I. Introduction

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) to regulate employee pension plans as a response to turmoil caused by “highly publicized pension plan disasters,” and as a way to regulate benefit and pension plans on a national level. What began as a seemingly straightforward piece of legislation has grown and expanded into a complicated area of law, encompassing a broad range of statutes and regulations.

Individual states now take on the financial burden of rising health care costs. For instance, states are expanding health care funding for their poorest residents because little agreement at the federal level exists in how to respond to the problem of providing indigent individuals with adequate health care services. Recent reports indicate that states pay 43 percent of total Medicaid costs and Medicaid spending comprises 22.9 percent of state budgets. In light of this more active role for states, a question exists as to whether ERISA preemption will prevent significant health care reform at the state level. According to the most recent court decisions, it appears that ERISA will continue to have a severe impact on state health care reforms.

II. Background

As America faces what can be characterized as a health care crisis, addressing the dual goals of containing costs while expanding access becomes increasingly important. Aggregate health care costs in America are tremendous, making up roughly 16 percent of this country’s gross domestic product. One major problem is the impact on a health care system forced to absorb the cost of 46.1 million uninsured Americans. Additionally, while the United States spends the most money on health care, Americans are among the least healthy people in the industrialized world.

A. The Changing Landscape of Health Care in America

When Congress enacted ERISA in 1974, it seemed no one could have predicted the problems with America’s health care system today. Few could have known that states would play such a crucial role in solving these problems. At the time of ERISA’s enactment, the health care system in this country looked very different from how it does today. For instance, the simple patient-doctor paradigm that existed in 1974 has been replaced by a much more complex system of Managed Care Organizations (MCO).

The rise of MCOs and the shifts in the financing of health care coverage have changed how – and even if – Americans are insured. The Health Maintenance Organization (HMO) Act of 1973 provided MCOs with an economic edge over more traditional forms of health insurance. As a result, MCOs grew more competitive and began to offer better premiums to employers because MCOs could leverage their costs through contractual agreements with providers to give comprehensive coverage to members, financial incentives to use member providers, and accountability through quality assurance programs. Attempting to appeal to employers providing health care, MCOs needed to improve their bottom line and achieved this by controlling costs and provider incentives.

The shift to increased employer-provided coverage in the 1990’s demonstrates how much health care systems have changed since ERISA’s enactment. The purpose of ERISA was to achieve uniformity in a regulatory scheme for employee benefits and, perhaps more importantly, pension funds. Congress, however, arguably “paid little heed to its implications for medical care.” Today, the reality is that many state laws seeking to regulate health care plans now face a high probability of ERISA preemption. ERISA’s language includes regulation of any “employee welfare benefit plan” and any plans provided by an employer to offer coverage of any “medical, surgical, or hospital care benefits.” These regulations have had far-reaching effects on state laws that attempt to regulate such benefit plans. ERISA’s unforeseen intrusion into state sovereignty has also generated enormous amounts of litigation over state health care laws. In addition to states’ inability to change substantially health care laws without the threat of ERISA preemption, individual patients cannot sue under state laws, which, more often than not, provide more relief for individual plaintiffs because ERISA enrollees may only receive ERISA remedies.

* Sabrina Dunlap is a J.D. candidate, May 2008, at American University’s Washington College of Law.
B. ERISA Preemption

Supreme Court decisions often turn on the Court’s interpretation of ERISA’s preemption clause. Section 514(a) of ERISA mandates the preemption of “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . .”23 The purpose of this section was to ensure uniformity in laws regulating ERISA benefit plans; however, Supreme Court decisions have led to the preemption of various state health care laws.24

i. Shaw v. Delta Airlines

In Shaw v. Delta, the Supreme Court considered whether ERISA preempted a New York human rights law that prohibited discrimination in employment, including discrimination based on sex or pregnancy.25 The law included pregnancy as a disability and required employer-provided coverage for pregnancy-related disabilities.26 Delta Airlines and various other airlines that provided health benefits to employees through plans subject to ERISA brought a federal declaratory judgment action against New York state claiming that ERISA preempted the state’s human rights and disability laws.27

The Supreme Court first looked to congressional intent regarding ERISA’s Section 514(a) preemption clause.28 In so doing, the Court took a textualist approach. Referring to Section 514(a)’s “relates to” language, the Court asserted that “[a] law ‘relates to’ an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.”29 The Court only looked to the plain language of New York laws and found that both laws related to plans for preemption purposes. Citing congressional intent, the Court reasoned that Congress could have decided to limit the preemption clause, leaving the Court to interpret the preemption clause as it saw fit; however, Congress failed to so act.30

Shaw virtually guaranteed ERISA preemption for state laws that regulated employee benefits.31 The Court’s interpretation of “relates to” preempted any state law that had any effect, even if indirectly, on employee benefit plans.32 One judge’s description of this broad interpretation as a “preemptive vortex that could swallow virtually any state remedial law” remained for years until the Court started to limit ERISA preemption.33

ii. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.

In New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Co., which challenged another New York law, the Supreme Court narrowed ERISA’s preemption power.34 New York required hospitals to take surcharges from patients covered by certain commercial insurers but did not require the same surcharge for Blue Cross/Blue Shield subscribers.35 Commercial insurers brought suit in federal district court seeking to invalidate the surcharge statute under ERISA.36 Consequently, the Court had to reassess the meaning of the “relates to” language of the preemption provision.37

As it had done in Shaw, the Supreme Court began its analysis by turning to the statutory language and congressional intent of Section 514(a).38 The Court first acknowledged the important presumption that “Congress does not intend to supplant state law,” thereby suggesting a narrower interpretation of Section 514(a) than in Shaw.39 Looking at the plain language of Section 514(a), the Court noted that “[i]f ‘relate to’ were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course, for ‘[r]eally, universally, relations stop nowhere.’”40

Finding the statutory language unhelpful, the Court examined the purpose of ERISA.41 Citing its own precedent, the Court held that Congress intended to ensure a “uniform body of benefits law” and to reduce the number of conflicting laws between states and/or between states and the federal government.42 Further, the Court distinguished the surcharge law at issue from the laws in Shaw, which related to ERISA, because they mandated certain coverage requirements, while the purpose and effect of New York’s surcharge law was different.43 Rather than mandating certain coverage requirements, the surcharge statute merely had an “indirect economic effect on choices made by insurance buyers,” by creating financial incentives to purchase a “Blues” plan over other commercial insurers.44

The Court thus found no grounds for ERISA preemption because the law only affected the costs of services – not the administration of ERISA plans or the uniformity of benefit plans.45 Recognizing that various factors affect cost, the Court rejected Delta Airline’s attempt at federal preemption because “nothing in the language of ERISA” indicated that Congress intended to “displace general health care regulation . . . .”; which traditionally had been controlled at a state and local level.46 Travelers’ limited view of preemption essentially provided state laws, which would not have survived under Shaw, some hope of survival.47 Nonetheless, ERISA preemption continues to prove a substantial obstacle to reform of state laws in health care.48
iii. California Division of Labor Standards of Enforcement v. Dillingham Construction

The Supreme Court continued its ERISA analysis in *California Division of Labor Standards of Enforcement v. Dillingham*, a California case involving a prevailing wage law that required contractors on public works projects to pay a lower wage to workers in unapproved apprentice programs. Two contractors argued that their apprenticeship programs were an “employee welfare benefit plan” qualifying as a plan under ERISA, which, according to the contractors, should preempt the prevailing California wage law. Relying on *Travelers* and other cases, however, the Supreme Court rejected this argument. The *Dillingham* Court applied a two-part test to determine if the law “related” to an ERISA plan: “if [the law] (1) had a connection to or (2) reference to such a plan” then it would be considered to relate to an ERISA plan. Similar to *Travelers*, the Court in *Dillingham* looked to congressional intent because a mere “uncritical literalism” application of this two-part test was insufficient to determine preemption. Accordingly, the Court compared California’s prevailing wage laws to the surcharge law in *Travelers* and found them indistinguishable. Similar to New York’s law in *Travelers*, California’s law did not “bind” ERISA plans to a certain structure, nor did it dictate the choices under the plan; it merely created incentives. The Court concluded “[w]e could not hold pre-empted a state law in an area of traditional state regulation based on so tenuous a relation without doing grave violence to our presumption that Congress intended nothing of the sort.”

iv. Egelhoff v. Egelhoff

Three years after *Dillingham*, however, the Court upheld federal preemption of a state law that could be characterized as having a “tenuous relation” with an ERISA plan. *Egelhoff* involved a Washington state statute that automatically revoked the designation of a spouse as a beneficiary of certain assets, including employee benefit plans, upon divorce. As the named beneficiary of his plan, Mr. Egelhoff’s ex-wife stood to collect his life insurance proceeds upon his death. Mr. Egelhoff’s children from a previous marriage sued, arguing their status as the true beneficiaries under Washington law.

Applying the framework of *Shaw*, *Travelers*, and *Dillingham*, which looked to the objectives of ERISA to determine if a state law “related to” an ERISA plan, the Court found that the Washington statute had an “impermissible connection” to ERISA. The *Egelhoff* Court distinguished this connection with a permissible “incidental effect” on ERISA, finding that the law went to a core element of ERISA – namely, regulating the payment of benefits. Further, the Court held that the Washington law would force administrators to learn the laws of every state before paying out benefits, which is the sort of administrative burden Congress intended ERISA to prevent.

In their dissent, Justices Breyer and Stevens noted that the Court should remember the “strong presumption against preemption” in this case because the Washington statute regulated family property law, which is an area of law traditionally dealt with exclusively by the states. The dissent did not find a distinction between non-preempted laws that might in some way burden administrators of plans (such as the laws in *Travelers* and *Dillingham*) and a law, such as the Washington law, that eased the administration of benefits and yet was preempted. In addition, the dissent warned that the majority’s logic could eventually lead to federal preemption in other areas traditionally left to states. Breyer and Stevens ultimately saw no conflict between this law and ERISA, and thus no reason to preempt it.

v. Retail Industry Leaders Association v. Fielder

In *Retail Industry Leaders Association v. Fielder*, the Fourth Circuit Court of Appeals struck down Maryland’s Fair Share Act aimed at forcing large employers in the state to pay a certain percent of revenue towards employees’ health care benefits. Faced with rising Medicaid costs, the Maryland legislature enacted this novel law to require employers with 10,000 or more employees to pay at least 8 percent of their payroll towards employee health benefits or pay the difference directly to the State. Because Wal-Mart employed 16,000 workers in Maryland, it was the only corporation affected.

In finding that ERISA preempted the Fair Share Act, the Fourth Circuit emphasized that ERISA’s “primary objective” was to “provide a uniform regulatory regime over employee benefit plans.” Citing the decision in *Shaw*, the Fourth Circuit found that ERISA preempted this law because it directly regulated “employers’ contributions to or structuring of their plans.” Although Wal-Mart technically had a choice in deciding whether to meet the 8 percent threshold, the Fourth Circuit stated that Wal-Mart’s only “rational choice” was compliance, which, in turn mandated how Wal-Mart structured its benefit plans. Additionally, the court found that this law interrupted Wal-Mart’s ability to administer a uniform national benefit plan and that this “spending mandate would clash” with

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other state laws, which is precisely what Congress intended to avoid with the enactment of ERISA.\(^3\)

Though Maryland argued that the main purpose of the Fair Share Act was to increase its Medical Assistance Program funds, the Fourth Circuit court decided that the law’s aim was to require employers to structure their benefit spending in a particular way.\(^4\) This structured how ERISA benefit plans could provide certain benefits and spend their money,\(^5\) which the Fourth Circuit characterized as impermissible under ERISA.\(^6\)

The dissent, however, began its analysis by noting the state’s extraordinary health care costs and characterizing the Fair Share Act as a legitimate response to what it viewed as a budgetary crisis.\(^7\) In its view, the law was seen as a reasonable response to Congress’ expectations that states would help with the growing costs of Medicaid and Medicare.\(^8\) The dissent found that the Act made no reference to ERISA, and more importantly, did not dictate choices of ERISA plans; rather, it merely created incentives for employers to spend on health care in a particular way.\(^9\)

Irrespective of the holding in Retail Industry Leaders, the case is an indication of things to come regarding how state laws regulate health care and ERISA preemption. In the aftermath of this decision, it is less certain whether states can in fact force employers to help cover the growing costs of health benefits.\(^10\) As a result, future reform will likely avoid the Fair Share Act model and states will have to create mere incentives, not mandates, for providers in order to survive ERISA preemption.\(^11\)

III. Analysis

Congress enacted ERISA for the narrow purpose of protecting individuals from the mismanagement of their pensions, not to “serve as a comprehensive federal health care regulation.”\(^12\) Yet despite ERISA’s original intent, it has significantly affected states’ abilities to enact substantial health care laws. Retail Industry Leaders serves as an additional example of a state legislature attempting to address a budget crisis by encouraging employers to share burdensome health care costs. While past court jurisprudence leaves room for states to remedy health care spending crises with laws that “relate to” ERISA, it remains unclear how the current Supreme Court might rule on a case similar to Retail Industry Leaders. If the Fourth Circuit was correct in its decision, then many other states’ laws will face the same ERISA preemption as Maryland’s Fair Share Act.

A. The Fourth Circuit Could Have Saved the Fair Share Act From Preemption

Given that Maryland enacted the Fair Share Act in response to a perceived state-wide health care crisis, the Fourth Circuit arguably could have decided against federal preemption. Under the Supreme Court’s line of ERISA cases and Retail Industry Leaders, the court could have found a more tenuous connection to ERISA plans, such as with the surcharge law in Travelers. Perhaps, the Fourth Circuit should have given more weight to a legitimate state response to its health care spending crisis. Further, the Act had repercussions in public health, an area of law traditionally regulated by states.\(^13\)

In Retail Industry Leaders, the Fourth Circuit first examined the scope of ERISA’s preemption provision and the “nature and effect” of the Act to determine whether it was preempted by ERISA. The Fourth Circuit emphasized that Congress enacted ERISA to “provide a uniform regime over employee benefit plans” and to reduce administrative burdens on plans of complying with many varying state laws.\(^14\) Under Shaw, the court next examined whether the Act “related[] to” an ERISA plan and, further, if this was the type of law that Congress intended to be preempted by ERISA.\(^15\)

Additionally, the Act allowed for uniformity of administration of employee benefit plans. As the dissent in Retail Industry Leaders stated, a problem might have existed if the Act “dictated a plan’s system for processing claims, paying benefits, or determining beneficiaries,” as the Court found happened in Egelhoff— but that did not occur.\(^16\) Instead, the only impact might have been a slight administrative inconvenience. For example, Wal-Mart may have had to report certain data about its Maryland employees and its spending on Maryland employees’ health care.\(^17\) This administrative burden is not enough to trigger ERISA preemption, but rather, amounts to an incidental inconvenience for employers to help defray rising health care costs.\(^18\)

The Fourth Circuit’s narrow approach failed to look at other jurisprudential guidance. Keystone Chapter Associated Builders & Contractors, Inc. v. Bell Telephone Co., a Third Circuit case, is instructive, in that the court looked at whether a state law’s effects on ERISA benefit plans “were optional or avoidable” under the statute.\(^19\) By upholding Pennsylvania’s Prevailing Wage Act, the Third Circuit found that the law survived “through means unconnected to ERISA plans.”\(^20\) While the Fourth Circuit could have contemplated this “optional or avoidable” approach, it instead summarily disposed of the issue of whether employers truly had a choice under the Fair Share Act. According to the Fourth Circuit, since adjusting a benefit plan to meet the 8 percent threshold would be a more logical choice for employers, rather than paying money to the State of Maryland, it really was the only choice.\(^21\) If the court had looked at whether the effects were avoidable, it may have decided that paying money to state was, arguably, a real option that permitted Wal-Mart to avoid changing the administration of its benefit plans.\(^22\)

Congress intended states to be “innovators[,]” to help curb the health care spending crisis.\(^23\) If more courts follow the logic of Retail Industry Leaders, many states will likely be restricted from reaching this kind of innovation. The dissent in Egelhoff is especially informative in explaining that ERISA analyses should begin with the presumption that Congress did not intend to entirely remove state power to legislate health care issues.\(^24\) This “pay or play” law was the first of its kind when the Maryland legislature first enacted it in 2006, though other states have since begun to enact similar laws.\(^25\) Ultimately, whether ERISA preempts a state law will depend on how carefully legislators design the law so as to avoid excessive interference with ERISA plans. Other attempts to force employers to share in the burden of health care costs could face preemption, especially if they resemble Maryland’s preempted Fair Share Act.

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The Act became widely known as the “Wal-Mart law,” which probably contributed to the Fourth Circuit’s rejection.1 In fact, the court called it a “stretch to claim” that the Act was a “revenue statute of general application.” The majority speculated that the Maryland legislature intended for Wal-Mart to be the only employer covered by the Act, especially since the Act automatically exempted other large employers in the state. Also, Giant Food stores already met the 8 percent threshold and a later amendment worked to exclude Northrop Grumman.9 The majority believed that the main purpose of Maryland’s law was to force large employers to provide a certain amount of health care benefits to employees rather than to raise money to defray health care costs.10 The fact that only Wal-Mart was affected was not sufficient to show this was the legislature’s intent. The law also specifically created the “Health Care Fund” to support Maryland’s Medical Assistance Program, which provides care for indigent individuals.10

B. How the Maryland Fair Share Act Might Survive ERISA Preemption

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The majority in Retail Industry Leaders also noted a lack of “meaningful alternatives” to adjusting benefit plans to comply with the law.101 Maryland had argued that employers could comply by contributing to employee health care in non-ERISA spending by contributing to employees’ Health Savings Accounts (HSAs). The majority rejected that proposition, opining that HSAs have limited availability, and that few Wal-Mart employees would likely make this election.102

In light of the Fourth Circuit’s decision, the Maryland legislature might somehow adjust the Act to allow for more employer options. The state could also pursue other alternatives to HSAs for increasing non-ERISA spending, such as on-site clinics.103 Furthermore, it might also help to build in more flexibility so that employers have a meaningful alternative to changing the structure of benefit spending. Maryland could further emphasize that the law’s core purpose is to defray its health care spending crisis. If other states can enact reforms that avoid the pitfalls of Retail Industry Leaders, then meaningful health care reform can exist at the state level.

IV. Reconciling State Reform with ERISA: Surviving Preemption

A. Massachusetts’ Universal Health Care Plan

In April 2006, the Massachusetts legislature passed, by a significant majority, a universal health care plan that would aim to insure 90-95 percent of uninsured residents – about 500,000 people.104 The law, which took effect in June 2007 is the first of its kind to require that all residents show proof of health insurance on their annual tax returns.105 Failure to comply will result in the loss of the personal income tax deduction and further penalties.106 The law also requires employers with ten or more employees to offer their employees health insurance or face annual assessments of $295 per employee.107

The Massachusetts law represents the result of extensive negotiations between businesses, health care providers, hospitals, and insurers in an attempt to force individuals and businesses to share responsibility for the costs of health care.108 The state will subsidize the purchase of insurance plans for individuals who fall between 100 and 300 percent of the poverty level by requiring those who are healthy and uninsured to share the risk.109 This sharing of risk involves spreading costs among a larger group of people and serves as a model of how insurance should function. Ultimately, the hope is that Massachusetts will be able to lower the costs of health care for all its residents.110

A key provision of the Massachusetts plan creates an “individual mandate” requiring every individual to purchase some form of coverage.111 The question of ERISA preemption still exists, however, for the “employer mandate” that requires employee-provided coverage. Anticipated revenues from this “penalty” are about $50 million, but $295 per employee is arguably an insignificant financial incentive for employers.112
There are a number of distinctions between the Massachusetts plan and Maryland’s Fair Share Act at issue in Retail Industry Leaders. First, the Massachusetts law is not aimed at one particular employer. The Fourth Circuit in Retail Industry Leaders emphasized that the law seemed to focus on one employer, Wal-Mart, and was not really focused on raising revenue.\textsuperscript{13} Many individuals involved in enacting the Massachusetts law believed that it “struck a balance” between businesses, insurers, and health care providers.\textsuperscript{14}

Moreover, the Massachusetts plan does not appear to represent an impermissible “connection with” ERISA. Unlike the Fair Share Act, the contribution of employers is just one element of insurance coverage rather than exclusively employer participation. Under Travelers and Dillingham, it is unlikely that the Massachusetts law would “relate to” ERISA plans. Similar to Travelers and Dillingham, the Massachusetts law does not refer to ERISA plans, and does not affect the uniformity of administering ERISA benefits to warrant preemption.\textsuperscript{15} At most, the annual penalty of $295 per employee could be characterized as a mere “incentive,” like the surcharge law in Travelers. Further, this low fee provides a legitimate alternative for employers who do not wish to provide or contribute to benefit plans for employees. Massachusetts’ law appears broad enough to survive ERISA preemption.\textsuperscript{16}

B. California’s Universal Health Care Plan

Notwithstanding the Massachusetts plan, California’s proposed universal health care plan might be the most extensive plan in the country. California’s plan attempts to cover every resident at a total cost of nearly $12 billion.\textsuperscript{17} There are about 6.5 million uninsured Californians (about 19 percent of its 36 million residents) – the highest number of uninsured in the country.\textsuperscript{18} The plan would require employers with ten or more employees to offer health care coverage or pay 4 percent of their payroll into a public health program intended to help cover the uninsured.\textsuperscript{19} Additionally, physicians would pay 2 percent, and hospitals 4 percent, of their revenues to help cover residents enrolled in the State Medicaid program, Medi-Cal.\textsuperscript{20}

In addition to likely challenges from health care industry lobbies, there are possible ERISA-preemption problems, as well, if the requirement on employers with ten or more employees to provide health insurance or pay 4 percent of their payroll is viewed as a mandate.\textsuperscript{21} The plan’s alternative to providing health insurance (the payment of 4 percent of payrolls to a state-wide fund) would also need to represent a viable choice for employers to avoid having an “unavoidable effect” on ERISA plans,\textsuperscript{12} especially since the lack of a reasonable choice for employers in Retail Industry Leaders was part of the Fourth Circuit’s reasoning to determine that ERISA preempted the Act.

Similar to the Massachusetts plan, California’s plan might survive preemption because it is clearly not intended to apply to any one particular employer in the state. Employers with ten or more employees include a large number of businesses. Also, employers under the plan have a viable alternative by paying 4 percent of total payrolls into a fund to help cover the uninsured. The California plan could also be construed as creating incentives for employers to provide health benefits to employees and not as a mandate, as the “indirect effect” language demonstrates an incentive rather than a mandate.\textsuperscript{22} Due to the broad applicability of this law, and the alternatives designed to incentivize employers to comply, the California law has a high likelihood of surviving any potential ERISA preemption.

C. Recommendations

As states begin addressing the growing costs of health care, it is important to design laws to avoid ERISA conflicts. Massachusetts and California seem to have designed laws broad enough to cover a wide-range of employers and might successfully avoid the problem the Maryland legislature had in Retail Industry Leaders. A state law that merely has an indirect economic effect on plans, like in Travelers, should also survive. As the Supreme Court emphasized in Travelers, a law will likely survive so long as it does not adversely impact the uniform administration of ERISA plans.\textsuperscript{124}

Despite past failures to amend ERISA, this still remains a valid objective.\textsuperscript{125} ERISA’s effect on health care appears to be partially unintended, since Congress initially enacted ERISA to regulate pension plans at a national level.\textsuperscript{126} If states could design laws to address health care needs without the looming threat of ERISA preemption, they could more effectively address the needs of their citizens, who ultimately bear the brunt of ERISA preemption. Because courts are limited in restricting ERISA preemption, Congress should revisit this law. In the 33 years since Congress passed ERISA, enough has changed to warrant amendments allowing state innovation in health care reform.

V. Conclusion

In 2016, spending on health care in America is expected to reach $4.1 trillion – roughly 20 percent of this country’s gross domestic product.\textsuperscript{127} In addition to rising health care costs, 16 percent of the population lacks health insurance.\textsuperscript{128} Whatever Congress intended ERISA to do with regard to health care, there is little question that ERISA represents a “substantial obstacle” to meaningful health care reform for states.\textsuperscript{129} If states want their health reform laws to survive ERISA preemption, then legislatures must draft legislation that is broadly applicable and not aimed at a particular employer.\textsuperscript{130} The president of the National Coalition on Health Care, Henry Simmons, aptly stated that: “[w]e can afford health-care reform . . . [w]hat we cannot afford is a continued failure to address the crisis in health care.”\textsuperscript{131} As health care costs and the number of uninsured increase, states must have the ability to address the health care needs of their residents. Given the potential ramifications and the jurisprudence on the issue, it is inconceivable that Congress would have intended ERISA to prevent states from achieving this goal.
1 29 U.S.C. §1001 et seq.
3 See Aaron S. Kesselheim & Troyen A. Brennan, The Swinging Pendulum: The Supreme Court Reverses Course on ERISA and Managed Care, 5 YALE J. HEALTH POL’Y L. & ETHICS 451, 454 (2005).
4 See Stempel & von Madenko, supra note 2, at 687-88.
8 See Solomon & Wessel, supra note 6, at A1.
9 See generally Kesselheim & Brennan, supra note 3, at 451 (pointing out that the importance of health care costs will only continue to rise as the population of the United States changes demographically).
12 See McOwen, supra note 5, at 41-42.
14 See id. at 535-37.
15 See Kesselheim and Brennan, supra note 3, at 453.
16 See id.
17 See Schmall & Stevens, supra note 13, at 535-36.
18 See generally id. at 538 (pointing out that ERISA “so broadly affects national health policy because almost all insurance, other than Medicare, is provided through employer plans”).
19 See id. at 542-43.
22 See Kesselheim & Brennan, supra note 3, at 455-56.
23 See 29 U.S.C. § 1144(a) (formerly §514(a)); see also Stempel & von Magdenko, supra note 2, at 699 (noting that this section is “often referred to as section 514 preemption” because that was the original code number; it is now codified as 29 U.S.C. §1144).
24 See Rich & Erb, supra note 16, at 242-43 (arguing that many attempts by states to regulate MCOs are very often preempted by ERISA as a result of the “adoption and continued strict application of this [ERISA] statute”); see also Elizabeth Barnidge, What Lies Ahead for ERISA’s Preemption Doctrine After a Judicial Call to Action is Issued in Actua Health Inc. v. Devila, 43 Hous. L. REV. 125, 134 (2006) (pointing out that the purpose behind § 514(a) was to “avoid multiple and conflicting state laws”).
26 See id. at 90.
27 See id. at 92.
28 See id. at 95.
29 See id. at 96-97.
30 See id. at 98-99 (pointing out that a narrower preemption clause had in fact been rejected by the Conference Committee).
32 See Barnidge, supra note 24.
33 Id. at 135 (quoting DiFelice v. Actua U.S. Healthcare, 346 F. 3d 442, 456-57 (3d Cir. 2003) (Becker, J. concurring)).
35 See id. at 649.
36 See id. at 651-52.
37 See id. at 649.
38 See id. at 655.
39 See id. at 654-55.
40 See id. at 655 (quoting Henry James, Roderick Hudson xiii (New York ed., World’s Classics 1980)).
41 See id. at 656.
42 See id. at 656-57 (quoting Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990)).
43 See id. at 658.
44 See id. at 659.
45 See id. at 660.
46 See id. at 661.
47 See id. at 456-57.
48 See Retail Indus. Leaders Ass’n v. Fielder, 475 F.3d 180 (4th Cir. 2007).
50 See id. at 322.
51 See id. at 334.
52 See id. at 325.
53 See id.
54 See id. at 330-31, 334.
55 Id. at 334.
57 See id. at 144.
58 See id. at 145.
59 See id. at 147.
60 See id. at 147-48.
61 See id. at 149-50.
62 See id. at 156-57 (Breyer, J., and Stevens, J., dissenting) (emphasis in original).
63 See id. at 158.
64 See id. at 159-60 (stressing the importance that “ERISA preemption analysis . . . respect the separate sphere of state authority”) (quoting Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987)) (internal quotations omitted).
65 See id. at 154.
66 475 F.3d 180 (4th Cir. 2007).
nyt&emc=rss (last visited Sept. 28, 2007).
68 See Retail Indus. Leaders Ass’n, 475 F.3d at 183.
69 See id. at 185 (stating that only four companies in Maryland employee at least 10,000 people: Johns Hopkins University, Giant Food, Northrop Grumman, and Wal-Mart; Johns Hopkins was excluded for being a non-profit, Giant Food met the 8 percent threshold, Northrop Grumman was excluded for technical reasons).
70 See id. at 191.
71 See id. at 192-93.
72 See id. at 193.
73 See id. at 194-95.
74 See id. at 194.
75 See id.
76 See id. at 193-94.
77 See id. at 198-99 (Michael, J., dissenting) (noting that in 2007 the projected spending on state Medicaid costs totaled $4.7 billion or 17 percent of the State’s total budget).
78 See id. at 201.
79 See id. at 202.
80 See Barbaro, supra note 67.
81 See id. (quoting Naomi Walker, director of state legislative programs at the AFL-CIO as saying “[s]tate level health care reform is still possible, but it’s not going to be the Maryland model . . . [w]e have to go back to the drawing board”).
82 See McOwen, supra note 5, at 73.
83 See generally id. at 64 (noting that the New York City Health Care Security Act, enacted to control the costs of health care in New York, should not be preempted by ERISA because it was clearly within the regulation of health, which is traditionally an area of state concern).
84 Retail Indus. Leaders Ass’n, 475 F.3d at 191 (quoting Actera Health Inc. v. Davila, 542 U.S. 200, 208 (2004) and Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990)).
85 See id.
86 See id. at 202 (Michael, J., dissenting) (citing Egelhoff, 532 U.S. at 147).
87 See id.
88 See id.
89 See McOwen, supra note 5, at 50.
90 See id. at 50.
91 Retail Indus. Leaders Ass’n, 475 F.3d at 193.
92 See id. at 195 (pointing out that an employer can avoid the 8 percent threshold required by the Fair Share Act by (1) increasing its spending on employee health care that do not qualify as ERISA plans or (2) paying the State of Maryland the amount which the employer’s spending fell short of the 8 percent threshold).
93 See id. at 200, 203-04 (Michael, J., dissenting).
94 See Egelhoff, 532 U.S. at 159-60. (Breyer, J., dissenting).
95 See McOwen, supra note 5, at 68, n. 168 (noting that the term “pay or play” is now widely used, and means that the employer can either pay the required amount to the State, or meet the required spending threshold—that is, “play”).
96 See Barbaro, supra note 67.
97 Retail Indus. Leaders Ass’n, 475 F.3d at 194.
98 See id. at 185, 194
99 See id. at 194.
100 See id. at 200 (Michael, J., dissenting) (citing MD. CODE ANN. HEALTH-GEN. § 15-1421; see also MD. CODE ANN. HEALTH-GEN. § 15-103(a)2).
101 See Retail Indus. Leaders Ass’n, 475 F.3d at 196.
102 See id.
103 See id. at 196 (arguing that on-site clinics are not a viable option for employers to increase health care spending because they only allow treatment of minor injuries).
104 See Altman & Doonan, supra, note 83.
105 See States’ New Health-Care Prescription, supra note 7.
107 See id.
109 See id. at 2094.
110 See id. at 2095.
111 Belluck, supra note 106.
112 See Robert Steinbrook, Health Care Reform in Massachusetts—A Work in Progress, 354 NEW ENG. J. MED. 2093, 2093 (2006), available at http://content.nejm.org/cgi/content/full/354/20/2095 (last visited Sept. 28, 2006) (noting that this portion of the law is the “fair share” portion; i.e. businesses are forced to pay their fair share of costs).
113 See 475 F.3d at 194.
114 Belluck, supra note 106.
115 See generally McOwen, supra note 5, at 48 (contending that part of the “connection” with inquiry must look at whether a state law is “optional or avoidable”).
116 See generally Solomon & Wessel, supra note 6, at A1 (hypothesizing that the Massachusetts law would probably survive ERISA preemption because the “overhaul is broad and not targeted at a single employer”).
117 See States’ New Health-Care Prescription, supra note 7.
119 See States’ New Health-Care Prescription, supra note 7.
120 See Steinhauser, supra note 119.
121 See States’ New Health-Care Prescription, supra note 7.
122 See Retail Indus. Leaders Ass’n, 475 F.3d at 193 (stating that “the only rational choice employers have under the Fair Share Act is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold”).
123 See Travelers, 514 U.S. at 659 (stating that the surcharge law merely had an “indirect economic effect on choices” made by plans, and did not “bind plan administrators to any particular choice”).
124 See id. at 657.
125 See Kesselheim & Brennan, supra note 3, at 455.
126 See Barnidge, supra note 24, at 131.
128 See McOwen, supra note 5, at 42.
129 See id. at 43.
130 See Solomon & Wessel, supra note 6.
131 See id.