

ERISA Preemption of State "Play or Pay" Mandates: How PPACA Clouds an Already Confusing Picture

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ERISA PREEMPTION OF STATE “PLAY OR PAY” MANDATES: HOW PPACA CLOUDS AN ALREADY CONFUSING PICTURE

MARY ANN CHIRBA-MARTIN, J.D., Sc.D., M.P.H.*

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INTRODUCTION

Although ERISA preemption was ranked among the top “eight pertinent issues”¹ that needed to be addressed in order to achieve comprehensive health care reform, Congress opted to avoid it when it passed the Patient Protection and Affordable Health Care Act² on March 23, 2010, and the Health Care and Education Reconciliation Act³ just one week later (“PPACA” or the “Act”, collectively). Currently 180 million Americans receive employer-sponsored health benefits, and millions more will do so once PPACA takes full effect over the next few years. This expansion of employer based coverage, coupled with what the Act does and does not do regarding the role of employers, makes ERISA preemption potentially more problematic than ever. Thus, to accomplish meaningful improvements in how employer-sponsored health benefits are financed and delivered, Congress must tackle ERISA preemption of state “play or pay” laws if it expects to improve instead of simply expand and exacerbate existing problems with employer coverage.

The evolution of employer-sponsored health insurance and the pros and cons of “play or pay” mandates have been ably recounted elsewhere and will not be revisited here.⁴ What warrants further consideration is why employer mandates have been so difficult to implement at the state level. Obviously, there are numerous reasons for this, with fears of employer exodus from a state, lower wages, higher prices and job losses among them.⁵ Beyond the economic factors, though, lies a significant legal obstacle: ERISA preemption of state law. Spanning three decades and growing more complex with each year, ERISA preemption jurisprudence is often mentioned, but rarely explained in the context of employer mandates.⁶ Such confusion is likely to intensify with PPACA’s passage since the

1. *E.g.*, PETER D. JACOBSON, O’NEILL INST. FOR NAT’L & GLOBAL HEALTH LAW, *THE ROLE OF ERISA PREEMPTION IN HEALTH REFORM: OPPORTUNITIES AND LIMITS*, at iii (2009), available at <http://www.rwjf.org/files/research/39410.erisa.final1.pdf> (describing ERISA preemption as one of the “eight pertinent issues” that must be addressed in any significant health reform proposal).

2. Pub. L. No. 111-148, 124 Stat. 119 (2010).

3. Pub. L. No. 111-152, 124 Stat. 1029 (2010).

4. *See, e.g.*, David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 *NEW ENG. J. MED.* 82, 82–84 (2006) (describing the history of employer-sponsored health insurance); Alan C. Monheit & Pamela Farley Short, *Mandating Health Coverage for Working Americans*, *HEALTH AFF.*, Winter 1989, at 22, 23–25 (discussing the benefits and criticisms of employer-based insurance mandates).

5. *See, e.g.*, MICHAEL J. CHOW & BRUCE D. PHILLIPS, NAT’L FED’N OF INDEP. BUS., *SMALL BUSINESS EFFECTS OF A NATIONAL EMPLOYER HEALTHCARE MANDATE 2*, 16 (2009), available at https://www.nfib.com/Portals/0/PDF/AllUsers/NFIBStudy_HealthcareMandate.pdf (identifying increased costs, layoffs, and even closure as risks businesses may face under an employer mandate program).

6. *E.g.*, PATRICIA A. BUTLER, CAL. HEALTHCARE FOUND., *FACT SHEET: ERISA IMPLICATIONS FOR STATE PAY OR PLAY LAWS* (2007), available at

Act includes an employer “play or pay” incentive, but is silent regarding the continued viability of existing state and local “play or pay” measures that require something more or different of employers in providing health benefits for their workers.

With the goal of explaining how to head off a collision of PPACA and ERISA, this Article begins with an analysis of PPACA’s treatment of employer responsibilities,⁷ followed by a review of the mechanics of ERISA preemption.⁸ It next examines recent state and local efforts to enact employer mandates and their mixed success in surviving ERISA preemption challenges, particularly those of Maryland, Massachusetts, and San Francisco.⁹ Finally, an evaluation of PPACA’s potential impact on ERISA preemption of state “play or pay” provisions demonstrates why Congress must clarify the interaction of PPACA and § 514 of ERISA with regard to the intended role, if any, of state or local employer mandates in national reform.¹⁰ Anything less perpetuates a major, but poorly understood obstacle to meaningful reform despite all that Congress accomplished in enacting PPACA.

I. EMPLOYER RESPONSIBILITY UNDER PPACA

Enacting significant legislative reform in the United States can involve years of extended debate and substantial compromise. However, it took decades of failed attempts before Congress passed PPACA. The final push proved especially contentious¹¹ with charges of government takeovers¹² and death panels¹³ diverting the spotlight from one typical lightning rod of controversy: the use of employer

<http://calhealthreform.org/pdf/ERISAFactsheetButlerP.pdf> (showing uncertain views regarding how ERISA affects “play or pay” laws); *but see* Timothy S. Jost, *Health Care Reform Requires Law Reform*, 28 HEALTH AFF. w761, w762–63 (2009), <http://content.healthaffairs.org/cgi/reprint/28/5/w761> (discussing the areas in which ERISA preempts state law).

7. *See infra* Part I.

8. *See infra* Part II.

9. *See infra* Parts III–V.

10. *See infra* Part VI.

11. *See, e.g.*, Press Release, Office of the Press Secretary, The White House, Remarks by the President to a Joint Session of Congress on Health Care (Sept. 9, 2009), http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care (imploping Congress to enact health care reform legislation); CNNPolitics.com, *Obama Resumes Health Care Push, Vows to ‘Get It Done This Year’* (Sept. 27, 2009), <http://www.cnn.com/2009/POLITICS/09/26/obama.health/index.html>.

12. *See, e.g.*, Matt Spetalnick, Reuters, *Healthcare Critics Make Outlandish Claims: Obama* (Aug. 8, 2009), <http://www.reuters.com/article/idUSN0742097620090808> (“Republicans call [Obama’s push for healthcare reform] a government takeover of healthcare . . .”).

13. *See* Jim Rutenberg & Jackie Calmes, *False ‘Death Panel’ Rumor Has Some Familiar Roots*, N.Y. TIMES, Aug. 14, 2009, at A1, available at <http://www.nytimes.com/2009/08/14/health/policy/14panel.html> (describing allegations that Obama’s proposals for health care reform would result in government-sponsored “death panels”).

“play or pay” provisions to expand coverage and spread cost.¹⁴ Typically, such “shared responsibility” measures either mandate or incentivize employers to “play” by sponsoring employee health benefits or “pay” via a “fair share” contribution (usually a tax or flat fee) to cover the uninsured in general or its own uncovered workers.¹⁵

Prior to PPACA’s enactment, the federal Employee Retirement Income Security Act (ERISA) permitted an employer to do neither.¹⁶ Whether this would change was a major point of disagreement between the two chambers of Congress. The House of Representatives’ Affordable Health Care for America Act (H.R. 3962),¹⁷ passed with a narrow margin of 220 to 215,¹⁸ and required employers with annual payrolls exceeding \$500,000 to “play” by contributing 75.2% to employees’ individual coverage or 65% to family coverage,¹⁹ or “pay” a payroll tax ranging from 2% to 8%, depending on the amount of that payroll.²⁰ By a vote of 60 to 39 along party lines,²¹ the Senate voted to consider an amendment to the House bill (S.Amdt. 2786), which would have omitted the overt mandate that existed in the House measure.²² However, it did impose a substantial incentive in the form of a \$750 “free rider” penalty that would be triggered when an employee of a large firm obtained federally subsidized coverage.²³

As Congress wrestled with this and the literally countless details of national reform, the business community displayed mixed reactions to an employer mandate. The National Retail Foundation viewed any “play or pay” scenario as

14. See Monheit & Short, *supra* note 4, at 23 (describing employer mandates as a subject of continuing controversy).

15. See Jeanne Sahadi, CNNMoney.com, Health Care: Will ‘Pay or Play’ Chase Employers Away? (July 2, 2009), http://money.cnn.com/2009/07/02/news/economy/health_reform (explaining the latest iteration of a “play or pay” proposal that was included in a Senate proposal).

16. 29 U.S.C. § 1144(a) (2006).

17. Affordable Health Care for America Act, H.R. 3962, 111th Cong. (2009).

18. 155 CONG. REC. H12,598, H12,967–68 (daily ed. Nov. 7, 2009). That most House Democrats supported and most Republicans opposed H.R. 3962 in general and the employer mandate in particular is nothing new. Employer mandates provoked a similar split during the Clinton administration’s unsuccessful health reform initiative. Roger Thompson, *Support Wanes for Employer Mandate—Health Care Reform Policy*, NATION’S BUS., Aug. 1994, available at http://findarticles.com/p/articles/mi_m1154/is_n8_v82/ai_15637930. The House Ways and Means Committee approved an employer mandate by a 20 to 18 vote, but not one Republican voted for it. *Id.* Once the Republican Revolution regained congressional control in November 1994, the employer mandate as well as health reform in general fell off the legislative agenda. See MARK E. RUSHEFSKY & KANT PATEL, POLITICS, POWER & POLICY MAKING: THE CASE OF HEALTH CARE REFORM IN THE 1990S 108 (1998) (indicating that in September 1994, Senate Majority Leader Mitchell declared the health care bill was dead).

19. H.R. 3962 § 412(b)(1)(A)–(B).

20. *Id.* § 413(a)–(b).

21. 155 CONG. REC. S13,834 (daily ed. Dec. 23, 2009).

22. Patient Protection and Affordable Care Act, S.Amdt. 2786, 111th Cong. (2009).

23. *Id.* sec. 1513, § 4980H(a)(1), (d)(1).

"catastrophic" and "devastating."²⁴ The National Federation of Independent Business opposed the imposition of significant costs on employers, especially small ones, at a time when unemployment was at a twenty-five-year high and the economy continued to struggle, despite the government's insistence that the recession was over.²⁵ Republicans tended to agree,²⁶ with Senator Orrin Hatch calling such measures "job killing."²⁷ Yet, a struggling economy,²⁸ growing health care cost pressures²⁹ and shrinking coverage actually made "shared responsibility" more palatable for some employers, as evidenced by Wal-Mart's dramatic shift from vehement opponent to staunch supporter.³⁰ Thus, by the close of 2009, the lack of strong consensus in the political and business sectors indicated that H.R. 3962's "play or pay" provision could change considerably, or disappear entirely during the process of reconciliation and a full vote of both houses.³¹

With PPACA's passage, however, "play or pay" lives on, albeit in still another permutation. Technically, it is not a true "mandate" since it does not require health-related payments in every instance (unlike the House's original unconditional insistence that employers sponsor benefits or pay additional taxes). Rather, the Act encourages employers to "play" through conditional "pay" penalties that only attach in certain circumstances. As such, it is more aptly characterized as an incentive than a mandate, although the term "employer mandate" is often applied to both strategies.

Specifically, PPACA's version of "play or pay" will take effect in 2014 and covers "applicable large employers" who employed 50 or more full-time

24. Letter from Tracy Mullin, Pres. & CEO, Nat'l Retail Fed'n, to members of the Nat'l Retail Fed'n (July 13, 2009), available at http://www.nrf.com/modules.php?name=Documents&op=viewlive&sp_id=3358.

25. Susan Eckerly, Nat'l Fed'n Indep. Bus., NFIB Statement: Senate Health Bill (Nov. 19, 2009), <http://www.nfib.com/issues-elections/issues-elections-item/cmsid/50237>.

26. See John Boehner, *The GOP's Job Creation Plan*, WASH. POST, Dec. 11, 2009, at A29 (describing Republican opposition to increasing costs to employers).

27. FOXNews.com, Will Democrats Go at It Alone on the Health Care Bill? (Aug. 20, 2009), <http://www.foxnews.com/story/0,2933,540941,00.html>.

28. See Eric Dash & Vikas Bajaj, *In 2009, Economy Will Depend on Unlocking Credit*, N.Y. TIMES, Dec. 31, 2008, at B1 (describing the continuing effect of the 2008 financial crisis on the current economy).

29. E.g., Lisa Girion, *Healthcare Costs Pinch Employers: Study Suggests That Manufacturers Have Limited Resources to Offset Rising Fees*, L.A. TIMES, May 7, 2008, at C3.

30. Letter from John Podesta, Pres. & CEO, Ctr. for Am. Progress, Andrew L. Stern, Pres., Serv. Employees Int'l Union, & Mike Duke, Pres. & CEO, Wal-Mart Stores, Inc., to President Barack Obama (June 30, 2009), available at http://online.wsj.com/public/resources/documents/walmart_letter_063009t.pdf.

31. Compare CHOW & PHILLIPS, NAT'L FED'N OF INDEP. BUS., *supra* note 5, at 2, 16 (describing how an employer mandate will harm the economy in general and small businesses in particular), with Thomas C. Buchmeuller & Alan C. Monheit, *Employer-Sponsored Health Insurance and the Promise of Health Insurance Reform*, 46 INQUIRY 187, 195-96 (2009) (describing the positive outcomes of an employer mandate in Hawaii).

equivalents for more than 120 days in the preceding calendar year.³² These employers need not offer or contribute to premiums for minimum benefits, but they may choose to “play” by offering “minimum essential coverage” to full-time employees and their beneficiaries.³³ Such coverage must meet minimum requirements regarding the benefits themselves and be affordable; the employee’s required contribution cannot exceed 9.5% of total household income or 40% of covered expenses. Automatic enrollment is required if the full-time workforce equals 200 or more, although employees can opt out of coverage.³⁴

Because PPACA creates an incentive, not a mandate, there is no consequence to a large employer that decides not to “play” unless and until one of its full-time employees becomes a “free rider” by receiving federally subsidized health care through a newly created, state-based health insurance exchange. Thus, a large employer that offers no coverage pays nothing at all if none of its full-time employees receives a federal premium credit or cost-sharing reduction to buy exchange-based coverage. Should one or more of its full-time workers do so, however, the employer will “pay” a stiff penalty in the form of a monthly excise tax equal to:

$$(Number\ of\ full-time\ employees - 30) \times (\$2000/12\ or\ \$166.67).^{35}$$

It is important to note that the fine is based on *all* full-time employees (minus the first 30), even if only one was a free rider. For an employer with 50 full-time workers, this would amount to \$40,000 per year. A full-time workforce of 100 would generate an annual penalty of \$140,000.

Employers that do offer coverage could face somewhat lighter penalties if one of its full-time employees receives a premium credit to buy exchange coverage. Such employers will pay the lesser of:

$$(Number\ of\ full-time\ employees - 30) \times (\$2000/12\ or\ \$166.67)$$

-or-

32. Full-time equivalents, as opposed to full-time employees (averaging thirty or more hours per week, determined on a monthly basis) are used to determine whether an employer is large enough to be subject to PPACA’s “play or pay” requirements. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1513(a) (2010) (amending 43 I.R.C. § 4980H) [hereinafter § 1513(a)]. However, only full-time employees are counted when calculating the Act’s “pay” penalties. *Id.* §§ 1513(a), 10106(e), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1003.

33. Patient Protection and Affordable Care Act § 1513(a). The content and scope of essential benefits will be defined through future rule-making.

34. See generally THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: DETAILED SUMMARY 3 (2010), available at <http://dpc.senate.gov/healthreformbill/healthbill95.pdf>.

35. *Id.*

*(Number of full-time employees receiving premium credits for exchange coverage) x (\$3000/12 or \$250).*³⁶

There is no such penalty for employers that offer “free choice vouchers” that are then used by the employee to participate in a health exchange.³⁷ After 2014, all penalty amounts will be adjusted annually.³⁸

Given the inherent complexity of PPACA’s original “play or pay” language and subsequent reconciliation, its 2014 effective date, and the growing chorus of critics vowing to repeal the Act or at least litigate much of it away, it is not at all clear whether and to what extent employers will eventually play or pay. As discussed *infra*, several states already have “play or pay” requirements and many more were actively considering them, but put them on hold in the face of federal reform efforts.³⁹ Moreover, one month prior to PPACA’s enactment, the U.S. Department of Labor (DOL) submitted to the Office of Management and Budget a proposed rule to “clarify the circumstances under which certain health care arrangements established or maintained by state or local governments for the benefit of non-governmental employees do not constitute an employee welfare benefit plan” under § 505 of ERISA.⁴⁰ Although the vague submission did not mention “play or pay” provisions explicitly and might simply be intended to address state health exchanges as opposed to mandatory contributions thereto, it unleashed a torrent of criticisms from industry groups that the DOL was about to exempt state or local fair share mandates from § 514 preemption.⁴¹ The National Benefits Council Steering Committee complained that the proposed rule “appears to move in exactly the opposite direction” of PPACA’s determination that “ERISA

36. *Id.*

37. PPACA requires large employers that offer coverage and pay a portion of its cost to provide the alternative of free choice vouchers to those full-time employees with incomes below 400% of the federal poverty level who would face an employee premium contribution of between 8% and 9.8%. Patient Protection and Affordable Care Act § 10108(h)–(i)

38. See generally HINDA CHAIKIND & CHRIS L. PETERSON, CONGRESSIONAL RES. SERV., SUMMARY OF POTENTIAL EMPLOYER PENALTIES UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) (2010), available at <http://www.ncsl.org/documents/health/EmployerPenalties.pdf>.

39. See *infra* Parts III–VI.

40. Health Care Arrangements Established by State and Local Governments for Non-Governmental Employees, 74 Fed. Reg. 64,275, 64,275–76 (Dec. 7, 2009) (proposing to amend 29 C.F.R. 2510.3-1 pursuant to 29 U.S.C. § 1135).

41. See, e.g., HR Policy Ass’n, DOL Proposed Regulation Would Create ERISA Preemption Carveout (Feb. 26, 2010), http://www.hrpolicy.org/issues_story.aspx?GID=33&SID=3567&miid=3&msid=4 (implying that the rule’s timing was intended to influence the U.S. Supreme Court’s expected Fall 2010 resolution of *Golden Gate Restaurant Ass’n v. City of San Francisco*, 546 F.3d 639 (9th Cir. 2008), *petition for cert. filed*, 130 S. Ct. 357 (June 5, 2009) (No. 08-1515), discussed *infra* Part V.C).

should remain intact and preserve the protection against a patchwork of different and conflicting municipal and state benefit plan requirements”⁴²

Of critical concern, therefore, is whether PPACA’s “play or pay” measure sets a minimum floor above which states can require more of employers or instead, either immediately or as of 2014, preempts any state action along these lines. Through its silence on such matters, the Act casts a large and threatening shadow over the already perplexing impact of ERISA preemption on state health reform efforts. Thus, as explained below, the chronic problem of inconsistent judicial interpretation of ERISA preemption may now play an even larger role in derailing state efforts to impose employer mandates and jeopardize those that are already in existence.⁴³

II. A REVIEW OF ERISA’S COMPLEX “PREEMPTION” CLAUSES

A. Section 514’s “Relate to” Clause

ERISA defines an “employee welfare benefit plan” as “any plan, fund, or program . . . established or maintained by an employer . . . through [which] the purchase of insurance or otherwise” provides various benefits, including health benefits.⁴⁴ To protect plan administrators from the negative impact of unduly complicated and potentially contradictory state regulations that foster plan mismanagement and abuse, ERISA also contains a three-part preemption provision.⁴⁵ Section 514(a) states that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to an employee benefit plan”⁴⁶ Section 514(b) then exempts or “saves” from preemption certain types of state laws, including state insurance laws.⁴⁷ Subsection (b) clarifies, though, that states cannot “deem” a law to constitute insurance regulation for the purpose of “saving” a law that would otherwise “relate to” a plan and trigger “relate to” preemption.⁴⁸ Because § 514 is “not a model of legislative drafting,”⁴⁹ each of its three clauses will be considered separately in an effort to dispel at least some of their inherent confusion.

42. Andrew Jensen, *Fight Over ERISA Preemption Moves to Courts, Regulators*, ALASKA J. COMMERCE, Apr. 9, 2010, http://www.alaskajournal.com/stories/040910/loc_13_001.shtml (quoting a letter from the National Coalition on Benefits to Peter Orszag, Director of the Office of Management and Budget, on March 15, 2010).

43. See *infra* Part II.

44. 29 U.S.C. § 1002(1) (2006).

45. *Id.* § 1144(a), (b)(2)(A)–(B).

46. *Id.* § 1144(a). State laws subject to possible preemption “include[] all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.” *Id.* § 1144(c)(1).

47. *Id.* § 1144(b)(2)(A).

48. *Id.* § 1144(b)(2)(B).

49. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 722, 740 (1985).

While § 514 supersedes a state law that “relates to” any employee benefit plan, it does not explain that term. In *Shaw v. Delta Air Lines, Inc.*,⁵⁰ the U.S. Supreme Court offered the equally amorphous definition of having “a connection with or reference to” an ERISA plan—as long as such claims are not “too tenuous.”⁵¹ In theory, a law makes a “reference” to a plan if it explicitly mentions it or depends on its existence.⁵² A “connection” occurs when a statute does not mention a benefits plan *per se*, but effectively regulates plans by restricting their choices or creating the threat of conflicting state requirements.⁵³

For example, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,⁵⁴ § 514 did not preempt a generally applicable New York surcharge on hospital bills because it affected plans only indirectly and, therefore, did not target or regulate the plans themselves.⁵⁵ Nevertheless, the Court explained that “relate to” preemption can occur if such an indirect economic impact “force[s] an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict[s] its choice of insurers”⁵⁶ Apparently, altering a plan’s incentives is fine, but dictating its choices is not.⁵⁷

B. Section 514’s “Saving” and “Deemer” Clauses

A state law that relates to an employee benefit plan can still be “saved” from preemption if it regulates health insurance. In *Rush Prudential HMO, Inc. v. Moran*,⁵⁸ an Illinois external review mandate for medical necessity determinations concerning employer-sponsored coverage related to a plan, but survived § 514 preemption as a “saved” state insurance law.⁵⁹ Reconciling § 514’s broad “relate to” preemption with its broad reservation of state insurance oversight has proved difficult because “[w]hile Congress occasionally decides to return to the States

50. 463 U.S. 85 (1983).

51. *Id.* at 96–97, 100 n.21.

52. *See id.* at 96–99 (stating that both the legislative intent and the Court’s inclination are to read the term “relate to” as broadly as possible so as to work toward the goal of complete federal preemption of conflicting state laws).

53. *See Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (stating that “‘connection with’ is scarcely more restrictive than ‘relate to’” and that the Court will “look to ‘the objectives of the ERISA statute as a guide to the scope of the state law that Congress would survive,’ as well as the nature of the effect of the state law on ERISA plans”).

54. 514 U.S. 645 (1995).

55. *Id.* at 668 (basing its holding on the fact that the statute in question only indirectly affected employee benefit programs and thus was not subject to ERISA preemption).

56. *Id.*

57. *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc.*, 519 U.S. 316, 334 (1997) (holding that the statute in question “alter[ed] the incentives, but [did] not dictate the choices” and thus was not related to an ERISA plan).

58. 536 U.S. 355 (2002).

59. 536 U.S. at 372–73. The “saving clause” exempts insurance, banking, or securities laws from preemption. 29 U.S.C. § 1144(b)(2)(A) (2006).

what it has previously taken away, it does not normally do both at the same time.”⁶⁰ Further complicating matters is § 514’s “deemer” clause, which qualifies the saving clause that qualifies the “relate to” clause.⁶¹ Basically, a state law cannot evade “relate to” preemption simply by deeming a benefits plan as constituting an insurance plan if it would not otherwise qualify as one. Although § 514 does not define insurance, it is the reason why states can regulate insured, but not self-insured plans—and also why firms increasingly self-insure to evade state oversight.⁶²

As if § 514 were not sufficiently confounding, ERISA offers an additional source and type of preemption through its § 502 civil enforcement scheme, which actually says nothing about displacing state law.⁶³ According to the Supreme Court, however, § 502 is the sole means for enforcing ERISA and, thus, necessarily preempts state claims that threaten ERISA’s exclusive federal oversight of plan administration.⁶⁴ Consequently, a state law that escapes § 514 “relate to” or “conflict” preemption must also survive § 502 “complete” preemption.⁶⁵ Not surprisingly, the textual complexity and ambiguity of § 514 and § 502 make this an extremely unstable area of the law. Due to the Supreme Court’s expansive interpretations of both sections, § 514 preempted almost any state law that had any impact on employee health benefits plans in the 1980s and early 1990s.⁶⁶ Preemption narrowed in the mid-1990s⁶⁷ but recent years show the Court returning

60. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739–40 (1985); see also *Rush Prudential*, 536 U.S. at 392 (Thomas, J., dissenting) (noting that the “relate to” and “saving” clauses are “almost antithetically broad”).

61. § 1144(b)(2)(B). The “deemer clause” found in § 514 limits the “saving clause” by stating that an employee benefit plan covered by ERISA “shall [not] be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . .” *Id.*

62. See *id.* § 1002 (lacking a definition of insurance); *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (discussing application of the “deemer” clause to insurance regulation); Kathlynn L. Butler, Comment, *Securing Employee Health Benefits Through ERISA and the ADA*, 42 EMORY L.J. 1197, 1204 n.41 (1993) (quoting Representative Wyden’s statement that “[f]irms that are too small to successfully self-insure health plans are reorganizing to do just that, with the goal of escaping state oversight”).

63. See § 1132 (omitting any explicit mention of preemption); Donald T. Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 SANTA CLARA L. REV. 105, 110–11 (2001) (describing § 502 as an implied preemption).

64. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52–53 (1987).

65. See Bogan, *supra* note 63, at 161–64 (discussing complete preemption and how it can convert a state law claim for relief into a federal cause of action).

66. Lindsey Gastright Churchill, Note, *Rush Prudential HMO v. Moran: Federal Intervention Looms as Supreme Court Rules That ERISA Does Not Preempt State Laws Requiring Independent Review of Medical Necessity Decisions and Lays Groundwork for Different Independent Review Provisions from All Fifty States*, 19 GA. ST. U. L. REV. 535, 564 (2002) (noting the court’s trend of broadly interpreting ERISA preemption in the 1980s and early 1990s).

67. See *id.* (noting that the Supreme Court moved away from its broad interpretation of preemption after the early 1990s).

to broad § 514 “relate to” or “conflict” preemption as well as § 502 “complete” preemption.⁶⁸

III. STATE “PLAY OR PAY” MANDATES

ERISA does not require employers to offer health benefits, and prevents states from mandating that they do so.⁶⁹ At present, approximately 70% of private sector employees are covered by commercially insured or self-funded employer-sponsored plans.⁷⁰ With annual policy costs averaging \$4,824 for individuals and \$13,375 for families,⁷¹ some 40% of private sector employers choose not to provide coverage.⁷² Over the past decade, 98% of large employers (i.e., employers with greater than 200 workers) have continued to offer coverage,⁷³ while the percentage of small and mid-size firms (3 to 199 workers) offering coverage has dropped from 68% in 2000 to 59% in 2009.⁷⁴ Those that do offer health benefits contribute, on average, 83% of the total premium for their workers’ individual coverage and 73% for family coverage.⁷⁵ According to one pre-PPACA estimate, whether through loss of jobs or simply loss of benefits, 14,000 people become uninsured each day.⁷⁶ This places additional financial burdens on already cash-strapped, “safety net” hospital emergency departments since most states only partially reimburse uncompensated care by using Medicaid payment rates.⁷⁷

68. See, e.g., *Aetna Health Inc. v. Davila*, 542 U.S. 200, 221 (2004) (holding that the state causes of action fell within § 502 and were removable to federal court); *Beneficial Nat’l Bank v. Anderson*, 539 U.S. 1, 8, 11 (2003) (applying complete preemption in allowing the removal of a case to federal court even when the complaint relies entirely on state law). For an extensive discussion of how the U.S. Supreme Court’s inconsistent ERISA preemption jurisprudence has adversely affected health care in general, see Mary Ann Chirba-Martin, *Drawing Lines in Shifting Sands: The U.S. Supreme Court’s Mixed Messages on ERISA Preemption Imperil Health Care Reform*, 36 NOTRE DAME J. LEG. 91 (2010).

69. 29 U.S.C. § 1002 (2006) (indicating that benefit plans are not mandatory); *id.* § 1144 (stating that ERISA supersedes any state laws that relate to employee benefit plans).

70. Press Release, U.S. Bureau of Labor Statistics, *Employee Benefits in the United States* (July 28, 2009), available at <http://www.bls.gov/news.release/ebs2.nr0.htm>.

71. HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, *EMPLOYER HEALTH BENEFITS: 2009 ANNUAL SURVEY 2* exhibit B (2009), available at <http://ehbs.kff.org/pdf/2009/7936.pdf> [hereinafter *EMPLOYER HEALTH BENEFITS 2009 SURVEY*].

72. *Id.* at 38 exhibit 2.1.

73. *Id.* at 38 exhibit 2.2.

74. *Id.*

75. *Id.* at 68 exhibit 6.1.

76. CTR. FOR AM. PROGRESS ACTION FUND, *HEALTH CARE IN CRISIS: 14,000 LOSING COVERAGE A DAY 1* (2009), http://www.americanprogressaction.org/issues/2009/02/pdf/health_care_crisis.pdf.

77. See Teresa A. Coughlin & David Liska, *Changing State and Federal Payment Policies for Medicaid Disproportionate-Share Hospitals*, 17 HEALTH AFF. 118, 119 (1998) (noting that hospitals are only partially reimbursed for uncompensated care); Kevin N. Rask & Kimberly J. Rask, *Public Insurance Substituting for Private Insurance: New Evidence Regarding Public Hospitals, Uncompensated Care Funds, and Medicaid*, 19 J. HEALTH ECON. 1, 2–3 (2000) (noting that hospitals are acting as a “safety net” for the uninsured).

With federal reform efforts perennially stalled by congressional distraction and gridlock in recent years, states looked for their own solutions, and focused increasingly on the 40% of (mostly small) private sector employers that do not pay their “fair share” for their employees’ uncompensated care. Vermont and Massachusetts have enacted “play or pay” requirements that, to date, have not been challenged as preempted by ERISA.⁷⁸ An additional fourteen states have attempted, or are at least considering similar measures.⁷⁹ However, § 514’s inherent complexity and its inconsistent judicial interpretations have clearly had a chilling effect on whether and how a state will pursue an employer mandate.⁸⁰ Accordingly, despite their promise as a way to expand and finance coverage, they have often been viewed as not worth the substantial costs of defending them against ERISA challenges.⁸¹

A. State Efforts to Create Employer “Play or Pay” Mandates

Prior to PPACA, a number of states attempted to work around ERISA in trying to require or at least encourage employers to offer or contribute to employee health coverage.⁸² Most initiatives fell between inchoate ideas and near-final proposals, but some were actually voted on.⁸³ Of those, most were voted down, but a few became law, including three that were challenged under § 514—with two succumbing to preemption and a third probably on its way to a similar fate.⁸⁴

78. See *infra* Part V.

79. KAISER COMM’N ON MEDICAID & THE UNINSURED, HENRY J. KAISER FAMILY FOUND., STATES MOVING TOWARD COMPREHENSIVE HEALTH CARE REFORM (2009), available at <http://www.kff.org/uninsured/upload/State-Health-Reform1.pdf>.

80. Cf. Jane D. Bailey, *ERISA Preemption*, 74 DENV. U. L. REV. 473, 486–87 (1997) (noting that ERISA has proven frustrating to courts and is frequently litigated because of the complexity of the statute); Rebecca Entigar Nauta, *ERISA Preempts Maryland’s Fair Share Health Care Fund Act: The Chilling Effect on State Innovation in Health Care Cost-Sharing with Big Business*, 35 J.L. MED. & ETHICS 756, 758 (2007) (predicting that judicial interpretation of § 514 cases, such as *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180 (4th Cir. 2007), will have a chilling effect on state action in encouraging employer-provided coverage).

81. See PATRICIA A. BUTLER, NAT’L ACAD. FOR STATE HEALTH POLICY, ERISA IMPLICATIONS FOR STATE HEALTH CARE ACCESS INITIATIVES: IMPACT OF THE MARYLAND “FAIR SHARE ACT” COURT DECISION 7–8, 11 (2006) (describing the difficulty states will have in defending “play or pay” laws).

82. See KAISER COMM’N ON MEDICAID & THE UNINSURED, *supra* note 79, at 1–19 (noting states that have attempted to enact differing health legislation despite the possibility of ERISA preemption); Richard Cauchi, Nat’l Conf. of State Legs., States’ Use of “Cafeteria Plans” to Provide Health Insurance, <http://www.ncsl.org/?tabid=14515> (last visited June 11, 2010) (discussing state efforts to require employers to offer health coverage through the use of cafeteria plans).

83. See KAISER COMM’N ON MEDICAID & THE UNINSURED, *supra* note 79, at 5, 16, 18 (discussing various state attempts at reform that have failed at different stages of the legislative process); *id.* at 3, 9, 15, 17 (noting that Colorado, Massachusetts, Oregon, and Vermont have all implemented initiatives to expand health care access).

84. See *infra* Parts IV–V (discussing federal preemption in Maryland and New York and the ongoing litigation in San Francisco).

B. Proposals and Initiatives

Oregon recently enacted a number of reforms to finance expanded coverage by taxing hospitals and insurers.⁸⁵ However, ERISA concerns led it to defer employer mandates for further study while urging Congress to “create ‘safe harbor’ policies for state health care reform elements (such as ‘play or pay’ payroll taxes) that would protect states from ERISA court challenges.”⁸⁶

New York’s *Partnership for Coverage Initiative* contains four reform proposals modeled by the Urban Institute, with two relying on employer mandates.⁸⁷ The *Health Plus* plan would offer a state-run plan as an alternative to current employer sponsored private plans and levy non-capped payroll taxes of ten percent.⁸⁸ A second proposal calls for as-yet-undetermined annual assessments on employers with ten or more employees to be offset by an employer’s other contributions to employee health coverage.⁸⁹

In Pennsylvania, Governor Rendell’s *Prescription for Pennsylvania* would impose a three percent “fair share tax” on the payrolls of employers that do not offer health coverage to their workers.⁹⁰ A single payer proposal was recently filed in the state legislature that included a “fair share tax” equal to ten percent of gross payroll.⁹¹

In early 2007, the Illinois Health Care for All Act⁹² came before the state’s General Assembly, but activity has since been suspended.⁹³ The Act would require a “covered assessment” (a tax of three percent of annual wages up to a maximum of \$7500 per employee) from employers with ten or more employees “for the

85. KAISER COMM’N ON MEDICAID & THE UNINSURED, *supra* note 79, at 15.

86. OR. HEALTH FUND BD., AIM HIGH: BUILDING A HEALTHY OREGON: FINAL REPORT 111 (2008), available at http://www.oregon.gov/OHPPR/HFB/docs/Final_Report_112908.pdf. On June 26, 2009, H.B. 2009 took effect as Chapter 595 (2009 Laws). H.B. 2009, 75th Leg., Reg. Sess. (Or. 2009); Oregon State Archives, Oregon Health Authority, http://arcweb.sos.state.or.us/rules/OARS_900/OAR_943/943_001.html (last visited June 11, 2010).

87. COMM’R OF HEALTH & INS. SUPERINTENDENT, STATE OF N.Y. DEP’T’S OF HEALTH & INS., REFORMS TO ACHIEVE QUALITY, AFFORDABLE COVERAGE FOR ALL NEW YORKERS 2, 5 (2009), available at http://partnership4coverage.ny.gov/reports/docs/2009-07-17_release_of_urban_institute_report.pdf.

88. *Id.* at 5.

89. *Id.*

90. FAMILIESUSA, PENNSYLVANIA’S 2007 HEALTH CARE PROPOSAL: PRESCRIPTION FOR PENNSYLVANIA 5 (2007), available at <http://www.familiesusa.org/assets/pdfs/state-expansion-pa.pdf>.

91. See H.R. 1660, 2009 Gen. Assem., Reg. Sess. (Pa. 2009) (describing single payer plan); S. 400, 2009 Gen. Assem., Reg. Sess. (Pa. 2009) (describing single payer plan).

92. S. 5, 95th Gen. Assem., Reg. Sess. (Il. 2007).

93. See Illinois General Assembly, Bill Status of SB0005, <http://www.ilga.gov/legislation/billstatus.asp?DocNum=5&DocTypeID=SB&GAID=9&SessionID=51> (last visited June 11, 2010) (noting suspension as of January 2009); see also John Bouman & Jennifer Hrycyna, Caro v. Blagojevich: *What Happens When Working Families’ Health Care Becomes a Political Football*, 42 CLEARINGHOUSE REV.: J. POVERTY L. & POL’Y 615, 616 n.11 (2009) (noting that the Illinois Senate “never voted on the Illinois Health Care for All Act”).

privilege of doing business in [Illinois]”⁹⁴ Employers spending 2.5% or more of wages on health benefits could offset that amount with tax credits.⁹⁵ The bill expressly precludes employers from collecting that amount from their employees.⁹⁶

In 2008, the New Mexico state legislature rejected the Health Solutions for New Mexico Act.⁹⁷ It would have required employers with as few as six employees and eventually all employers to make “work force fund” contributions equaling the difference between \$500 per full-time worker (and \$250 per part-time worker) and any other payments toward employee health care that were less than \$500 (\$250).⁹⁸

California’s 2007 Health Care Security and Cost Reduction Act⁹⁹ pursued universal coverage by imposing “shared responsibility” on: 1) individuals to obtain coverage; 2) the government to ensure the availability of affordable coverage, including subsidizing coverage for those who could not otherwise afford it; and 3) employers to offer § 125 cafeteria plans, and either “play” by covering their workers directly or “pay” in the form of a state payroll tax.¹⁰⁰ The nature and amount of the employer mandate was the subject of extensive negotiations between Governor Schwarzenegger and Democratic members of the state legislature.¹⁰¹ The final version called for a wage tax ranging from 1% to 6.5% depending on the size of the firm’s payroll.¹⁰² After passing in the General Assembly, it quickly derailed in the Senate Finance Committee once the non-partisan Legislative Analyst’s Office projected that, within five years, the plan’s unstable financing mechanisms and lack of cost controls could increase the state’s already-mounting deficit by as much as \$1.5 billion.¹⁰³

IV. ERISA PREEMPTION IN MARYLAND AND SUFFOLK COUNTY, NEW YORK

With an eye toward the threat of ERISA preemption, Maryland enacted an extremely limited employer “play or pay” provision in its Fair Share Health Care

94. S. 5 §§ 50-301, -401.

95. *Id.* § 50-302.

96. *Id.* § 50-301(c).

97. H.R. 62, 48th Leg., 2d Sess. (N.M. 2008); KAISER COMM’N ON MEDICAID & THE UNINSURED, *supra* note 79, at 13.

98. H.R. 62 §§ 3, 12.

99. Assem. 1, 2007 Leg., 1st Extra. Sess. (Cal. 2007).

100. *Id.*

101. Jordan Rau, *Some Steps, No Leaps on Healthcare; Legislators Vote to Curb Extreme Practices, but Such Key Issues as Cost and Uneven Care Are Unaddressed*, L.A. TIMES, Sept. 4, 2008, at B1 (discussing the piece-meal manner of enacting health reforms because of aggressive lobbying).

102. Assem. 1 § 82(d).

103. Letter from Elizabeth G. Hill, Leg. Analyst, Leg. Analyst’s Office, to the Hon. Don Perata, Pres. Pro Tempore, Cal. Senate (Jan. 22, 2008), available at http://www.lao.ca.gov/2008/hlth/health_reform/health_reform_012208.aspx.

Fund Act.¹⁰⁴ It applied to four employers with 10,000 or more workers, but effectively targeted the only one that fell short of the statutory spending requirement: Wal-Mart, which was already under fire for being the nation's largest employer and failing to cover thousands of its employees.¹⁰⁵ Maryland's new law required Wal-Mart to meet various reporting requirements and devote at least eight percent of its total payroll to employee health care expenses.¹⁰⁶ It could do the latter by providing benefits directly or paying the difference between eight percent and its current health expenditures to the state's Medicaid fund.¹⁰⁷

Before the law could take effect, it was invalidated by the Court of Appeals for the Fourth Circuit in *Retail Industry Leaders Ass'n v. Fielder*¹⁰⁸ as being § 514 "relate to" preempted.¹⁰⁹ Wal-Mart itself did not sue; instead, the Retail Industry Leaders Association (RILA) led the charge by arguing that the "fair share" requirement violated ERISA's § 514 "relate to" clause.¹¹⁰ Maryland countered that it was a generally applicable revenue statute like the one that survived § 514 preemption in *Travelers*.¹¹¹ The trial and appellate courts agreed with RILA,

104. Fair Share Health Care Fund Act, ch. 1, 2006 Md. Laws 1 (codified at MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to -107 (West 2006), *invalidated by* Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 198 (4th Cir. 2007)); *see also* Edward A. Zelinsky, *Maryland's "Wal-Mart" Act: Policy and Preemption*, 28 CARDOZO L. REV. 847, 847-49 (2006) (providing general background on the impetus for and content of Maryland's Fair Share Act).

105. *See* Andrew A. Green, *Health Bill Is Up for Debate: At Conference, Firms Support Wal-Mart Law Veto, Top Democrats Vow to Override It*, BALT. SUN, Oct. 28, 2005, at 1B (reporting that a Wal-Mart official had acknowledged that criticisms about the company's health care policies were valid and that many Wal-Mart employees were uninsured or receiving public assistance); Susan Parker, Editorial, *Our View—Fair Share Health Care Act*, DAILY TIMES (Salisbury, Md.), July 23, 2006, at 12 (noting that the law was known as the "Wal-Mart law" because it would have only impacted Wal-Mart); Ann Zimmerman, *Wal-Mart to Stock Emergency-Contraception Pill*, WALL ST. J., Mar. 4, 2006, at A6 ("Wal-Mart faces rising criticism around the country for offering relatively bare-bones health benefits for its workers."). At the time the Maryland law was enacted, three other companies employing more than 10,000 workers operated in Maryland. Dan Rodricks, *Politicians, Listen Up—The Public Has Spoken*, BALT. SUN, July 16, 2006, at 1B. Wal-Mart was the only company of the four large employers who did not already "pay [its] fair share or more." *Id.*

106. *See* MD. CODE ANN., LAB. & EMPL. §§ 8.5-102 to -104 (requiring reports on health care spending for qualified employers, and that eight percent of the sum of all total wages must be spent on health insurance).

107. *Id.* § 8.5-104(b); *see also* Zelinsky, *supra* note 104, at 848-49 (discussing Maryland's Fair Share Act).

108. 435 F. Supp. 2d 481, 501 (D. Md. 2006), *aff'd*, 475 F.3d 180, 197-98 (4th Cir. 2007). Although Maryland's bill never had legal effect, some suggest that it nevertheless compelled Wal-Mart to improve the health care options it provided for its employees. Andrew A. Green, *Wal-Mart Bill Is Celebrated, Despite Ruling; Backers Say It Pressured Retailer to Improve Employee Health Plans*, BALT. SUN, July 21, 2006, at 1B.

109. *Fielder*, 475 F.3d at 197 (holding the Act has a "connection with" ERISA plans and, accordingly, is preempted).

110. *Fielder*, 435 F. Supp. 2d at 485-86, 493-94 & n.13 (discussing RILA's standing and claim before the court).

111. *Fielder*, 475 F.3d at 195 (citing N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 658-59 (1995)).

reasoning that, despite the “pay” option, the eight percent spending provision was a benefits mandate, and the reporting requirements interfered with plan administration.¹¹² In each respect, the statute threatened § 514’s goal of uniform plan administration by requiring Wal-Mart to “keep an eye on conflicting state and local minimum spending requirements and adjust its healthcare spending [and recordkeeping] accordingly.”¹¹³ Since this “connection” with a plan triggered “relate to” preemption, the court saw no need to determine whether an improper “reference” also existed.¹¹⁴ Within the year, a similar fair share mandate (this time a county ordinance) was preempted on similar grounds in *Retail Industry Leaders Ass’n v. Suffolk County*.¹¹⁵

V. WHAT REMAINS: MASSACHUSETTS, VERMONT, AND SAN FRANCISCO— BUT FOR HOW LONG?

A. Massachusetts’ “Health Care for All” Statute

In drafting and negotiating the various bills that ultimately emerged as PPACA, congressional leaders relied heavily on what Massachusetts had already accomplished—and Massachusetts did so by deliberately avoiding Maryland’s narrow strategy. Massachusetts’ Act Providing Access to Affordable, Quality,

112. *Id.* at 194–95. For the trial court’s reasoning as it relates to plan administration, see *Fielder*, 435 F. Supp. 2d at 494–95.

113. *Fielder*, 475 F.3d at 197; see also *Fielder*, 435 F. Supp. 2d at 496 (“[T]he Act violates ERISA’s fundamental purpose of permitting multi-state employers to maintain nationwide health and welfare plans”); Matthew Dolan et al., *Court Voids “Wal-Mart Law”*: U.S. District Judge Says Md. Violated Federal Authority, *BALT. SUN*, July 20, 2006, at 1A (indicating that Maryland’s Fair Share Act was invalidated by the Fourth Circuit because it violated federal law requiring uniform treatment of employers by requiring Wal-Mart to submit reports regarding its health care expenditures while other employers in the state were not so required); Editorial, *The Wal-Mart Decision*, *BALT. SUN*, July 21, 2006, at 12A (reporting that the limitations ERISA places on states’ ability to regulate the benefit plans offered by employers proved fatal to the legislation).

114. *Fielder*, 475 F.3d at 192 n.2 (noting that neither the Circuit Court nor the District Court found it necessary to reach the “reference” question as both courts found preemption through the “connection” language). The Fourth Circuit noted, however, that the “reference to” standard applies more narrowly in preempting state law. *Id.*

115. 497 F. Supp. 2d 403, 416–17 (E.D.N.Y. 2007). With reporting obligations that mirrored Maryland’s, the ordinance again targeted Wal-Mart by requiring large, non-unionized retailers to make annual health care expenditures equal to the “public health care cost rate” for each full- or part-time employee. *Id.* at 416; see *SUFFOLK COUNTY, N.Y., REGULATORY LOCAL LAW §§ 325-1 to -6* (Sept. 27, 2005), available at <http://legis.suffolkcountyny.gov/resos2005/i1903-05.htm> (detailing annual reporting requirements for covered employers); Ross Daly, *Federal Judge Tosses Suffolk County’s Health-Coverage Law*, *LONG ISLAND BUS. NEWS* (Long Island, N.Y.), July 27, 2007 (reporting that a U.S. District Court judge ruled that Suffolk County’s fair share law was preempted by federal law and that “[t]he arrival of Wal-Mart . . . was a motivating factor” for law’s creation); Julia C. Mead, *Suffolk Requires Big Stores to Help with Health Care*, *N.Y. TIMES*, Sep. 28, 2005, at B5 (indicating that Suffolk County’s Fair Share for Health Care Act was aimed at retailers like Wal-Mart and noting that employers covered by the law would be required to contribute a minimum of \$3 for each hour worked to an employee’s health coverage).

Accountable Healthcare¹¹⁶ took effect in 2007 with the goal of achieving universal coverage by 2009.¹¹⁷ Unlike Maryland's focus on getting Wal-Mart to play or pay, Massachusetts foreshadowed PPACA's formulation of "shared responsibility" by imposing an array of requirements on insurers, individuals, and certain employers.¹¹⁸ For example, employers of more than ten full-time workers must make a "reasonable contribution" to employee health care by: 1) providing health benefits to at least twenty-five percent of the workforce; 2) paying at least a third of the cost of all workers' individual plans; or 3) making an annual "fair share" contribution, which, in 2008, was up to \$295 per full-time worker.¹¹⁹ Firms must also offer § 125 cafeteria plans or face "free rider" penalties.¹²⁰ In Massachusetts, then, employers can choose which type of payment to make, but some form of payment is still mandated. This distinguishes it from PPACA's use of an incentive that predicates the need to "pay" on the actual occurrence of free riding employees (in terms of basic coverage as opposed to § 125 plans).

116. Act of Apr. 12, 2006, ch. 58, 2006 Mass. Acts, available at <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>.

117. See Richard Knox, *Romney's Mission: Massachusetts Health Care* (Apr. 8, 2006), <http://www.npr.org/templates/story/story.php?storyId=5330854> (noting the goal of the legislation is to provide health insurance to virtually every citizen by 2009).

118. MASS. GEN. LAWS ANN. ch. 118E § 9A (West 2008); COMMONWEALTH CONNECTOR, EMPLOYER HANDBOOK 1 (2007), available at <https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/Employer/Overview/Employer%2520Handbook.pdf> ("The guiding principle behind this reform is one of shared responsibility."). Located within the Massachusetts bill is the newly created *Commonwealth Health Insurance Connector*, which assists individuals and small businesses with less than fifty employees to find suitable private plans and promote consumer driven competition. MASS. GEN. LAWS ANN. ch. 176Q § 1 (West Supp. 2009); COMMONWEALTH OF MASS., HEALTH CARE ACCESS AND AFFORDABILITY CONFERENCE COMMITTEE REPORT 1 (2006), available at <http://www.mass.gov/legis/summary.pdf>. To date, the greatest criticism of the individual mandate is that it may not be economically sustainable since it is feared that premiums will be too high for the insured, too low for the insurer, and therefore require too much in the way of state subsidies. *E.g.*, Alice Dembner, *Healthcare Cost Increases Dominate Mass. Budget Debate: Controlling Them Said Key to Keeping Universal Coverage*, BOSTON GLOBE, Mar. 26, 2008, at A12, available at http://www.boston.com/news/local/articles/2008/03/26/healthcare_cost_increases_dominate_mass_budget_debate/?page=full.

119. MASS. GEN. LAWS ANN. ch. 149 § 188(b)-(d) (West Supp. 2009); see also COMMONWEALTH CONNECTOR, *supra* note 118, at 2-3 (summarizing the statutory requirements).

120. MASS. GEN. LAWS ANN. ch. 149 § 188; *id.* ch. 151F § 2; see also COMMONWEALTH CONNECTOR, *supra* note 118, at 8 (explaining when the Free Rider Surcharge applies under the 26 U.S.C. § 125 plan). Free rider penalties, ranging from 10% to 100% of the cost of the services, for failing to offer Section 125 plans to employees will be used to pay for uncompensated care sought by that employer's workers on five or more occasions. See Robert E. Moffit & Nina Owcharenko, *Understanding Key Parts of the Massachusetts Health Plan*, HERITAGE FOUND., Apr. 20, 2006, available at <http://www.heritage.org/Research/HealthCare/wm1045.cfm>. Because § 125 Plans permit pre-tax employee contributions, they may offer savings of up to 40% of each employee dollar contributed, saving employers about \$160 in annual federal withholding tax for each participating employee, despite the fact that it costs about \$100 a year per employee to create and administer a health-only cafeteria plan and that several national companies compete for this business. See Cauchi, *supra* note 82.

Initially, the cost of health reform in Massachusetts raised concerns that small and medium-sized businesses would leave the state.¹²¹ A contravening worry was that the fair share contribution was so low that it would lead employers to drop coverage.¹²² Initial data show that neither has occurred—at least not yet. Approximately 70% of Massachusetts employers offered health benefits from 2001 through 2005.¹²³ Notwithstanding escalating costs, this figure rose to 72% when the employer mandate took effect in 2007 even though nationally, employer coverage fell from 68% in 2001 to about 60% in 2007.¹²⁴

Massachusetts' health care reform law has attracted attention not only because of its innovative approach, but also because of the broad political support for its enactment.¹²⁵ That employers backed it from the start and continue to stand by it is obviously essential to its financial sustainability.¹²⁶ However, employer support is just as crucial for its "legal" sustainability insofar as it has escaped the kinds of ERISA challenges that occurred in Maryland, Suffolk County, and, as explained below, San Francisco.

For at least three reasons, however, Massachusetts' "play or pay" provision has always been more vulnerable to § 514 preemption than its Maryland and Suffolk County predecessors, and PPACA's enactment makes its longterm prospects even more tenuous. First, Massachusetts' imposition of more

121. See Nina Owcharenko & Robert E. Moffit, *The Massachusetts Health Plan: Lessons for the States*, BACKGROUNDERS, July 18, 2006, at 7–8 (noting that the costs of an employer mandate could make it difficult for the start-up and maintenance of small businesses); Ryan Menard, *Bill Offers Family Leave with Pay: Chamber, Union Leaders Differ on Plan; Employee Premiums Would Fund It*, PATRIOT LEDGER (Quincy, Mass.), Apr. 24, 2006, at 9 (voicing concern that businesses considering relocating to Massachusetts might now look elsewhere).

122. See Jeffrey Krasner, *Business Leader Suggests Health Law Too Easy on Firms*, BOSTON GLOBE, Feb. 2, 2007, at C1 (noting that most employers provide a 50% to 80% premium contribution, far more than the 33% required by the fair share plan to avoid assessments). To forestall such a result, one bill has already been submitted that would exempt companies to pay for at least 50% of individual premiums to avoid paying the \$295 employee insurance fee. S. 661, 185th Gen. Court, Reg. Sess. (Mass. 2007); Krasner, *supra*.

123. DIV. OF HEALTH CARE FIN. & POL'Y, EXECUTIVE OFFICE OF HEALTH & HUMAN SERVS., HEALTH CARE IN MASSACHUSETTS: KEY INDICATORS 4 (2009) (providing an overview of health care statistics in Massachusetts, including data which shows that 68% to 70% of Massachusetts employers offered health insurance to their employees in 2001, 2003, and 2005), available at http://www.mass.gov/Eeoehs2/docs/dhcfp/r/pubs/09/key_indicators_02-09.pdf.

124. *Id.*

125. See, e.g., Gillian K. SteelFisher et al., *Physicians' Views of the Massachusetts Health Care Reform Law—A Poll*, 361 NEW ENG. J. MED. e39(1), e39(1) (2009), available at <http://content.nejm.org/cgi/reprint/NEJMp0909851.pdf?ssource=hrc> (stating that U.S. policymakers are looking to Massachusetts's health care plan as a potential model for health care reform).

126. See Robert J. Blendon et al., *Massachusetts Health Reform: A Public Perspective from Debate Through Implementation*, HEALTH AFF., Oct. 28, 2008, at w556, w564 (reviewing a four stage public opinion study that relayed information about the implementation and impact of the new health reform law in Massachusetts); Press Release, Health Affairs, Massachusetts Businesses Express Support for Health Care Reform Objectives: Survey Reveals Few Signs That Public Subsidies Are Crowding Out Private Coverage (Nov. 14, 2007), available at <http://www.healthaffairs.org/press/novdec0705.htm>.

requirements on all employers with eleven or more workers risks antagonizing far more firms than just Wal-Mart. Second, the mandate to “pay something” through coverage or an annual fair share contribution might be viewed as an effective benefits mandate and/or administrative interference amounting to a § 514 preempted “connection” with a plan. Third, although the Internal Revenue Service does not categorize § 125 plans as ERISA plans *per se*, their compulsory inclusion may constitute a § 514 preempted benefits mandate and/or plan interference, especially given their attendant financial and administrative costs.¹²⁷ In response to an ERISA challenge, the state could argue that the law actually creates options, not mandates, and that any payments make the law a funding measure with the kind of indirect economic impact that evaded § 514 preemption in *Travelers*. Whether this argument would prevail is unclear. Its failure in *Fielder* and *Suffolk County* and early success in San Francisco’s litigation¹²⁸ only underscores the unfortunate reality that when it comes to ERISA preemption litigation, anything can happen.

So far, employers have not challenged Massachusetts’ law but their support may erode should health care costs, including fair share contributions and free rider penalties, continue to climb. The fault lines may already be forming. Recent budgetary constraints led the state to scale-back coverage for 30,000 legal immigrants and reduce reimbursements for “safety net” hospitals.¹²⁹ This led Boston Medical Center, the state’s largest provider of uncompensated care, to sue the state for violating its health reform statute, with more hospitals threatening to do the same.¹³⁰ While not an ERISA case, it could be a sign of eroding support among other stakeholders—including employers.

127. One analysis explains:

[B]ecause the definition of employer group health coverage is different under ERISA than under the federal tax code, as long as employers do not endorse or promote specific individually purchased health insurance policies, [§ 125 plans] . . . should not be subject to ERISA. Nor should a state requirement that employers offer [§] 125 plans be preempted by ERISA.

PATRICIA A. BUTLER, CAL. HEALTHCARE FOUND., EMPLOYER CAFETERIA PLANS: STATES’ LEGAL AND POLICY ISSUES 2 (2008), available at <http://www.chcf.org/resources/download.aspx?id=%7b0973EF72-1F9C-4985-8D60-DA35B418751E%7d>. However, the National Conference of State Legislatures points out that “states still cannot regulate ‘self-insured’ health plans sponsored by many large employers” and that “[d]rafters need to recognize that care is needed to avoid a challenge to any broader law.” Cauchi, *supra* note 82.

128. See *infra* Part V.C.

129. Abby Goodnough, *Massachusetts Takes a Step Back from Health Care for All*, N.Y. TIMES, July 15, 2009, at A10; see also Carla K. Johnson, *Will Safety Net Hospitals Survive Health Reform?*, ASSOCIATED PRESS FIN. WIRE, Sept. 8, 2009 (critiquing Massachusetts’s decision to eliminate health care coverage for legal immigrants in hopes of closing the state’s growing deficit).

130. Wendy E. Parmet, *Litigation Amidst Reform—The Boston Medical Center Case*, 361 NEW ENG. J. MED. 1819, 1819–21 (2009) (evaluating Boston Medical Center’s recent challenge in state court questioning Massachusetts’s Medicaid reimbursement protocol).

B. Vermont's "Catamount" Plan

Vermont's "Catamount" Plan,¹³¹ passed in 2006, also expects employers to share the responsibility of financing universal coverage.¹³² Employers with uninsured workers must make a quarterly health care premium contribution of \$1 per day for each full time equivalent employee (\$365 per year), but there are no free rider penalties for noncompliance.¹³³ As in Massachusetts, Vermont's mandatory employer contribution has not yet provoked an ERISA challenge, but it may share the same vulnerabilities as the Massachusetts statute.

C. San Francisco's Mandate—A Preemption Survivor or Merely on Life Support?

Undaunted by the demise of Maryland and Suffolk County's fair share mandates, San Francisco passed its own "play or pay" measure: the San Francisco Health Care Security Ordinance.¹³⁴ It was immediately challenged but the Ninth Circuit Court of Appeals surprisingly found no § 514 preemption in *Golden Gate Restaurant Ass'n v. City of San Francisco*.¹³⁵

The Ordinance applies to for-profit employers doing business in the city with an average of twenty "covered" employees per quarter, as well as to nonprofit employers that average fifty such workers.¹³⁶ These employers must make quarterly "required health care expenditures" equal to the total number of hours paid for each covered worker multiplied by an annual "health care expenditure rate."¹³⁷ The City

131. Act of May 25, 2006, 2006 Vt. Acts & Resolves 190 (amending 2006 Vt. Acts & Resolves 191).

132. See James Maxwell, Interview, *Comprehensive Health Care Reform in Vermont: A Conversation with Governor Jim Douglas*, HEALTH AFF., Oct. 16, 2007, at w697, w699 (relaying the Vermont governor's participation in and opinions on the state's comprehensive health reforms implemented in 2006).

133. See Harry Chen, Representative, House Health Care Committee, Presentation at the Council of State Governments: Eastern Regional Conference Annual Meeting: Vermont Health Care Reform "Catamount Health" (Aug. 1, 2006), available at http://www.csgeast.org/Annual_Meeting/2006/healthchen.ppt.

134. S.F., CAL., ADMIN. CODE §§ 14.1–.8 (2006), available at <http://library.municode.com/index.aspx?clientId=14131&stateId=5&stateName=California> (follow "Chapter 14" hyperlink); see also *Groundbreaking City Health Care Plan Passes in S.F.*, SAN JOSE MERCURY NEWS (San Jose, Cal.), July 19, 2006 (detailing the history and unanimous passage of the Health Care Security Ordinance). The Ordinance created a city-administered health care program called the *Health Access Plan*, now formally entitled *Healthy San Francisco* but still referred to as HAP. Samuel C. Salganik, *What the Unconstitutional Conditions Doctrine Can Teach Us About ERISA Preemption: Is It Possible to Consistently Identify "Coercive" Pay-or-Play Schemes?*, 109 COLUM. L. REV. 1482, 1504 & n.150. To be eligible for HAP coverage, an employee must reside in the city, be uninsured, and have a low or moderate income, although ineligible employees may be entitled to establish medical reimbursement accounts with the City. S.F., CAL., ADMIN. CODE § 14.2(a)–(d).

135. 546 F.3d 639, 642–43 (9th Cir. 2008), petition for cert. filed, 130 S. Ct. 357 (June 5, 2009) (No. 08-1515).

136. § 14.1(b)(3), (11)–(12) (defining *covered employers*).

137. *Id.* §§ 14.1(b)(2)–(12), .3(a). *Covered employees* must "(1) work in the City, (2) work at least ten hours per week, (3) have worked for the employer for at least ninety days, and (4) are not excluded

has a right to inspect the employer’s quarterly expenditure records.¹³⁸ Noncompliance with recordkeeping requirements raises a presumption of nonpayment that can only be rebutted with clear and convincing evidence.¹³⁹ Under certain circumstances, the spending requirement also applies to self-funded plans, although they are exempt from tracking their per-employee expenditures.¹⁴⁰ The early indications are that San Francisco’s employer mandate has not produced job losses and has reduced the number of uninsured from 82,000 to less than 23,000.¹⁴¹

Mandating quarterly payments based on each worker’s hours and variable health expenditure rates, and requiring that quarterly records of those payments be kept and made accessible is more burdensome than the fair share measures that triggered § 514 “relate to” preemption in *Fielder* and *Suffolk County*.¹⁴² Furthermore, § 514 has previously preempted potentially conflicting state and local directives and here, this potential was already reality given Maryland’s and Suffolk

from coverage by other provisions of the Ordinance.” *Golden Gate Rest. Ass’n*, 546 F.3d at 644. At the time of the Ninth Circuit’s ruling, the per employee health care expenditure was \$1.17 per hour for for-profit employers with twenty to ninety-nine employees and non-profit employers with fifty or more employees, and \$1.76 per hour for for-profit employers with 100 or more workers. *Id.* (citing OFFICE OF LABOR STANDARDS ENFORCEMENT, CITY & COUNTY OF S.F., REGULATIONS IMPLEMENTING THE EMPLOYER SPENDING REQUIREMENT OF THE SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE (HCSO) 13 (2007), available at <http://sfgsa.org/Modules/ShowDocument.aspx?documentid=1246>).

138. § 14.3(b)(i).

139. *Id.* § 14.3(b)(ii).

140. See *Golden Gate Rest. Ass’n*, 546 F.3d at 645 (“An employer providing ‘health coverage to some or all of its covered employees through a self-funded/self-insured plan’ will ‘comply with the spending requirement . . . if the preceding year’s average expenditure rate per employee meets or exceeds the applicable expenditure rate’ for the employer.”).

141. Brief for Respondent at 6, *Golden Gate Rest. Ass’n v. City of San Francisco*, No. 08-1515 (9th Cir. Aug. 24, 2009); ARINDRAJIT DUBE ET AL., INST. FOR RESEARCH ON LABOR & EMPLOYMENT, THE IMPACT OF SAN FRANCISCO’S EMPLOYER HEALTH SPENDING REQUIREMENT: INITIAL FINDINGS FROM THE LABOR AND PRODUCT MARKETS 1–2 (2009), available at http://www.irl.berkeley.edu/cwed/wp/sthealth_09.pdf (indicating that the ordinance has not yet resulted in the substantial job losses some worried might occur); Heather Knight, *Health Plan Did Not Hurt City Jobs*, S.F. CHRON., Aug. 21, 2009, at D1 (reporting that, due to the ordinance, seventy-five percent of San Francisco’s 60,000 previously uninsured residents now have access to health care).

142. Compare S.F., CAL., ADMIN. CODE § 14.3(a)–(b) (requiring a covered employer to “make required health care expenditures . . . each quarter” and to “maintain accurate records of health care expenditures, required health care expenditures, and proof of such expenditures made each quarter each year, and allow OLSE reasonable access to such records”), with MD. CODE ANN., LAB. & EMPL. §§ 8.5-103(a)(1) (West 2006) (requiring a covered employer to annually submit forms indicating the number of people it employed, the amount spent by the employer on health insurance, and the percentage of payroll the employer spent on health insurance), and SUFFOLK COUNTY, N.Y., REGULATORY LOCAL LAW § 325-3(E) (Sept. 27, 2005), available at <http://legis.suffolkcountyny.gov/resos2005/i1903-05.htm> (requiring an employer to “(1) maintain accurate records for each employee’s . . . hours worked . . . ; (2) permit employees . . . access to records . . . for inspection and copying; and (3) maintain accurate records of the covered employer’s health care expenditures each year”).

County's similarly intended, but differently designed "play or pay" mandates.¹⁴³ Thus, *Golden Gate* presented an even stronger case for preemption than had existed in Maryland and Suffolk County.

Yet, a panel of three appellate judges from the Ninth Circuit saw things quite differently. It reasoned that, as explained in *Travelers*, any preemption inquiry should begin with a strong presumption against preemption, especially in an area traditionally controlled by state law, such as health care.¹⁴⁴ In its opinion, the presumption prevails here, since the employer spending requirement has no improper connection with an employee benefits plan, primarily because it provides options for satisfying it.¹⁴⁵ Payments can be directed toward the benefits themselves or be paid to the City.¹⁴⁶ Such a "meaningful alternative" protects employers from having to establish or restructure existing plans, although they may elect to do so.¹⁴⁷ Moreover, if an employer chooses to pay for benefits directly, the Ordinance does not restrict how those dollars are used.¹⁴⁸

According to the court, the "City-payment" option also shows that the Ordinance does not mandate creation of an ERISA plan,¹⁴⁹ interfere with administration of existing plans,¹⁵⁰ or bind plan administrators to particular choices.¹⁵¹ Any administrative obligations fall on the employer, not the plan, indicating that the Ordinance also fails to expose plans to the kind of conflicting directives that ERISA preemption is designed to prevent.¹⁵² As a result, there is no § 514 preempted "connection."¹⁵³ An impermissible "reference" to a plan is absent, too, because the Ordinance neither targets ERISA plans nor depends on their existence.¹⁵⁴

Interestingly, the Ninth Circuit in *Golden Gate* found no conflict with the Fourth Circuit's *Fielder* ruling.¹⁵⁵ The Ninth Circuit interpreted Maryland's "play or pay" statute as forcing Wal-Mart to *play* since opting to *pay* the state returned

143. See Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J.L. MED. & ETHICS 88, 100 app. A (2009), for a side-by-side comparison of the Maryland and San Francisco measures.

144. *Golden Gate Rest. Ass'n*, 546 F.3d at 647 (citing *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995)).

145. *Id.* at 655–57.

146. *Id.* at 655–56.

147. *Id.* at 646, 660.

148. *Id.* at 646–47.

149. *Id.* at 650.

150. *Id.* at 653–54.

151. *Id.* at 656.

152. *Id.* at 657.

153. *Id.* at 661.

154. *Id.* at 657.

155. *Id.* at 659.

nothing but “lower employee morale and increased public condemnation.”¹⁵⁶ Under this interpretation, Maryland’s law related to plan administration in violation of § 514 because Wal-Mart’s only “rational choice” was to play by establishing or altering an ERISA plan.¹⁵⁷ In “stark contrast,” San Francisco’s City-payment option offers “a meaningful alternative” to employers since their workers can enroll in the City-run plan or establish medical reimbursement accounts with the City.¹⁵⁸ The court reasoned that this permits employers to fulfill the spending requirements without having “to alter or establish ERISA plans”¹⁵⁹

The Ninth Circuit denied the Restaurant Association’s petition for *en banc* review by the full panel of eighteen judges.¹⁶⁰ However, eight judges would have reheard the case because they identified a circuit split with the Fourth Circuit in *Fielder* and thought that *Fielder* got it right.¹⁶¹ In their view, the three judge *Golden Gate* panel ran afoul of the Supreme Court’s ruling in *Egelhoff v. Egelhoff*¹⁶² because the Ordinance “effectively requires ‘ERISA administrators to master the relevant laws of 50 States’” despite ERISA’s insistence on uniform, federal oversight of plan administration.¹⁶³ The payment, record-keeping, and inspection obligations forges “an impermissible connection with . . . ERISA plans” by directly and indirectly affecting an employer’s decisions regarding whether and how to offer health benefits.¹⁶⁴ A “reference” also exists since the Ordinance and its regulations explicitly refer to employer plans and require employers to examine their plans to calculate their expenditure obligations.¹⁶⁵ Enforcing the Ordinance additionally interferes with an employer’s determination of its overall health expenditures.¹⁶⁶ Any one of these occurrences warrants § 514 preemption; combined, they create an impermissible intrusion on employer autonomy and an intolerable threat to ERISA’s overall goal of nationally uniform plan administration. Consequently, *en banc* review might have affirmed the trial court’s finding of § 514 preemption.

The Restaurant Association has petitioned the U.S. Supreme Court for certiorari.¹⁶⁷ As of April 2010, the Court had not formally granted review; however,

156. *Id.* at 659–60 (citing *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 193 (4th Cir. 2007)).

157. *Id.* (citing *Fielder*, 475 F.3d at 193).

158. *Id.* at 660.

159. *Id.*

160. *Golden Gate Rest. Ass’n v. City of San Francisco*, 558 F.3d 1000, 1001 (9th Cir. 2009).

161. *Id.* at 1004, 1006–07 (Smith, J., dissenting).

162. 532 U.S. 141 (2001).

163. *Golden Gate Rest. Ass’n*, 558 F.3d at 1004 (Smith, J., dissenting) (quoting *Egelhoff*, 532 U.S. at 149).

164. *Id.* at 1005.

165. *Id.*

166. *Id.* at 1008–09.

167. *Golden Gate Rest. Ass’n v. City of San Francisco*, 546 F.3d 639 (9th Cir. 2008), *petition for cert. filed*, 130 S. Ct. 357 (June 5, 2009) (No. 08-1515).

in October 2009, it asked the U.S. Solicitor General to submit an amicus brief.¹⁶⁸ This allows the Obama Administration to endorse or reject the prior administration's support for the Restaurant Association's unsuccessful preemption argument before the Ninth Circuit.¹⁶⁹ There is no formal deadline for the Solicitor General's brief, but the customary thirty-day response time has long since passed.¹⁷⁰ This may reflect the political risks of taking a stand on this issue amid the increasingly antagonistic push to enact health care reform in late 2009 through March 2010, and an ongoing reluctance to do so given the fragile support for PPACA's enactment.¹⁷¹

It is always difficult to predict how the Court will rule in ERISA preemption cases. Nevertheless, even before PPACA's enactment, and notwithstanding any DOL efforts to exempt "play or pay" mandates from § 514's reach,¹⁷² the Court would probably have rejected the general objective of requiring employers to play or pay as well as San Francisco's specific techniques for doing so. That it will do so regardless of the Solicitor General's ultimate position in *Golden Gate* seems even more likely given its April 2010 decision in *Conkright v. Frommert*.¹⁷³

Focused on the discretion owed to an ERISA plan administrator, the *Conkright* case did not implicate § 514. However, it did lead Justice Roberts, writing for a five to three majority,¹⁷⁴ to invoke the Court's 2002 preemption ruling in *Rush Prudential* to emphasize that ERISA demands "a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred."¹⁷⁵ The *Conkright* majority refused to subject multi-state plans to "patchwork" interpretations that "would introduce considerable inefficiencies in benefit program

168. *Id.*; see also Press Release, Office of the City Att'y, U.S. Supreme Court Asks Obama Administration to Weigh In on "Healthy San Francisco" (Oct. 5, 2009), available at <http://www.sfcityattorney.org/index.aspx?page=218> (stating that, "[i]n calling for the views of Solicitor General Elena Kagan, the Supreme Court has effectively postponed [its] decision" as to whether to grant certiorari in *Golden Gate*); U.S. Supreme Court Docket for No. 08-1515, <http://www.supremecourt.gov/docketfiles/08-1515.htm> (last visited June 11, 2010) (indicating that no response has yet been filed).

169. Bob Egelko, *Top Court Requests Advice on S.F. Plan*, S.F. CHRON., Oct. 6, 2009, at A1.

170. SUP. CT. R. 15(3), 37(2) ("Any brief in opposition shall be filed within 30 days after the case is placed on the docket, unless the time is extended by the Court or a Justice . . .").

171. See Egelko, *supra* note 169 (discussing President Obama's struggle to overhaul health coverage nationwide, and the central role that employer-based coverage plays in that debate). Others have suggested that the Supreme Court harbors strong deference to Congress as far as ERISA is concerned, and that any policy changes relating to the preemption issue must come from the legislature, not the courts, for example, JACOBSON, *supra* note 1, at 11.

172. For a discussion of DOL's proposed amendment of 29 C.F.R. 2510.3-1 pursuant to 29 U.S.C. § 1135, see *supra* notes 40–41.

173. 130 S. Ct. 1640 (2010).

174. The majority consisted of Justices Roberts, Scalia, Kennedy, Thomas, and Alito; Justice Breyer dissented, joined by Justices Stevens and Ginsberg; Justice Sotomayor took no part in the decision. *Id.*

175. *Id.* at 1649 (quoting *Rush v. Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002)).

operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them.”¹⁷⁶ Quoting *Egelhoff*, it stressed that “[u]niformity is impossible . . . if plans are subject to different legal obligations in different States.”¹⁷⁷ Such insistence on predictability, efficiency and uniformity in plan administration makes it highly improbable that the Court will tolerate exposing plans to varying “play or pay” requirements at the state and local levels. This is especially true for large firms that are now covered by PPACA’s “play or pay” incentives. San Francisco remains undaunted, however, and actually raised employer fair share contributions in April 2010.¹⁷⁸

VI. THE FUTURE OF EMPLOYER MANDATES IN THE COURTS

In general, fair share measures usually apply to employers instead of their benefits plans in order to avoid § 514 preemption. The Supreme Court will probably dismiss this as an impermissible attempt to circumvent preemption through artful legislative drafting. Fair share laws, especially those that mandate some form of payment as Massachusetts and San Francisco do, could also fail for effectively forcing employers to establish or alter benefits plans, or fund public sources of coverage, whether for their own workers or a general pool. As explained in *Egelhoff*, § 514 preempts forced or restricted administrative choices, regardless of any benefits that might accrue from those choices.¹⁷⁹ Consequently, in *Golden Gate*, the “pay” option’s *quid pro quo*—allowing employees to enroll in San Francisco’s plan or set-up medical reimbursement accounts—may have impressed the Ninth Circuit as influencing without dictating plan choices, but is unlikely to sway the Supreme Court. Additionally, certain types of mandates may be especially vulnerable to “relate to” preemption despite their effort to avoid it.

For instance, payroll taxes were chosen by Maryland and San Francisco as their “pay” option, and are appealing since employers already face an array of federal, state, and local taxes.¹⁸⁰ To date, varying tax liabilities have not qualified as § 514 preempted conflicting state directives.¹⁸¹ Given public disdain for new

176. *Id.* (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11(1987)).

177. *Id.* at 1651 (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001)).

178. See Erin Sherbert, *Healthy SF Fees Set to Increase*, S. F. EXAMINER, Apr. 23, 2010, available at <http://www.sfexaminer.com/local/Healthy-SF-fees-set-to-increase-91887114.html> (noting that fees for employers with twenty to ninety-nine workers will increase in 2011 from \$1.31 to \$1.37 per hour, and, for 100 or more workers, will increase from \$1.96 to \$2.06).

179. *Egelhoff*, 532 U.S. at 146–47.

180. MD. CODE ANN., LAB. & EMPL. § 8.5–103(a)(1)(iii) (West Supp. 2006), *invalidated by* Retail Indus. Leaders Ass’n v. Fielder, 475 F.3d 180 (4th Cir. 2007); S.F., CAL., ADMIN. CODE § 14.3(a) (2006), available at <http://library.municode.com/index.aspx?clientId=14131&stateId=5&stateName=California> (follow “Chapter 14” hyperlink).

181. See, e.g., *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund.*, 520 U.S. 806 (1997). In *De Buono*, the Court considered whether ERISA preempted New York from imposing a gross receipts tax on the income of medical centers operated by ERISA funds. *Id.* at 808–09. The Court held that ERISA

taxes, state and local legislators may prefer the term “contribution” to “tax,” but the latter would be the wiser choice if trying to avoid preemption. A tax also holds the advantage of arguably creating an indirect financial incentive regarding the existence and structure of a plan as permitted in *Travelers*. However, *Travelers* stated that even indirect financial incentives will be preempted if they effectively bind the plan’s choices.¹⁸² Section 514 preemption occurred in *Egelhoff*, where the only “choice” was to comply with state law or alter the benefits plan.¹⁸³ Since this is also true for “play or pay” mandates,¹⁸⁴ the Supreme Court will probably characterize a public-pay option as preempted under § 514 as a restriction of plan choice.

Flat fees—a variant of the “pay” option such as the per capita, annual “contribution” enacted in Massachusetts and proposed in California’s failed state reform effort—present other problems. California had initially pegged the contribution to cover workers at firms opting to pay the state in lieu of paying for health care directly.¹⁸⁵ Because this seemed too close to a benefits mandate preempted under § 514, the contribution was redirected to a general pool.¹⁸⁶ The advantage of an annual flat fee is that it is less administratively burdensome than the ongoing calculations needed to satisfy a quarterly payroll tax.¹⁸⁷ There is still a problem though since, as in *Egelhoff*, the only alternative to making the mandated contribution is to offer health benefits that meet the statutorily required minimum coverage.¹⁸⁸ This is particularly concerning where employers that neither play nor pay face “free rider” penalties, as they would in Massachusetts.¹⁸⁹ That this penalty

did not preempt the New York tax law and reasoned that the tax was “one of ‘myriad state laws’ of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not ‘relate to’ them within the meaning of [ERISA].” *Id.* at 815. The Court further noted that “[a]ny state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute.” *Id.* at 816.

182. N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 664 (1995).

183. *Egelhoff*, 532 U.S. at 150–51.

184. *Fielder*, 475 F.3d at 183.

185. See generally Rick Curtis & Ed Neuschler, *Affording Shared Responsibility for Universal Coverage: Insights from California*, HEALTH AFF., Mar. 24, 2009, at w417, w420–29 (analyzing key features from California’s latest experience in working towards developing a plan for universal health coverage with a “shared responsibility” framework between individuals, employers, and state governmentalities).

186. See *id.* at w425–26 (noting that the contributions were used as credits against money the employer owed to the state).

187. See Rick Curtis & Ed Neuschler, *Designing Health Insurance Market Constructs for Shared Responsibility: Insights from California*, HEALTH AFF., Mar. 24, 2009, at w431, w437–38 (noting that fees only require a majority vote, while taxes require a two-thirds vote for enactment).

188. Cf. *Egelhoff*, 532 U.S. at 147.

189. See Mary Ann Chirba-Martin & Andres Torres, *Universal Health Care in Massachusetts: Setting the Standard for National Reform*, 35 FORDHAM URB. L.J. 409, 440 (2008) (discussing several implications that the Massachusetts “free rider” penalties imposes on employers).

attaches only when an uncovered worker uses uncompensated care under certain conditions does not erase the concern; it is the restriction of choice and intrusion on administration that is the problem, not the dollar amount involved. Thus, § 514 may preempt a flat fee as an improper interference with plan administration.

A novel approach is Illinois's proposed "privilege to employ" fee, which would require covered employers to pay a flat fee each year for the privilege of hiring each worker. This might survive § 514 preemption if the fee applies without regard to the extent of the employer's health care expenditures. This completely divorces the mandated payment from plan design and administration even though the resulting revenues could be used to finance expanded coverage.¹⁹⁰ Nevertheless, Illinois' proposed fee might undermine the basic purpose of fair share mandates by doing little to encourage the creation of new benefits plans, leading some firms to curtail or drop existing coverage.

Recording and reporting requirements used to monitor and enforce "play or pay" provisions may trigger preemption problems, too. PPACA requires large employers to submit annual reports to the Treasury Department stating whether it offers coverage to full-time employees and, if so, whether waiting periods applied, how many workers were covered during each month, along with the name, address and tax identification number of each such employee and their months of coverage.¹⁹¹ State and local "shared responsibility" initiatives typically impose recording and reporting obligations, too, although differing on the content and timing of reports.¹⁹²

States will argue that § 514 preemption is not implicated since merely recording and reporting in no way interferes with the processing or payment of benefits claims *per se*.¹⁹³ According to *Egelhoff*, however, "[r]equiring ERISA administrators to master the relevant laws of 50 States" regarding plan design and administration jeopardizes ERISA's goal of national uniformity and efficient plan administration.¹⁹⁴ As such, this future of state and local "play or pay" mandates is clearly threatened by § 514 preemption.¹⁹⁵

190. *Compare* S. 5, 95th Gen. Assem., Reg. Sess. § 50-301 (Il. 2007) (imposing a flat fee regardless of employer expenditures on health care), *with* Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 195-97 (4th Cir. 2007) (striking down Maryland's "play or pay" legislation, which mandated payment depending on the level of employee coverage).

191. Patient Protection and Affordable Care Act § 10108.

192. For a discussion of varying requirements of Maryland, Suffolk County, and San Francisco, see *supra* Parts IV-V.

193. *Cf.* Minn. Chapter of Associated Builders & Contractors, Inc. v. Minn. Dep't of Labor & Indus., 866 F. Supp. 1244, 1247 (D. Minn. 1993) ("The requirements of calculating costs and keeping records may somewhat increase the cost of the benefits plans, but this incidental impact on the plans need not lead to preemption.').

194. *Egelhoff v. Egelhoff*, 532 U.S. 141, 149-50 (2001).

195. *See id.* at 150 (suggesting that complying with different state recording and reporting requirements might cause a lack of uniformity that ERISA preemption was intended to avoid).

Cafeteria plans under § 125 of the Internal Revenue Code allow employees to pay for health care with pre-tax dollars, while permitting employers to reduce their FICA withholdings by about \$160 per participating employee.¹⁹⁶ Under federal law, § 125 cafeteria plans are entirely optional for employers and do not qualify as ERISA benefit plans.¹⁹⁷ States have been increasingly attracted to § 125 plans since they may lower employer and employee costs and expand coverage without violating § 514.¹⁹⁸ As of May 2009, five states require employers to offer cafeteria plans: Connecticut, Massachusetts, Minnesota, Missouri, and Rhode Island.¹⁹⁹ Seven states do not require, but encourage them through employer incentives: Florida, Indiana, Iowa, Kansas, Maine, Tennessee, and Washington.²⁰⁰ During the 2009 legislative session, another six considered, but did not pass § 125 mandates: Alaska, California, Kansas, Mississippi, New Jersey, and Oklahoma.²⁰¹

Relatively speaking, however, § 125 mandates and incentives have been easier to enact than “play or pay” mandates, largely because they are often viewed as more likely to survive “relate to” preemption.²⁰² Yet, even though cafeteria plans are not themselves ERISA plans, mandating their creation could violate § 514’s explicit ban on state benefits mandates. While simpler to set up and operate than direct benefits plans, § 125 plans still entail administrative costs in terms of both time and money. An employer may realize some \$160 per employee savings in FICA withholdings, but may also spend about \$100 per employee to create and administer a health-only cafeteria plan.²⁰³ Conceivably, then, the Supreme Court could decide that the logistics of having to do so in one state but not in another may interfere with the national uniformity that ERISA is determined to preserve.²⁰⁴

196. Cauchi, *supra* note 82.

197. *Id.* However, PPACA prohibits an employee from using pre-tax § 125 contributions to purchase coverage through a health exchange. Patient Protection and Affordable Care Act § 1515(a) (amending 26 U.S.C. § 125(f)(3)).

198. Cauchi, *supra* note 82.

199. *Id.*

200. *Id.*

201. *Id.* None of these six states passed the legislation in 2009. See S. 61, 26th Leg., 2009–10 Reg. Sess. (Alaska 2010) (referred to Labor & Commerce Committee); S. 594, 2009–10 Leg., Reg. Sess. (Cal. 2010) (returned to the Secretary of the Senate); S. 2262, 2009–10 Leg., Reg. Sess. (Kan. 2010) (referred to Appropriations Committee); H.R. 573, 2009 Leg., Reg. Sess. (Miss. 2009) (referred to Insurance Committee); Assem. 2283, 2008–09 Leg., Reg. Sess. (N.J. 2009) (withdrawn from consideration); H.R. 1034, 2009–10 Leg., Reg. Sess. (Okla. 2010) (referred to Appropriations & Budget Committee). Of these states, however, each has proposed similar legislation in 2010, with Mississippi being the only state to pass the legislation. S. 2554, 2010 Leg., Reg. Sess. (Miss. 2010).

202. Compare Cauchi, *supra* note 82 (listing thirteen states that successfully use either mandatory or optional § 125 plans), with *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 197 (4th Cir. 2007), and *Retail Indus. Leaders Ass’n v. Suffolk County*, 497 F. Supp. 2d 403, 416–17 (E.D.N.Y. 2007) (invalidating “play or pay” mandates as being § 514 “relate to” preempted).

203. Cauchi, *supra* note 82.

204. See, e.g., *Egelhoff v. Egelhoff*, 532 U.S. 141, 148–49 (2001) (“One of the principal goals of ERISA is . . . to establish a uniform administrative scheme . . .” (quotations omitted)).

CONCLUSION: A CALL FOR CONGRESSIONAL GUIDANCE ON THE ROLE OF STATE AND LOCAL “PLAY OR PAY” PROVISIONS FOLLOWING FEDERAL REFORM

Regardless of the wisdom of federal health reform in general and “play or pay” measures in particular, passing either, let alone both through PPACA was an epic political accomplishment. Perhaps it is because Congress is so deeply divided and voting blocks are so fragile that PPACA uses a “play or pay” incentive instead of a mandate. This may also explain why the statute’s employer responsibility language says nothing about ERISA or PPACA itself preempting states from requiring more in terms of minimum benefits or fair share contributions. Massachusetts, for instance, does require more in terms of employers covered (eleven or more full-time workers in contrast with PPACA’s requirement of fifty) and payments (mandatory fair share contributions of some kind as opposed to PPACA’s imposition of penalties only if free-riding actually occurs).²⁰⁵ Thus, the courts are left to divine whether Congress intended PPACA (either independently or in conjunction with ERISA) to preempt similar state mandates or merely set a minimum floor. Failing to clarify this jeopardizes the gains in covering workers at small firms already realized in Massachusetts and Vermont.²⁰⁶ Since the early U.S. House and Senate proposals and the final version of PPACA leave § 514 preemption intact, most courts would probably find that a federal employer mandate would preempt comparable state measures, but others could differ just as they have in handling the endless array of preemption battles over the past three decades.²⁰⁷

Amidst all of these uncertainties, one thing remains clear: PPACA may have drastically increased the federal government’s role in overseeing health care, but even 2000 page bills²⁰⁸ leave more than enough for the states to do. PPACA’s heavy reliance on what Massachusetts had already done without addressing preemption head-on can cut both ways. Arguably, Congress intended § 1513’s “play or pay” provision to peacefully co-exist with Massachusetts’ and San Francisco’s more rigorous requirements. Alternatively, § 1513’s clear differences signal a rejection and displacement of their approach. Such competing scenarios make Congress’ avoidance of the preemption question not only confusing, but inexcusable. Thus, it must clarify when and to what extent § 514 preempts state reform initiatives in general and employer mandates in particular. Otherwise, as Congress’ long awaited and hard-fought response to an intractable national crisis, PPACA will have made the ever-confounding area of ERISA preemption even more impenetrable simply by saying nothing about it.

205. Compare Parts I, V.

206. *Id.*

207. See *supra* Part II.

208. See, e.g., H.R. 3962, 111th Cong. (1st Sess. 2009); H.R. 3590, 111th Cong. (1st Sess. 2009).

