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What Employers Need to Know About Access to Reproductive Care After *Dobbs*

by Christopher S. Lockman on July 7, 2022

The United States Supreme Court's decision in ***Dobbs v. Jackson Women's Health Organization***, No. 19-1392 (June 24, 2022) overturning *Roe v. Wade* and *Planned Parenthood v. Casey,* has led to a host of different responses from employers across the country—specifically those with employees in states that now ban abortions. Many are asking how the Court's holding will affect employers, their benefit plans, and their communications about this controversial topic. This post and the upcoming HR Power Hour segment airing on July 9 (see details at the end of this post) will discuss challenges faced by employers who sponsor self-funded and fully insured group health plans in states that restrict access to abortion services.

The *Dobbs* decision upholds a Mississippi law banning abortions after the 15th week of pregnancy. The majority in *Dobbs* held that the U.S. Constitution does not guarantee the right to an abortion and reserves the authority to regulate abortion "to the people and their elected representatives" in the individual states. This change has led to significant questions from employers about their employees' access to abortion services and their ability to aid in providing continued access to reproductive health care. Below is an overview of some of the key questions and initial answers regarding the evolving state of the law.

What States Restrict Abortion Access?

Approximately half of the states in the United States currently have laws that criminalize, ban, or restrict abortion. The exact number is hard to pin down because of differences in the level of various states' restrictions, the different effective dates of so-called trigger bans following *Dobbs* decision, and the questionable status of previously stayed pre-*Roe* laws that would ban abortion access but that may not be enforced by the state's governing officials (for example, in Michigan and North Carolina).

Eleven states have laws that restrict coverage of abortion in all private insurance plans written in the state. In addition, Texas and Oklahoma currently have "aiding or abetting" laws that allow a private party to bring a civil action against any person who performs an abortion or who "knowingly engages in conduct that aids or abets . . . an abortion, including paying for or reimbursing the costs of an abortion through insurance or otherwise . . ." Texas, S.B. 8.[1] These laws give private citizens the ability to sue for injunctive relief (that is, to stop the "aiding or abetting" activity) and for statutory damages of not less than $10,000 for each abortion performed. Further, the state laws encourage litigious behavior by enabling an individual who initiates an "aiding or abetting" lawsuit to collect their costs and attorney fees from the defendant if they are successful. It is a near certainty that other states will adopt similar laws (there is already proposed legislation in Missouri) or otherwise seek to punish employers and insurance plans that offer access to abortion.

[1] Oklahoma's S.B. 1503 is almost substantively identical to the Texas "aiding or abetting" law.

Why is the distinction between self-funded and fully insured group health insurance plans important regarding access to abortion coverage?

The distinction between self-funded and fully insured plans is critical because self-funded plans have more flexibility to provide abortion access to their members. Employers that sponsor fully insured plans pay premiums to a state licensed insurance carrier, and the carrier bears the risk of loss with respect to medical claims. Conversely, employers that sponsor self-insured plans bear the risk of loss by paying claims out of their general assets and hire a third-party administrator to process medical claims.

As a general rule, state laws that regulate insurance are preempted by the Employee Retirement Income Security Act of 1974 (ERISA) for group health plans that are self-insured. Specifically, Section 514(a) of ERISA preempts "any and all State laws insofar as they are related to any employee benefit plan [under ERISA]."[2] Application of ERISA preemption to different state statutes is nuanced – but it is broadly accepted that state insurance laws that either require a self-insured ERISA plan to provide certain health benefits or exclude certain health benefits from coverage are "related to" the ERISA plan and, thus, are preempted (meaning they have no effect). Accordingly, there is little doubt that ERISA will preempt any state law that would attempt to exclude coverage for abortion services under a self-insured ERISA plan, because such an exclusion is clearly "related to" the plan.

Despite ERISA preemption of state laws that would attempt to restrict the ability of a self-insured plan to reimburse the cost of abortion services, there may not be facilities or clinics in certain states that provide those services. Accordingly, employers are seeking ways to assist employees in accessing abortion services in other states where the services remain legal.

Several large companies have pledged to pay for abortion procedures and the travel costs associated with accessing the procedures for employees who are in states that currently prohibit abortions. How can employers do this legally?

We expect they can, but it is not entirely clear they can do it without risk. As stated above, for self-insured group health plans subject to ERISA, there is little doubt that ERISA will preempt any state law that would attempt to exclude insurance coverage for abortion services, because such an exclusion is clearly "related to" the plan. It is less clear whether state laws prohibiting "aiding or abetting" abortion access are preempted for self-insured ERISA plans that provide travel benefits to employees to allow them to access abortion services outside of their state of residence. There are, however, good arguments that support the ability of self-insured group health plans to provide these benefits.

[2] Section 514(b) of ERISA excepts state laws regulating insurance from preemption. Under long-recognized U.S. Supreme Court precedent known as the "deemer clause," however, a self-funded ERISA plan cannot be "deemed" to be an insurance company for purposes of state law regulation. See *FMC Corp. v. Holliday*, 498 U.S. 52, 62 (1990). Therefore, states are prohibited from regulating self-funded ERISA plans like insurance, and ERISA preemption under Section 514(a) applies to self-funded group health plans.

First, recent Supreme Court precedent has broadly interpreted the "related to" preemption provision under ERISA as encompassing any state law that has a "reference to" or "connection with" an employee benefit plan. *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 319-20 (2016). A state law has a "reference to" an ERISA plan if it acts "immediately and exclusively" on an ERISA plan, or if the existence of the ERISA plan is essential to the law's operation. A state law has an impermissible "connection with" an ERISA plan if it "governs . . . a central matter of plan administration" or "interferes with nationally uniform plan administration." *Id*. Self-insured ERISA plans have a strong argument that claims made under state "aiding or abetting" laws have an impermissible "reference to" ERISA plans because the conduct prohibited under the state statute would not have occurred absent the terms of the ERISA plan that require the administrator to reimburse abortion and medical travel services. Similarly, self-insured ERISA plans could argue that the aiding or abetting laws have an impermissible "connection with" ERISA plans because they seek to restrict how the plan administrator is able to administer the benefits under its plan, which is inconsistent with ERISA's purpose of providing a uniform national scheme for benefits administration.

Second, under the Supremacy Clause of the U.S. Constitution, both the Constitution and federal laws promulgated under it preempt any conflicting state laws. Applying this principle to ERISA, the U.S. Supreme Court has held that ERISA completely preempts "any state-law cause of action that duplicates, supplements, or supplants" the civil enforcement remedies available under ERISA Section 502, which provides plaintiffs with the ability to enforce and clarify rights under an ERISA plan and to seek equitable relief with respect to employee benefit plans. See *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004). Therefore, an action initiated against a self-insured plan or the employer sponsoring that plan for "aiding and abetting" access to an abortion legally performed in another state appears as though it should, under the Supremacy Clause, be removed to federal court or dismissed.

Finally, Justice Kavanaugh's concurring opinion in *Dobbs* reflects a common view that the constitutional right to interstate travel would prevent a state from barring a resident from traveling to another state to obtain an abortion. Although this may seem comforting to employers offering medical travel services, before venturing to predict future decisions we should remember that Justice Kavanaugh's vote in *Dobbs* runs contrary to his earlier statements that *Roe* is "settled law." We should also be mindful of language in the concurring and dissenting opinions that suggests the Court may reexamine other rights with a foundation in the Fourteenth Amendment like that recognized in *Roe*.

Employers that provide reproductive services and reimbursement for medical travel through group health plans may also find some comfort in the privacy protections under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) but should be aware of HIPAA's limitations. HIPAA generally prohibits the use and disclosure of protected health information (PHI) of the type that is transmitted and maintained when an employee seeks abortion services or reimbursement for related medical travel. HIPAA's protections are limited, however, when a group health plan is responding to a request to disclose PHI pursuant to a court order or subpoena, and employees do not have the ability to request restriction on this type of disclosure. Accordingly, the employee (and the plan) may be powerless to stop disclosure of PHI if faced with an enforcement action by their state of residence, although the HIPAA requirements create procedural hurdles for an individual attempting to pursue a case under the aiding and abetting laws.

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How can employers sponsoring self-funded and fully insured plans continue to provide access to reproductive care?

As described above, self-funded group health plan sponsors may continue offering abortion coverage in states where abortion services are legal. To ensure continued access for employees who reside in a state where abortion is, or will soon be, restricted, these employers have the option to expand the medical travel benefit under their major medical plan to include reimbursement for medical travel expenses incurred for travel to a state where abortion is not prohibited.

Sponsors of fully insured group health plans face a more difficult road. Because their plans are subject to state laws that regulate insurance, it is unlikely they can continue covering the cost of obtaining an abortion or of associated travel, regardless of where the procedure is performed. However, employers sponsoring fully insured plans could attempt to reimburse travel costs for gaining access to abortion care through a type of health reimbursement account (HRA) or employee assistance program (EAP).

The disadvantage of the HRA and EAP approaches is that employers must carefully design and administer the options to ensure they comply with ERISA and the requirements of the Patient Protection and Affordable Care Act (ACA). For example, an HRA that reimburses medical travel expenses must be "integrated" with an employer's major medical plan or qualify as an "excepted benefit HRA" (EBHRA), which limits benefits to $1,800 per year (as indexed). EAPs must also qualify as an excepted benefit to avoid ACA requirements. An EAP may qualify so long as it (1) does not provide "significant benefits in the nature of medical care," (2) is not coordinated with benefits under a group health plan, (3) does not require employee premiums or contributions, and (4) does not impose cost-sharing obligations. Both options will be challenging to establish and administer and will require partnering with a vendor that is both willing and able to administer the benefit.

Where can I learn more?

Tune into HR Power Hour on Saturday, July 9 at 10:30AM on 100.5FM in the Portland, ME area or on hrpowerhour.com to learn more from Verrill attorneys Tawny Alvarez and Christopher Lockman. If you have any questions on how the *Dobbs* decision affects your organization and its group health plans, please contact Tawny, Chris, or another member of Verrill's Employment & Labor or Employee Benefits & Executive Compensation Groups.

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