*

[5] *See* 29 U.S.C. § 1002.

[6] 29 U.S.C. § 1141(a).

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

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

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

[10] *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).

Thus, employers who purchase fully-insured health plans from insurers get plans that are regulated by state law. But the Supreme Court has held that employers who self-fund their plans are not deemed part of the insurance savings clause. So ERISA preemption prevents states from applying their insurance regulations to employer "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.[11] Because employer self-funded plans make up roughly 2/3 of the employer-sponsored insurance market, the self-funded exception puts a sizeable chunk of these plans beyond many state regulations.

ERISA preemption is complex and opaque. Our analysis here untangles the aspects of ERISA preemption implicated by three main functions in the PC4YOU Bill: (1) collection of revenue into the Fund; (2) conditions of participation for providers, billing and payment provisions, (3) cost-sharing restrictions; and (4) primary care spending targets.

(1) REVENUE COLLECTION FOR THE FUND

The Fund would consist of appropriations specifically designated for it and revenue from an annual assessment on carriers, providers, provider organizations, and "for profit non-traditional healthcare corporations and entities" that provide primary care in MA "including but not limited to": retailers, pharmacy benefits managers, private equity firms, and urgent care clinics.[12] The Bill's definition of "carrier" includes all MA-licensed health insurers and expressly excludes "an employer purchasing coverage or acting on behalf of its employees."[13]

The tax on health *insurers* may have a ripple effect on the cost of plans sold to employers, but this is not enough to trigger ERISA preemption. The express exclusion of employers from the tax, however, is likely not necessary in order to avoid preemption, as courts have held that payroll taxes on *employers* to fund public-payer alternatives likewise do not sufficiently "relate to" to employer health plans.

While a state law mandating that employers provide or cease providing benefits would almost certainly be preempted because it directly interferes in employers' benefit decisions, there are many other regulatory options that do not directly interfere. The Supreme Court recently held in *Rutledge v. PCMA* that a state law with indirect economic effects on employer plans did not have a "connection with" those plans that would trigger ERISA preemption. 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."[14] The *Rutledge* case involved a state law regulating pharmacy benefit managers, further supporting the Bill's assessment on those entities.

Other legislative options that likely avoid preemption under the "indirect economic effects" reasoning include payroll taxes, provider restrictions, and assignment or secondary-payer provisions.[15] There is federal appellate precedent supporting states' ability to enforce payroll

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

[12] Bill, section 2PPPPP(b), line 413.

[13] *Id.*, lines 398-400

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

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

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.[16] 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.[17] The Fourth Circuit, by contrast, has held that a state reform which taxed employers who did not provide health insurance, but did not use that tax money to fund a public source of coverage was preempted because it created a "Hobson's choice" between paying for insurance benefits or paying a tax and having uninsured employees.[18]

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. So, a payroll tax on employers could be another revenue option for the Fund. In sum, while the bill currently excludes employer-based plans from the assessment, it does not need to do so for ERISA preemption purposes. With the large majority of commercially insured patients in Massachusetts are covered by self-funded employer-based plans, expanding the assessment to these plans would substantially expand the revenue for the program.

To accomplish this, the Bill could add "other employers" on line 421 to the list of assessed entities in lines 417-421 (Section 2PPPP(b)):

> [417] There shall be credited to the fund: (i) an annual [418] assessment on carriers~~,~~; providers~~,~~; provider organizations~~,~~; ~~and~~ for profit non-traditional [419] healthcare corporations and entities that provide, as part of a larger business model, primary care [420] services in the commonwealth, including, but not limited to, retailers, pharmacy benefits [421] managers, ~~and~~ private equity firms, and urgent care clinics~~,~~; and other employers ….

The designation of "*other* employer" clarifies that the entities in the preceding list (involved directly in financing or providing primary care) will not be assessed twice – once as a primary care entity and once as an employer. Instead, the term would capture entities that have employees and do not provide or directly finance primary care services, but may sponsor employee health plans that do. "Employer" is not separately defined in the Bill. If a definition already exists elsewhere in the code sections modified by the Bill, you could add a cross-referenced definition like, "For the purposes of this section, the terms 'employer,' has the same meaning as defined in section __ of __."[19] If a definition needs to be supplied, it could include some common features: "any person, partnership, corporation, association, joint venture, or

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[16] 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), *cert. denied*, 143 S. Ct. 443 (2022).

[17] The preemption status of such pay-or-play provisions has not been settled at the Supreme Court level. The Fourth Circuit has held that a differently-designed pay-or-play tax in Maryland was preempted.

[18] Retail Indus. v. Fielder, 475 F.3d 180 (4th Cir. 2007).

[19] A 2017 single-payer Bill introduced in Washington provides an example of this language. S.B. 5747, 65th Leg., 2017 Reg. Sess. (Wash. 2017). Several other states have used this style of provision in single-payer bills. *See, e.g.*, Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. Pa. L. Rev. 389, 403-405 (descriptions), 432-435 (analysis), Tables 1 & 2 (list of states) (2020).

public or private entity operating in Massachusetts and employing for wages, salary, or other compensation one or more residents."[20]

(2) CONDITIONS OF PARTICIPATION FOR PROVIDERS, BILLING AND PAYMENT

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.[21] That leaves states with the design option of using provider regulation to incentivize physicians to participate in the publicly-funded program.

A provider condition of participation tells providers that if they participate in the public program, they cannot bill other payers or bill for amounts in excess of the public program's prospective payment rates.[22] An example of such a provision might require that participating providers may not "charge any rate in excess of the payment established under this title for any health care service provided to a member under the program and shall not solicit or accept payment from any member or third party for any health care service, except as provided under a federal program."[23]

One benefit of exclusive provider participation is to ease the administrative burden on participating providers from negotiating with and billing and collecting from multiple payers. Given the stickiness of PCP-patient relationships, as primary care providers opt-in to the fund, a provider condition of participation may draw the PCPs' patients—and their accompanying employer-based primary care payments—into the program. ERISA preempts state mandates for employer-based plans to participate in the Fund's prospective payment model,[24] but ERISA does not preempt state provider regulation, particularly those involving reimbursement and payment.[25] Combining a requirement for participating providers to seek all payment exclusively from the Fund with a provision empowering the Fund to seek reimbursement from the employer-based plan could provide an alternative mechanism to capture ERISA-plan spending without running afoul of ERISA preemption.

Currently, the PC4You Bill does not contain any provider conditions of participation. Primary care providers may voluntarily opt-in to the primary care prospective payment model to receive monthly lump-sum payments from the Fund.[26] "Carriers" that provide health insurance coverage to patients receiving primary care services from a participating primary care provider must "comply with the requirements" of the payment model, presumably requiring state-regulated health insurers (but not all ERISA plans) to remit payment for

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[20] *See, e.g.*, S.B. 5747, 65th Leg., 2017 Reg. Sess. (Wash. 2017), lines 26-29.

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

[22] Fuse Brown & McCuskey, *supra* note 1, at 407.

[23] S. 562, 2017–2018 Leg., Reg. Sess. § 2 (Cal. 2017) (§ 100639(e)(2)) (this single-payer proposal was introduced but not passed in California in 2017).

[24] A state mandate that employers must provide certain health benefits to employees or, if the employer opts to provide benefits, cover employees under the state's single-payer plan would be preempted by ERISA because such a mandate would "relate to" an employee benefit plan by altering the structure of the employer's plan.

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

[26] Ch. 6D, § 9B(i).

primary care to participating providers via the fund.[27] It is unclear, however, whether the Fund is supposed to be the *exclusive* source of payment for participating providers or whether they would be allowed to seek additional payment from carriers or ERISA plans.

Nor is there a pay-and-recoup provision in the current Bill. The Bill requires that at least 95% of the payments made under the model go "directly to primary care providers for the delivery of primary care services."[28] This seems to require that the recipients of reimbursement from the Fund allocate no more than 5% of their payment to administrative functions.[29] Because this provision regulates providers and provider organizations, it does not trigger ERISA preemption. However, the provision only addresses how participating providers may allocate moneys from the Fund; it does not specify whether the Fund may seek payment from patients' collateral sources of private coverage, such as employer-based coverage.

If a patient receives care from a PCP participating in the public plan and also has employer coverage, *pay-and-recoup* provisions allow the public payer to pay providers for services and then seek reimbursement from the employer plan as a collateral source of coverage. Pay-and-recoup provisions can take a variety of forms, including assignment and secondary payer provisions. An assignment of benefits is a legal agreement where the individual agrees to transfer the right to reimbursement for their health care services to another party, typically to a provider.[30] In the public payer context, an assignment provision would transfer to the public payer the individual's right to reimbursement from another third-party payer, such as an employer health plan. An example of language from a Rhode Island single-payer bill[31] (introduced but not passed), modified to create an assignment to the Fund:

> Receipt of health care services from a participating primary care provider shall be deemed an assignment by the primary care provider's patient of any right to payment for primary care services from a policy of insurance, a health benefit plan, or other source. The other source of health care benefits shall pay to the Fund all amounts it is obligated to pay to, or on behalf of, the patient for covered primary care services. The Commission may commence any action necessary to recover the amounts due.

An additional example of language modified from an Oregon bill (introduced but not passed):

> The Fund is subrogated to the rights of any participating provider's patient that has a claim against an insurer, tortfeasor, employer, third party administrator, pension manager, public or private corporation, government entity or any other person that may be liable for the cost of health services

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[27] Ch. 6D, § 9B(l). As noted above, the definition of "carrier" in the Bill excludes employer-based health plans, so this provision would not apply to them as currently written.

[28] 9B(j)

[29] Though it is somewhat ambiguous from the Bill's definitions what activities would and would not count for the 95% minimum. The definition of "primary care service" is just "a service provided by a primary care provider. 9B(a) 82. Primary care providers, under the Bill's definition, provide general medical care, as well as "supervise[]" and "coordinate[]" care, "initiate[] referrals," and "maintain[] continuity of care." 9B(a)(1). Various administrative functions may be in included in those categories, or not.

[30] *See* 46A C.J.S. *Insurance* § 2001 (Dec. 2019 update) ("A form authorizing a [health care provider] to receive payment of a patient's insurance benefits is sufficient to effect an assignment of the patient's claim against the insurance company to the [health care provider]."

[31] S.B. 2237, 2018 Leg. Sess. (R.I. 2018), § 23-95-12(g).

> provided to the patient and paid for by the Fund. The Commission may enter into an agreement with any person for the prepayment of claims anticipated to arise under this section during a defined period of time. At the end of each defined period, the Commission shall appropriately charge or refund to the payer the difference between the amount prepaid and the amount due.[32]

Alternatively, secondary-payer provisions make the public payer the secondary payer to any other coverage the patient may have, including employer-based coverage. This means that the collateral source of coverage has the first obligation to pay for the patient's services, and the public Fund will only pay for services not otherwise covered by the primary payer. The secondary-payer provision may be paired with an assignment provision that authorizes the public plan to recover amounts that it paid that were the responsibility of the primary payer. An example of secondary-payer language modified from a Maine bill (introduced but not passed):[33]

> The Fund serves as a secondary payer, and the total of primary and secondary payments that a participating provider receives may not exceed the amount that the Fund would pay if it were the only payer. The Commission may recover health care payments from any other collateral source, such as a health insurance plan, health benefit plan or other payer that is primary to the Fund, to be credited to the Fund.

Our previous analysis of pay-and-recoup provisions concluded that they would likely avoid ERISA preemption because they would not improperly bind employer-benefit decisions.[34]

We have observed provider conditions of participation and pay-and-recoup provisions in other states' single-payer bills,[35] and these may be options to consider for PC4YOU. For administrative ease, primary care providers could be required to seek payment only from the Fund for all services provided to privately insured patients, instead of having to deal with multiple payers. An Assignment/Secondary-Payer provision would allow the Fund to pay the provider and then recover payment from the collateral source, thereby capturing some of the employer plan expenditures for primary care claims. This would be particularly helpful if the PC4YOU Bill excludes employer-based ERISA plans from the assessment to pay for the Fund. If PC4YOU is amended to apply assessments to ERISA plans (as discussed above), Fund recoupments from ERISA plans and carriers could be limited to amounts in excess of (net of) the assessments paid by those payers to the Fund. Alternatively, ERISA plans could be given the option whether the pay the assessment or be subject to recoupment for primary care services delivered to their enrollees by participating providers. The latter option would have

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[32] S.B. 631, 78th Leg. Assemb., 2015 Reg. Sess. (Or. 2015), § 15(2), (3).

[33] *See, e.g.*, H.R. 887, 128th Leg., 1st Reg. Sess. pt. A (Me. 2017) (§ 7506) (providing that "Healthy Maine serves as a secondary payor" and that the total of primary and secondary payments "may not exceed the amount that Healthy Maine would pay if it were the only payor. . . Healthy Maine may recover health care payments from any other collateral source, such as a health insurance plan, health benefit plan or other payor that is primary to Healthy Maine.").

[34] Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. Pa. L. Rev. 389, 436-438(2020), https://scholarship.law.upenn.edu/penn_law_review/vol168/iss2/3/

[35] Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. Pa. L. Rev. 389 (2020), https://scholarship.law.upenn.edu/penn_law_review/vol168/iss2/3/

the advantage (for ERISA preemption purposes) of preserving employers' choice of how to structure their provider networks and primary care benefit.

(3) COST-SHARING REQUIREMENTS

The Bill requires that "[a]ny carrier that provides health insurance coverage to a patient receiving primary care services from a primary care provider participating in the primary care prospective payment model shall comply with the requirements of said payment model."[36] Additionally, the Bill seeks to eliminate the insurance practice of cost-sharing for primary care services, providing that:

> Health insurance coverage for a patient's primary care services delivered by a [participating] primary care provider … shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible.[37] . . .

As noted above, because the Bill's definition of "carrier" expressly excludes employer self-funded plans, those plans would be exempt from the requirement that carriers use the prospective payment model to reimburse participating providers. The cost-sharing prohibition, as written, has a broader application to all "health insurance coverage," which the Bill does not further define. The imposition (or not) of cost-sharing is a central feature of plan design and administration, and therefore directly "relates to" employer plans that provide "health insurance coverage," triggering ERISA preemption. Those fully-insured plans sold by the regulated "carriers" would have to comply with the Bill's cost-sharing prohibition under ERISA's savings clause. But enforcement directly against employer self-funded plans providing health coverage would remain preempted.

The passive construction of the cost-sharing prohibition in the Bill leaves room for an alternative interpretation of how the prohibition would get enforced. The Bill states that primary care services shall not "*be subject to* any cost-sharing" (emphasis added). To the extent that the third-party payer is the actor prohibited from imposing cost-sharing, employer self-funded plans are exempt from the provision. But to the extent that participating providers collecting cost-sharing payments at point-of-service are the intended actors, there exists an argument that the provision might avoid ERISA preemption entirely under the logic of the *Travelers* case.

Read as a provider billing and collection restriction, the provision still allows ERISA plans to decide whether or not to subject primary care services to deductible and cost-sharing. The Affordable Care Act already has a federal prohibition on health insurance cost-sharing for a defined set of "preventive services," some of which fit within the Bill's definition of "primary care services."[38] The current list of services subject to the ACA's "preventive services mandate" include routine many screenings, counseling, immunizations, and some prescription

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[36] Ch. 6D, § 9B(l).

[37] Ch. 6D, § 9B(k).

[38] 42 U.S.C. § 300gg-13 (2010). .

medications.[39] Note that in those areas of "preventive services" overlap, the federal law prohibits cost-sharing for all commercial plans.[40]

Plans that choose cost-sharing for primary care services not subject to the ACA preventive services mandate could still follow that practice, though under the Bill they would need to find a way to collect it directly from patients as opposed to having providers collect it at point-of-service. The indirect economic effect on ERISA plans would have some analogous features to the state law upheld *Travelers*. In *Travelers*, New York law required hospitals to collect surcharges from patients covered by a commercial insurer but not from patients insured by a Blue Cross/Blue Shield plan. Despite that this provider billing provision effectively made non-Blue plans more expensive, the Supreme Court held the indirect economic effect on employers' plan choices did not sufficiently "relate to" those plans for preemption to apply.

Travelers involved a law that asked providers to collect from patients a state surcharge that was not part of the insurance plan. Unlike in *Travelers*, however, the Bill's cost-sharing provision might be read to alter the collection practice of the plan itself. That is, it affects the relationship between the plan and its network providers, rather than just the relationship between the provider and their patients. If some of the plan's network providers participate in the Fund and some do not, that could create internal disuniformity in the plan's billing and reimbursement practices. Despite the Supreme Court's extension of *Travelers* into the PBM context with the *Rutledge* decision, some lower courts have identified cost-sharing as a "key benefit design[]" protected from state law by ERISA preemption within the more limited circumstances of prescription drug benefits.[41] Thus, even as a provider collection restriction, the cost-sharing prohibition may prove difficult to enforce.

(4) Spending Targets for Health Care Entities

The Bill's imposition of primary care expenditure targets on "health care entities" appears to apply to third-party payers, which would include employer-sponsored plans. The targets would require regulated entities devote at least 10% of their total health care expenditures to primary care initially, with the percentage escalating to at least 15% in 2029.[42] Entities that fail to meet their target percentage would be subject to various oversight actions by the Commission.

"Health care entities" subject to the spending targets are defined in the Bill as the same ones subject to regulation by the Center for Healthcare Improvement and Affordability,[43] which are defined in the Code of Massachusetts Regulations as:

> A clinic, hospital, ambulatory surgical center, physician organization, accountable care organization or *payer*; provided, however, that physician contracting units with a patient panel of 15,000 or fewer, or which represents

[39] *See* https://www.healthcare.gov/coverage/preventive-care-benefits/.

[40] *See, e.g.*, https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-covered-by-private-health-plans/.

[41] Pharm. Care Mgmt. Ass'n v. Mulready, 78 F.4th 1183, 1198 (10th Cir. 2023). The Supreme Court is currently considering whether to grant a petition for writ of certiorari in this case. Mulready v. Pharm. Care Mgmt. Ass'n, Dkt. No. 23-1213 (2024).

[42] Sec. 9A(b)

[43] 10A(a), lines 232-233.

> providers who collectively receive less than $25,000,000 in annual net patient service revenue from carriers shall be exempt.[44]

The inclusion of *payers* would regulate both health insurers that sell group plans to employers, and employer self-funded plans.

The spending target more closely "relates to" these employer plans than the provider provisions discussed above. This provision dictates how those payers allocate their funds for the medical services they cover, which is a more direct economic effect and could further be read to require that plans cover particular services (the "primary care services" defined by the Bill). By this effect, it would sufficiently "relate to" employer plans to trigger ERISA preemption.

The so-called "savings clause" in ERISA would still enable the Commission to enforce the target for health insurers and the fully-insured group plans they sell to employers – which makes up about 1/3 of the employer-sponsored market. Because self-funded plans are not included in the ambit of the savings clause, however, enforcement of the targets against them would remain preempted. Because the Bill uses the codified definition of "health care entities," it is slightly more complicated to alter that definition. The Bill could add a specific exclusion in line 233: "any entity identified by the center under section 18 of chapter 12C, except that 'payer' shall include only 'carriers' as defined herein."

CONCLUSION

We must reiterate that ERISA litigation is nothing if not unpredictable and inconsistent, so challenge is likely and the result in any particular court is not guaranteed. That said, the main features of the PC4YOU Bill should endure. The Bill's provisions for bringing money into the Fund and using it to pay participating providers under the prospective payment model should avoid ERISA preemption as written, and could even be strengthened. The prohibition on cost-sharing for primary care services beyond the ACA's definition of "preventive services" has a narrower path around preemption and likely could be enforced against fully-insured ERISA plans, but not against self-funded ERISA plans. Likewise, to the extent that self-funded plans fall within the ambit of "health care entities," the spending targets could not be enforced against them. As a general matter, it might be advisable to include a "severability clause" in the Bill, so that if a court determines that any of the individual provisions are preempted by ERISA, the rest of the law would remain intact because the court would simply sever the preempted provision with respect to self-funded ERISA plans.[45]

[44] 958 C.M.R. 10.00 (2017) (emphasis added).

[45] An example of a severability clause might read, "If any provision of this article or the application thereof to any entity or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this article which can be given effect without the invalid provision or application, and to this end the provisions of this article are declared to be severable."