

# Revisiting Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints

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## A Briefing Paper

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## INTRODUCTION

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The vast majority of insured Americans receive health coverage through the workplace, but over one-third of working people (37 percent) are not covered by their employers. The likelihood of having coverage declines with firm size: only 41 percent of employees in firms with under ten workers receive coverage through their employment compared to 66 percent of employees in firms with 200 or more workers.<sup>1</sup> Some of these workers are offered coverage in which they do not enroll, but most work for firms that do not offer coverage at all.<sup>2</sup> Employers not offering health coverage justify this choice based on cost and/or worker preferences. The problem small businesses experience in affording health coverage has led states to experiment with premium subsidies and other initiatives to make coverage more affordable and therefore more sustainable by employers. But often those subsidies were available only to employers who had not previously offered coverage, creating an uneven playing field with those who had. The enactment of the State Children's Health Insurance Program (SCHIP) exacerbated the inequity. SCHIP provides funding for children in families with incomes up to 200% FPL (or lower at the state's option) and requires the program to avoid "crowding out" private coverage. Generally, public funds cannot subsidize children already covered by an employer but can cover children whose parents work for an employer who does not provide insurance.

To reduce the number of uninsured people while distributing the costs of health coverage more equitably, some state health policy makers may wish to consider employer "pay or play" approaches that impose a tax on all employers used to fund coverage under a public program while allowing a credit for employee health coverage costs. The purpose of this Issue Brief is to help policy makers design a state pay or play law to withstand an ERISA preemption challenge. As background for this discussion, the paper briefly outlines why ERISA raises problems for this type of state health policy initiative and how recent Supreme Court decisions have reduced ERISA's preemptive impacts. (An earlier report on ERISA preemption provides more detailed analysis of the objectives of ERISA's preemption provisions, court interpretations thereof, and its impacts on an array of state health policy legislation.<sup>3</sup>) Because no court has considered a state employer pay or play law, it is likely to be contested, but this issue brief concludes with a checklist of drafting suggestions (pages 6-7) to help avoid or overcome such a challenge.

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<sup>1</sup> Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits: 2001 Annual Survey*. Menlo Park, CA: Henry J. Kaiser Family Foundation.

<sup>2</sup> Only 58 percent of firms with under ten workers offer health coverage, compared with 99 percent of firms with 200 or more workers. *Ibid.*

<sup>3</sup> For a more detailed legal analysis of ERISA's preemption provisions as well as discussion of ERISA implications for other state health policy initiatives, see, Butler, Patricia. 2000. *ERISA Preemption Manual for State Health Policymakers*. National Academy for State Health Policy and Academy for Health Services Research and Health Policy, [www.Statecoverage.net](http://www.Statecoverage.net).

## Policy Environment

For several reasons, there may be interest in the state pay or play model. The number of uninsured people, including workers, continued to grow during even the strong economy of the 1990s. Despite increased flexibility for states to use Medicaid and SCHIP to expand health coverage, it is unlikely that states can cover all their uninsured residents through present public programs or develop new public programs without new revenue sources. Although employers generally do not embrace new taxes, they may be more open to new health coverage approaches as health insurance premiums grow. For example, one reason employers express interest in “defined contribution” health coverage is to limit their exposure to medical care cost inflation.

A major obstacle to states enacting pay or play laws in the early 1990s was ERISA, the federal pension reform law whose preemption clause prohibits certain kinds of state health policy initiatives. But a 1995 U.S. Supreme Court decision interpreting ERISA’s preemption provisions more favorably to states suggests that ERISA should not bar carefully designed state pay or play programs.<sup>4</sup>

## ERISA’s Preemption Provisions

ERISA, the federal Employee Retirement Income Security Act of 1974, was enacted to remedy fraud and mismanagement in private-sector employer pension plans, but the law applies to many other types of employee benefit plans, including health coverage offered through insurance or otherwise. Although it prescribes relatively few federal standards governing employee health coverage, the ERISA statute includes broad preemption language providing that the federal law supercedes all state laws that “relate to” employee benefit plans sponsored by private-sector employers or unions. ERISA also includes several exceptions to preemption, including the authority for states to regulate insurance.<sup>5</sup> Read together, these preemption provisions create the distinction between self-insured health coverage plans (that states cannot regulate at all) and insured health coverage plans (that states can affect indirectly by regulating insurance). Both insured and self-insured plans, however, are ERISA plans, which state laws cannot directly regulate.

Because ERISA’s preemption provisions are not particularly clear on their face, courts have been interpreting them for more than 25 years since the law was enacted. For two decades, the U.S. Supreme Court took an expansive view of ERISA state law preemption. The Court noted that the

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<sup>4</sup> *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

<sup>5</sup> States cannot, however, deem self-insured employers to be insurers in order to regulate their activities. The insurance regulation exception to ERISA preemption is not relevant to state authority to enact pay or play tax programs.

preemption clause was “conspicuous in its breadth” and overturned state laws that had virtually any impact on or referred to a private sector employee plan’s benefits, structure, or administration.

But in its 1995 *Travelers Insurance* decision, the Supreme Court narrowed the reach of ERISA’s preemption provisions by limiting the types of state law impacts that “relate to” private sector employer-sponsored plans.<sup>6</sup> In that case, the Court upheld New York’s hospital rate-setting law that imposed surcharges on hospital bills paid by insurers other than Blue Cross even though it increased costs for ERISA health plans buying coverage from these insurers. The Court noted that the purpose of ERISA’s preemption clause was to minimize employer-sponsored plans’ administrative and financial burdens of complying with conflicting state and local laws. The Court upheld the New York surcharges on the ground they would have, at most, an indirect economic effect on an employer-sponsored plan’s choices about which insurer to offer. It held that the law was not preempted because it would not compel plan administrators to structure benefits in any particular way or limit a plan’s ability to design uniform benefit packages or administrative practices across the country. This ground-breaking case and several that followed stand for the proposition that ERISA preemption does not condemn all types of state health care legislation as long as state law is not directed at ERISA plans themselves, even if the law has some effect on plan costs, benefit design, or administrative responsibilities.

While not directly addressing the precise issues that are likely to be presented by a state employer pay or play law, the *Travelers Insurance* case offers useful precedent to defend such laws, as discussed below. It is important to keep in mind, however, that while the Supreme Court’s decisions permit state laws that indirectly affect employer-sponsored health coverage in various ways, ERISA still prohibits state attempts to *mandate* that employers offer health insurance and other state laws directed explicitly at employer-sponsored health plans. For example, the federal courts held that ERISA preempted Hawaii’s 1973 employer health insurance mandate (later explicitly authorized by Congress).<sup>7</sup> A 1993 Washington employer mandate raised ERISA issues but was repealed before implementation. Other laws directed explicitly at employer-sponsored plans that would raise ERISA preemption issues include requirements that employer-sponsored health plans cover a minimum set of benefits or that employers contribute at least a minimum percentage of the premium.

## The Employer Pay or Play Model

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<sup>6</sup> Cited in end note 4.

<sup>7</sup> In 1983 ERISA amendments, Congress authorized Hawaii’s law but noted in legislative history that this should not be seen as precedent for other similar state laws. Although there appears to be little congressional support for amending ERISA, H.R. 1033 in the current Congress would waive ERISA preemption for state universal health care access demonstration programs.

Although the term has been used by state and federal policymakers to refer to several approaches to expand access to health coverage, for purposes of this paper, a state “pay or play” program would impose a tax on all employers (public as well as private sector) as one source of revenue to finance a public health coverage program but credit against the tax the cost of any coverage provided to employees and dependents. (Pay or play programs are, therefore, different from the simple tax credits several states have enacted for small employers offering health coverage.<sup>8</sup>) Designing a pay or play program raises many thorny policy issues, such as the tax rate and indexing features, whether to exempt some employers or types of employees from the tax, how to collect the tax, and tax sources beyond employers. This Issue Brief focuses only on legal issues raised by ERISA preemption concerns. As discussed below, both a state law’s design and the motivation behind it will be important. For example, it will be more difficult to defend a state law whose explicit purpose is to encourage employers to insure their workers.

## Previous State Pay or Play Laws and Proposals

Two states adopted pay or play laws over ten years ago (although both were repealed before implementation) and several states have considered similar proposals in recent years. In 1988 the Massachusetts legislature enacted the Health Security Act, which would have required employers with more than five employees to pay a payroll tax<sup>9</sup> to finance a public health coverage program while providing a credit for the costs of any employee health benefits the employer actually funded (up to the limit of the tax liability). (Appendix A sets forth relevant provisions of the Massachusetts law.) The law did not refer to ERISA plans but only to employers, did not prefer whether employers would “pay” the tax or “play” (by covering workers), and imposed no standards on the types of benefits offered, the amount the employer must pay, or any other plan features. Consequently, the Massachusetts law had no direct impact on the employer-sponsored *plan* but rather was directed to the employer.<sup>10</sup>

In 1989, Oregon enacted an employer pay or play program (although sponsors and the legislative intent clause also referred to it as an employer mandate). The law imposed a payroll tax on employers who

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<sup>8</sup> See, State Coverage Initiatives. *State-Only Tax Incentives*, [www.statecoverage.net](http://www.statecoverage.net).

<sup>9</sup> The tax would have applied to wages up to \$14,000 at a rate of 12 percent (indexed to inflation). Massachusetts Labor & Industrial Code 151A Sec. 14G. Wages of certain part-time, seasonal, and temporary workers as well as those covered under Medicare or non-employer based private insurance were exempt.

<sup>10</sup> The Massachusetts law was developed in consultation with private attorneys familiar with ERISA court decisions and, even though it preceded the Travelers Insurance case, was designed as carefully as possible to overcome a ERISA preemption challenge.

had not provided employee and dependent coverage.<sup>11</sup> The fund created with these tax revenues would be used by the state to buy health coverage for these employers' uninsured employees and dependents. In contrast to the Massachusetts law, the Oregon tax applied only to employers *not* covering their workers.

In recent years, several states have considered similar legislation but not enacted these proposals. In 1998, as part of a minimum wage increase, the Washington legislature considered permitting employers to pay a lower minimum wage if they financed an acceptable level of health coverage. In 2000, a Tennessee bill declared that "the primary source of health insurance for employed individuals should be an employer-sponsored health insurance plan," and would have imposed a tax on the gross revenue of employers that did not cover their workers. A legislative proposal discussed in Maryland in 2000 would have created a universal coverage program, financed in part by a payroll tax but allowing employers to opt out by continuing to cover their employees with benefits prescribed by state law.

## **ERISA Problems Posed by State Employer Pay or Play Initiatives**

ERISA may raise preemption problems for state employer pay or play laws on the ground that they have an impact on private-sector employer-sponsored health coverage. No court has addressed these issues directly. The Massachusetts state restaurant association challenged the Massachusetts Health Security Act but dropped the case when the law was repealed. Because of the way the law was drafted, opponents could not claim it imposed significant burdens on employee health plans themselves; instead, they asserted that ERISA preempted the law because it required employers (acting as plan sponsors) to evaluate their plans and modify them to minimize tax burdens. Whether this argument might have prevailed in the early 1990's, it seems very unlikely to succeed in the wake of the *Travelers Insurance* decision. A state facing this argument could respond that the incentive a pay or play law gives a plan administrator to re-evaluate whether to pay the tax or provide coverage is no different from the incentive in New York's differential hospital surcharges for plan administrators to evaluate which type of insurance to buy. In the words of the Supreme Court's *Travelers* opinion, the state law incentive does not *bind* plan administrators to any particular choice.<sup>12</sup>

Consequently, a law drafted like the Massachusetts Health Security Act should be defensible, unless a court was willing to hold that the influence of an employer tax was considerably more onerous than the

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<sup>11</sup> The tax was to equal 75 percent of the cost of a basic benefits package (to be defined by the state agency) for employee coverage and 50 percent of this cost for dependent coverage. The law also provided tax credits for small employers that began to cover their workers.

<sup>12</sup> A payroll tax that involves no credit for employer-sponsored coverage would undoubtedly cause employers to drop coverage, but since it is directed at the employer, not the employer-sponsored health plan, it should not raise ERISA preemption problems.

provider tax at issue in the *Travelers* case.<sup>13</sup> Because employers would probably pay the tax if it would cost less than covering workers, the pay or play program is likely to save money for an employer offering coverage making it harder to argue that the law imposes substantial costs on them. (Of course, an employer not offering coverage would incur higher costs due to the tax, but since it had not previously operated a health plan, the new tax would not impose costs on a *plan*.)

Other state laws and proposals would face more difficult ERISA preemption problems, however. The Oregon law referred to employer-sponsored health plans and imposed the tax on only non-insuring employers. The Tennessee bill (an employer health coverage mandate with a tax imposed for noncompliance) both referred to employer-sponsored plans and attempted to regulate them directly. Both these approaches resemble employer coverage mandates in contrast to the more neutral Massachusetts tax-plus-credit model. The more recent proposals in Washington and Maryland also would have set minimum benefits coverage standards for plans to qualify for the tax credit or reduced minimum wage.

As a *policy* matter, states may want to assure that an employee health plan in a pay or play program is adequate by some objective standards, but as a *legal* matter, ERISA would prohibit a state from regulating plans directly. The tax amount (and associated credit) would need to be set at a level that would cover an adequate insurance package from an actuarial standpoint, but that would not guarantee the adequacy of all workplace coverage by employers who were “playing.”<sup>14</sup>

## Designing State Pay or Play Laws to Avoid ERISA Preemption

Because no courts have considered a state employer pay or play law, it is not possible to be certain that one can entirely avoid an ERISA challenge, but the following design features should help a state defend a pay or play law:

- # **Do not require employers to offer health coverage to their workers.** Such employer mandates would be preempted under the precedent of the case that invalidated Hawaii’s law.
- # **Establish a universal coverage program funded in part with employer taxes.** The state’s legislative objective should be to establish a publicly-financed health coverage program that is

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<sup>13</sup> This surcharge could amount to as much as 24 percent of the cost of the hospital bill.

<sup>14</sup> Policy makers can hope that employers choosing to offer coverage would not buy a “bare bones” plan, such as high deductible, catastrophic coverage. If so, however, such a plan would probably be less expensive than the tax and the employer would pay some tax, which would enable the state to provide supplemental benefits for individuals with inadequate employer-sponsored coverage.

funded partially with taxes on all types of employers. Neither the law nor its sponsors should refer to objectives such as assuring that employers cover their workers.

- # **Do not refer to ERISA plans.** State laws are easily invalidated if they refer specifically to private-sector employer-sponsored (i.e., ERISA) health plans.<sup>15</sup> The pay or play tax should be imposed on *employers* not on the employer-sponsored plan and the law should not refer to such plans.<sup>16</sup>
- # **Remain neutral regarding whether employers offer health coverage or pay the tax.** If the state's objective is to assure universal coverage, it should be neutral with respect to whether an employer pays the tax or covers its workers. The justification for a tax credit is to permit employers to cover workers, but the law and its sponsors should not express a preference for either option.
- # **Impose no conditions on employer coverage to qualify for the tax credit.** Despite the state's concerns about adequacy of benefits packages, cost sharing, employer premium contributions, or other employer plan design features, conditioning the tax credit on meeting certain state qualifications will affect ERISA plan benefits and structure and therefore raise preemption problems. Like the Massachusetts Health Security Act (designed carefully to avoid these pitfalls), state laws that impose no standards on qualification for the tax credit stand the best chance of overcoming a preemption challenge.
- # **Minimize administrative impacts on ERISA plans.** States cannot tax ERISA plans directly; the pay or play tax must be imposed on the employer. While the state law does provide an incentive for the employer (in its capacity as ERISA plan administrator) to assess whether it is more preferable (from cost, management, and employee relations perspectives) to

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<sup>15</sup> Several courts have recently invalidated state "any willing provider" laws because they directly referred to employee health plans: *Cigna Healthplan v. State of Louisiana*, 82 F. 3d 642 (5<sup>th</sup> Cir. 1996), *cert. denied*, 519 U.S. 964 (1996); *Texas Pharmacy Assoc. v. Prudential Ins. Co.*, 105 F. 3d 1035 (5<sup>th</sup> Cir. 1997), *cert. denied*, 118 S. Ct 75 (1997); *Prudential Ins. Co. v. National Park Med. Ctr.*, 154 F. 3d 812 (8<sup>th</sup> Cir. 1998) (where the law attempted to exempt self-funded or other ERISA-exempt plans from the state law).

<sup>16</sup> A U.S. Supreme Court case involving workers' compensation health coverage might offer an additional argument supporting preemption. In *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992), the Court invalidated a D.C. law requiring employers that offer employee health insurance to provide equivalent coverage to injured employees eligible for workers' compensation. The Court held that ERISA preempted the D.C. law because it was "premised on" the existence of an ERISA health plan. Although a pay or play law's tax credit does depend on expenditures for an employee health plan, it is the tax credit, not the basic obligation to pay the tax, that depends on the existence of a health plan, and this should help states distinguish the *Washington Board of Trade* holding.

pay the tax or cover workers, this burden alone should not compel ERISA preemption. Designing the pay or play program like other state tax laws (e.g., for remitting unemployment compensation taxes or withholding employee income taxes) can overcome arguments that the state law interferes with interstate employer benefits design and administration, because employers already are subject to varying state tax systems

## **CONCLUSION**

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The Supreme Court has narrowed ERISA's preemptive reach in recent years, providing states more flexibility to finance access to health coverage. Because no court has considered a state employer pay or play law, such programs are likely to be challenged. But states should be able successfully to defend pay or play laws designed as suggested in this Issue Brief.

**Appendix A:**  
**Selected Provisions of Massachusetts Pay or Pay Law (Stat. 1988, Chapter 23)**

Massachusetts Labor and Industries Code 151A section 14G

**14G. Unemployment health insurance contribution; medical security contribution**

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(b) Each employer, except those employers who employ five or fewer employees, subject to the provisions of section fourteen, fourteen A, or fourteen C shall pay, in the same manner and at the same times as the director prescribes for the contribution required by section fourteen, a medical security contribution for each employee computed by multiplying the wages paid each employee by twelve per cent. For the purposes of this section, "employee" shall not include the following employees of any employer: (i) any employee who has been employed by such employer for fewer than ninety days from date of hire, (ii) any employee who normally works for fewer than thirty hours per week; provided, however, that any head of household who has dependent children living at home and is working at least twenty hours per week or any employee having worked at least five hundred and twenty hours in the prior six months shall be considered to be an employee for the purposes of this section; (iii) any employee who is hired to perform a service for a period of less than five months; (iv) any seasonal agricultural employee, who for the purposes of this section shall be defined as an individual who is employed in agricultural employment of a seasonal or other temporary nature; and (v) any employee who is covered by a group or nongroup health benefit plan which is financed without any participation by the employer, who is enrolled in the medicare program, or who is covered by a government operated medical assistance program; and provided, further, that any employee covered by a health insurance plan established pursuant to section nine of chapter one hundred and eighteen F shall be considered to be an employee for the purposes of this section. Each employee as defined in section one shall be presumed to be an employee as included in this section unless the employer certifies to the director, in such form and manner as the director may require, that such employee should not be included under the provisions of this section. Each employer may require any employee to verify his health insurance status pursuant to such rules and regulations as the director shall promulgate. No employer may require an applicant for employment to disclose his health insurance status or that of his spouse, dependents, or other family members. In no case may an employer discriminate against such applicant on the basis of said applicant's health insurance status. Any person aggrieved by a violation of the preceding two sentences may institute within three years of such violation a civil action for injunctive relief and any damages thereby incurred. Any employer found to be in violation pursuant to the action of the aggrieved person shall reimburse such reasonable attorney fees and court costs incurred in the protection of rights granted as shall be determined by the court.

(c) An employer may deduct from the amount owed for each employee under subsection (b) its average expenses per employee for providing health insurance coverage or other health care benefits for its employees, allowable for the current quarter by the Internal Revenue Service as a deductible business expense; provided, however, that any nonincorporated employer may deduct from the amount owed for each employee under subsection (b) its average expenses per employee for providing health insurance coverage or other health care benefits for its employees as reported and allowed pursuant to rules and regulations promulgated by the director; and provided, further that such deduction for any employer shall not reduce the contribution for any employee below zero.

...

(e)(1) For the purposes of this section, the term “wages” shall not include that part of remuneration which, after remuneration equal to the medical security wage base with respect to employment with such employer has been paid to an individual during the calendar year, is paid to such individual during such year. For the purposes of this paragraph, remuneration shall include remuneration paid to an individual during the calendar year with respect to employment with a transferring employer, as that term is used in subsection (n) of section fourteen.

(2) For the purposes of this section, the term “medical security wage base” shall mean fourteen thousand dollars for the calendar years nineteen hundred and ninety to nineteen hundred and ninety-two, inclusive. For each subsequent calendar year the medical security wage base shall equal the product of (i) the medical security wage base for the previous calendar year and (ii) the sum of one and the health insurance inflation rate for the then previous calendar year, as reported by the rate review board established pursuant to subsection (h).

(f)(1) The provisions of this section shall not apply to an employer newly subject to this chapter, as defined in paragraph (3) of subsection (i) of section fourteen, until it has been an employer for not less than the twelve consecutive months’ period specified in paragraph (1) of subsection (b) of section fourteen.

(2) During the first calendar year in which this section applies to an employer newly subject to this chapter pursuant to paragraph (1): (i) such employer’s unemployment health insurance contribution shall be computed by substituting in subsection (a) the words “four hundredths of one per cent” for the words “twelve hundredths of one per cent”, and (ii) such employer’s medical security contribution shall be computed by substituting in subsection (b) the words “four per cent” for the words “twelve per cent”.

(3) During the second calendar year in which this section applies to an employer newly subject to this chapter pursuant to paragraph (1): (i) such employer’s unemployment health insurance contribution shall be computed by substituting in subsection (a) the words “eight hundredths of one per cent” for the words “twelve hundredths of one per cent”, and (ii) such employer’s medical security contribution shall be computed by substituting in subsection (b) the words “eight per cent” for the words “twelve per cent”.

(g) Except where inconsistent with the provisions of this section, the terms and conditions of this chapter which are applicable to the payment of and the collection of contributions or payments in lieu of contributions shall apply to the same extent to the payment of and the collection of such unemployment health insurance contribution and such medical security contribution; provided, however, that said contributions shall not be credited to the employer’s account or the solvency account established pursuant to section fourteen, fourteen A, or fourteen C of this chapter.

...

Massachusetts Public Welfare Code 118F

## **9. Group insurance; purchase for commonwealth residents**

The department shall, subject to appropriation or subject to the availability or unappropriated funds, negotiate with and purchase, on such terms as it deems to be in the best interest of the department and its

enrollees, from one or more insurance companies, hospital service corporations, medical service corporations, or health maintenance organizations, a policy or policies of group general or blanket insurance providing hospital, surgical, medical, and other health insurance benefits covering the following persons: (1) residents of the commonwealth, and their dependents, who are receiving benefits under chapter one hundred and fifty-one A and who are not enrolled in health insurance plans, self-insurance health plans, or medical assistance programs, (2) employees and their dependents not eligible for group health insurance partially or fully paid for by employers and who are not enrolled in any other health insurance plans, self-insurance health plans, or medical assistance programs, and (3) all other residents of the commonwealth not enrolled in health insurance plans, self-insurance health plans, or medical assistance programs.

The department shall execute all agreements or contracts pertaining to said policies or any amendments thereto for and on behalf and in the name of the department. Said department may negotiate any contract for such term not exceeding three years as it may in its discretion deem to be the most advantageous to the department and its enrollees; provided, however, that the department shall endeavor to contract with such insurance companies, a hospital service corporation, or medical service corporations only for managed health care plans or for health insurance plans which employ other methods to reduce costs of health care services; provided, further, that the department shall ensure that every enrollee shall have a choice of at least two plans providing health care insurance benefits; and provided, further, that not more than thirty percent of the enrollees may be enrolled in a health insurance plan of a single health insurance company, hospital service corporation, or health maintenance organization.

The department shall promulgate regulations regarding eligibility criteria, enrollment, and termination policies. The department shall establish procedures consistent with the provisions of chapter thirty A by which individuals who participate or are seeking to participate in the health insurance program of the department may appeal determinations of noneligibility, enrollment, and termination. The department shall allow, on an annual basis, an opportunity for enrollees to transfer their enrollments among participating health insurance plans.

The department shall establish a schedule of premium contributions, copayments, deductibles, or co-insurance amounts to be paid by individual enrollees for any policy or policies purchased by the department. The schedule shall establish a sliding scale of payments for enrollees based on family income and size and any other factor or factors determined to be relevant or appropriate by the department; provided, however, that such schedule shall provide for enrollees to pay one hundred per cent of such premium contributions if their income substantially exceeds the non-farm poverty guidelines of the United States office of management and budget. The department shall establish procedures by which any enrollee may appeal the determination of his contribution.

The department shall require that any insurance company, hospital service corporation, medical services corporation, or health maintenance organization, shall provide a reasonable range of health care services to enrollees shall establish grievance procedures which are approved by said department and, in the case of actions taken directly by the department, the department shall establish its own grievance procedures. Such procedures shall not be subject to the requirements of chapter thirty A.

Any health insurance plan provided by the department to its enrollees through a contract with a health insurance company, hospital service corporation, medical service corporation, or health maintenance organization, shall provide a reasonable range of health care services to enrollees, shall ensure access to an adequate range of health care providers, and shall include any mandated benefits otherwise required by law. Any such health insurance plan which constitutes a managed health care plan shall provide, at a minimum,

the following benefits: inpatient and outpatient acute hospital services, inpatient and outpatient physician services, diagnostic and screening tests, preventive care, prenatal and well-baby care; medically necessary emergency health services; and all other benefits which health maintenance organizations are required by law to provide. For the purposes of this chapter, the term “physician” shall include a podiatrist acting within the limitations imposed by section thirteen of chapter one hundred and twelve.

The department may, consistent with business practices in the health insurance industry, pay in advance for any health insurance plan purchased from a health insurance company, hospital service corporation, medical service corporation, or health maintenance organization.