

The Relationship Between ERISA, State and Local Health Care Experimentation, and the Passage of National Health Care Reform

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THE RELATIONSHIP BETWEEN ERISA, STATE AND LOCAL HEALTH CARE EXPERIMENTATION, AND THE PASSAGE OF NATIONAL HEALTH CARE REFORM

CHRISTOPHER J. FRANKENFIELD*

ABSTRACT

The Employee Retirement Income Security Act of 1974 (ERISA) provides a comprehensive federal scheme for the regulation of employee benefit plans, which include employee welfare benefit plans. Under Section 514(a) of ERISA, any state law that relates to employee benefit plans is preempted by ERISA. Judicial decisions have generally interpreted the scope of ERISA preemption to be fairly expansive; however, some recent decisions have narrowed the scope of Section 514(a) to some degree. Nonetheless, ERISA's preemption clause continues to significantly limit state and local efforts at health care reform. Several states and localities have experimented with fair share laws, which seek to increase access to health care and provide a means by which to finance such expansion. Employer spending mandates under such laws have been subject to legal challenges as expressly preempted by ERISA. To date, only San Francisco's fair share law has survived an ERISA challenge. More importantly, the debate over the relationship between ERISA preemption and fair share laws implicates significant issues with respect to health care reform at the local, state, and national levels. The U.S. Supreme Court should grant certiorari in this matter in order to clarify the boundaries of health care reform within which state and local governments can safely operate without conflicting with ERISA. Even with the enactment of national health care reform, if the Supreme Court decides not to hear *Golden Gate Restaurant Ass'n v. City & County of San Francisco*,¹ Congress should consider amending ERISA (1) to enable state and local governments to continue

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1. 558 F.3d 1000 (2009).

experimenting with health care reform in the short term, since many of the national benefits will not be available for several years and (2) to grant state and local governments the option of enacting expanded health care benefits beyond the scope of the national legislation. This course of action would not only enhance the federal government's efforts to develop a national model for health care reform, but it would also increase the likelihood of bridging the gap between the uninsured and access to health care.

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INTRODUCTION

The Employee Retirement Income Security Act of 1974 (ERISA)² provides a comprehensive federal scheme for the regulation of employee benefit plans, which include employee welfare benefit plans.³ By definition, employee welfare benefit plans generally provide for hospital, medical, surgical, sickness, accident, disability, death, unemployment, severance, or similar benefits; thus, health care benefit plans fall within the scope of ERISA.⁴ Under Section 514(a) of ERISA, any state law that relates to employee benefit plans is preempted by ERISA.⁵ In general, judicial decisions have interpreted the scope of ERISA preemption to be fairly

2. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 29 U.S.C.).

3. See *infra* Part I.

4. 29 U.S.C. § 1002 (2006).

5. Employee Retirement Income Security Act of 1974 § 514(a).

expansive;⁶ however, some more recent decisions have narrowed the scope of Section 514(a) to some degree.⁷ Nonetheless, ERISA's preemption clause continues to significantly limit state and local efforts at health care reform.⁸

As the number of uninsured individuals has increased and access to health care has decreased in the United States,⁹ a range of measures has been implemented in an effort to reverse these trends.¹⁰ In particular, several states and localities have experimented with fair share laws, also known as *pay or play* statutes.¹¹ In general, fair share laws require employers subject to the statute to choose between either paying a requisite amount in employee health care expenditures or contributing to a fund, administered by the state or locality, which offsets health care costs for the uninsured.¹² In this manner, fair share laws not only seek to address the twin issues of reducing the number of uninsured and increasing access to health care but also the means by which to finance such efforts.¹³

Notwithstanding these laudable goals, such state and local health care reform initiatives have been subject to legal challenges on the grounds that ERISA expressly preempts fair share laws in general and their employer spending mandates in particular. Specifically, Maryland, Suffolk County, NY, and the city of San Francisco all enacted their own versions of fair share laws;¹⁴ in each instance, however, trade associations representing affected employers attacked the laws as preempted by ERISA. In both Maryland and Suffolk County, the courts have sided with the trade associations, concluding that ERISA preempted the challenged fair share laws.¹⁵ In stark contrast, however, San Francisco's fair share law has survived its legal challenge to date.¹⁶

6. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 & n.21 (1983) (noting ERISA applies to "any employee benefit plan" and analyzing the "narrow" exceptions to preemption).

7. *E.g.*, *Mattei v. Mattei*, 126 F.3d 794, 811 (1997).

8. Jesselyn Alicia Brown, *ERISA and State Health Care Reform: Roadblock or Scapegoat?*, 13 YALE L. & POL'Y REV. 339, 339-40 (1995); see also Amy B. Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 U. KAN. L. REV. 1203, 1203 (2007) (recognizing state efforts to legislate health care reform around ERISA).

9. *E.g.*, John Holahan & Johnny Kim, *Why Does the Number of Uninsured Americans Continue to Grow?*, HEALTH AFF., July/Aug. 2000, at 188, 189.

10. See generally Jonathan Oberlander, *The US Health Care System: On a Road to Nowhere?*, 167 CANADIAN MED. ASS'N J. 163, 163-65 (2002) (discussing constant efforts to alleviate drastic numbers of uninsured Americans).

11. Monahan, *supra* note 8, at 1203.

12. *Id.*

13. JON O. SHIMABUKURO & JENNIFER STAMAN, CONG. RESEARCH SERV., LEGAL ISSUES RELATING TO STATE HEALTH CARE REGULATION: ERISA PREEMPTION AND FAIR SHARE LAWS 1 (2008).

14. See *infra* Parts III-IV.

15. See *infra* Part III.

16. See *infra* Part IV.

More importantly, the debate over the relationship between ERISA preemption and fair share laws implicates significant issues with respect to health care reform at the local, state, and national levels. While the recent passage of sweeping federal health care legislation makes it clear that states will be required to provide some minimum level of health care benefits,¹⁷ the extent to which they can provide additional benefits funded by an employer spending mandate remains unclear in light of existing ERISA preemption doctrine. In other words, while the federal government has established the floor, ERISA sets the ceiling for the manner in which state and local governments can improve access to health care. Thus, the enactment of federal health care legislation does not reduce the necessity and urgency for the U.S. Supreme Court to assess the validity of the San Francisco Health Care Security Ordinance.

Absent intervention by the U.S. Supreme Court in this matter, Congress should consider amending ERISA to allow continued experimentation at the state and local level. Since many of the benefits of the national health care law will not be realized for several years, such a course of action would enable state and local governments to continue to increase access to health care for the uninsured in the short term. Similarly, looking at health care reform from a long-term perspective, amending ERISA would provide state and local governments with the freedom and flexibility to enact expanded or custom-tailored health care benefits that go beyond the scope of the national legislation. This course of action would not only enhance the federal government's efforts to implement a national model for health care reform but it would also help to further reduce the gap between the uninsured and access to health care.¹⁸

I. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

By enacting ERISA, Congress established a regulatory framework that applies to all employee benefit plans. Although the primary purpose of ERISA was to regulate pension plans, health benefit plans also fall within the scope of the act.¹⁹ The goals of ERISA "are to establish uniform national standards, safeguard employee benefits from loss or abuse, and encourage employers to offer those

17. See, e.g., Alec MacGillis, *First Wave of Overhaul Will Inundate Insurers with New Rules: Change Will Come More Slowly to Doctors, Hospitals, Consumers*, WASH. POST, Mar. 23, 2010, at A8 (discussing various aspects of the recent health care reform legislation, including the changes to the health insurance industry).

18. See *infra* Part II.

19. ERISA regulates "employee welfare benefit plans," which include employer health plans and generally provides for hospital, medical, surgical, sickness, accident, disability, death, unemployment, severance, or similar benefits. 29 U.S.C. § 1002 (2006). ERISA does not, however, regulate health insurance purchased by individuals as individuals, including self-employed individuals or health benefits not provided through employment-related group plans. See Employee Retirement Income Security Act of 1974 § 514(a) (explaining application of ERISA is in reference to "employee benefit plans").

benefits.”²⁰ While ERISA does not mandate that employers offer benefit plans, in the event that such plans are provided to employees, plan administrators are subject to strict requirements.²¹

Currently, Hawaii is the only state that has received an exemption from ERISA.²² This is primarily due to the fact that Hawaii enacted the Prepaid Health Care Act of 1974 (PHCA)²³ shortly before congressional passage of ERISA in 1974.²⁴ Under the PHCA, Hawaii included an employer mandate that required all employers to provide a standard health package and pay for seventy-five percent of its premium.²⁵ In 1981, the Supreme Court ruled that ERISA preempted Hawaii’s legislation;²⁶ however, Congress responded in 1983 by amending ERISA and granting Hawaii’s PHCA an express and limited exemption from ERISA.²⁷

A. Preemption Under ERISA Section 514(a)

Congress’ principal goal under ERISA was to create a uniform set of standards for employee benefit plans, thereby protecting employees by eliminating the need for employers to adhere to inconsistent state and local regulations.²⁸ In order to achieve this goal of uniformity, ERISA includes an express preemption provision, Section 514(a), which states that ERISA “shall supersede any and all

20. Peter D. Jacobson & Scott D. Pomfret, *ERISA Litigation and Physician Autonomy*, 283 JAMA 921, 921 (2000); see also 29 U.S.C. § 1001 (describing the congressional findings and policy reasons for ERISA).

21. In particular, ERISA regulates reporting and disclosure, participation and vesting, funding, and performance of fiduciary obligations. Employee Retirement Income Security Act of 1974 §§ 101–414.

22. 29 U.S.C. § 1144(b)(5).

23. HAW. REV. STAT. §§ 393-1 to -51 (2010).

24. *Council of Hawaii Hotels v. Agsalud*, 594 F. Supp. 449, 451–52 (D. Haw. 1984) (explaining Congressional activity in passing exception under 29 U.S.C. § 1144(b)(5)); see also H.R. REP. NO. 105-149, at 999 (1997); 128 CONG. REC. H9,609–10 (daily ed. Dec. 13, 1982).

25. U.S. GEN. ACCOUNTING OFFICE, PUB. NO. GAO/HEHS-95-167, EMPLOYER-BASED HEALTH PLANS: ISSUES, TRENDS, AND CHALLENGES POSED BY ERISA 33 (1995), available at <http://www.gao.gov/cgi-bin/getrpt?HEHS-95-167>. As part of Hawaii’s “Prepaid Health Care” system, PHCA “requires all employers . . . to offer a health insurance plan” to its employees “that covers at least a minimum set of specified benefits.” CONG. BUDGET OFFICE, KEY ISSUES IN ANALYZING MAJOR HEALTH INSURANCE PROPOSALS 50 box 2-3 (2008), available at <http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf>.

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

27. CONG. BUDGET OFFICE, *supra* note 25, at 50 box 2-3. According to Congressman Erlenborn, the ERISA exemption granted to Hawaii was not to “be considered a precedent with respect to extending similar treatment to any other State law.” *Council of Hawaii Hotels*, 594 F. Supp. at 455 n.9.

28. See 120 CONG. REC. 29,197 (1974) (statement of Rep. Dent) (“With the preemption of the field, we . . . eliminat[e] the threat of conflicting and inconsistent State and local regulation.”); *id.* at 29,933 (statement of Sen. Williams) (“It should be stressed that . . . the narrow exceptions specified in the bill . . . are intended to preempt the field . . . , thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.”); *id.* at 29,942 (statement of Sen. Javits) (“[T]he interests of uniformity with respect to interstate plans required . . . the displacement of State action in the field of private employee benefit programs.”).

State laws insofar as they now or hereafter *relate to* any employee benefits plan”²⁹ As a result, ERISA generally preempts state regulation of employment-based health insurance and, in effect, “established the federal government as the primary regulator of private-sector employee benefit plans.”³⁰

Despite this broad preemption, ERISA Section 514 also includes a savings clause and a deemer clause. Section 514(b)(2)(A), ERISA’s savings clause, explicitly preserves states’ rights to regulate the business of insurance.³¹ Specifically, ERISA will not “be construed to exempt or relieve any person from any law of any State [that] regulates insurance”³² Therefore, a state insurance law might relate to employee benefit plans but nonetheless will not be preempted by ERISA. Effectively, this provision protects state laws that directly regulate insurance from federal preemption, thereby reinforcing the states’ authority to regulate insurance under the McCarran-Ferguson Act of 1945.³³ Section 514(b)(2)(B), ERISA’s deemer clause, narrows the potential scope of the savings clause.³⁴ In general, the deemer clause provides that no employee benefit plan will be deemed to be an insurer or in the insurance business (among other things) in order to make such plans subject to state law and therefore avoid ERISA preemption. As a result, the deemer clause restricts the extent to which state insurance regulation can impact employee benefit plans and prevents states from circumventing federal preemption under ERISA through the pretext of regulating insurance.³⁵

B. Judicial Interpretation of ERISA Preemption

With respect to preemption under ERISA, the critical inquiry is determining whether, or to what extent, a state law “*relate[s] to* an[] employee benefit plan”³⁶ As noted by the U.S. General Accounting Office, “ERISA preemption language was sufficiently ambiguous that courts have had to elaborate on its scope . . . [and] tried to delineate how closely state laws must relate to employer health plans to be preempted.”³⁷ A series of recent U.S. Supreme Court cases has attempted to develop an analytical framework for determining whether state or local law sufficiently “relates to” employee benefit plans so as to cause such laws to be preempted by ERISA. Early cases interpreting Section 514(a) of ERISA

29. 29 U.S.C. § 1144(a) (2006) (emphasis added).

30. William Pierron & Paul Fronstin, *ERISA Pre-emption: Implications for Health Reform and Coverage*, ISSUE BRIEF NO. 314 (Empl. Ben. Res. Inst., Washington, DC), Feb. 2008, at 6.

31. 29 U.S.C. § 1144(b)(2)(A).

32. *Id.*

33. Pierron & Fronstin, *supra* note 30, at 6.

34. 29 U.S.C. § 1144(b)(2)(B).

35. U.S. GEN. ACCOUNTING OFFICE, *supra* note 25, at 32.

36. 29 U.S.C. § 1144(a) (emphasis added).

37. U.S. GEN. ACCOUNTING OFFICE, *supra* note 25, at 6.

applied the provision very broadly. In *Shaw v. Delta Air Lines, Inc.*,³⁸ one of the first cases to consider the scope of Section 514(a), the Supreme Court interpreted the “relate to” language to include any provision having either “a connection with or reference to” an employee benefits plan.³⁹ A “reference to” a benefits plan that will result in ERISA preemption arises “[w]here a State’s law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the [state] law’s operation”⁴⁰ Alternatively, a “connection with” an employee benefits plan that gives rise to preemption under ERISA requires an examination of “the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, [and] . . . the nature of the effect of the state law on ERISA plans.”⁴¹ The “connection with or reference to” test adopted by the Supreme Court in *Shaw* assumes a very literal and expansive view of preemption under Section 514(a) of ERISA. Although this view has maintained much of its vitality over time, subsequent cases interpreting and applying Section 514(a) have narrowed its scope to some degree and signaled that its reach is not limitless.

Most notably, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*,⁴² “finally recognized the limits of ERISA preemption”⁴³ In *Travelers*, the Supreme Court concluded that Section 514(a) did not preempt a New York law requiring hospitals to charge different rates to insured, HMO, and self-insured plans.⁴⁴ Taking a noticeable step back from its traditionally expansive interpretation of ERISA preemption, the court reaffirmed the traditional principle recognized in other areas of law that there is a “presumption that Congress does not intend to supplant state law.”⁴⁵ To determine whether Congress intended to preempt state law, the court examined “the structure and purpose of the Act”⁴⁶ With respect to federal preemption generally, where federal law is said to bar state action in fields of traditional state regulation, the Supreme Court assumes that federal law does not supersede states’ historic police powers unless Congress clearly manifests such a purpose in its legislation.⁴⁷ In *Travelers*, the court specifically identified health care as an area of traditional state regulation and suggested that a

38. 463 U.S. 85 (1983).

39. *Id.* at 96–97.

40. *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc.*, 519 U.S. 316, 324–25 (1997).

41. *Id.* at 325 (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656, 658–59 (1995) (internal quotations omitted)).

42. 514 U.S. 645.

43. BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 337 (abr. 6th ed. 2008).

44. 514 U.S. at 667–68.

45. *Id.* at 654.

46. *Id.* at 655.

47. *Id.* at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

congressional intent to preempt state law should not be presumed unless it was “clear and manifest.”⁴⁸ This examination led the court to conclude that “nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern.”⁴⁹ Defining the purpose of ERISA as freeing employee benefit plans from conflicting state and local regulations,⁵⁰ the Court held that Congress intended ERISA to preempt only state and local laws that operated *directly* on the structure or administration of employee benefit plans.⁵¹ Laws that only *indirectly* affected employee benefit plans should not be preempted by ERISA.⁵² Therefore, while the “decision did not delineate fully between state actions that are preempted and those that are not,”⁵³ it seemed to indicate that state regulation would be permissible where it did not (1) conflict with the underlying objectives of ERISA or (2) impact employee benefit plans too greatly.⁵⁴ As the first Supreme Court case that narrowed the scope of ERISA preemption, the U.S. General Accounting Office suggested that the ruling would not only make states “likely to perceive that they have more options and greater flexibility than previously recognized” in drafting laws affecting employee benefit plans but also that such laws would “have to be judged individually on the facts and circumstances in each case.”⁵⁵

While *Travelers* scaled back the scope of ERISA preemption to some degree,⁵⁶ the decision did not provide a bright-line test as to when federal law would preempt state or local law. Two years later, in *De Buono v. NYSA-ILA Medical & Clinical Services Fund*,⁵⁷ the Supreme Court permitted the state of New York to impose a tax on gross receipts for patient services performed by medical providers on a hospital owned and operated by an ERISA plan.⁵⁸ Similar to *Travelers*, the Court noted that the law regulated health and safety matters, “a field . . . traditionally occupied by the States.”⁵⁹ In addition, the Court concluded that nothing in New York’s law suggested it was the type of law that Congress intended

48. *Id.* at 655.

49. *Id.* at 661.

50. *Id.* at 656–57.

51. *Id.* at 657–58.

52. *See generally id.* at 658–64 (discussing the relationship between ERISA preemption and laws that indirectly affect employee benefit plans).

53. U.S. GEN. ACCOUNTING OFFICE, *supra* note 25, at 7.

54. *Travelers*, 514 U.S. at 662, 668.

55. U.S. GEN. ACCOUNTING OFFICE, *supra* note 25, at 7–8.

56. “The [Supreme] Court’s post-*Travelers* preemption cases suggest that the Court in fact turned a corner in *Travelers*,” as the Court “has rejected ERISA preemption in the majority of . . . cases” post-*Travelers* but typically had not done so pre-*Travelers*. FURROW ET AL., *supra* note 43, at 337.

57. 520 U.S. 806 (1997).

58. *Id.* at 809–10.

59. *Id.* at 814–16.

ERISA to supersede.⁶⁰ Ultimately, *De Buono* rejected an expansive, literal interpretation of Section 514(a), holding that the tax at issue was one of “general applicability.”⁶¹ While the Court acknowledged that the challenged law “impose[d] some burdens on the administration of ERISA plans,” the statute nevertheless had only an incidental effect on employee benefit plans and did not “relate to [ERISA plans] within the meaning of” ERISA; therefore, the challenged law did not affect ERISA’s objectives.⁶² When read in conjunction with the *Travelers* decision, the *De Buono* opinion implies that a state or local law may survive ERISA preemption, even if it imposes burdens of administration on ERISA plans, so long as the challenged law is a law of general applicability and not the type of law that Congress intended for ERISA to supersede.

In *Kentucky Ass’n of Health Plans, Inc. v. Miller*,⁶³ a recent Supreme Court case addressing ERISA preemption, a trade association brought a suit challenging Kentucky’s “any willing provider” law (AWP law).⁶⁴ This law prohibited insurers from discriminating against a health care provider willing to meet the insurer’s criteria for participation in the health plan by requiring health insurers and managed care organizations to reimburse all licensed physicians or health professionals as long as they were willing and qualified to participate in the insurer’s network.⁶⁵ In the Sixth Circuit, a three-judge panel concluded that although Kentucky’s AWP law “related to” employee benefit plans, the AWP law only applied to directly insured plans; therefore, ERISA’s savings clause prevented federal preemption.⁶⁶ The Supreme Court subsequently affirmed the Sixth Circuit ruling, holding that a state law is deemed to regulate insurance under Section 514(b)(2)(B) if it satisfies the following requirements: the state law must (1) “be specifically directed toward entities engaged in insurance” and (2) “substantially affect the risk pooling arrangement between the insurer and the insured.”⁶⁷ This new two-part test departed from the traditional approach taken by the Supreme Court in interpreting Section 514(b)(2)(A),⁶⁸ significantly clarifying and expanding, the scope of

60. *Id.* at 814.

61. *Id.* at 815–16; *see also* New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 668 (1995) (focusing its analysis on the question of a laws general applicability).

62. *De Buono*, 520 U.S. at 815–16 (internal quotations omitted).

63. 538 U.S. 329 (2003).

64. *Id.* at 332.

65. *Id.* at 332–34. Kentucky’s AWP law required reimbursement regardless of whether an insurer actually had a contractual relationship with the licensed physician or health care professional. *Id.* at 332.

66. *Ky. Ass’n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 360, 372 (6th Cir. 2000).

67. *Ky. Ass’n*, 538 U.S. at 342. According to the court, Kentucky’s AWP law satisfied both prongs of this test and, therefore, was not preempted by ERISA. *Id.*

68. Historically, to determine whether the savings clause protected a state law from ERISA preemption, the Supreme Court had applied a “common sense test” and also examined whether the challenged law regulated the “business of insurance” under the McCarran-Ferguson Act’s multi-factored test. A state law regulates the business of insurance if it (1) has the effect of transferring or spreading the

ERISA's savings clause. Effectively, "the court abandoned its earlier precedents and crafted a new approach to interpreting the savings clause."⁶⁹ Under the analytical framework articulated by the Supreme Court in *Kentucky Ass'n*, ERISA's savings clause would appear to protect any state law that requires insurers to provide particular benefits.⁷⁰

The Supreme Court decisions in *Travelers*, *DeBuono*, and *Kentucky Ass'n* indicate a gradual shift toward a more narrow judicial interpretation of ERISA preemption. Nonetheless, Section 514(a) is still generally considered to broadly preempt state and local law, and ERISA remains "a significant barrier to state health care reform."⁷¹ In effect, the expansive reach of Section 514(a) has constrained experimentation with health care reform at the state and local level. In particular, ERISA preemption has proved to be a formidable challenge to fair share laws enacted by state and local governments in Maryland, Suffolk County, NY, and San Francisco, CA in an effort to provide uninsured residents with access to health care.⁷²

II. UNINSURED & ACCESS TO HEALTH CARE

In 2007, an estimated 45 million Americans under the age of 65 did not have health insurance.⁷³ In 2008, the Congressional Budget Office projected that approximately "one in six nonelderly people in the United States [would] be without health insurance at any given time during 2009."⁷⁴ The incremental cost of health insurance for low-wage workers is relatively high;⁷⁵ therefore, those most

policyholder's risk, (2) is an integral part of the policy relationship between the insurer and the insured, and (3) is limited to entities within the insurance industry that could be included under the savings clause. *See, e.g.*, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48–49 (1987) (recounting and applying the McCarran-Ferguson test); *Metro. Life Ins. v. Massachusetts*, 471 U.S. 724, 743 (1985) (reviewing the McCarran-Ferguson factors).

69. FURROW ET AL., *supra* note 43, at 338.

70. *Id.*; *see also* Matthew O. Gatewood, Note, *The New Map: The Supreme Court's New Guide to Curing Thirty Years of Confusion in ERISA Savings Clause Analysis*, 62 WASH. & LEE L. REV. 643, 648 (2005) (discussing the role of the savings clause in ERISA preemption analysis).

71. FURROW ET AL., *supra* note 43, at 340.

72. *See infra* Parts III–IV.

73. HENRY J. KAISER FAMILY FOUND., *THE UNINSURED: A PRIMER—KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 1* (2008) [hereinafter KAISER UNINSURED PRIMER]. Between 2003 and 2007, the number of uninsured individuals in the U.S. increased approximately 1.6%. HEALTH RESEARCH INST., PRICEWATERHOUSECOOPERS, *TOP NINE HEALTH INDUSTRY ISSUES IN 2009: UNDISRUPTED FORCES WILL DISRUPT THE INDUSTRY 2* (2009) [hereinafter PWC INDUSTRY ISSUES 2009].

74. CONG. BUDGET OFFICE, *supra* note 25, at 27.

75. Jack Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs*, 27 HEALTH AFF. w399, w408 (2008), <http://content.healthaffairs.org/cgi/reprint/27/5/w399>.

likely to be uninsured will be least able to pay for their own health care.⁷⁶ Whether the uninsured receive health care will depend upon a combination of where each uninsured patient lives, the care needed, and what organizations are willing to pay for such care.⁷⁷ Rising health care costs have made health care coverage less affordable or even prohibitively expensive for many individuals and employers, contributing to both the growing number of uninsured as well as a decreased level of access to care.⁷⁸ In 2007, employer-sponsored health insurance accounted for the majority of insured individuals,⁷⁹ however, many businesses do not offer health benefits to their employees.⁸⁰ In addition, the number of employers offering employer-sponsored coverage has either stalled or declined over the past decade.⁸¹ With respect to the relationship between the uninsured and access to care, studies indicate that lack of health care coverage reduces access to care and results in unmet need for such care, regardless of the length of time that one is uninsured.⁸²

During the economic downturn at the start of the decade, “nonelderly Americans with employer-sponsored health insurance decreased for the first time since 1993, dropping from [sixty-six percent] in 2000 to [sixty-one percent] by 2004.”⁸³ As suggested by historical experience, a declining economy will result in a greater number of individuals becoming unemployed, self-employed, or working in smaller firms; under all of these scenarios, the number of uninsured will presumably increase. According to a recent study by the Kaiser Commission on Medicaid and the Uninsured, a one-percent increase in the unemployment rate in 2008 would result in a 1.1 million increase in the number of uninsured.⁸⁴ Similarly,

76. Jean S. Fraser, CEO, San Francisco Health Plan, Presentation at Universal Healthcare Council: Covering San Francisco: Private and Public Coverage and the Gaps (Feb. 23, 2006), available at http://www.sfhp.org/files/presentations/UA_CoveringSF__2-23-06.pdf.

77. HEALTH RESEARCH INST., PRICEWATERHOUSECOOPERS, HEALTHCARE POLICY IN AN OBAMA ADMINISTRATION: DELIVERING ON THE PROMISE OF UNIVERSAL COVERAGE 14 (2008) [hereinafter PWC HEALTHCARE POLICY].

78. HENRY J. KAISER FAMILY FOUND., HEALTH CARE COSTS: A PRIMER—KEY INFORMATION ON HEALTH CARE COSTS AND THEIR IMPACT 1 (2009) [hereinafter KAISER HEALTH CARE COSTS PRIMER]; KAISER UNINSURED PRIMER, *supra* note 73, at 8.

79. In 2007, 159 million Americans, or sixty-one percent of the nonelderly population, were covered by employer-sponsored health insurance. KAISER UNINSURED PRIMER, *supra* note 73, at 15.

80. *Id.* at 15–16 & fig.16. Small firms, in particular, are generally less likely to provide coverage in comparison to larger firms. *Id.* at 16.

81. *Id.* at 15. Employer-sponsored health insurance is especially sensitive to changes in the economy and health insurance premiums. *Id.* The economic downturn in early 2001, combined with double-digit inflation in health insurance premiums, resulted in a decrease in employer-sponsored coverage. *Id.* More recently, growth of health insurance premiums has slowed, but the percentage of individuals covered by employer-sponsored insurance has not increased. *Id.*

82. *Id.* at 8.

83. *Id.* at 13.

84. STAN DORN ET AL., HENRY J. KAISER FAMILY FOUND., MEDICAID, SCHIP, AND ECONOMIC DOWNTURN: POLICY CHALLENGES AND POLICY RESPONSES 5 (2008), available at <http://www.kff.org/medicaid/upload/7770.pdf>.

a downward shift in incomes associated with falling economic conditions will result in a greater number of low-income individuals, “where uninsured rates are the highest.”⁸⁵ Since the number of uninsured will undoubtedly continue to multiply at increasing rates in the near-term, the need to institute health care reform that addresses the twin problems of the uninsured and access to health care is critical. Notwithstanding this pressing need, ERISA serves as a formidable obstacle to state and local efforts to expand health care coverage.

III. FAIR SHARE LAWS

Several state and local governments have turned to fair share laws as one possible solution to the problem of the uninsured and the failure to achieve comprehensive health care reform at the national level. Fair share laws generally require employers to pay into a state fund if employers (1) “pay less than a specified percentage of their payroll[] toward” employee health benefits or (2) do not provide any health insurance coverage for their employees.⁸⁶ As a result, such laws require employers to either provide a minimum level of health benefits for their employees or help to offset the cost of public health care coverage provided by the state or locality.⁸⁷

For example, in April 2006, Massachusetts enacted a law that required all residents of the state to have health insurance.⁸⁸ The Massachusetts program is funded in part by an employer spending mandate; employers with eleven or more employees must either provide health insurance coverage for their employees or contribute up to \$295 annually per employee to the state.⁸⁹ So far, no ERISA preemption suit has been brought against Massachusetts’ health care reform statute and its employer spending mandate.⁹⁰ The lack of a legal challenge may be attributable to the strong support from leading business groups for the state’s reform initiative; alternatively, it might be due to the fact that the minimum health care expenditure amount imposed by Massachusetts’ law is much smaller relative

85. KAISER UNINSURED PRIMER, *supra* note 73, at 13.

86. Pierron & Fronstin, *supra* note 30, at 12.

87. *Id.* Also commonly referred to as *pay or play* statutes, these laws generally require employers to choose between either paying a certain amount for health care expenditures or coverage on behalf of their employees (the *play* option) or making contributions to a state or locality to offset the costs of medical expenses for uninsured residents (the *pay* option). *Id.*

88. 2006 Mass. Acts Ch. 58. According to a study by PricewaterhouseCoopers LLP, Massachusetts’ health care reform has resulted in the nation’s lowest uninsured rate in the country; the state recently reported that its uninsured rate dropped to three percent compared with fifteen percent nationally. PWC HEALTHCARE POLICY, *supra* note 77, at 11.

89. Pierron & Fronstin, *supra* note 30, at 12.

90. PWC HEALTHCARE POLICY, *supra* note 77, at 17 fig.7; see also Mary Ann Chirba-Martin & Andrés Torres, *Universal Health Care in Massachusetts: Setting the Standard for National Reform*, 35 FORDHAM URB. L. J. 409, 441 (2008) (“[I]t is too soon to tell whether the possibility of an ERISA preemption claim will become a reality.”).

to other fair share programs.⁹¹ Nonetheless, speculation persists as to whether Massachusetts' employer spending mandate will be subject to an ERISA challenge and, if so, whether it would survive such a challenge.⁹²

Despite the notable absence of an ERISA preemption suit against Massachusetts' health care reform law, other states and localities have not been as fortunate. In particular, Maryland and Suffolk County, NY both attempted to implement their own fair share laws.⁹³ However, in each instance, a retail trade association brought a suit challenging the law under ERISA, and the court ultimately found that ERISA preempted the fair share law in question.

A. Maryland—Fair Share Health Care Fund Act

In January 2006, Maryland enacted the Fair Share Health Care Fund Act (Fair Share Act).⁹⁴ This legislation required for-profit employers with 10,000 or more employees in Maryland to either spend at least eight percent of total payroll costs on employee health insurance costs⁹⁵ or pay the state the amount that those employers' spending fell short of that threshold percentage.⁹⁶ However, shortly after the Fair Share Act was enacted, the Retail Industry Leaders Association (RILA), a trade association that included Wal-Mart as a member, brought a suit challenging the law on the grounds that it was preempted by ERISA.⁹⁷ Ultimately, the Fourth Circuit affirmed the district court decision, which concluded that Section 514(a) of ERISA preempted the Fair Share Act.⁹⁸

The state made two arguments in defense of upholding the Fair Share Act: (1) the law was a statute of general applicability and (2) did not have a "connection

91. John McDonough et al., *A Progress Report on State Health Access Reform*, 27 HEALTH AFF. w114 (2008), available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.27.2.w105v1>; see also Phyllis C. Borzi, *There's "Private" and Then There's "Private": ERISA, Its Impact, and Options for Reform*, 36 J. L. MED. & ETHICS 660, 666 n. 51 (2008) ("It is possible that employers saw sufficient potential benefit to them from reform that they decided not to challenge it or that the burdens imposed by the Massachusetts law were not sufficiently great to justify the expense of litigation.").

92. See, e.g., Joan Indiana Rigdon, *Universal Health Care?*, WASHINGTON LAWYER, Aug. 2008, http://www.dcbbar.org/for_lawyers/resources/publications/washington_lawyer/august_2008/universal_health.cfm (discussing the possibility that an ERISA challenge will be made to the Massachusetts law).

93. See *infra* Part I.A–B.

94. 2006 Md. Laws 1.

95. *Id.* at 3–4. The statute defined *health insurance costs* as "the amount paid by an employer to provide health care or health insurance to employees in [Maryland] to the extent the costs may be deductible by an employer under federal tax law." *Id.* at 3.

96. *Id.* at 4.

97. Retail Indus. Leaders Ass'n v. Fielder, 435 F. Supp. 2d 481, 484 (D. Md. 2006).

98. Retail Indus. Leaders Ass'n, v. Fielder, 475 F.3d 180, 183 (4th Cir. 2007). In addition, the U.S. Department of Labor filed an amicus brief in November 2006 in support of RILA and ERISA preemption of the Fair Share Act. See Brief of the Secretary of Labor as Amicus Curiae Supporting Plaintiff-Appellee and Requesting Affirmance, Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180 (4th Cir. 2007) (Nos. 06-1840, 06-1901).

with” employee benefit plans.⁹⁹ Presumably, under *De Buono*, a law of general applicability may survive an ERISA preemption challenge.¹⁰⁰ In support of this argument, the state contended that the revenue obtained under the minimum spending requirement would fund the Fair Share Health Care Fund, which was established under the Fair Share Act and would be used to offset costs under the Maryland Medical Assistance Program.¹⁰¹ With regard to whether the Fair Share Act had a “connection with” employee benefit plans, the state argued that no such connection existed because employers could act in ways that did not involve employee benefit plans but satisfied the minimum spending requirement imposed by the Fair Share Act.¹⁰² For example, an employer could establish on-site medical clinics, contribute more money to employees’ health savings accounts, or not increase benefits under any ERISA plan and simply pay the difference between existing ERISA benefit spending and the eight percent required under the Fair Share Act.¹⁰³

The Fourth Circuit rejected both arguments presented by the state and concluded that ERISA preempted the Fair Share Act.¹⁰⁴ One critical issue with respect to the Fair Share Act is the extent to which it directly impacted Wal-Mart while not affecting either large nonprofit employers or other for-profit employers operating within the state.¹⁰⁵ Under Maryland’s law, Wal-Mart would have been the only for-profit employer in the state subject to the Fair Share Act requirements.¹⁰⁶ Before enacting the Fair Share Act, state legislators considered testimony that reported rising costs within the Maryland Medical Assistance Program, which provided access to health care for Maryland’s low income residents.¹⁰⁷ In addition, the General Assembly reviewed information showing Wal-Mart failed to provide adequate health benefits to its employees.¹⁰⁸ For example, Wal-Mart employed 16,000 workers in Maryland, many of whom received inadequate health care coverage or no coverage at all.¹⁰⁹ This led many Wal-Mart employees and dependents to enroll in Medicaid and the Maryland’s Children’s

99. *Felder*, 475 F.3d at 194–95.

100. *See supra* note 61 and accompanying text.

101. *Felder*, 475 F.3d at 190.

102. *Id.* at 194–95.

103. *See id.* at 195 (identifying the choices available to businesses under the Maryland law).

104. *Id.* at 197.

105. *See id.* at 185 (comparing the Fair Share Act’s impact on Walmart as compared with non-profit employers).

106. *Id.* Other for-profit employers with at least 10,000 employees in Maryland either satisfied the eight percent spending threshold or were exempted from the Fair Share Act. *Id.*

107. *Id.* at 183.

108. *Id.* at 183–84.

109. *See id.* at 183–84 (discussing the Maryland legislature’s finding that Wal-Mart only provides coverage to forty-five percent of its workforce, and that many employees and their families receive outside assistance for healthcare).

Health Insurance Program.¹¹⁰ Based on the legislative history of the act, the court found that the Fair Share Act “could hardly be intended to function as a revenue act of general application,” rejecting the state’s argument in that regard.¹¹¹

Similarly, the Fourth Circuit found the Fair Share Act had an impermissible “connection with” employee benefit plans.¹¹² In *Travelers*, the Supreme Court upheld the law at issue, finding that it merely created an “indirect economic influence” on employers with respect to employee benefit plans.¹¹³ In contrast, the Fourth Circuit concluded that the Fair Share Act “directly regulate[d] employers’ structuring of their employee health benefit plans.”¹¹⁴ As a result, “the only rational choice” for an employer subject to the Fair Share Act requirements was “to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold.”¹¹⁵ Alternatives to increase spending suggested by the state were not sufficient to avoid ERISA preemption. The options provided by Maryland’s law were “not *meaningful* alternatives by which an employer [could] increase healthcare spending to comply with the Fair Share Act without affecting its ERISA plans.”¹¹⁶ In the court’s opinion, it was unrealistic and impractical to assume that employers would be able to differentiate between ERISA and non-ERISA health care spending as isolated and unrelated costs.¹¹⁷ Since “[d]ecisions regarding one would affect the other and thereby violate ERISA’s preemption provisions,” a prohibited “connection with” ERISA plans existed under Maryland’s law.¹¹⁸

Having lost at both the district court and appellate court levels, Maryland’s Attorney General concluded a reversal was highly unlikely and decided not to seek review of the Fourth Circuit decision by the Supreme Court.¹¹⁹ *Post-Fielder*, it

110. *See id.* at 184 (describing Maryland’s legislative response to the dilemma).

111. *Id.* at 194.

[L]egislators and interested parties uniformly understood the Act as *requiring* Wal-Mart to increase its healthcare spending. If this is not the Act’s effect, one would have to conclude, which we do not, that the Maryland legislature misunderstood the nature of the bill that it carefully drafted and debated. For these reasons, the amount that the Act prescribes for payment to the State is actually a fee or penalty that gives the employer an irresistible incentive to provide its employees with a greater level of health benefits.

Id.

112. *Id.* at 197.

113. *Id.* at 195 (quoting *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659 (1995)) (emphasis added).

114. *Id.*

115. *Id.* at 193.

116. *Id.* at 196 (emphasis added).

117. *Id.* at 197.

118. *Id.*

119. *Maryland Attorney General Will Not Seek Supreme Court Review of ‘Fair Share’ Law*, Daily Lab. Rep. (BNA) No. 73, at A-9 (Apr. 17, 2007).

would seem clear that “a direct mandate requiring employers to offer specified coverage to their employees is out of the question.”¹²⁰

B. Suffolk County, NY—Fair Share for Health Care Act

In October 2005, Suffolk County, NY passed the Suffolk County Fair Share for Health Care Act (Suffolk County Act).¹²¹ As originally enacted, the Suffolk County Act required certain large retail stores selling groceries¹²² to make “health care expenditures”¹²³ “equivalent to not less than \$3.00 per hour worked by . . . employees in Suffolk County[, NY].”¹²⁴ Four categories of non-ERISA health care expenditures could satisfy the employer spending mandate: (1) contributions by the employer to a health savings account, (2) reimbursement by the employer of health care expenses incurred by an employee or its family members, (3) expenditures incurred by the employer to provide a health clinic or any health-related services in the workplace, and (4) contributions by the employer to any federally funded health center or other community center.¹²⁵ If covered employers failed to satisfy the mandated expenditures, the Suffolk County Act required such employers to pay a civil penalty to the county.¹²⁶ The Act was later amended, redefining the health care expenditures requirement as equivalent to the “public health care cost rate multiplied by the total number of hours worked” by employees in Suffolk County, NY.¹²⁷ The “public health care cost rate” was defined under the law as “a rate that approximates the cost to the public health care system of providing health care to one uninsured employee.”¹²⁸

120. FURROW, *supra* note 43, at 345.

121. Retail Indus. Leaders Ass’n v. Suffolk County, 497 F. Supp. 2d 403, 406 (E.D.N.Y. 2007).

122. Suffolk County, N.Y., Reg. Local Law No. 30-2005, § 352-2 (Sept. 27, 2005). “Covered employers” are defined as:

[A]ny person that operates at least one retail store located in Suffolk County where groceries or other foods are sold for off-site consumption and where either (1) twenty-five thousand square feet or more of the store’s selling area floor space is used for the sale of groceries or other foods for off-site consumption, or (2) 3% or more of the store’s selling area floor space is used for the sale of groceries or other foods for off-site consumption and the store contains at least 100,000 square feet of selling area floor space, or (3) [the retail store] had total annual revenues of \$1 billion or more in the most recent calendar year and the sale of groceries comprise more than 20% of a company’s revenue.

Suffolk County, 497 F. Supp. 2d at 407.

123. The law defined *health care expenditures* as “any amount paid by a covered employer to employees or to another party for the purpose of providing health care services or reimbursing the cost of such services for employees or family of employees.” *Suffolk County*, 497 F. Supp. 2d at 407.

124. *Id.* at 406.

125. *Id.* at 407.

126. *Id.* at 406. Initially, covered employers were also required to make up the shortfall; however, this was later repealed. *Id.*

127. *Id.*

128. *Id.* Under the law, Suffolk County’s Department of Labor was required to publish the official public health care cost rate by October 1 of each year. *Id.*

Similar to the *Fielder* decision, the legislative history of the Suffolk County Act and its particular impact on Wal-Mart played a critical role in the disposition of the Suffolk County case. The act “expressly acknowledge[d] a legislative intent to protect small retailers in Suffolk County from large employers who do not provide health care for employees.”¹²⁹ In addition, Wal-Mart met the definition of a “covered employer” under the Suffolk County Act “because it operate[d] stores in Suffolk County in which groceries and other foods [were] sold for offsite consumption and . . . ha[d] total annual revenue more than \$1 billion with at least [twenty percent] of that revenue produced by the sale of groceries.”¹³⁰ Several sponsors of the Suffolk County Act expressed a desire not only to protect small businesses but also to have a direct effect on Wal-Mart’s operations in Suffolk County.¹³¹ Most notably, Legislator Foley expressed concerns “about the looming threat of Wal-Mart type stores that have wreaked havoc in a number of communities.”¹³² Similarly, in dramatic fashion, Legislator Tonna described a scene from a movie where an entire town had collapsed as a result of one individual’s actions and suggested that “if you look around the communities of the United States, you see that’s what Wal-Mart has done.”¹³³ It is no surprise that almost immediately after the Suffolk County Act was enacted, RILA challenged the law on the basis of ERISA preemption.¹³⁴

In defense of its law, Suffolk County argued that a local “law is not preempted by ERISA where the existence of a plan is not necessary to be in compliance with the [local] law.”¹³⁵ The county contended that the existence or modification of an ERISA plan was not necessary under the Suffolk County Act due to the fact that employers could achieve compliance with the law through four categories of non-ERISA expenditures expressly identified under the law as satisfying the employer spending mandate.¹³⁶ In addition, the county asserted that the primary purpose of its law was to reduce the county’s financial burden of subsidizing health care for residents; since containing health care costs is a traditional area of state regulation, the county maintained that ERISA did not preempt its fair share law.¹³⁷

129. *Id.* at 408. The Suffolk County Act stated that “historically, most retail employers in Suffolk County have provided paid health care for their employees and families but mounting competitive pressures from large employers who do not follow this practice have forced many Suffolk retail employers to eliminate health care coverage.” *Id.*

130. *Id.*

131. *See id.* (noting that the legislature expressly considered the impact of the proposed legislation on Wal-Mart in particular).

132. *Id.*

133. *Id.*

134. *Id.*

135. *Id.* at 409–10.

136. *Id.* at 410.

137. *Id.* at 409.

The district court commented that it was not bound by the Fourth Circuit's decision in *Fielder* several months earlier; nonetheless, the district court noted that the Suffolk County Act was substantially similar to Maryland's Fair Share Act.¹³⁸ Thus, stating that it was "in accord with the Fourth Circuit's well reasoned and comprehensive analysis"¹³⁹ in *Fielder*, the district court held that ERISA preempted Suffolk County's fair share law.¹⁴⁰ The district court asserted that the only rational choice for covered employers was "to structure their ERISA health care benefit plans to meet the minimum spending threshold" required by the Suffolk County Act.¹⁴¹ Despite the Suffolk County Act providing alternatives by which employers could satisfy the minimum spending requirement, the district court found these options did not constitute "meaningful alternatives," maintaining that the alternative options were unrealistic and would be difficult for covered employers to actually utilize.¹⁴² Once those options for compliance with the Suffolk County Act were eliminated, "all that [was] left [was] for covered employers . . . to increase contributions to ERISA plans."¹⁴³ Much like *Fielder*, the district court also noted that the legislative history made it clear that the Suffolk County Act was targeted at Wal-Mart, concluding that "Suffolk County enacted [its law] in order to mandate that covered employers and specifically, Wal-Mart, increase spending on healthcare coverage for Suffolk County employees."¹⁴⁴ The district court also expressed concern that the Suffolk County Act would disrupt uniform plan administration, resulting in differing state regulations and "impos[ing] precisely the burden that ERISA pre-emption was intended to avoid."¹⁴⁵ Based on the aforementioned factors, the district court found that the Suffolk County Act obviously had a prohibited connection with employee benefit plans and was therefore preempted by Section 514(a) of ERISA.¹⁴⁶

IV. SAN FRANCISCO—HEALTHY SAN FRANCISCO

San Francisco has had a long history of seeking to improve the health care delivery system for its uninsured residents.¹⁴⁷ Beginning in the mid-1990's the city launched initiatives to provide high quality medical care to the largest possible

138. *Id.* at 416.

139. *Id.*

140. *Id.* at 418.

141. *Id.* at 417.

142. *Id.* at 417–18.

143. *Id.* at 418.

144. *Id.* at 417.

145. *Id.* at 418 (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001)).

146. *Id.* at 419.

147. HEALTHY SAN FRANCISCO, HEALTHY SAN FRANCISCO PROGRAM IN-DEPTH 3 (n.d.), available at http://www.healthysanfrancisco.org/files/PDF/HSF_Program_In-Depth.pdf.

number of low-income residents.¹⁴⁸ Shortly thereafter, in 1998, San Francisco voters approved an initiative encouraging health care expansion to the city's uninsured residents.¹⁴⁹ In February 2006, the city "established the multi-disciplinary Universal Healthcare Council [(UHC)] to explore expansion of health care access to all of San Francisco's [uninsured] residents."¹⁵⁰ Ultimately, the UHC developed a framework for implementing such a program, and in July 2006, the city of San Francisco adopted its own fair share law.¹⁵¹ Thus, San Francisco became the first city in the U.S. to implement a program designed to provide all of its uninsured residents with universal access to health care.¹⁵² Initially referred to as the San Francisco Health Access Program, the program has come to be known as Healthy San Francisco.¹⁵³

Unlike many other health care reform efforts, Healthy San Francisco is not health insurance.¹⁵⁴ Instead, the program provides each participant with the following: (1) a "medical home;" (2) a primary care provider; and, (3) access to specialty care, urgent and emergency care, mental health care, substance abuse services, laboratory, inpatient hospitalization, radiology, and pharmaceuticals.¹⁵⁵ In order to receive care, a participant must be a resident of the city of San Francisco and is limited to receiving care through the Healthy San Francisco program within the city.¹⁵⁶ Healthy San Francisco began by targeting the most vulnerable segment of San Francisco's uninsured population. Residents whose income was at or below 100% of the Federal Poverty Level (FPL) were the first to be eligible to enroll in

148. *See id.* at 3–4 (identifying the major initiatives enacted by the city). Most notably, the city and county of San Francisco established the San Francisco Health Plan in 1997, which initially served the Medi-Cal population in a managed care setting; however, the plan was created with a vision toward helping to provide high quality medical care to the largest possible number of low-income residents in the city and county of San Francisco. *Id.* at 3.

149. *Id.* at 3. Partnering with the San Francisco Health Plan, the city launched several initiatives targeted toward certain segments of San Francisco's uninsured population. *Id.* These initiatives included health insurance programs for low-income children and youth not eligible for public programs and requiring all city and county contractors to provide health insurance to their employees. *Id.*

150. *Id.*

151. *Golden Gate Rest. Ass'n v. City & County of S.F.*, 535 F. Supp. 2d 968, 970 (N.D. Cal. 2007); *see also* S.F., CAL., ADMIN. CODE, SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE § 14.1–8 (2006) (outlining the payment requirements and other provisions of the fair share law).

152. Elena Conis & Carol Medlin, *San Francisco Health Access Program Update*, HEALTH POL'Y MONITOR, April 2008, http://www.hpm.org/en/Surveys/IGH_-_USA/11/San_Francisco_Health_Access_Program_Update.html?content_id=1570&language=en; *see also* HEALTHY SAN FRANCISCO, *supra* note 147, at 6 (explaining that the San Francisco program "represents the first time a local government has sought to provide universal health care to its residents").

153. HEALTHY SAN FRANCISCO, *supra* note 147, at 3. The program is officially titled the San Francisco Health Care Security Ordinance. § 14.1(a)

154. § 14.2(a) (stating that program is not an insurance plan within the confines of the San Francisco ordinance); *see also* HEALTHY SAN FRANCISCO, *supra* note 147, at 3.

155. § 14.2(e)–(f); HEALTHY SAN FRANCISCO, *supra* note 147, at 8.

156. § 14.2; *see also* HEALTHY SAN FRANCISCO, *supra* note 147, at 7 (summarizing the eligibility requirements).

Healthy San Francisco.¹⁵⁷ As of January 2008, eligibility was expanded to include San Francisco residents whose income was at or below 300% of the FPL.¹⁵⁸ The Healthy San Francisco program started by enrolling several hundred patients at two Chinatown clinics in July 2007; since that time, the program has expanded to include twenty-seven participating clinics and has added roughly 1,500 participants per month.¹⁵⁹ When Healthy San Francisco was enacted, San Francisco had an estimated uninsured population of 82,000 residents;¹⁶⁰ as of May 2010, more than 52,000 residents had enrolled in Healthy San Francisco.¹⁶¹ Of the 82,000 residents initially identified as uninsured, approximately 46,000 of those residents were employed but lacked health insurance.¹⁶² Based on a study conducted by the San Francisco Health Plan,¹⁶³ the majority of employed individuals without health care coverage cited their employer not offering health benefits as the reason for being uninsured.¹⁶⁴ Other reported reasons included either not being eligible for coverage¹⁶⁵ or declining to accept coverage offer by an employer,¹⁶⁶ presumably due to the high cost of contribution to the employer's health plan.

At the time of enactment, Healthy San Francisco was expected to cost approximately \$200 million per year or slightly more than \$2,400 per year for each uninsured resident.¹⁶⁷ In order to finance universal access to health care for San Francisco's uninsured residents, Healthy San Francisco relies on a combination of four major funding sources:¹⁶⁸ city funds,¹⁶⁹ state funds,¹⁷⁰ individual premiums and

157. HEALTHY SAN FRANCISCO, *supra* note 147, at 4.

158. *Id.*

159. *Id.*; HEALTHY SAN FRANCISCO, ANNUAL REPORT TO THE SAN FRANCISCO HEALTH COMMISSION (FOR FISCAL YEAR 2008-09) 8 (2009).

160. UNIVERSAL HEALTHCARE COUNCIL, SAN FRANCISCO HEALTH ACCESS PROGRAM: SERVING UNINSURED ADULTS 3 (2006) [hereinafter UHC REPORT], available at http://laborcenter.berkeley.edu/healthpolicy/uhc_report.pdf.

161. Healthy San Francisco, About Us: Program Stats, http://www.healthysanfrancisco.org/about_us/Stats.aspx# (last visited May 16, 2010).

162. SAN FRANCISCO HEALTH PLAN, ABOUT THE NUMBERS: A PROFILE OF UNINSURED ADULTS IN SAN FRANCISCO 5-6 (2006) [hereinafter SFHP ABOUT THE NUMBERS], available at http://www.sfhp.org/files/PDF/SFHAP/2006_ProfileofUninsuredinSF.pdf.

163. San Francisco Health Plan is a city-sponsored health plan that provides health insurance for approximately 55,000 residents of San Francisco, separate and apart from Healthy San Francisco. See San Francisco Health Plan, About Us: Who We Are, available at http://www.sfhp.org/about_us/who_we_are/ (last visited May 16, 2010).

164. SFHP ABOUT THE NUMBERS, *supra* note 162, at 8. Sixty-nine percent of uninsured workers cited this as the reason for being uninsured. *Id.*

165. This reason accounted for fifteen percent of uninsured workers in San Francisco. *Id.*

166. Approximately seventeen percent of uninsured workers claimed this as the reason why they were uninsured. *Id.*

167. UHC REPORT, *supra* note 160, at 4. These figures are based on the estimated cost of SFHAP in 2006 dollars and the number of uninsured residents as of 2006. *Id.*

168. *Id.* at 9-10; see also HEALTHY SAN FRANCISCO, *supra* note 147, at 16 (listing the major funding sources)

copayments,¹⁷¹ and mandatory employer contributions.¹⁷² Payments made by covered employers pursuant to Section 14.3 of the Health Care Security Ordinance cover about a quarter of Healthy San Francisco's annual cost.¹⁷³ Essentially, under the Healthy San Francisco definition for "covered employer,"¹⁷⁴ any for-profit business operating in San Francisco and employing twenty or more people or any nonprofit corporation operating in San Francisco and employing fifty or more people is required to either provide health care coverage for its employees or pay a fee to the city to help finance the Healthy San Francisco program.¹⁷⁵ If an employer chooses to provide health care coverage for its employees, then it must meet a minimum spending requirement established by Healthy San Francisco.¹⁷⁶ In particular, smaller companies are required to spend roughly \$200 per employee per month, and larger companies are required to spend roughly \$300 per employee per month.¹⁷⁷ In the event that a covered employer decides not to provide health care coverage for its employees at the minimum amounts established by the ordinance,

169. S.F., CAL., ADMIN. CODE, SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE § 14.2(d) (2006). A portion SFHP's cost is covered by the \$104 million per year that the city previously paid to provide emergency care and other services to its uninsured residents. Conis & Medlin, *supra* note 152.

170. Conis & Medlin, *supra* note 152. In 2007, SFHP received an award of \$73 million from the state health department to be apportioned over three years. *Id.*

171. § 14.2(d). Enrollees are required to pay quarterly participant fees and point of service fees at rates determined by their level of income. *Id.* §§ 14.2(d), 14.3; Conis & Medlin, *supra* note 152.

172. §§ 14.2(d), 14.3.

173. Conis & Medlin, *supra* note 152.

174. The ordinance defines *covered employer* as:

[A]ny medium-sized or large business . . . engaging in business within the [c]ity [of San Francisco] . . . or, in the case of a nonprofit corporation, an employer for which an average of fifty (50) or more persons per week perform work for compensation during a quarter. Small businesses are not "covered employers" and are exempt from the health care spending requirements under Section 14.3 [of the Health Care Security Ordinance].

§ 14.1(b)(3). A *large business* is defined as "an employer for which an average of one hundred (100) or more persons per week perform work for compensation during a quarter," *id.* § 14.1(b)(11), while a *medium-sized business* means "an employer for which an average of between twenty (20) and ninety-nine (99) persons per week perform work for compensation during a quarter." *Id.* § 14.1(b)(12).

175. *Id.* §§ 14.1(b)(3), (7)–(8), 14.3. Self-employed individuals, independent contractors, employers with nineteen or fewer employees total (including any employees located outside of San Francisco), and nonprofits with forty-nine or fewer employees total (including any employees located outside of San Francisco) are not covered by the Health Care Security Ordinance. *Id.* §§ 14.1(b)(3), 14.3; Labor Standards Enforcement, City & County of San Francisco, Health Care Security Ordinance (HCSO), <http://sfgsa.org/index.aspx?page=418> (last visited May 16, 2010).

176. § 14.1(b)(8); *see also* Conis & Medlin, *supra* note 152 (stating that San Francisco businesses must either provide minimum coverage to its employees or pay a fee to the City to finance Healthy San Francisco).

177. Conis & Medlin, *supra* note 152. SFHAP spending per enrollee is estimated to be approximately \$200 per month. *Id.*

then such employers must pay fees ranging from \$1.23 per employee per hour for medium-sized businesses and \$1.85 per employee per hour for large businesses.¹⁷⁸

An employer subject to Healthy San Francisco's requirements must only make required health care expenditures on behalf of its covered employees.¹⁷⁹ Such expenditures must be made quarterly and are calculated based on the total number of hours worked by covered employees multiplied by the health care expenditure rate.¹⁸⁰ Similar to the Suffolk County Act, certain expenditures are expressly identified under Healthy San Francisco as complying with a covered employer's required health care expenditures.¹⁸¹ Qualifying health care expenditures include the following: (1) employer contributions to a health savings account, (2) employer reimbursement of employee expenses incurred in purchasing health care services, (3) employer payments to a third party for the purpose of providing health care services for employees, (4) costs incurred by an employer in the direct delivery of health care to its employees, and (5) employer payments to the city of San Francisco to be used on behalf of its employees.¹⁸² In addition to the health care expenditure requirements, a covered employer must also satisfy certain record keeping and reporting requirements under Healthy San Francisco.¹⁸³

A. Small Business Opposition to Healthy San Francisco

Similar to other health care reform efforts attempting to implement fair share laws, Healthy San Francisco has not come without challenges from affected employers.¹⁸⁴ The mandatory employer contribution component has faced fierce opposition from the San Francisco business community in general and small businesses in particular.¹⁸⁵ Small businesses have argued that Healthy San

178. HEALTHY SAN FRANCISCO, *supra* note 147, at 5 tbl.1. The initial health care expenditure rate was set at \$1.06 per employee per hour for medium-sized businesses and \$1.60 per hour for large businesses from the effective date of the ordinance through June 30, 2007; thereafter, the health care expenditure rate increased by five percent over the calculated expenditure for the previous year. § 14.1(b)(8)(a)–(b). The first increase incurred on July 1, 2007, followed by subsequent increases on January 1 of each following year. *Id.* § 14.1(b)(8)(b). As of January 1, 2010, the health care expenditure rate will be determined annually based upon an annual ten-county survey of the “average contribution” for a full-time employee to the City Health Service System. § 14.1(b)(8)(c).

179. *Id.* § 14.3(a). Under the San Francisco Health Care Security Ordinance, *covered employee* includes any person, regardless of residence, who works in San Francisco for a covered employer, either full- or part-time, for at least eight hours per week (as of January 1, 2009), and for at least ninety days. *Id.* § 14.1(b)(2). The term *covered employee* does not include certain classes of employees, such as managerial or supervisory employees (subject to certain conditions not being satisfied). *Id.* In addition, although Healthy San Francisco became operative as of July 1, 2007, the employer spending requirement did not go into effect until January 1, 2008. *Id.* § 14.8.

180. *Id.* §§14.1(b)(8), 14.3(a).

181. *Id.* §14.1(b)(7).

182. *Id.*

183. *Id.* § 14.3(b).

184. HEALTHY SAN FRANCISCO, *supra* note 147, at 5–6.

185. *Id.*; Conis & Medlin, *supra* note 152.

Francisco forced them to bear an unfair share of financial responsibility for the program and “would force them to lay off employees, raise prices, cut salaries, or go out of business,” all of which would be detrimental to the city of San Francisco.¹⁸⁶ The 900-member Golden Gate Restaurant Association (GGRA),¹⁸⁷ in particular, alleged that compliance with Healthy San Francisco would raise restaurant operating costs by five percent, significantly reducing historically small profit margins.¹⁸⁸ On November 8, 2006, shortly after the enactment of Healthy San Francisco, the GGRA sued the city of San Francisco in an effort to overturn the employer spending mandate on the grounds that it was preempted by ERISA.¹⁸⁹

B. Legal Challenge to Healthy San Francisco—Northern District of California

As if expecting an ERISA challenge, Section 14.6 of the San Francisco Health Care Security Ordinance states “[n]othing in this Chapter shall be interpreted or applied so as to create any power, duty or obligation in conflict with, or preempted by, any Federal or State law.”¹⁹⁰ Nevertheless, on December 26, 2007, Judge White entered judgment in favor of the GGRA on the grounds that Section 514(a) of ERISA preempted the San Francisco Health Care Security Ordinance.¹⁹¹ In reaching this result, Judge White analyzed the extent to which San Francisco’s ordinance “relate[d] to” an employee benefit plan by applying the two-part test established in *Shaw*, whereby satisfaction of either prong results in preemption under Section 514(a) of ERISA.¹⁹²

Applying the first prong of the *Shaw* test, Judge White concluded that San Francisco’s law had a prohibited connection with employers’ ERISA-regulated plans. Specifically, Healthy San Francisco (1) affected ERISA plan administration, (2) imposed ongoing administrative burdens upon employers, including record

186. Conis & Medlin, *supra* note 152.

187. Conis & Medlin, *supra* note 152. Similar to RILA, the GGRA is a non-profit trade association. Golden Gate Rest. Ass’n, About GGRA, <http://www.ggra.org/About.aspx> (last visited May 16, 2010). The GGRA’s goals are “to promote, extend, and protect the interests of . . . restaurant industry” members in the San Francisco Bay Area. *Id.*

188. Conis & Medlin, *supra* note 152.

189. Complaint for Declaratory Relief and Injunction, *Golden Gate Rest. Ass’n v. City & County of S.F.*, 535 F. Supp. 2d 968 (N.D. Cal. 2007) (No. C 06-6997 JSW), 2006 WL 3853281. The GGRA sought a permanent injunction against the employer spending requirements imposed by Healthy San Francisco. *Id.* at 3.

190. S.F., CAL., ADMIN. CODE, SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE § 14.6 (2006) (emphasis added). The ordinance includes a severability provision:

If any section, subsection, clause, phrase, or portion of [the ordinance] is for any reason held invalid or unconstitutional by any court or Federal or State agency . . . , such portion shall be deemed a separate, distinct and independent provision and such holding shall not affect the validity of the remaining portions [of the ordinance].

Id. § 14.5.

191. *Golden Gate Rest. Ass’n*, 535 F. Supp. 2d at 970.

192. *Id.* at 973, 975–77.

keeping and reporting, that directly affected the scheme of providing health care benefits, (3) both directly and indirectly affected the structure and administration of ERISA plans, and (4) interfered with national uniform plan administration.¹⁹³ Similarly, Judge White found that San Francisco's law also failed the second prong of the *Shaw* test by making an unlawful reference to employee benefit plans in two ways. First, Judge White interpreted Healthy San Francisco as implicitly referencing the existence of ERISA plans in its expenditure requirements provisions.¹⁹⁴ Second, he concluded that liability under Healthy San Francisco was determined exclusively with reference to employer-sponsored health benefits that are predominantly provided under existing ERISA plans.¹⁹⁵ In Judge White's opinion, a covered employer could only determine its liability under Healthy San Francisco by ascertaining how much it paid for employee health coverage under existing plans.¹⁹⁶ Therefore, "under either analysis, [Healthy San Francisco was] preempted because it [had] both a connection with and references [to] ERISA plans."¹⁹⁷ Due to the fact that Healthy San Francisco "fail[ed] to withstand the expansive test of ERISA preemption," the district court enjoined the implementation and enforcement of the program.¹⁹⁸

C. Legal Challenge to Healthy San Francisco—Ninth Circuit Court of Appeals

Despite Judge White's ruling, the city of San Francisco immediately filed a motion with the district court seeking a stay of the injunction pending an appeal to the Ninth Circuit Court of Appeals. Although the district court denied the motion,¹⁹⁹ on January 9, 2008, a unanimous three-judge panel of the Ninth Circuit ordered a stay of the district court order pending an appeal by the city of San Francisco.²⁰⁰ In reaching this decision, the Ninth Circuit panel noted the legal standard for granting a stay constitutes a continuum, which requires an assessment of the probability of success on the merits at one end and, at the other end, whether "the balance of hardships tip[ped] sharply in favor of the party seeking the stay"²⁰¹ Under this analytical framework, the court held that not only did a strong likelihood of success on the merits exist but also that the balance of hardships

193. *Id.* at 975–77.

194. *Id.* at 978; *see also* § 14.1(b)(7) (calculating employer liability by looking at "amount[s] paid by a covered employer to its covered employees or to a third party . . . for the purpose of providing health care services for covered employees").

195. *Golden Gate Rest. Ass'n*, 535 F. Supp. 2d at 978.

196. *Id.*

197. *Id.* at 979.

198. *Id.* at 980.

199. *Golden Gate Rest. Ass'n v. City & County of S.F.*, No. C 06-06997 JSW, 2007 WL 4591729 (N.D. Cal. Dec 28, 2007).

200. *Golden Gate Rest. Ass'n v. City & County of S.F.*, 512 F.3d 1112, 1127 (9th Cir. 2008).

201. *Id.* at 1119 (internal quotes omitted).

tipped sharply in favor of the city of San Francisco.²⁰² In addition, the panel found that public interest supported granting the stay.²⁰³ On February 7, 2008, the GGRA filed an application to the U.S. Supreme Court, seeking to lift the Ninth Circuit's ruling.²⁰⁴ However, on February 21, 2008, acting in his capacity as Circuit Justice for the Ninth Circuit, Justice Kennedy denied the GGRA request.²⁰⁵ Thus, Healthy San Francisco and its employer spending requirement remained in effect pending the city of San Francisco's appeal of the district court decision.²⁰⁶ On September 30, 2008, the Ninth Circuit's three-judge panel issued an opinion reversing the district court's ruling and upholding Healthy San Francisco's employer spending requirement.²⁰⁷ In response to this ruling, on October 22, 2008, the GGRA petitioned for a rehearing en banc before the Ninth Circuit.²⁰⁸ Nonetheless, on March 9, 2009, the Ninth Circuit denied the request for rehearing en banc, upholding the panel's decision that ERISA did not preempt the Healthy San Francisco program.²⁰⁹ The Ninth Circuit's denial of an en banc rehearing elicited both dissenting and concurring opinions, which is relatively uncommon in terms of federal appellate procedure.²¹⁰

Joined by seven other judges, Judge Smith voiced his belief that "the San Francisco Ordinance [was] clearly preempted by ERISA Section 514(a)" and strongly dissented on several grounds.²¹¹ Specifically, Judge Smith asserted that the Ninth Circuit's decision (1) created a circuit split with the Fourth Circuit Court of Appeals, (2) rendered the *Shaw* test meaningless and ignored ERISA preemption guidelines established by Supreme Court precedent, and (3) "most importantly, flout[ed] the mandate of national uniformity in the area of employer-provided healthcare" that was at the core of ERISA's enactment.²¹² In relation to the issue of

202. *Id.*

203. *Id.*

204. Labor Standards Enforcement, City & County of San Francisco, GGRA Litigation, <http://sfgsa.org/index.aspx?page=424> (last visited May 16, 2010).

205. *Id.* Justice Kennedy did not issue an opinion explaining the reasons for denying the request. *Justice Kennedy Denies Request for Order to Block San Francisco Fair Share Health Law*, Pens. & Ben. Daily (BNA) No. 36 (Feb. 25, 2008) [hereinafter *Justice Kennedy Denies Request*].

206. *Justice Kennedy Denies Request*, *supra* note 205.

207. *Golden Gate Rest. Ass'n v. City & County of S.F.*, 546 F.3d 639, 661 (2008). This ruling was made by the same panel that issued the stay of the district court's decision. *Id.*

208. *Petition for Rehearing En Banc, Golden Gate Rest. Ass'n v. City & County of S.F.*, 546 F.3d 639 (9th Cir. 2008) (Nos. 07-17370, 07-17372), 2008 WL 4918566.

209. *Golden Gate Rest. Ass'n v. City & County of S.F.*, 558 F.3d 1000, 1001 (9th Cir. 2009).

210. *Id.* at 1001 (Fletcher, J., concurring); *id.* at 1004 (Smith, Kozinski, O'Scannlain, Kleinfeld, Tallman, Bybee, Callahan, & Bea, JJ., dissenting). More typically, such a denial is purely procedural, resulting in neither concurring nor dissenting opinions. See Michael E. Solimine, *Due Process and En Banc Decisionmaking*, 48 ARIZ. L. REV. 325, 332-33 & tbl.1 (2006) (stating that the number of published opinions accompanying orders of denying en banc requests did not seem particularly large within each circuit).

211. *Id.* at 1004, 1009-10 (Smith, J., dissenting).

212. *Id.* at 1004.

national uniformity, the dissenting opinion raised a more overarching policy concern with respect to the Ninth Circuit's decision, suggesting that the decision to allow San Francisco to implement Healthy San Francisco created "a roadmap" for other state and local governments to circumvent ERISA preemption.²¹³ "[S]imilar laws [would] become commonplace," undermining the congressional goal of minimizing the administrative and financial burdens imposed on employee benefit plan administrators and resulting in "adverse consequences to employers and employees alike."²¹⁴

With respect to the creation of a circuit split between the Ninth Circuit and Fourth Circuit, the dissent argued that the employer spending requirements imposed by Healthy San Francisco and Maryland's Fair Share Act were functionally indistinguishable.²¹⁵ The issue was not whether employers had a "meaningful alternative" through which to make non-ERISA payments; rather, "[c]overed employers under San Francisco's Ordinance must coordinate their non-ERISA payments with their ERISA plans in the very manner the *Fielder* court deemed impermissible."²¹⁶ Essentially, a non-complying covered employer in San Francisco faced the same choice as a non-complying covered employer in Maryland; the employer could either "[m]ake a payment to the government or change its current ERISA plan."²¹⁷ Regardless of which payment the employer decides to make, the practical effect is to impose a penalty upon the employer rather than to provide a meaningful alternative for compliance.²¹⁸ Therefore, by allowing Healthy San Francisco to impose its employer spending requirement, the dissent contended that the Ninth Circuit "create[d] a circuit split on the issue of whether ERISA preempts 'fair share' or 'play-or-pay' ordinances."²¹⁹

In addition, the dissent alleged that the Ninth Circuit chose to disregard Supreme Court precedent establishing ERISA preemption principles, conflicting with decisions in both *Egelhoff v. Egelhoff*²²⁰ and *District of Columbia v. Greater Washington Bd. of Trade*.²²¹ Emphasizing the fact ERISA was enacted to eliminate the burden of conflicting obligations on employers operating in multiple jurisdictions,²²² the dissent cited *Egelhoff* for the proposition that states and localities cannot avoid preemption by offering employers a theoretical means by

213. *Id.*

214. *Id.*

215. *Id.* at 1006-07.

216. *Id.* at 1006.

217. *Id.* at 1006-07.

218. *Id.* at 1007.

219. *Id.*

220. 532 U.S. 141 (2001).

221. 506 U.S. 125 (1992).

222. *Golden Gate Rest. Ass'n*, 558 F.3d at 1007 (citing *Egelhoff*, 532 U.S. at 151).

which to avoid changing existing ERISA plans.²²³ Under the dissent's interpretation of *Egelhoff*, an employer's ability to "opt out" of the state law did not prevent it from having an impermissible "connection with" ERISA plans.²²⁴ In this manner, the dissent analogized *Egelhoff* to San Francisco's ordinance, asserting that covered employers who have not achieved the minimum spending requirement face one of the two following choices: they can either (1) increase or maintain health care expenditures under existing plans or (2) pay San Francisco an amount equal to the mandated minimum.²²⁵ However, under the dissent's interpretation of Section 514(a) and Supreme Court precedent, either choice bears a prohibited "connection with" employer's employee benefit plans, preempting Healthy San Francisco under ERISA.²²⁶ In addition, notwithstanding the choices available to employers in complying with San Francisco's requirement, allowing such a law would require plan administrators to potentially contend with such provisions in every state; the necessary burden of monitoring, accounting for, and complying with a multitude of state and local laws was "exactly the burden ERISA [sought] to eliminate."²²⁷

Similarly, the dissent analogized the employer spending mandate under Healthy San Francisco to the Washington, D.C. law challenged in *Greater Washington*.²²⁸ Washington, D.C.'s "ordinance required employers to provide the same medical coverage to injured employees as to non-injured, active employees."²²⁹ Under that law, employers could provide benefits to injured employees through a separate non-ERISA plan; nonetheless, the court found the law was preempted by ERISA on the grounds that it "impermissibly referred to an ERISA plan."²³⁰ This prohibited reference arose because the benefits for each class of employees had to be equal, which necessarily required a comparison to the existing ERISA plan.²³¹ Similarly, while covered employers might not have to amend their ERISA plans in order to comply with San Francisco's ordinance, whether covered employers are in compliance with the spending requirement can only be determined by using such employers' current ERISA plans as a reference.²³² Consequently, the dissent flatly rejected the notion that the issue could be framed in terms of obligations measured by reference to payments provided by the employer to an ERISA plan or another entity under Healthy San Francisco

223. *Id.* (citing *Egelhoff*, 532 U.S. at 147–48).

224. *Id.*

225. *Id.*

226. *Id.*

227. *Id.* (quoting *Egelhoff*, 532 U.S. at 151).

228. *Id.* at 1008.

229. *Id.*

230. *Id.* (citing *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130 (1992)).

231. *Id.*

232. *Id.*

versus obligations measured by reference to the level of benefits provided by the ERISA plan to an employee in *Greater Washington*.²³³

“[M]ost importantly, [Judge Smith] dissent[ed] because this case concerns an issue of exceptional national importance, i.e., *national uniformity* in the area of employer-provided healthcare.”²³⁴ The dissent insisted that the Ninth Circuit decision “ignore[d] ERISA’s preemption goals,” focusing instead “on ERISA’s objective of protecting against misuse of [employee] benefit plan funds,” despite the fact that preemption, and not misuse, “was central to ERISA’s implementation.”²³⁵ Without uniformity, multi-state employers face significant hardships; such employers cannot offer all similarly situated employees the same benefits nor can they achieve continuity in their respective benefit programs.²³⁶ As an example, the dissent noted that employees of a national restaurant chain operating in Oakland and San Francisco would receive different benefits, and the employer would be subject to different requirements, notwithstanding their geographic proximity.²³⁷ While complying with San Francisco’s law may not be particularly onerous on a small scale, “if we consider the possibility of numerous cities, counties and states enacting similar laws, the burden this places on employers is potentially very great, thereby encouraging affected employers to drop their ERISA plans as a cost saving measure.”²³⁸ By allowing San Francisco’s health access program, the Ninth Circuit provided a roadmap for other states and localities to institute employer spending requirements, leading to “health care expenditure balkanization,” which is exactly what ERISA was meant to prevent.²³⁹

Having written the original Ninth Circuit panel decision, Judge Fletcher concurred in the court’s decision not to rehear the matter en banc and drafted a concurring opinion to respond to the dissent’s arguments. In particular, Judge Fletcher systematically rejected the dissent’s contentions that the Ninth Circuit’s decision (1) “create[d] a circuit conflict” with *Fielder*,²⁴⁰ (2) conflicted with Supreme Court precedent,²⁴¹ and (3) that ERISA “require[d] national uniformity in the provision of health care.”²⁴² Addressing the potential split with the Fourth Circuit’s decision in *Fielder*, Judge Fletcher suggested that the two cases can be distinguished on the issue of “meaningful choice.”²⁴³ Maryland’s Fair Share Act

233. *Id.*

234. *Id.* (emphasis added).

235. *Id.* at 1009.

236. *Id.*

237. *Id.*

238. *Id.*

239. *Id.*

240. *Id.* at 1001–02 (Fletcher, J., concurring).

241. *Id.* at 1003.

242. *Id.* at 1004.

243. *Id.* at 1002.

“require[d] employers with 10,000 or more Maryland employees to spend at least [eight percent] of their total payrolls on employees’ health insurance costs or pay the amount their spending falls short to the State of Maryland.”²⁴⁴ Any employer subject to the minimum spending threshold did not receive anything in return for itself or its employees as a result of payments made to the state; due to the employer size threshold, the only employer covered by the law was Wal-Mart. Since the practical effect of Maryland’s law was to *require* Wal-Mart to increase its ERISA coverage of employees,²⁴⁵ the law was impermissibly related to ERISA.²⁴⁶

In contrast, under San Francisco’s health access program, covered employees “are entitled to obtain health care benefits . . . at reduced rates.”²⁴⁷ According to Judge Fletcher, rather than “imposing a de facto obligation,” this structure presented a “meaningful choice” to covered employers between either (1) meeting the minimum spending threshold imposed by Healthy San Francisco or (2) paying the tax to San Francisco in exchange for its employees receiving access to health care services provided by the city.²⁴⁸ In addition, Judge Fletcher argued that San Francisco’s fair share law does not require covered employers to coordinate non-ERISA payments imposed by the minimum spending requirement with their existing ERISA plans.²⁴⁹ Under the Maryland law, “Wal-Mart’s use of the non-ERISA spending option would *necessarily produce a change* in its ERISA plans.”²⁵⁰ In Judge Fletcher’s opinion, no change in any ERISA plan resulted from a covered employer paying the tax imposed by Healthy San Francisco; however, Judge Fletcher makes this broad statement without any additional discussion or comparison.²⁵¹

In addition, Judge Fletcher asserted that the Ninth Circuit’s decision did not conflict with the Supreme Court’s decisions in either *Egelhoff* or *Greater Washington*.²⁵² In *Egelhoff*, the court examined a state law that required plan administrators to adhere to state law in designating plan beneficiaries. Respondents argued that the law was not preempted by ERISA because it provided an option to

244. Retail Indus. Leaders Ass’n v. Fielder, 475 F.3d 180, 183 (4th Cir. 2007).

245. *Id.* at 183, 193. According to *Fielder*, healthcare benefits represent a portion of an employee’s total compensation. *Id.* at 193. By increasing healthcare benefits and therefore total compensation, an employer receives consideration for this payment in the form of improved retention and performance of current employees and the ability to attract and recruit potential future employees; in contrast, the employer receives no consideration by making a payment to the state for which it receives nothing in return. *Id.* Effectively, “the only rational choice employers have under the [Maryland law] is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold.” *Id.*

246. *Id.* at 197.

247. *Golden Gate Rest. Ass’n*, 558 F.3d at 1002 (Fletcher, J., concurring).

248. *Id.*

249. *Id.* at 1002–03.

250. *Id.* at 1003 (emphasis added).

251. *Id.*

252. *Id.*

plan administrators; however, the court rejected this argument and held that the law bound “plan administrators to a particular choice of rules for determining beneficiary status.”²⁵³ By forcing administrators to either follow the state’s beneficiary designation scheme or alter the terms of their ERISA plans, the challenged statute forced plan administrators to make a change to their ERISA plans one way or another and was therefore preempted by Section 514(a).²⁵⁴ Relying upon his analysis in relation to *Fielder*, Judge Fletcher maintained that San Francisco’s ordinance did not require any change to an ERISA plan and was therefore distinguishable from the result in *Egelhoff*.²⁵⁵

While *Egelhoff* dealt with the issue of a state law imposing changes upon ERISA plans, *Greater Washington* analyzed the determination of the requisite level of benefits under an employer mandate.²⁵⁶ In *Greater Washington*, Washington, D.C. implemented a law that determined the requisite level of benefits by “reference to” existing health insurance coverage provided by employers; according to the court, this calculation constituted an impermissible reference to an ERISA plan.²⁵⁷ In contrast, Judge Fletcher argued that Healthy San Francisco’s required payments are determined by reference to hours worked by an employee rather than by reference to benefits provided by an ERISA plan.²⁵⁸ A covered employer’s required payments can be reduced or eliminated by making payments to, among other things, an employee’s ERISA plan,²⁵⁹ however, “the amount of the reduction is determined by reference to the *amount* of money paid” on behalf of the employee in reference to the number of hours worked.²⁶⁰ For this reason, Judge Fletcher argued that Healthy San Francisco is distinguishable from *Greater Washington*.²⁶¹ Notwithstanding the closely related issues raised in *Egelhoff* and *Greater Washington*, Judge Fletcher maintained that the Ninth Circuit’s decision was not inconsistent with existing Supreme Court precedent due to the particular facts and circumstances related to Healthy San Francisco’s structure and implementation.²⁶²

Finally, Judge Fletcher rejected the dissent’s position that “ERISA responds to the ‘need for nationally uniform plan administration’ and a ‘uniform regulatory

253. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147, 150 (2001).

254. *Id.* at 150.

255. *Golden Gate Rest. Ass’n*, 558 F.3d at 1003.

256. *Id.*

257. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130–31 (1992).

258. *Golden Gate Rest. Ass’n*, 558 F.3d at 1003; *see also* S.F., CAL., ADMIN. CODE, SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE § 14.1(b)(8) (2006) (defining the health care expenditure rate).

259. *Golden Gate Rest. Ass’n*, 558 F.3d at 1003; §§ 14.1(b)(7), 14.3.

260. *Golden Gate Rest. Ass’n*, 558 F.3d at 1003 (emphasis added).

261. *Id.*

262. *See supra* notes 252–61 and accompanying text.

system.”²⁶³ Citing the Supreme Court’s decision in *Fort Halifax Packing Co. v. Coyne*,²⁶⁴ Judge Fletcher argued that the purpose of ERISA was not to require national uniformity in the provision of health care but rather to ensure administrative practices of a benefit plan are governed only by a single set of regulations.²⁶⁵ Assuming that nothing in San Francisco’s plan required employers to establish an ERISA plan or to alter an existing ERISA plan, Judge Fletcher concluded that “nothing in the Ordinance interfere[d] in any way with the uniformity of ERISA regulations.”²⁶⁶

At least one thing is clear from the Ninth Circuit’s final decision—its members have distinctly different viewpoints on the permissibility of Healthy San Francisco and whether ERISA preemption affords any opportunity for health care reform through state or local fair share laws. Whether the Supreme Court will ultimately weigh in on this matter remains to be seen. On March 18, 2009, the GGRA filed an application to the Supreme Court for an emergency injunction, seeking to prevent San Francisco from continuing to impose the employer spending requirement while the GGRA appeals the Ninth Circuit decision to the Supreme Court.²⁶⁷ However, on March 30, 2009, Justice Kennedy once again denied the GGRA’s request for an emergency stay.²⁶⁸ On June 5, 2009, the GGRA filed a petition for certiorari with the U.S. Supreme Court, but so far, the Court has not decided whether to hear the case.²⁶⁹ Instead, the Supreme Court has invited U.S. Solicitor General Elena Kagan to file a brief expressing the federal government’s views with respect to the GGRA’s petition, but the Solicitor General has yet to file a brief in this matter.²⁷⁰ Thus, the health care benefits provided under the Healthy San Francisco program, as well as the employer spending requirements that fund a portion of the program, remain in effect for the time being.

CONCLUSION

“Although ERISA’s legislative history makes clear that Congress intended to craft a broad preemption provision, it is far from clear that Congress anticipated the

263. *Golden Gate Rest. Ass’n*, 558 F.3d at 1004 (Fletcher, J., concurring) (quoting *id.* at 1008–09 (Smith, J., dissenting)).

264. 482 U.S. 1 (1987).

265. *Golden Gate Rest. Ass’n*, 558 F.3d at 1004 (Fletcher, J., concurring) (citing *Fort Halifax Packing Co.*, 482 U.S. at 11).

266. *Id.*

267. Labor Standards Enforcement, *supra* note 204.

268. *Id.* Justice Kennedy did not issue an opinion explaining the reasons for denying GGRA’s second request for an emergency injunction. Bob Egelko, *High Court Denies Restaurants’ Stay Request*, S. F. CHRON., Mar. 31, 2009, at B2.

269. Petition for Writ of Certiorari, *Golden Gate Rest. Ass’n v. City & County of S.F.*, 558 F.3d 1000 (9th Cir. 2009) (N. 08-1515), 2009 WL 1630302.

270. *Golden Gate Rest. Ass’n v. City & County of S.F.*, 130 S. Ct. 357 (2009) (mem.).

extent of the law's impact on health care regulation."²⁷¹ Effectively, in enacting ERISA, members of Congress failed to consider the breadth of Section 514(a) and "the effect such a broad preemption clause would have on the ability of states to regulate in fields even remotely related to employee benefit plans."²⁷² Even with the recent enactment of sweeping federal health care legislation, the U.S. Supreme Court should take action on the issue of ERISA preemption as it relates to fair share laws and other state and local health care reforms. Many of the benefits of the national health care bill, including expanding health insurance coverage for the uninsured, will not be realized for several years. Even once national health care reform has been fully implemented, the issue of providing access to health care for the uninsured will persist, albeit at reduced numbers. While the recent federal health care bill makes it clear that states will be required to provide some minimum level of health care benefits, the extent to which they can provide additional benefits funded by an employer spending mandate remains unclear in light of existing ERISA preemption doctrine.

As evidenced by litigation in Maryland, Suffolk County, NY, and the city of San Francisco, Section 514(a) of ERISA significantly constrains state or local efforts to finance expanded health care coverage with an employer financing component. Certainly, state and local governments could expand access to health care without employer assistance, but this would eliminate a critical source of financing for such initiatives. As state and local budget deficits increase under the strain of the economic downturn, it is unlikely that they will be willing to expand coverage without some portion being financed by employers. Effectively, ERISA greatly limits the manner and means by which state and local governments can increase access to health care. Thus, the enactment of federal health care legislation does not reduce the necessity and urgency for the Supreme Court to intervene in *Golden Gate Restaurant Ass'n* and assess the validity of the San Francisco Health Care Security Ordinance.

The Supreme Court could deny certiorari in this matter and thereby implicitly uphold the Ninth Circuit decision. While such a result would certainly be a victory for Healthy San Francisco, it would fail to take advantage of an opportunity to add clarity to ERISA preemption doctrine. Failure to take action on the part of the Supreme Court would allow a legal gray area to persist with respect to the viability of employer spending mandates. Rather, the better approach would be for the Supreme Court to grant certiorari in this matter, taking an important step in defining Section 514(a) as it relates to employee benefit plans and health care

271. Sharon Jacobs, *On the Mend: The Ninth Circuit Gives San Francisco's Health Care Security Ordinance the Green Light (for Now)*, 36 J. L. MED. & ETHICS 431, 433 (2008) (citing Stephen F. Befort & Christopher J. Kopka, *The Sounds of Silence: The Libertarian Ethos of ERISA Preemption*, 52 FLA. L. REV. 1, 26-29 (2000)).

272. Emily V. Griffen, Comment, "*Relations Stop Nowhere*": *ERISA Preemption of San Francisco's Domestic Partner Ordinance*, 89 CAL. L. REV. 459, 487 (2001).

reform. Issuing a ruling in this matter would clarify the manner and means by which state and local governments can implement and finance health care reform aimed at expanding access to health. Even with the enactment of national health care reform, a decision by the Supreme Court in *Golden Gate Restaurant Ass'n*, would provide state and local governments with a roadmap as to how they can expand upon or supplement the federal health care legislation and finance such efforts without running afoul of ERISA.²⁷³

Absent judicial intervention clarifying the scope of ERISA preemption, Congress should consider amending ERISA to provide relief from Section 514(a) and allow continued experimentation at the state and local level. One option would be for Congress to eliminate Section 514(a) entirely and allow principles of implied preemption to guide judicial interpretation with respect to the proper balance between state and federal law.²⁷⁴ However, such action would be far too drastic. Not only would repealing Section 514(a) undoubtedly promote more, rather than less, litigation and uncertainty with respect to state and local initiatives aimed at expanding health care, but it would also throw the field of employee benefits law into utter turmoil.

Alternatively, Congress could choose to amend Section 514(a). Advocates for amending ERISA contend that ERISA's preemption provision unduly constrains comprehensive health insurance reform at state and local levels by preventing state and local governments from regulating employment-based group health plans.²⁷⁵ One way that Congress could amend Section 514(a) would be to establish minimum standards for health care plans and making employer-sponsored plans mandatory, including a requisite level of employer financing. Presumably, this approach would elicit substantial opposition from employers and industry leaders. Given the passionate response elicited by the debate over national health care reform, such an amendment hardly seems palatable, let alone possible. Conversely, Congress could amend ERISA to expressly allow limited and targeted experimentation at the state and local level. For example, Congress could enact express ERISA waivers for a handful of localities and states, such as San Francisco and Massachusetts, which have already begun experimentation with health care reform or have new programs in the pipeline.²⁷⁶ This would enable state and local governments to take the reins in designing programs that expand coverage in the most efficient and practicable way possible. At the same time, such an approach

273. In the event that the Supreme Court were to uphold San Francisco's Health Care Security Ordinance, such a ruling would firmly establish employer mandates as another source of financing available to fund state and local initiatives to expand access to health care for the uninsured.

274. Griffen, *supra* note 272, at 503 (stating that since the legislative history of ERISA clearly expresses an intent to preempt the field of pension plan administration, removing "[S]ection 514(a) would not allow state laws that conflict with ERISA's purposes to survive").

275. Pierron & Fronstin, *supra* note 30, at 13.

276. *See supra* notes 88–92 and accompanying text.

would allow for incremental, long-term health care reform and might be the best solution to overcoming the impasse between ERISA preemption and experimentation with health care reform at the state and local level.

Eliminating or mitigating the constraining effect of ERISA would not only allow state and local governments to supplement the federal health care legislation with their own health care reform initiatives, but it would also allow such governments to enact regulations that take local preferences and circumstances into consideration. For example, statistics show that between 2006 and 2007, employer-sponsored health insurance covered approximately sixty percent of nonelderly residents nationwide while almost eighteen percent of such residents were uninsured.²⁷⁷ Hawaii, Massachusetts, Minnesota, and Wisconsin all reported over sixty-eight percent of nonelderly residents insured under employer-sponsored programs while less than ten percent of such residents were uninsured.²⁷⁸ Thus, these four states significantly outperformed the national average at both ends of the spectrum.²⁷⁹ In contrast, Arizona, California, Florida, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas all significantly underperformed the national averages. Each of these states reported less than fifty-six percent of nonelderly residents insured under employer-sponsored programs while more than twenty percent of such residents were uninsured.²⁸⁰ These figures highlight the significant variation in the distribution of nonelderly residents covered under employer-sponsored insurance versus those without any coverage at the state level.²⁸¹ Differences in the distribution of state coverage suggest that allowing local government experimentation could be beneficial to the extent that states are able to adequately identify local preferences and adapt programs aimed at supplementing the health care mandates present under the federal legislation.

While the recent enactment of national health care legislation practically eliminates the likelihood that state or local governments will undertake significant health care reform in the short term, it does not eliminate the importance of clarifying the scope of ERISA preemption with regard to employer spending mandates. At least with respect to Healthy San Francisco specifically and health care reform generally, the optimal solution would be for the Supreme Court to grant certiorari and issue a definitive ruling in the matter. Regardless of whether the Supreme Court upholds or rejects the Ninth Circuit opinion, it would help to settle the question of whether state and local governments can rely upon employer

277. KAISER UNINSURED PRIMER, *supra* note 73, at 29 tbl.5.

278. *Id.*

279. *Id.*

280. *Id.*

281. Only the percent of nonelderly residents covered by employer-sponsored insurance and the percent of such residents with no insurance coverage are identified here. *Id.* The percentage of nonelderly residents covered under other forms of private and public insurance, including Medicaid and private individual insurance, also varies significantly by state. *Id.*

spending mandates as a financing component for expanding access to health care. In the event that the Supreme Court continues to take a pass on the issue, then the next best solution is for Congress to amend ERISA—although this seems even more unlikely. In either case, despite the enactment of sweeping federal health care legislation, state and local governments will continue to play an important role in bridging the gap between the uninsured and access to health care. How well they are able to perform that role, however, particularly in providing expanded or custom-tailored health care benefits that go beyond the scope of the national legislation, will depend upon the extent to which ERISA continues to impede state and local health care reform.

