

HAS ERISA CLOSED OUR LABORATORIES? OPTIONS FOR STATE HEALTH REFORM

INTRODUCTION

An individual's health and access to medical care are considered by many to be unassailable human rights.¹ This concept separates the medical care and health insurance industries from every other industry in our society. Since the beginning of the twentieth century, countries throughout the world have recognized the unique importance of medical care.² As a result, many have implemented universal healthcare systems to assure access to care for all of their citizens.³ Despite several efforts, the United States has never installed a system ensuring healthcare for the entire population.⁴ Consequently, a significant uninsured population exists in the United States.⁵ In 2006, the United States Census Bureau estimated the uninsured population to be forty-seven million Americans, representing 15.8% of the American population.⁶ While this number represents the largest uninsured population this country has ever faced, the United States has had more than thirty million uninsured individuals every year for the past two decades.⁷ In fact, according to a study conducted by Families USA, one in three

1. Universal Declaration of Human Rights, G.A. Res. 217A (III), at Article 25, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc A/810 (Dec. 12, 1948).

2. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 236-40 (1982) (describing the numerous European countries implementing a variety of health plans prior to World War I).

3. *Id.*

4. See Karen Davis, *Universal Coverage in the United States: Lessons from Experience of the 20th Century*, 78 J. URBAN HEALTH 46, 46-48 (2001) (discussing the attempts by Presidents Roosevelt, Truman, Eisenhower, Kennedy, Johnson, Nixon, Carter, Bush, and Clinton to expand healthcare and provide universal coverage); see also John E. McDonough, *The Road to Universal Health Coverage in Massachusetts: A Story in Three Parts*, NEW ENG. J. PUB. POL'Y, Fall 2004/Winter 2005, at 57, 57-58 (discussing the attempts of former Presidents to expand health coverage for various groups of Americans).

5. Gail R. Wilensky, *Viable Strategies for Dealing with the Uninsured*, HEALTH AFF., Spring 1987, at 33, 34.

6. CARMEN DENAVAS-WALT ET AL., U.S. DEP'T OF COMMERCE, U.S. CENSUS BUREAU, *INCOME, POVERTY, AND HEALTH INSURANCE IN THE UNITED STATES: 2006*, at 18 (2007), available at www.census.gov/prod/2007pubs/p60-233.pdf (last visited Feb. 13, 2009) [hereinafter 2006 CENSUS].

7. *Id.*; see also Wilensky, *supra* note 5, at 35.

Americans under the age of sixty-five was uninsured for all or part of 2006-2007.⁸ One of the leading reasons for the growing uninsured population is the decrease in employer-based health insurance.⁹ Traditionally, the perception has been that the uninsured population is largely comprised of unemployed individuals.¹⁰ However, in reality, four out of five uninsured individuals are members of working families.¹¹ This large percentage of uninsured, working individuals highlights the need for an affordable healthcare option and a shift in the way legislators perceive the necessity of healthcare reform.

The federal government has repeatedly enacted legislation attempting to reduce the number of uninsured Americans and protect the most vulnerable populations in society. These efforts include the creation of Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).¹² While these programs have had limited success in protecting the elderly, portions of the poor and disabled populations, and poor children, the number of uninsured in America continues to rise.¹³ The failure of the federal government to reduce the uninsured population has prompted states to take steps to insure the health of their citizens.

As noted by Justice Brandeis in *New State Ice Co. v. Liebmann*, states have long been recognized as the country's "laboratories."¹⁴ Since Justice Brandeis' famous words over seventy years ago, the growing uninsured population and the rapid escalation of medical costs have amplified the

8. FAMILIES USA, WRONG DIRECTION: ONE OUT OF THREE AMERICANS ARE UNINSURED 9 (2007), available at www.familiesusa.org/assets/pdfs/wrong-direction.pdf (last visited Feb. 13, 2009).

9. 2006 CENSUS, *supra* note 6, at 18 ("The percentage of people covered by employment-based health insurance decreased to 59.7 percent in 2006, from 60.2 percent in 2005."); THE HENRY J. KAISER FAMILY FOUND., THE UNINSURED AND THEIR ACCESS TO HEALTH CARE 1 (2007), available at www.kff.org/uninsured/upload/1420-10.pdf (last visited Feb. 13, 2009).

10. See Democratic Policy Committee, The Uninsured in America: Expert Panel Spotlights Consequences of Not Having Health Insurance, at <http://democrats.senate.gov/dpc/dpc.cfm?A=fs&B=108&C=1&D=355> (last visited Feb. 13, 2009); see also The NewsHour with Jim Lehrer/Kaiser Family Found., Survey Highlights: Part 1, PUBLIC BROADCASTING SYSTEM, at www.pbs.org/newshour/health/uninsured/survey_highlights.html (last visited Feb. 13, 2009).

11. THE HENRY J. KAISER FAMILY FOUND., *supra* note 9 (discussing the uninsured population in the U.S. in 2006).

12. Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., CMS Programs and Information, at www.cms.hhs.gov (last visited Feb. 13, 2009). See 42 U.S.C. § 1395 et seq. (Medicare) See 42 U.S.C. § 1396 et seq. (Medicaid); See H.R. 2015 (known as the Balanced Budget Act of 1997 which created the SCHIP program).

13. 2006 CENSUS, *supra* note 6, at 19.

14. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Justice Brandeis describing the benefit of states experimenting without putting the rest of the country at risk).

need for state experimentation. In 2004, the estimated cost of uncompensated care for the uninsured was forty-one billion dollars, with state governments paying roughly twenty-seven percent of those costs.¹⁵ To combat their expanding financial obligation, state governments have attempted to enact a spectrum of legislation geared to increase coverage for citizens and lower medical costs. However, the preemption clause included in the Employee Retirement Income Security Act of 1974 (ERISA) severely limits state innovation.¹⁶ When ERISA was passed, “almost no one imagined [the current] medical marketplace dominated by managed care;” thus the language of ERISA frequently conflicts with states’ health reform efforts.¹⁷ Consequently, the federal legislation preempts these reforms.¹⁸ Therefore, states not only have to be innovative with their health reform efforts, but they must also be equally innovative in drafting the reform in order for it to survive an ERISA challenge. With the majority of Americans stating that they favor both mandated health insurance and the continuation of employers financially contributing to the rising cost of healthcare, pressure is mounting on state officials to implement comprehensive health reform.¹⁹

The purpose of this article is to provide state legislatures with a how-to guide for drafting health reform legislation that will avoid ERISA preemption. Part I of this article provides a brief history of ERISA and the intent behind its creation followed by an examination of the relevant parts of the statute: the preemption clause, the savings clause, and the deemer clause. While the savings and deemer clauses are critical for understanding the preemption

15. THE HENRY J. KAISER FAMILY FOUND., *THE UNINSURED: A PRIMER* 11 (2007), available at www.kff.org/uninsured/upload/7451-03.pdf (last visited Feb. 13, 2009) [hereinafter *THE UNINSURED*].

16. Protection of Employee Benefit Rights, Pub. L. No. 93-406 § 514, 88 Stat. 832 (1974), (codified as amended at 29 U.S.C. §§ 1001-1461 (2000)); Walter E. Schuler, Note, *The ERISA Pre-Emption Narrows: Analysis of New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company and Its Impact on State Regulation of Health Care*, 40 ST. LOUIS U. L.J. 783, 783-784 (1996) (describing ERISA as “the most formidable obstacle to state health care reform efforts”).

17. M. Gregg Bloche & David M. Studdert, *A Quiet Revolution: Law as an Agent of Health System Change*, HEALTH AFF., Mar./Apr. 2004, at 29, 30.

18. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 108-109 (1983) (holding elements of New York’s Human Rights Law preempted by ERISA); *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 197-198 (4th Cir. 2007) (declaring Maryland’s Fair Share Act preempted by ERISA); *Retail Indus. Leaders Ass’n v. Suffolk County*, 497 F.Supp.2d 403, 418-419 (E.D.N.Y. 2007) (holding Suffolk County’s Fair Share for Health Care Act preempted by ERISA).

19. SARA R. COLLINS & JENNIFER L. KRISS, *THE COMMONWEALTH FUND, THE PUBLIC’S VIEWS ON HEALTH CARE REFORM IN THE 2008 PRESIDENTIAL ELECTION* 3-4 (2008), available at www.commonwealthfund.org/usr_doc/Collins_pubviewshltcarereform2008election_1095_ib.pdf?section=4039 (last visited Feb. 13, 2009).

clause, the discussion of this article centers around the preemption clause and its application to state health reform. Part II first outlines ERISA's judicial history relating to state reform on employer-based health plans, focusing on the Supreme Court cases of *Shaw*²⁰ and *Travelers*²¹ and the recent Fourth Circuit *Fielder*²² case. Part II then discusses a framework to utilize in evaluating ERISA challenges to state health reform. Part III introduces Massachusetts' 2006 health insurance legislation, "An Act Providing Access to Affordable, Quality, Accountable Healthcare (Massachusetts Act)",²³ and addresses the sections of the legislation that are vulnerable to an ERISA challenge.²⁴ Finally, Part IV delineates the lessons learned from case law and offers a comprehensive reform plan that would provide all of the benefits of the Massachusetts Act without the employer mandate and the accompanying ERISA concerns.

I. THE ORIGIN AND PURPOSE OF ERISA

A. *Historical Background of ERISA*

Congress enacted ERISA in 1974 to protect employee pension plans.²⁵ Throughout the 1960s and early 1970s, pension plan abuse increased dramatically, and no enforcement mechanisms existed to combat the problem.²⁶ Despite previous legislative attempts, no guarantee existed that benefits would ever be paid to the thirty million people who held pension plans in 1970.²⁷ The passage of ERISA federalized pension law provided a necessary enforcement mechanism to ensure the delivery of benefits.²⁸ To achieve this federalization, Congress recognized the importance of national uniformity and included a strong preemption clause in the legislation.

ERISA's preemption clause, Section 1144(a), states that "the provisions of this [Act] . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ."²⁹ The preemption

20. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

21. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 649 (1995).

22. *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007).

23. *An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts c. 58*, at www.mass.gov/legis/laws/seslaw06/sl060058.htm (last visited Feb. 13, 2009).

24. *Id.*

25. David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT L. REV. 427, 443, 446 (1987).

26. *Id.* at 443.

27. *Id.*

28. *Id.* at 446.

29. 29 U.S.C. § 1144(a) (2000).

clause is interesting in a number of aspects: the reach of the preemption clause is unusually broad and the language of the legislation puts very few limits on the preemptive powers. These strengths of the preemption clause are credited to the conference committee whose members believed that the preemptive power of the original bill was insufficient.³⁰ While this strong preemption clause was essential to achieve national uniformity, relating to pension law, it has created a “regulatory vacuum” regarding employee benefit plans.³¹ Unlike most federal legislation, ERISA’s preemption clause prohibits states from regulating an area that federal law does not address: employee health insurance.³² Finally, courts have interpreted the vague “relates to” language broadly for the past three decades.³³ This broad interpretation will be discussed in detail later in this article.

An employee benefit plan is defined as “any plan, fund, or program . . . established or maintained by an employer or by an employee organization . . . for the purpose of providing for its participants or their beneficiaries . . . medical, surgical, or hospital care or benefits”.³⁴ Consequently, most employer health insurance plans fall under the regulation of ERISA, and state laws attempting to regulate employee benefit plans invoke ERISA’s preemption clause. Additionally, two other important clauses are included in Section 1144. The first is 1144(b)(2)(A), the “savings clause,” which states that the preemption clause shall not “be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”³⁵ The savings clause carves out an area for states to regulate insurance companies, banks, and securities companies. While the savings clause clearly reserves the states’ ability to regulate certain areas, the next subsection of 1144, the “deemer clause,” severely limits the scope of the savings clause. The deemer clause asserts that states cannot deem employers to be “insurers,” nor can states deem

30. See CAROL S. WEISSERT & WILLIAM G. WEISSERT, *GOVERNING HEALTH: THE POLITICS OF HEALTH POLICY* 42 (3d ed. 2006).

31. Daniel M. Fox & Daniel C. Schaffer, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 *AM. J. TAX POL’Y* 47, 48 (1988).

32. DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 467 (3rd Cir. 2003) (discussing ERISA’s power to preempt state law without providing guidance in the area); see also Fox & Schaffer, *supra* note 31, at 48 (stating “[t]he preemption clause of ERISA is unusual because it forbids the states to regulate employee benefits even when federal law is silent.”).

33. See Deborah S. Davidson, Note, *Balancing the Interests of State Health Care Reform and Uniform Employee Benefit Laws Under ERISA: A “Uniform Patient Protection Act”*, 53 *WASH. U. J. URB. & CONTEMP. L.* 203, 205 (1998).

34. 29 U.S.C. § 1002(1) (2000).

35. 29 U.S.C. § 1144(b)(2)(A) (2000).

employee benefit plans to be insurance.³⁶ Furthermore, self-funded plans are not insurance and therefore laws regulating self-funded plans cannot be protected by the savings clause.³⁷ The vast majority of health benefit plans are self-funded plans and fit within the deemer clause, and thus cannot be saved under the savings clause.³⁸ As a result, many laws relating to health benefit plans offered by employers are not saved from the broad reach of the preemption clause.

While ERISA has largely succeeded in achieving the protection and uniformity Congress desired for pension plans, the broad scope and ambiguous language of the preemption clause often results in unintended consequences. The stifling of state innovation, essentially shutting down the nation's health reform laboratories, is one of the most detrimental of these consequences.

II. THE JUDICIAL HISTORY OF THE PREEMPTION CLAUSE

A. ERISA Case Law

The ambiguity of the preemption clause forces states to rely on court rulings to determine the breadth of the statute. For the first two decades after ERISA's enactment, case law suggested that the preemption clause was unrestricted. A footnote in *Shaw v. Delta Airlines, Inc.* was the first suggestion that the preemption clause was not limitless.³⁹ Despite this comment, the *Shaw* Court still found that the New York Human Rights Law at issue was preempted by ERISA because it "related to" employee benefit plans.⁴⁰ The Supreme Court's opinion in *Shaw* provided the first insight into how the Court would approach ERISA preemption by attempting to define "relates to." First, the Court stated that a "law 'relates to' an employee benefit plan . . . if it has a connection with or reference to such a plan."⁴¹

36. 29 U.S.C. § 1144(b)(2)(B) (2000) ("[No] employee benefit plan...shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State.").

37. *Id.*

38. Ctr. for Financing, Access, and Cost Trends, Agency for Healthcare Research & Quality. U.S. Dep't of Health & Human Servs., Medical Expenditure Panel Survey, Percent of Private-Sector Enrollees that Are Enrolled in Self-Insured Plans at Establishments That Offer Health Insurance by Firm Size and State: United States, 2005, at tbl.II.B.2.b(1), available at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2005/tiib2b1.pdf (last visited Feb. 13, 2009).

39. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 84, 100 n.21 (1983) (stating that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan.").

40. *Id.* at 86.

41. *Id.* at 96-97.

The Court determined that unless there was an indication that Congress intended the use of a different definition, the plain language definition of “relates to” should be used to determine if a law falls within the scope of ERISA.⁴² This broad definition was applied for over a decade to evaluate state laws. However, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company* eventually addressed the language that the *Shaw* Court introduced in its footnote.⁴³

Travelers is viewed by many scholars as a “paradigm shift” in the Court’s interpretation of the preemption clause toward a more relaxed standard that allows state legislatures more flexibility.⁴⁴ The Court in *Travelers* determined that a New York state statute requiring hospitals to collect surcharges from patients with health insurance from a commercial insurer, rather than a Blue Cross/Blue Shield plan, and placing surcharges on health maintenance organizations (HMOs) that vary depending on the number of Medicaid recipients enrolled in the plan, was not preempted by ERISA.⁴⁵ In so deciding, the Court noted that “pre-emption claims turn on Congress’s intent”.⁴⁶ Congress intended to create a uniform body of law and to minimize administrative burdens on multi-state employers.⁴⁷ The Court also noted that the “relates to” analysis established in *Shaw* was flawed because “[i]f ‘relate to’ were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for ‘[r]eally, universally, relations stop nowhere’”.⁴⁸ With this statement, the Court created a new framework to apply when a state law was challenged on ERISA preemption grounds.

The framework created by *Travelers* Court centered on Congress’s desire for a uniform body of law for multi-state employers to follow when establishing employee benefit plans.⁴⁹ Consequently, ERISA preempts state laws that mandate “employee benefit structures or their administration.”⁵⁰

42. *Id.* at 97.

43. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995).

44. Sharon Reece, *ERISA Preemption and Fair Share Legislation* 11 (Univ. of Md. Sch. of Law, Working Paper No. 2007-23, 2007), at <http://ssrn.com/abstract=1006026> (last visited Feb. 13, 2009); see also PATRICIA A. BUTLER, *ERISA AND STATE HEALTH CARE ACCESS INITIATIVES: OPPORTUNITIES AND OBSTACLES* 3 (2000), available at www.commonwealthfund.org/Content/Publications/Fund-Reports/2000/Oct/ERISA-and-State-Health-Care-Access-Initiatives--Opportunities-and-Obstacles.aspx (last visited Feb. 13, 2009).

45. *Travelers Ins. Co.*, 514 U.S. at 649.

46. *Id.* at 655.

47. *Id.* at 656-57.

48. *Id.* at 655 (quoting H. James, Roderick Hudson xli (New York ed., *World’s Classics* 1980)).

49. *Id.* at 656-57.

50. *Travelers Ins. Co.*, 514 U.S. at 658.

However, an indirect economic influence “does not bind plan administrators to any particular choice”, and therefore state laws that only impose an indirect economic influence are not preempted.⁵¹ The *Travelers* Court’s reasoning stemmed from the footnote in *Shaw* and sets the case apart from every preceding ERISA decision.⁵²

The Court limited the preemption clause further when it noted that nothing in the federal statute suggested that Congress intended to supplant state laws concerning “general health care regulation, which historically has been a matter of local concern.”⁵³ The protection of areas that have historically fallen under state regulation is cited by many legislators and scholars in their attempt to defend state laws from ERISA preemption.⁵⁴ Importantly, the Court stated that “cost uniformity was almost certainly not an object of pre-emption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those ‘conflicting directives’ from which Congress meant to insulate ERISA plans.”⁵⁵ However, the preemption exception carved out in *Travelers* is limited in scope.

The Court placed the boundary of the exception at the point in which a law created a “Hobson’s choice” by installing taxes or assessments so prohibitive that the choice offered was no real choice.⁵⁶ The Court further noted

that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be pre-empted under § 514.⁵⁷

This language is critical because it established that while a state law might not explicitly influence an employee benefit plan, ERISA still preempts the law if it has a strong enough indirect effect on the plan. Therefore, to avoid ERISA preemption, state legislatures must draft legislation that does not

51. *Id.* at 659.

52. *Id.* at 661 (discussing *Shaw*, citing *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 130 n.1 (1992)).

53. *Id.*

54. See *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 203 (4th Cir. 2007); see also Maureen McOwen, Note, *Through the Eye of the Needle: How the New York City Health Care Security Act Will Escape ERISA Preemption*, 40 COLUM. J.L. & SOC. PROBS. 37, 64 (2006); PATRICIA A. BUTLER, NAT’L ACAD. FOR STATE HEALTH POL’Y, ERISA IMPLICATIONS FOR STATE HEALTH CARE ACCESS INITIATIVES: IMPACT OF THE MARYLAND “FAIR SHARE ACT” COURT DECISION 8 (2006), a www.statecoverage.org/node/170 (last visited Feb. 13, 2009) [hereinafter BUTLER, FAIR SHARE ACT].

55. *Travelers Ins. Co.*, 514 U.S. at 662.

56. *Id.* at 664.

57. *Id.* at 668.

directly mention employee benefit plans, directly interfere with the structure or administration of the plans, or have a strong indirect effect on plans or their administration.

Since the decision in *Travelers*, many states have either drafted or enacted state health reforms.⁵⁸ One of these reforms, Maryland's Fair Share Health Care Fund Act (the Fair Share Act), both provides a useful example of the application of the *Travelers* frameworks and offers additional insight into how courts might apply ERISA's preemption clause.

Maryland's Fair Share Act mandated employers with more than 10,000 employees in the state of Maryland to contribute a "fair share" to their employees' healthcare costs.⁵⁹ Employers could satisfy this requirement in two ways: 1) use eight percent of their payroll to fund employee healthcare or health insurance, or 2) pay the state eight percent of their payroll or the difference between the amount that they spent on healthcare and eight percent of their payroll.⁶⁰ There were only four employers with more than 10,000 employees in the state of Maryland, and of the four employers Wal-Mart was the only employer who was not already contributing at least eight percent of its payroll to employee health care.⁶¹ The Fair Share Act quickly came under fire from the Retail Industry Leaders Association, who claimed the law was preempted by ERISA.⁶² After looking at the nature and effect of the Fair Share Act to determine whether it fell within ERISA's preemption, the Fourth Circuit affirmed the District Court's decision that ERISA preempted the Act.⁶³ The court reasoned that there was no real choice offered by the Fair Share Act because employers would always choose to build good will with their employees by offering health coverage rather than pay the state.⁶⁴ Consequently, the Court determined the Fair Share Act illegally mandated that the structure of employee benefit plans.⁶⁵ Further, the Court stated the Fair Share Act conflicted with Congress's desire to have uniformity because other states could easily adopt similar laws placing conflicting requirements on multi-state employers.⁶⁶ The Fair Share Act was preempted because it

58. See Gail A. Jensen & Michael A. Morrissey, *Employer-Sponsored Health Insurance and Mandated Benefit Laws*, 77 MILBANK QUARTERLY 425, 425 (1999).

59. MD. CODE ANN., LAB. & EMPL. § 8.5-102 (West 2008).

60. MD. CODE ANN., LAB. & EMPL. § 8.5-104(b) (West 2008).

61. Reece, *supra* note 44, at 18; Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 185 (4th Cir. 2007).

62. See generally Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180 (4th Cir. 2007).

63. *Id.* at 183, 193.

64. *Id.* at 193.

65. *Id.*

66. *Id.* at 194.

“related to” employee benefit plans and it conflicted with the Congressional intent behind ERISA.⁶⁷

Rather than simply applying the *Travelers* reasoning, the *Fielder* Court discussed several other factors in its decision. The Court gave weight to the fact that the Maryland legislature knew that the Fair Share Act would only apply to Wal-Mart, and the goal of the law was to have Wal-Mart provide health insurance to more of its employees.⁶⁸ This point is salient because it shows that the Court looks beyond the four corners of state legislation to determine the legislature’s objectives. Hence, a state cannot express on the record an aspiration to have employers cover more of the healthcare costs of their employees. Additionally, the Court pointed out that the Fair Share Act could not be considered a law of general applicability because the legislature knew that it would only affect, at most, four employers.⁶⁹ This statement suggests that any state health reform directed at employers must be broad in its application to avoid ERISA concerns. Although *Fielder* is not binding precedent beyond the Fourth Circuit, the case has received national attention and is likely to impact other circuits. When the factors discussed in *Fielder* are combined with the rules established in *Shaw*, *Travelers*, and other cases in which state laws were challenged by ERISA preemption, a framework can be created for state legislatures to use to evaluate the likelihood a law will survive an ERISA challenge.⁷⁰

B. Framework to Apply to State Laws

While ERISA was enacted over three decades ago, a tremendous amount of confusion remains about the law and how courts will apply the law. Numerous scholars have examined court holdings in an attempt to predict the application of the statute to future cases. The combination of these attempts yields a comprehensive framework to direct state legislatures.

1. Is the Law in an Area Traditionally Regulated by the States?

To determine whether a law pertains to an area traditionally regulated by the states, state legislatures should first consider how Congress intended ERISA to function. Both *Travelers* and *Fielder* emphasize that courts have denied the application of the preemption clause to areas that have

67. See *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 193-194 (4th Cir. 2007).

68. *Id.* at 185.

69. *Id.* at 194.

70. See, e.g., *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990) (discussing the variety of rules established in *Shaw*); see also *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 325 (1997).

historically been regulated by states.⁷¹ *DeBuono v. NYS-ILA Medical & Clinical Services Fund* declared that these areas “include the regulation of matters of health and safety.”⁷² As one author comments, under the *Travelers* exception, if the area of law is one typically reserved for the state, there is a strong presumption against preemption; however, if the area of law is not typically one reserved for the state, there is a strong presumption of preemption.⁷³ This interpretation seems to suggest that *Travelers* added another exception to the “too tenuous” exception to apply when evaluating whether a law “relates to” ERISA plans. This possible additional exception highlights the confusion still surrounding the limits of “relates to.” After determining whether a law regulates an area of traditional state authority, and whether there is a presumption of preemption, state legislatures must consider whether the law “relates to” an ERISA plan.

2. Does the Law “Relate to” Employee Benefit Plans?

Because the phrase “relates to” has not been interpreted uniformly, there are several elements that must be considered to determine whether a state law “relates to” an ERISA plan. The *Shaw*, *Travelers*, and *Fielder* cases provide examples of these varying interpretations. Some courts have examined whether the law relates to an ERISA plan in the traditional sense of the word. The *Shaw* Court employed this approach.⁷⁴ Under this interpretation, a law is preempted if it explicitly refers to an employee benefit plan.⁷⁵ Usually if a law falls into this category it requires employers to provide a specific type of coverage.⁷⁶ Plans that implicitly require employers to provide specific coverage are likewise considered to relate to ERISA plans and are henceforth preempted.⁷⁷ A second interpretation examines whether the law “regulates the same areas as ERISA (such as reporting, disclosure, or remedies)[.]”⁷⁸ The final element that a court examines to determine whether a law relates to an ERISA plan is whether or not the law relies on the existence of ERISA plans to take effect.⁷⁹ If a law depends on an ERISA

71. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995); *Fielder*, 475 F.3d at 191.

72. *De Buono v. NYS-ILA Medical & Clinical Services Fund*, 520 U.S. 806, 814 (1997).

73. Schuler, *supra* note 16, at 813.

74. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983).

75. *Id.* at 97.

76. Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Preemption*, 13 YALE J. ON REG. 255, 264 (1996).

77. *Id.*

78. BUTLER, *supra* note 44, at 4.

79. McOwen, *supra* note 54, at 59; see, e.g., *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139-40 (1990) (finding that a Texas law that depended on the existence of a pension plan for recovery was preempted); see also Cal. Div. of Labor Standards Enforcement

plan to take effect, a court considers the law to implicitly refer to the plan.⁸⁰ If the court determines that the state law does not relate to an ERISA plan under any of these categories, it then evaluates if the law has a “connection with” an ERISA plan.

3. Does the Law Have a “Connection to” Employee Benefit Plans?

To decide if a law has a connection to an ERISA plan, a court must look at the nature of the law’s effect on employee benefit plans.⁸¹ The *Travelers* Court utilized this type of analysis.⁸² The first step in evaluating whether the law has a connection is to determine if the law is one of general applicability. If the law is not one of general application, the likelihood that it will be preempted is higher.⁸³ However, if the law is generally applicable the court next looks at the effect that it will have on ERISA plans.⁸⁴ If there is only a limited, economic effect on the ERISA plan the court will likely rule, similarly to *Travelers*, that the law is not preempted. However, if the effect is “acute, albeit indirect,” the court will likely find that the law has a connection with the ERISA plan and is consequently preempted.⁸⁵ If the court determines that the economic effects are not severe enough to establish a connection and invoke the preemption clause, the court examines the other effects of the law.

If a state law affects the structure or administration of an employee benefit plan, it will be preempted by ERISA.⁸⁶ A direct mandate of a coverage type or the creation of a “Hobson’s choice” establishes these effects.⁸⁷ For example, in *Fielder*, Wal-Mart’s choice to either spend eight percent of its payroll on employee healthcare or pay eight percent of its payroll to the government was considered a Hobson’s choice.⁸⁸ Courts

v. *Dillingham Constr.*, 519 U.S. 316, 328, 332 (1997) (finding that because a California law did not require an ERISA plan in order to be enforced it did not relate to an ERISA plan and was therefore not preempted).

80. McOwen, *supra* note 54, at 59; see also *Ingersoll-Rand Co.*, 498 U.S. at 140.

81. Edward A. Zelinsky, *Maryland’s “Wal-Mart” Act: Policy and Preemption*, 28 CARDOZO L. REV. 847, 859-862 (2006) (quoting *Egelhoff, v. Egelhoff*, 532 U.S. 141, 147 (2001)).

82. See generally *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 649, 658-660 (1995).

83. See *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 198 (4th Cir. 2007).

84. Schuler, *supra* note 16, at 814.

85. *Travelers*, 514 U.S. at 668.

86. *Id.* at 658.

87. *Id.* at 664. A Hobson’s choice is “an apparent freedom to take or reject something offered when in actual fact no such freedom exists: an apparent freedom of choice where there is no real alternative” Webster’s Third New International Dictionary (Philip Babcock Gove et al. eds., 1993).

88. *Retail Indus. Leaders Ass’n v. Fielder*, 475 U.S. 180, 202 (2007) (Michael, J., dissenting).

have held that a Hobson's choice is the equivalent of a substantive mandate and therefore impermissibly regulates the structure of employee benefit plans.⁸⁹ The state law may avoid preemption if it provides a genuine choice for employers. However, several scholars note that this exception turns on whether or not employers are bound to a particular decision rather than the availability of choices that are outlined in the law.⁹⁰ The ambiguity of what binds an employer to a particular choice and what constitutes a legitimate choice is the topic of debate among scholars, leading to continued uncertainty about the fate of state health reform efforts.⁹¹

The state of Massachusetts recently enacted a healthcare reform plan. Applying the established framework to examine whether the new Massachusetts plan allows us to determine if the law will survive a preemption challenge. First, whether the Massachusetts statute regulates an area of traditional state authority should be evaluated. Next, whether or not the statute relates to ERISA plans must be established. Finally, it must be determined whether the statute has a connection with ERISA plans and, if so, whether the connection is direct enough to invoke the preemption clause.

C. *What We Have Learned About the Preemption Clause*

While case law provides some guidance about what types of legislation will be preempted by ERISA, significant ambiguity remains about how courts will apply the preemption clause to several areas of state health reform. Without Congressional or judicial direction, this uncertainty will continue to obscure reform efforts. However, a path for state legislatures to follow can be predicted by reviewing relevant case law.

Between *Shaw*, *Travelers*, and *Felder*, courts have distinguished particular types of legislation that will likely be preempted. While several scholars have produced checklists of steps for legislatures to follow, these guides are largely incomplete.⁹² However, the blending of these previous

89. *Id.* at 197.

90. See Reece, *supra* note 44, at 14 ("There is nothing in [the *Traveler* Court's] language that suggests the Court was implying that a state law can avoid pre-emption by offering some sort of "choice" for employers or plan administrators."); see also David B. Brandolph, *Reform Proposals: Practitioners Debate Impact of Court Ruling Against Maryland's 'Fair Share' Coverage Law*, 15 HEALTH CARE POL'Y REP. (BNA) No. 4, at 136 (Jan. 29, 2007), at <http://pubs.bna.com/ip/BNA/HCP.NSF/05c90bd7c41c619b85256b570059988c/f4b8bb1769a7edf88525726f00790deb?OpenDocument> (last visited Feb. 13, 2009) ("fair share laws cannot hide behind the rhetoric of merely offering ERISA-governed plans a 'choice'").

91. See Zelinsky, *supra* note 81, at 863; see also Reece, *supra* note 44, at 14.

92. See BUTLER, *supra* note 44, at 8; see also McOwen, *supra* note 54, at 59; PATRICIA A. BUTLER, NAT'L ACAD. FOR STATE HEALTH POL'Y, REVISITING PAY OR PLAY: HOW STATES COULD EXPAND EMPLOYER-BASED COVERAGE WITHIN ERISA CONSTRAINTS 6-8 (2002), available at www.nashp.org/Files/ERISA_pay_or_play.PDF [hereinafter BUTLER, PAY OR PLAY]; Darren

efforts with the lessons of recent case law can produce a comprehensive guide for policy-makers. Looking at each of the cases, courts thus far have established that state laws cannot:

- Refer implicitly or explicitly to employee benefit plans⁹³
- Mandate the structure or administration of employee benefit plans⁹⁴
- Create either substantial direct or acute indirect economic effects that will force an employer to provide an employee benefit plan⁹⁵
- Rely on the existence of an employee benefit plan for terms of the legislation to take effect⁹⁶
- State that the goal of the legislation is to increase the number of employers offering health insurance⁹⁷
- Direct the legislation at a small number of employers⁹⁸
- Require an employer to provide health insurance,⁹⁹ or
- Create a “Hobson’s choice” in which the employer has no reasonable option except to provide health insurance¹⁰⁰

While this list eliminates the majority of strategies states can use to increase the number of employers providing meaningful health coverage for their employees, courts have provided limited insight into the types of legislations that will avoid ERISA preemption. Additionally, scholars speculate about legislative strategies that might fit within the court’s guidelines. Some of these approaches include:

- If there will be economic effects, ensuring that the effects are indirect and unsubstantial¹⁰¹
- If the legislation includes a tax or assessment against employers, ensuring the language is neutral regarding whether the employer pays the assessment or provides health insurance¹⁰²

Abernethy, Note, *Of State Laboratories and Legislative Alloys: How “Fair Share” Laws Can Be Written to Avoid ERISA Preemption and Influence Private Sector Health Care Reform in America*, 49 WM. & MARY L. REV. 1859 (2008).

93. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983).

94. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995).

95. *Id.* at 668.

96. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990).

97. BUTLER, PAY OR PLAY, *supra* note 92, at 6-7.

98. *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 194 (4th Cir. 2007).

99. *Standard Oil Co. of California v. Agsalud*, 633 F.2d 760, 763 (9th Cir. 1980), *aff’d*, 454 U.S. 801 (1981).

100. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 664 (1995).

101. *Id.* at 668.

102. BUTLER, PAY OR PLAY, *supra* note 92, at 7.

- Avoiding setting minimum coverage levels and types of coverage for employers to qualify for the tax credit or exemption from the assessment¹⁰³
- Drafting the legislation in a way that will make the effects of the law avoidable¹⁰⁴
- Drafting the legislation so that it falls within an area that is traditionally regulated by the state (e.g. taxes, health and welfare)¹⁰⁵
- Ensuring the legislation is drafted so it is generally applicable¹⁰⁶
- Writing a tax designed to help generate money for the Medicaid budget and low-income health insurance programs, making sure the language places the legislation in the realm of financing public health programs¹⁰⁷

Legislation drafted following these guidelines has the support of case law and consequently the greatest probability of surviving an ERISA challenge. However, questions remain about the effectiveness of any reform written within these boundaries. The preemption of the pay or play legislation in both *Fielder* and *Retail Industry Leaders Association v. Suffolk County* and the tenuous position of the Massachusetts Act highlight the need for states to be very careful with the structure and language of the law when attempting to install pay or play legislation.¹⁰⁸ However, because the laws in *Fielder* and *Suffolk County* were narrow in construction and were directed at a small segment of employers, there remains uncertainty and cautious optimism about the future treatment of pay or play laws.

A recent ruling by the Ninth Circuit, declaring the San Francisco Health Care Security Ordinance requiring employers with more than twenty employees to help pay for healthcare costs safe from ERISA preemption, is likely to encourage legislatures drafting reform.¹⁰⁹ This ruling is significant for obvious reasons. The decision highlights the tension that exists between the various circuits, and suggests that legislation requiring a large number of employers to contribute to the health expenses of their employees might

103. *Id.*

104. McOwen, *supra* note 54, at 59.

105. *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 194 (4th Cir. 2007) (discussing laws traditionally regulated by the states); BUTLER, PAY OR PLAY, *supra* note 92, at 7.

106. *Id.*

107. See Abernethy, *supra* note 92, at 1877-79 (discussing such a tax and the necessity for that tax to be collected by the treasury, etc. to be considered a true state tax); see also Reece, *supra* note 44, at 32.

108. See generally *Fielder*, 475 F.3d180; see also *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F.Supp.2d 403, 406, 417- 418 (E.D.N.Y. 2007) (holding that a Suffolk County law requiring retail stores selling groceries to make "health care expenditures" per hour each employee worked was preempted by ERISA).

109. See generally *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 512 F.3d 1112, 1117, 1127 (9th Cir. 2008).

survive ERISA preemption. Like *Fielder* and *Suffolk County*, the recent decision is only controlling precedent in the Ninth Circuit. However, if the ruling is affirmed by the Supreme Court, in the likely event that the decision is appealed, the implications will be national. Additionally, the holding in *Golden Gate Restaurant Association* emphasizes the need for state and local governments to continue to be innovative in their healthcare efforts.

III. AN ACT PROVIDING ACCESS TO AFFORDABLE, QUALITY, ACCOUNTABLE HEALTH CARE

Massachusetts has developed a reputation as a “breakthrough innovator” of healthcare reform.¹¹⁰ Since the late 1970s, Massachusetts has consistently made efforts to extend health insurance to as many citizens as possible.¹¹¹ While some of these efforts have enjoyed greater success than others, combined they have helped to keep the number of Massachusetts residents without medical insurance below the national average. Between 2004-2006, an average of 10.3% of Massachusetts citizens were without health insurance coverage.¹¹² Although Massachusetts percentage was well below the national average of 15.3%, 10.3% of the population translates into roughly 653,000 uninsured people in the Commonwealth.¹¹³ When the Massachusetts legislature looked at these statistics, it decided to approach the uninsured problem from a different angle.

Massachusetts recognized that the inability of the federal government to implement significant health reform meant that the state must change from within to improve its already low uninsured rate. Accordingly, Governor Mitt Romney began drafting a plan in 2003 to provide universal coverage.¹¹⁴ Massachusetts recognized that the cycle leading to an increase in the number of uninsured individuals had to be broken. The goal of the Massachusetts Act is twofold. First, the Commonwealth wants every citizen to have health insurance and access to quality health care.¹¹⁵ Second, Massachusetts wants to curb the inflation of medical costs and health

110. John E. McDonough et al., *The Third Wave of Massachusetts Health Care Access Reform*, HEALTH AFF., Sept. 14, 2006, at w420, at <http://content.healthaffairs.org/cgi/reprint/25/6/w420> (last visited Feb. 13, 2009) [hereinafter McDonough et al., *Third Wave*].

111. See generally McDonough, *supra* note 4, at 58-59.

112. 2006 CENSUS, *supra* note 6, at 24.

113. *Id.*

114. McDonough, *supra* note 4, at 62.

115. See OFFICE OF MEDICAID, EXECUTIVE OFFICE OF HEALTH & HUMAN SERVS., COMMONWEALTH OF MASS., SECTION 1115 DEMONSTRATION PROJECT EXTENSION REQUEST 14-15 (2007), available at www.mass.gov/Eeohhs2/docs/eohhs/cms_waiver_2007/ma-1115-extension.pdf (last visited Feb. 13, 2009).

insurance.¹¹⁶ The widespread support of the legislation was a critical element to the passage of the Massachusetts Act and its ability to achieve its goals.¹¹⁷ This support stems partly from the “unusually bipartisan and bi-ideological” creation process of the legislation that included not only politicians from both sides of the aisle but also vital members of the business community.¹¹⁸ However, despite the broad support of the Massachusetts Act, a number of ERISA preemption concerns surround the major components of the legislation.

A. *The Main Elements of the Massachusetts Act*

1. Employer Mandate

Employers with more than ten full-time equivalent employees are required to “pay or play” by either paying \$295 annually for each employee without insurance or contributing a “fair and reasonable share” to their employees’ insurance.¹¹⁹ Employers fulfill the “fair share” requirement in one of two ways: 1) if twenty-five percent or more of their employees enroll in the employer’s health plan, the employer is deemed to have contributed a fair share; or 2) if an employer offers to pay at least thirty-three percent of their employees’ healthcare costs, the employer is likewise deemed to have contributed a fair share.¹²⁰ In addition to the “pay or play” requirement, employers must set up a Section 125 “cafeteria plan” allowing employees to pay for health benefits with pre-taxed dollars.¹²¹ If an employer does not offer a cafeteria plan and their employees’ use of uncompensated care exceeds a threshold limit, the employer may be subject to a “free-rider surcharge.”¹²² The surcharge comes into effect if an employer has not set up a cafeteria plan and its employees are frequent users of the state’s

116. *Id.*

117. Jon R. Gabel et al., *Report from Massachusetts: Employers Largely Support Health Care Reform, and Few Signs of Crowd-Out Appear*, HEALTH AFFAIRS, Nov. 14, 2007, at w13-14, available at www.allhealth.org/BriefingMaterials/HealthAff-Gabel-1206.pdf (last visited Feb. 13, 2009); see generally ROBERT J. BLENDON ET AL., BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION, THE MASSACHUSETTS HEALTH REFORM LAW: PUBLIC OPINION AND PERCEPTION (2006), available at www.bcbsmafoundation.org/foundationroot/en_US/documents/2006HealthReformPollingreport.pdf (last visited Feb. 13, 2009).

118. McDonough et al., *Third Wave*, *supra* note 110, at w420.

119. MASS. ANN. LAWS ch. 149, §188(b), (c) (LexisNexis 2008).

120. 114.5 MASS. CODE REGS. 16.03(1)(a), (b) (2008) (when employers fulfill their “fair share” requirement they become exempt from the Fair Share Contribution).

121. 114.5 MASS. CODE REGS. 18.01(1) (2008).

122. 114.5 MASS. CODE REGS. 17.03(1)(a)-(c) (2008); MASS. ANN. LAWS ch. 118G, §18B(a) (LexisNexis 2008).

Uncompensated Care Pool.¹²³ Costs to the Uncompensated Care Pool exceeding \$50,000 in a year triggers the surcharge which will vary depending on the frequency that employees use free care, the number of employees who use free care, and the cost of the free care.¹²⁴

2. The Commonwealth Health Insurance Connector

The Commonwealth Health Insurance Connector (the Connector) was created “to serve as [a] clearinghouse, or exchange, facilitating the buying, selling, and administration of private health insurance coverage.”¹²⁵ The Connector has two major components: Commonwealth Care and Commonwealth Choice.¹²⁶ Commonwealth Care “provides sliding-scale subsidies to individuals with incomes up to 300[%] of the federal poverty level . . . for the purchase of health insurance.”¹²⁷ The Commonwealth Care program also offers individuals health insurance plans which do not have deductibles and individuals earning less than 150% the federal poverty level do not pay any premiums.¹²⁸

Commonwealth Choice is multi-faceted. The first part of Commonwealth Choice helps individuals who are not eligible for Commonwealth Care purchase health insurance with providers who have been approved by the Connector.¹²⁹ The second part of Commonwealth Choice works with small businesses, defined as businesses with less than fifty employees, to select health insurance for their employees.¹³⁰ This insurance is bought through the Connector, allowing small businesses to reduce administrative costs.¹³¹ Commonwealth Choice also offers young adults,

123. MASS. ANN. LAWS ch. 118G, §18B(a)-(c) (LexisNexis 2008).

124. MASS. ANN. LAWS ch. 118G, §18B(b)-(c) (LexisNexis 2008).

125. Edmund F. Haislmaier & Nina Owcharenko, *The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs*, 25 HEALTH AFF. 1580, 1582 (2006).

126. Commonwealth Connector, Find Insurance: Individuals and Families, Getting Started, at www.mahealthconnector.org/portal/site/connector/template (follow ‘getting started’ link under ‘Individuals & Families’) (last visited Feb. 13, 2009).

127. THE HENRY J. KAISER FAMILY FOUND., MASSACHUSETTS HEALTH CARE REFORM PLAN: AN UPDATE (2007), available at www.kff.org/uninsured/upload/7494-02.pdf (last visited Feb. 13, 2009) [hereinafter KAISER FAMILY FOUND., UPDATE].

128. *Id.*

129. Commonwealth Connector, Find Insurance: Individuals and Families, Frequently Asked Questions, at www.mahealthconnector.org/portal/site/connector/template (follow ‘getting started’ link under ‘Individuals & Families,’ then click ‘FAQ’) (last visited Feb. 13, 2009).

130. CONFERENCE COMM. REP., HEALTH CARE ACCESS AND AFFORDABILITY 1, 2 (2006), available at www.mass.gov/legis/summary.pdf (last visited Feb. 13, 2009) [hereinafter COMM. REPORT].

131. See *Id.* at 1.

nineteen to twenty-six year olds, a population with a historically large uninsured rate, a “first dollar” plan that is tailored specifically to their needs.¹³²

3. Individual Mandate

As of July 1, 2007, every Massachusetts citizen over the age of eighteen is required to have a minimum level of health insurance.¹³³ This minimum level, as determined by the Connector Authority, covers “preventative and primary care, emergency services, hospitalization benefits, ambulatory patient services, mental health services and prescription drug coverage.”¹³⁴ Tax filings and a newly created database tracks covered individuals.¹³⁵ Although the penalty for not having insurance is initially small, with the uninsured not receiving a tax refund of just over \$200, the penalty eventually increases to fifty percent of the cost of the lowest acceptable coverage through the Connector.¹³⁶

These three central facets of the legislation are supported by other requirements that are designed to close the gaps in Massachusetts healthcare access systems as much as possible.¹³⁷ While on its face the legislation appears to be capable of achieving its goal of near-universal coverage, the likelihood of its success would be jeopardized if one of the three major elements were removed. The requirements placed on employers have received the most attention concerning ERISA preemption challenges and is therefore the subject of the next section.

B. Applying Our ERISA Preemption Framework to the Massachusetts Act

The two requirements placed on employers under the Massachusetts Act is that they must: 1) offer “cafeteria plans” to their employees, and 2) pay of a “fair share contribution” to employee healthcare premiums for an

132. *Id.* at 3.

133. MASS. ANN. LAWS ch. 111M, §2(a) (LexisNexis 2008).

134. KAISER FAMILY FOUND., UPDATE, *supra* note 127, at 2.

135. MASS. ANN. LAWS ch. 111M, §2(b) (LexisNexis 2008); Robert Steinbrook, *Health Care Reform in Massachusetts—A Work in Progress*, 354 NEW ENG. J. MED., 2095, 2096 (2006).

136. Steinbrook, *supra* note 135; Cynthia McCormick, *Health Insurance Penalties Announced by State*, CAPE COD TIMES, Jan. 5, 2008, at www.capecodonline.com/apps/pbcs.dll/article?AID=/20080105/NEWS/801050331/-1/LIFE03 (last visited Feb. 13, 2009).

137. See McDonough et al., *Third Wave*, *supra* note 110, at w422 (“The new Massachusetts law, An Act Providing Access to Affordable, Quality, Accountable Health Care, is a complex mix of Medicaid changes, subsidized insurance offerings, insurance market reforms, safety-net alterations, individual and employer and responsibility provisions, and more (Exhibit 1).”).

employer-sponsored plan, or in the alternative pay a tax of \$295 per employee to the state's Uncompensated Care Pool.¹³⁸

A general consensus among scholars is that "a premium-only cafeteria plan" requirement is unlikely to be preempted by ERISA.¹³⁹ The reasoning behind this assertion lies mainly in two arguments. First, the regulations for the cafeteria plans are not related to ERISA plans in any way because they neither refer to the plans nor rely on the existence of ERISA plans for the requirement to be implemented.¹⁴⁰ Further, the cafeteria plans do not have a connection with ERISA plans because they have no effect on the structure or administration of ERISA plans.¹⁴¹ Second, a United States Department of Labor Advisory Opinion stated that cafeteria plans are not considered employee benefit plans, and consequently they are not regulated by ERISA.¹⁴² While some scholars have noted that the cafeteria plans are connected to the payment mechanism for ERISA plans, and consequently could be preempted as affecting the administration of ERISA plans,¹⁴³ this argument is unlikely to persuade a court because it has been established that the plans fall outside of ERISA's authority. Without relating to or having a connection to ERISA plans, the cafeteria plan provision is safe from a preemption challenge.

While the cafeteria plans are unlikely to be preempted, the "fair and reasonable contribution" that is part of the "pay or play" requirement of the Massachusetts Act is likely to be preempted. Many scholars have examined whether the pay or play requirement will be preempted. Investigating these arguments is instructive to evaluate the future of the legislation. Under the developed framework, it must first be considered whether the area is traditionally regulated by the state. Supporters of the Massachusetts Act argue that the requirement is an attempt to spread the burden of funding healthcare costs so that healthcare can be provided for less-fortunate citizens, and therefore the law falls within an area traditionally regulated by

138. Steinbrook, *supra* note 135, at 2096.

139. Amy B. Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 U. KAN. L. REV. 1203, 1220-1221 (2007); See Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption and Experimentation*, 49 WM. & MARY L. REV. 229, 264-267 (2007); See BUTLER, *supra* note 44, at 9.

140. Zelinsky, *supra* note 139, at 264-267.

141. Frederick L. Pilot, *If Enacted, Health Reform Proposals Likely to Face Challenge from Employers*, 15 HEALTH CARE POL'Y REP. (BNA) No. 35, at 1192 (Sept. 10, 2007) at <http://pubs.bna.com/ip/BNA/HCP.NSF/05c90bd7c41c619b85256b570059988c/5f04fc3c13da2d738525734f0077b76e?OpenDocument> (last visited Feb. 13, 2009).

142. See Advisory Opinion from Susan G. Lahne, Chief, Division of Coverage, U.S. Dep't of Labor, Pension & Welfare Benefits Admin., Office of Regs. & Interpretations, to Durward J. Gehring. Bell, Boyd & Lloyd (July 17, 1996), at www.dol.gov/ebsa/programs/ori/advisory96/96-12a.htm (last visited Feb. 13, 2009).

143. Monahan, *supra* note 139, at 1225; see also Reece, *supra* note 44, at 39.

the states (public welfare) and should not be preempted.¹⁴⁴ However, the fact that the law relates to citizens' health, an area traditionally under state regulation, is unconvincing because every employee benefit plan affects citizens' health and could arguably affect the state's ability to finance healthcare for less-fortunate citizens. Consequently, the law does not fall in the category of an area traditionally regulated by states.¹⁴⁵

The next step in the analysis is whether the "fair and reasonable contribution" relates to an ERISA plan. Scholars argue that because the regulation applies to government organizations and churches, two sectors exempted from ERISA regulation, as well as private-sector employers, it does not refer to ERISA plans directly and therefore does not relate to ERISA plans.¹⁴⁶ However, these arguments ignore a critical phrase in the regulation's language. The regulation requires employers to provide a "group health plan" or otherwise pay the \$295 tax.¹⁴⁷ One scholar, Edward A. Zelinsky, argues that the Internal Revenue Code of 1986 states that a "group benefit plan" includes any self-insured plan.¹⁴⁸ Zelinsky also contends that because a group benefit plan includes any self-insured plan, and self-insured plans are deemed to be ERISA plans, the group benefit plans referenced in the Massachusetts Act are ERISA plans.¹⁴⁹ While this argument has merit, the counter-argument that the law is generally applicable and regulates both self-insured plans and insured plans compels further analysis.

Unlike the Maryland Fair Share Act, which applied to a single employer, the Massachusetts Act requires all employers to provide coverage. Consequently, supporters of Massachusetts Act argue that the legislation should not be preempted.¹⁵⁰ However, this argument is tenuous because ERISA does not require a law to regulate *only* ERISA plans in order to trigger the preemption clause. State legislation is preempted "insofar as" it regulates ERISA plans.¹⁵¹ If part of the employer mandate regulates ERISA plans, the section is preempted. Therefore, it is likely a court would determine that the "fair share and contribution" requirement is related to ERISA plans and is subsequently preempted.

144. BUTLER, FAIR SHARE ACT, *supra* note 54, at 9.

145. Schuler, *supra* note 16, at 813.

146. See BUTLER, FAIR SHARE ACT, *supra* note 54, at 9 ("The fair share assessment applies to government as well as private-sector employees and so does not specifically refer to ERISA plans.").

147. MASS. ANN. LAWS ch. 149, §188(b), (c)(10) (LexisNexis 2008).

148. Zelinsky, *supra* note 139, at 255 (citing § 5000(b)(1) of the Internal Revenue Code of 2000, as amended).

149. *Id.* at 255-56; see also 29 U.S.C. § 1144(b)(2)(B) (2000).

150. BUTLER, *supra* note 44, at 9-10.

151. 29 U.S.C. § 1144(a).

Although the regulation potentially refers to ERISA plans, significantly more discussion exists regarding the “connection with” rule employed by the *Travelers* Court. Proponents of the legislation center their argument around the small \$295 tax per employee if employers decide not to provide health insurance.¹⁵² These supporters argue that the tax is analogous with the surcharges in *Travelers* and are merely an “indirect economic influence” for plan administrators.¹⁵³ Patricia Butler further asserts that the tax credit is purely voluntary, and even if it is a strong incentive, a plan administrator is not bound to a particular choice.¹⁵⁴ Therefore, Butler argues it should not be preempted under the *Travelers* doctrine.¹⁵⁵ This reasoning is echoed by Amy B. Monahan, who categorizes Massachusetts’ pay or play requirement as “weak.”¹⁵⁶ Monahan distinguishes the Massachusetts Act from Maryland’s Fair Share Act on the grounds that, in Maryland, the only reasonable choice for employers was to increase their spending on employee healthcare to eight percent of their payroll to avoid paying the same amount to the state government, while in Massachusetts, in almost every circumstance it is cheaper for employers to pay the tax rather than offer health coverage.¹⁵⁷ The Court’s language in *Dillingham*, stating that California’s “‘prevailing wage statute alters the incentives, but does not dictate the choices. . . .” supports the belief that Massachusetts employers might be presented with an incentive to provide healthcare, but ultimately they have the choice to not provide coverage.¹⁵⁸ Each argument is substantive, and each highlights the complexity of evaluating state health reform legislation.

While the issues raised by the defenders of the Massachusetts Act have merit, a court will likely find that the legislation has an impermissible connection with ERISA plans. The legislation arguably affects the structure and administration of ERISA plans because it not only requires employers to establish the plans, but it also requires employers to make continual “fair

152. E.g., Monahan, *supra* note 139, at 1205 (“Unlike Maryland’s Act, which has a very strong ‘pay’ provision, Massachusetts’s fair share contribution law has a weak ‘pay’ provision—arguably allowing it to survive an ERISA preemption challenge....”); BUTLER, FAIR SHARE ACT, *supra* note 54, at 9.

153. Monahan, *supra* note 139, at 1209; see also Cal. Div. of Labor Standards Enforcement v. *Dillingham Constr.*, 519 U.S. 316, 329 (1997).

154. BUTLER, *supra* note 44, at 8.

155. *Id.* at 5, 8; see also *Dillingham*, 519 U.S. at 329 (for *Dillingham* doctrine in court’s holding).

156. Monahan, *supra* note 139, at 1213-14; see also Sidney D. Watson et al., *The Road from Massachusetts to Missouri: What Will It Take for Other States to Replicate Massachusetts Health Reform?*, 55 U. KAN. L. REV. 1331, 1350-51 (2007) (discussing the low cost of the assessment compared to the cost of employer sponsored health care costs).

157. Monahan, *supra* note 139, at 1215-16.

158. See Zelinsky, *supra* note 139, at 262-63 (quoting *Dillingham*, 519 U.S. at 334).

and reasonable contributions” to the plans. By stating that an employer demonstrates a “fair and reasonable contribution,” either by the employer offering to fund one-third of employees’ healthcare costs or by twenty-five percent of the employees enrolling in the benefit plan, the regulation dictates that an employer must design his benefit plan in a certain manner.¹⁵⁹ Zelinsky asserts that the Massachusetts Act is more like the law in *Egelhoff, v. Egelhoff* than *Dillingham* because the Massachusetts law governs a “central matter of plan administration”, while the *Dillingham* law only had an “incidental” connection with ERISA plans.¹⁶⁰ The central matter in the Massachusetts law, according to Zelinsky, is the payment of benefits and the requirements placed on employers.¹⁶¹

Scholars who fall on both sides of this argument recognize that the Massachusetts Act will have difficulty satisfying Congress’ desire for uniformity. These concerns stem from two areas of the pay or play mandate. First, “[w]hile the assessment of \$295 per employee by itself wouldn’t prohibit the uniform administration of employee benefit plans, if other states are able to follow in Massachusetts['] footsteps, national employers would not be able to effectively offer and administer one national employee benefit plan.”¹⁶² Furthermore, the “fair and reasonable contribution” requirement of the legislation provides guidelines that may conflict with those promulgated by other states.¹⁶³ Consequently, multi-state employers would find themselves having to comply with varying sets of regulations. This potential conflict is exactly the type of conflict Congress intended the preemption clause to prevent.

Whether a court determines that the Massachusetts Act explicitly refers to ERISA plans through its “group health plan” language, has an “impermissible connection” with ERISA plans through its “fair and reasonable contribution” requirement, or merely conflicts with Congress’s desire for uniformity, the employer mandate of the Massachusetts Act is likely to be preempted.¹⁶⁴

159. Monahan, *supra* note 139, at 1215.

160. Zelinsky, *supra* note 139, at 263-64; *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001). In *Egelhoff*, the Supreme Court held that a Washington statute that eliminated the designation of a spouse as a beneficiary of a non-probate asset, including life insurance policies falling within ERISA’s authority, was preempted by ERISA. *Id.* Although the statute permitted employers to opt out of the law with specific language, the Supreme Court reasoned that the statute was preempted because it mandated plan structure and language. *Id.*

161. Zelinsky, *supra* note 139, at 263-64.

162. Reece, *supra* note 44, at 38.

163. Monahan, *supra* note 139, at 1215.

164. See Reece, *supra* note 44, at 38 (“While we acknowledge that the Massachusetts law falls into the category of broad health regulations that Congress didn’t envision preempting

Interestingly, the Massachusetts Act has not yet been challenged in court. The legislation's survival thus far may be attributable to its extensive support. This popularity combined with its potentially widespread, positive effects have led some scholars to believe that Massachusetts could receive a waiver similar to the waiver that the state of Hawaii received shortly after the enactment of ERISA for its "Hawaii Prepaid Health Care Act".¹⁶⁵ This waiver would exempt the Massachusetts Act from ERISA preemption. However, Hawaii is the only state that has received an exemption and Congressional willingness to issue another exemption remains unclear.

C. *Lessons From Massachusetts For States Aiming for Universal Coverage*

While there are a number of aspects of the Massachusetts Act that other states may want to adopt, the unique circumstances that exist in Massachusetts limit the portability of the legislation. Massachusetts entered the reform process with several elements in its favor. First, not only has Massachusetts historically had a low uninsured population, but it also started with several sources of financing that other states will not be able to draw upon. Since the creation of the Uncompensated Care Pool in 1985, the Commonwealth paid hundreds of millions of dollars for care provided to the uninsured.¹⁶⁶ This funding was shifted to help subsidize care for individuals obtaining insurance through Commonwealth Care.¹⁶⁷ Furthermore, one of the reasons that Massachusetts enacted the reform was to ensure that the state would not lose the \$385 million it was receiving from the federal government under the Medicaid extension it had been granted.¹⁶⁸ Most states would not be able to draw upon such significant funding sources as the Uncompensated Care Pool and the federal Medicaid extension. Consequently, other states would have to be creative to make universal coverage financially feasible.

The political environment in Massachusetts was also unique. During the creation of the legislation, a Republican governor and a Democratic state Congress worked together to create a broadly supported, comprehensive bill. Additionally, the business community recognized the importance of increasing health coverage in order to reign in the ever increasing price of

when it passed ERISA, the 'fair share' provision of the law has an impermissible connection with an employee benefit plan.").

165. 29 U.S.C. § 1144(b)(5)(A) (2000); see also Zelinsky, *supra* note 139, at 282 ("Because of the bipartisan provenance of the new Massachusetts health law, Massachusetts is particularly well positioned to request that Congress amend section 514 to immunize the Massachusetts law from ERISA preemption.").

166. McDonough et al., *Third Wave*, *supra* note 110, at w422.

167. *Id.* at w426.

168. Haislmaier & Owcharenko, *supra* note 125, at 1586.

medical care and worked with the legislature. The business community supported the legislation even though the employer mandate would statutorily place a burden on employers to help fund the health coverage for the state. Attempts by other state legislatures to shift a larger portion of healthcare funding to employers resulted in lawsuits being filed by employers, suggesting that passing coverage similar to Massachusetts and gaining support for the legislation will be difficult.¹⁶⁹

Despite the likelihood that other states will have to structure their health reform differently, there are a number of lessons that can be taken away from the Massachusetts Act. First, states should work closely with their business communities when drafting healthcare reform plans. States can increase the likelihood that the legislation will later be accepted by including the business community in the development of the policy. Second, the state should attempt to incorporate previous, successful health reform efforts. The Massachusetts Act would never have been possible without drawing upon the Uncompensated Care Pool and Medicaid extension. Finally, states hoping to provide universal health care systems need to take a comprehensive approach to drafting the legislation. An individual towered solution will be unable to succeed. By creating the Commonwealth Health Insurance Connector and the Individual and Employer Mandates, Massachusetts accounted for as broad a spectrum of the population as possible.

Overall, it is uncertain whether the Massachusetts Act will survive an ERISA challenge or whether other states have the capability to replicate the reform. However, the legislation is the most comprehensive state health reform that the nation has seen and consequentially other states should monitor the progress of the reform as they struggle to design their own health reform to combat the growing uninsured population and the cost of medical care.

169. See, e.g., *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 183 94th Cir. 2007) (Maryland Fair Share Act that would require employers with more than 10,000 employees to either spend eight percent of their revenues on employer healthcare or pay the difference to the state struck down); see also *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F.Supp.2d 403, 405, 411-13, 418 (E.D.N.Y. 2007) (striking down New York law requiring grocery stores to provide health insurance).

IV. HOW LEGISLATURES CAN DRAFT HEALTH REFORM TO AVOID ERISA PREEMPTION

A. *A Comprehensive Health Reform Option Designed Within ERISA's Restrictions*

Scholars have offered suggestions concerning how to draft legislation to avoid ERISA preemption.¹⁷⁰ However, most of these solutions are incomplete and do not offer the comprehensive strategy essential to a successful reform. If states have available resources, the optimal solution for avoiding ERISA preemption is a combination of a tax on all employers and elements of the Massachusetts Act. By retaining Massachusetts' Commonwealth Connector and the Individual Mandate, but excluding the Employer Mandate from future legislation, states can avoid many of the ERISA preemption concerns that have arisen with the Massachusetts Act.

A general tax on employers serves several purposes. First, the tax should be written as a general tax on employers to raise money for public health programs. By focusing on public health programs, the tax falls within an area traditionally regulated by the state, the health and safety of citizens, and consequently avoids ERISA challenges.¹⁷¹ The money collected from the tax can be used to subsidize health insurance on a sliding-scale for individuals, similar to the Uncompensated Care Pool in the Massachusetts Act. Under this tax, employers would no longer directly contribute to the cost of health insurance for their employees, but states could still rely on the business community to contribute to the overall cost of medical care. Because employees would be responsible for securing their own insurance, the subsidies through the exchange would have to be designed to ensure this is financially feasible. However, if the tax was written so the employer paid a certain amount per employee, the state could essentially create an employer mandate through alternative means. Additionally, the inclusion of all businesses in the tax should help generate the necessary funds.

Creating an exchange similar to Massachusetts' Commonwealth Connector is also critical to achieving high levels of meaningful health coverage. Through the exchange, the state can regulate the insurance options available to citizens and ensure that a minimal level of care is offered by each insurer. The connector system allows the insurance market to continue to enjoy the benefits of competition between private insurers but

170. See McOwen, *supra* note 54, at 58-59; see also BUTLER, *supra* note 44, at 6-8 (advocating for state reporting requirements and tax benefits); see also Reece, *supra* note 44, at 32 (suggesting that "tax credits should be offered for any and all health insurance coverage provided by employers..."); see also Abernethy, *supra* note 92, at 1883-96.

171. Abernethy, *supra* note 92, at 1883-89 (discussing the language of the tax as well as the need for particular collection methods).

also eliminates any substandard coverage plans. All individuals would acquire their health insurance through the Connector. By disconnecting health insurance from employers, states guarantee the absolute portability of coverage. Clearly, the design and infrastructure of this element is pivotal in the success of the entire system.

The individual mandate is likewise essential to the feasibility of the legislation. Without this mandate, there is no indication that any substantial change would occur. Consequently, the critical population of young adults would continue to have a large number of uninsured individuals. Because young adults tend to be healthier than other segments of the population, insurance companies rely on these individuals to balance out the high payments they have to make for the medical care for their other beneficiaries. A large portion of young adults choosing to forego health insurance and pay the penalties would leave insurers with a larger number of costly patients without a significant population of enrolled healthy patients to help provide balance. Insurance companies might not be able to bear this financial burden. This possibility led the Massachusetts legislature to create a special, low-priced healthcare option specifically for young adults and include significant penalties for individuals refusing to secure insurance. The individual mandate ensures a robust enrollee population capable of effectively spreading the risk and cost among themselves.

The elimination of the employer mandate significantly reduces the likelihood of a successful ERISA challenge. Furthermore, states can achieve an even higher probability of each citizen receiving high quality health insurance by requiring that each prospective insurer to be approved before selling insurance in the state. As with most comprehensive health reform, this reform effort would have to overcome significant political opposition.¹⁷² However, the current national environment concerning healthcare might encourage law-makers to compromise to pass meaningful legislation.¹⁷³

CONCLUSION

Since the time of ERISA's enactment, the federal legislation has grown into a law with frustratingly vague limits to its power. While ERISA has largely achieved its goal of ensuring that individuals receive their retirement benefits, it has also had the effect of stifling state innovation in the name of national uniformity. As case law continues to build and states are given more guidance, legislatures will undoubtedly become more savvy and sophisticated with the laws they produce. This sophistication will push courts

172. See generally JULIUS B. RICHMOND & RASHI FEIN, *THE HEALTH CARE MESS: HOW WE GOT INTO IT AND WHAT IT WILL TAKE TO GET OUT* 228-63 (2005).

173. See generally COLLINS & KRISS, *supra* note 19; see also 2006 CENSUS, *supra* note 6; FAMILIES USA, *supra* note 8.

to consistently refine their interpretation of the scope of ERISA preemption. Additionally, the cultivation will provide courts with the opportunity to reduce the power of the preemption clause and provide an opening for legislatures to address their citizens' concerns. Many scholars feel that ERISA is an antiquated law that can only be remedied by Congressional intervention.¹⁷⁴ When considering the length of time that a Congressional revision would take, the current healthcare situation, the constantly changing political atmosphere, and the power of business lobbies, it is evident that this solution is not a practical resolution for the near future. As Massachusetts took over three years to develop its reform, state reform will not be instantaneous, but it remains a more reasonable solution than Congressional revision. However, Congressional revision of ERISA should not be discounted. The law's detachment from the healthcare industry will likely grow without federal intervention. In the meantime, states must continue to be the laboratories for the country and attempt to develop and implement comprehensive healthcare reform.

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174. See Zelinsky, *supra* note 139, at 282-83 (suggesting that Congress should abolish §514); see also Wendy K. Mariner, *The Health Care Mess: How We Got Into It and What It Will Take to Get Out*, 10 DEPAUL J. HEALTH CARE L. 543, 545-46 (2007) (reviewing JULIUS B. RICHMOND & RASHI FEIN, *THE HEALTH CARE MESS: HOW WE GOT INTO IT AND WHAT IT WILL TAKE TO GET OUT* (2005) (discussing how "health reform that offers universal access to reasonable care at an affordable cost probably is not possible unless it comes from Congress, and Congress is not likely to act without Presidential leadership.")).

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