

Pay or Play Programs and ERISA Section 514: Proposals for Amending the Statutory Scheme

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INTRODUCTION

Forty-seven million Americans lack health insurance, and public opinion polls demonstrate that the electorate is increasingly interested in government action to expand access to health care.¹ Much of the debate has focused on comprehensive national legislation to reform our health care system, but over the last five years state and local governments have taken important steps to ensure that their own citizens can obtain needed health care services. One type of state law, “pay or play” health care reform, places burdens on employers in order to expand the number of adults that receive health care through their workplace. In particular, seven state and local governments have adopted laws that require employers to either “pay” a tax that is used to provide public health care services or “play” by providing health insurance for their employees.²

These state and local reform projects from Massachusetts to San Francisco stand out as examples of at least potential success in a broken and deeply fractured health care system. As national leaders work to craft a federal reform project, the Massachusetts experiment is frequently cited as an example from which important lessons can be drawn. Reformers across the country continue to point to these efforts in their attempts to expand coverage in new places.³ But, at the same time, a largely unrelated federal statute places enormous obstacles in front of this major strategy toward achieving universal health insurance.

These state and local programs are threatened by federal preemption under section 514 of the Employee Retirement Income Security Act (ERISA).⁴ The language of ERISA explicitly disallows a broad cross-section of state law affecting employer-provided benefits, which affects state pay or play laws in

1. See Kaiser Family Foundation, Kaiser Health Tracking Poll – April 2009, <http://www.kff.org/kaiserpolls/posr042309pkg.cfm> (last visited Nov. 12, 2009).

2. The seven jurisdictions include Hawaii, Maryland, Massachusetts, Vermont, New York City, San Francisco, and New York’s Suffolk County. See HAW. REV. STAT. ANN. § 393-2 (LexisNexis 2004); Fair Share Health Care Fund Act, 2005 Md. Laws 3 (codified as amended at MD. CODE ANN., HEALTH-GEN. § 15-142 (LexisNexis 2007); MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to -107 (LexisNexis 2006)); An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts 77; An Act Relating to Health Care Affordability for Vermonters, 2006 Vt. Acts & Resolves 455; N.Y., N.Y., ADMIN. CODE § 22-506 (2009), available at <http://public.leginfo.state.ny.us> (follow “Laws of New York” hyperlink, then follow “ADC” hyperlink, then navigate to Title 22, Section 506); S.F., CAL., HEALTH CARE SECURITY ORDINANCE § 14.1-14.8 (2007); Retail Indus. Leaders Ass’n v. Suffolk County, 497 F. Supp. 2d 403 (E.D.N.Y. 2007) (describing the Suffolk County law).

3. Dawson Bell, *Democrats Test Water for Ballot Proposals*, DETROIT FREE PRESS, July 23, 2009, at A8, available at 2009 WLNR 15669318.

4. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 29 U.S.C.).

profound ways. Indeed, since its enactment in 1974, section 514—which contains ERISA’s broad preemption clause and complicated savings language—has become a case study in unintended legislative consequences.⁵ In 2006, courts concluded that a Maryland pay or play law was preempted by ERISA.⁶ Today, states continue to experiment with pay or play schemes designed to avoid ERISA preemption, and lawsuits that threaten their viability continue to make their way through the federal courts.

At the time of this writing, the Obama administration and the Democratic Congress appear well on their way toward achieving comprehensive national health care legislation.⁷ But national legislation will inevitably leave profound gaps in health care coverage—and we should look to states and localities to solve the remaining problems. One proposal circulated in the summer of 2009, for example, involved a federal mandate on individuals that required them to obtain health insurance, but no requirement on employers to contribute to their employees’ coverage.⁸ Of course, absent an amendment to ERISA, many state and local policymakers will continue to fear preemption and will face severe design constraints.

The negotiation of a national health insurance package provides an excellent opportunity to amend ERISA section 514. Scaling back ERISA preemption of state and local schemes is essential to achieving broad insurance coverage. More importantly, many of ERISA’s important stakeholders—unions, employers, indemnity insurers, and HMOs—will already be at the table to hammer out the particulars of the national health insurance bill. As this window of opportunity opens, this Note discusses the options for “fixing” section 514 to accommodate state and local schemes.

The central aim of this paper is to illustrate how section 514 might be amended in the coming years. That analysis requires an understanding of ERISA preemption and its relationship to pay or play laws. Part I introduces the debate by describing recent state experimentation with pay or play health insurance programs. It then turns to a brief overview of ERISA preemption jurisprudence and proceeds to outline the ways in which pay or play laws are inevitably ERISA-preempted. Part II embarks on the core analytic contribution of this Note, articulating and evaluating six different approaches that Congress could use to

5. See, e.g., Peter D. Jacobson, *Health Law 2005: An Agenda*, 33 J.L. MED. & ETHICS 725, 732 (2005) (calling ERISA an “interesting study in the doctrine of unintended consequences”).

6. *Retail Indus. Leaders Ass’n v. Fielder*, 435 F. Supp. 2d 481 (D. Md. 2006).

7. See Robert Pear, *Senator Takes Initiative on Health Care*, N.Y. TIMES, Nov. 12, 2008, at A18 (explaining that Obama “still considered health care a top priority, despite the urgent need to address huge problems afflicting the economy”).

8. See David Espo, *AP Sources: Senate Group Omits Employer Mandate*, ABC NEWS, July 27, 2009, available at <http://abcnews.go.com/Politics/wirestory?id=8180071>.

“fix” ERISA preemption of pay or play laws. The Note concludes with a brief comparison of the approaches offered.

I. ERISA PREEMPTION OF PAY OR PLAY LAWS

A. An Introduction to Pay or Play Health Care Reform

Health care regulation has long been an area of state dominance in America’s federalist system, and states have taken the lead in broad health care reform efforts.⁹ States have developed a number of approaches to expand their citizens’ access to health care—including public-private partnerships to develop insurance purchasing pools and creative leveraging of public funds in the Medicaid and State Children’s Health Insurance Program (SCHIP) programs—but the most comprehensive approaches focus on “pay or play” health reform, also called employer mandates.¹⁰ Under pay or play statutes, employers are given two options for every qualifying employee: either they can “pay” a state tax that subsidizes health care for the uninsured or they can “play” by providing that individual with health insurance coverage.¹¹ President Clinton’s proposed Health Security Act was a variation on the pay or play scheme, and employer mandates were a centerpiece of the Congressional reform proposals of 2009.¹²

As governments seek to expand health insurance coverage, employer mandates offer two primary advantages. First, they promise to build on the United States’ existing employer-based health system. With more than eighty percent of Americans insisting they are satisfied with their existing health insurance, health reformers must find a way to introduce change without

9. See, e.g., Eleanor D. Kinney, *Clearing the Way for an Effective Federal-State Partnership in Health Reform*, 32 U. MICH. J.L. REFORM 899, 899 (1999); Arthur Birmingham LaFrance, *Healthcare Reform in the United States: The Role of the States*, 6 SEATTLE J. FOR SOC. JUST. 199, 199 (2007).

10. See AMANDA BRODT ET AL., STATE COVERAGE INITIATIVES, STATE OF THE STATES: BUILDING HOPE, RAISING EXPECTATIONS 20-27 (2007), available at <http://www.rwjf.org/files/publications/other/StateoftheStates2007.pdf> (discussing various reform initiatives).

11. See PATRICIA A. BUTLER, NAT’L ACAD. FOR STATE HEALTH POLICY, REVISITING PAY OR PLAY: HOW STATES COULD EXPAND EMPLOYER-BASED COVERAGE WITHIN ERISA CONSTRAINTS 4 (2002), available at http://www.nashp.org/sites/default/files/ERISA_Pay_Or_Play.pdf (defining “pay or play”).

12. See, e.g., H.R. 3962, 111th Cong. §§ 411-15 (2009) (describing the employer mandate in one 2009 proposal); Kevin Fickenscher & David Kindig, *Elements of the American Health Security Act of 1993*, PHYSICIAN EXECUTIVE, Nov.–Dec. 1993, at 4 (describing the pay or play aspects of the Health Security Act).

fundamentally rocking the boat for a “satisfied majority.”¹³ Pay or play, of course, entrenches employer provided insurance, helping to ensure that things remain largely unchanged for the employer-insured population. Second, pay or play offers governments a way to expand coverage by spreading the financial burden across the private sector. By asking employers to shoulder a significant percentage of the costs of health reform, employer mandates can control the public price tag for expanded coverage. Critics of pay or play programs, on the other hand, emphasize the burden that mandates place on small businesses,¹⁴ the long-term impact on employment prospects, and the failure of mandates to tackle unsustainable growth in health insurance premiums.¹⁵

Pay or play programs vary along several dimensions. The two most important variations are: 1) the type of employer actions that qualify as “playing,” and 2) the amount of the required payment should an employer choose to “pay.” Recently enacted employer mandates in Massachusetts and San Francisco illustrate this variation.¹⁶ In particular, Massachusetts sets a very high bar for qualifying health coverage, requiring “a group health plan . . . to which the employer makes a fair and reasonable premium contribution.”¹⁷ The “play” option is thus limited to employers who offer subsidized insurance plans that meet substantive standards. Employers who fail to meet this requirement, however, are charged a very small fee: no more than \$295 per employee per year, ten percent of the average cost of qualifying coverage.¹⁸ San Francisco, by contrast, defines “playing” in very broad terms—employers must spend \$1.76 per employee-hour on health related costs, including everything from providing

13. See Rob Stein & Alexi Mostrous, *Debate Focuses on Satisfied Majority*, WASH. POST, July 28, 2009, at A4.

14. See, e.g., Robert J. Landry, III & Amy K. Yarbrough, *Global Lessons from Consumer Bankruptcy and Healthcare Reforms in the United States: A Struggling Social Safety Net*, 16 MICH. ST. J. INT'L L. 343, 363 (2007); Lin Lin, Note, *All Is Well in Massachusetts? Diagnosing the Effects of the 2006 Employer Mandate on Health Care Reform Efforts*, 25 J. CONTEMP. HEALTH L. & POL'Y 406, 410 (2009).

15. See, e.g., Landry & Yarbrough, *supra* note 14, at 363.

16. See generally An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts 77; S.F., CAL., HEALTH CARE SECURITY ORDINANCE § 14.1-14.8 (2007).

17. § 47, 2006 Mass. Acts at 115 (limiting employer contribution to the use of traditional group health plans, not other tools like health savings accounts, direct reimbursement of employee medical expenses, etc.).

18. § 44, 2006 Mass. Acts at 111; see also KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2009 ANNUAL SURVEY 14 (2009), available at <http://ehbs.kff.org/pdf/2009/7936.pdf> (showing that average cost of employer-provided insurance for an individual is \$4824); Amy B. Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 U. KAN. L. REV. 1203, 1214 (2007) (noting the weakness of a \$295 cap).

traditional insurance to reimbursing employees directly for doctor's visits.¹⁹ Employers who fall short must make up the difference up to the full \$1.76 per employee-hour (or \$3660 per year for a full-time employee) into a city fund dedicated to the provision of health care.²⁰

Other state laws illustrate even greater diversity. Maryland's statute considered only employers' *total* spending on health expenditures, without regard to the expenditure on particular employees.²¹ Other states have counted employers' charitable contributions to community clinics or investments in on-site employee health facilities towards their health care expenditures.²² And the payment requirements are no more uniform. Some are assessed as a tax²³ and others as a fine.²⁴ Massachusetts actually assesses a variable payment based on each employer's "share" of the state's uncompensated care fund, and that share is calculated based on actual utilization of free care by individuals that work for each employer.²⁵ Thus, pay or play should be conceptualized as a general framework for involving employers in health care funding, which affords governments wide latitude to define program requirements.

To date, seven different state and local laws embodying pay or play requirements have been enacted. Hawaii enacted the country's first employer mandate in 1974, which requires employers to pay one half of their employees' health insurance costs.²⁶ In 2006, Maryland made headlines with its so-called "Walmart law," officially known as the Fair Share Act, which required private employers with 10,000 or more employees to spend eight percent of their total payroll on health insurance.²⁷ Though the statutory language targeted all large employers, in practice, Walmart was the only covered employer who was not making an adequate contribution to employee health care. Later that year, two New York local governments—Suffolk County and New York City—adopted local pay or play ordinances, requiring large retail stores to make health care

19. S.F., CAL., HEALTH CARE SECURITY ORDINANCE § 14.1.

20. *Id.*

21. See MD. CODE ANN., LAB. & EMPL. § 8.5-104 (LexisNexis 2006).

22. See, e.g., Retail Indus. Leaders Ass'n v. Suffolk County, 497 F. Supp. 2d 403, 416-17 (E.D.N.Y. 2007).

23. See HAW. REV. STAT. ANN. §§ 393-2, 393-31 (LexisNexis 2004) (vesting the Director of Internal Revenue with enforcement authority).

24. See N.Y., N.Y., ADMIN. CODE § 22-506 (2009), available at <http://public.leginfo.state.ny.us> (follow "Laws of New York" hyperlink, then follow "ADC" hyperlink, then navigate to Title 22, Section 506).

25. See An Act Providing Access to Affordable, Quality, Accountable Health Care § 47(c)(1), 2006 Mass. Acts 77, 116. The statute also caps the required contribution at \$295 per employee. § 47(c)(10), 2006 Mass. Acts at 117.

26. Standard Oil Co. of Cal. v. Agsalud, 633 F.2d 760, 760 (9th Cir. 1980).

27. MD. CODE ANN., LAB. & EMPL. § 8.5-104(b) (LexisNexis 2006).

contributions. The Massachusetts and San Francisco programs described above are the highest profile recent excursions into pay or play laws. Vermont has also implemented a plan that is similar to the Massachusetts program.²⁸ The Michigan Democratic Party recently announced that they were considering an employer mandate-based ballot initiative for the fall of 2010,²⁹ and advocates continue to prod large states to explore pay or play reforms.³⁰

Indeed, it is clear that pay or play health care reform offers state and local governments a flexible tool for shrinking the ranks of the uninsured and improving access to health care for their citizens. Moreover, employer mandates are now a staple of all comprehensive reform discussions.³¹ However, as we shall see in the next section, these laws are extremely vulnerable to challenges of federal preemption under ERISA. We turn to a brief overview of the contours ERISA jurisprudence in Section I.B, before applying these concepts to pay or play laws in Section I.C.

B. ERISA Preemption in the Courts

In the main, the Employee Retirement Income Security Act (ERISA) provides a comprehensive federal scheme regulating benefits that employers provide to their employees. The statute's regulatory scheme governs two broad categories of employee benefits: "pension plans," which provide income to employees after their retirement, and "employee welfare benefit plans," which offer short-term benefits like health or life insurance to employees.³² The law was intended to balance the needs of labor and management, offering employees a regulatory regime that would ensure access to promised benefits, while ensuring that employers would be bound by a set of uniform national laws rather than a patchwork of state pension regulations. This tradeoff required Congress to enact an explicit preemption clause, barring state law from regulating pensions and benefits.³³

28. STATE OF VT. AGENCY OF ADMIN., OVERVIEW OF VERMONT'S HEALTH CARE REFORM I (2008), available at http://hcr.vermont.gov/sites/hcr/files/Revised_Vermont_HCR_Overview_October_08__0.pdf.

29. See Dawson Bell, *Democrats Test Water for Ballot Proposals*, DETROIT FREE PRESS, July 23, 2009, at A8, available at 2009 WLNR 15669318.

30. See BRODT ET AL., *supra* note 10, at 1.

31. See, e.g., *id.* at 34.

32. See JOHN H. LANGBEIN, SUSAN J. STABILE & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW 89-90 (4th ed. 2006).

33. Federal preemption of state law can be either express (federal legislation explicitly states that state law is preempted) or implied (legislation is silent but state and federal law cannot logically coexist). Implied preemption is further divided into two categories, conflict and field preemption. Conflict preemption refers to those cases where it is simply impossible to comply with

It is that preemption clause that threatens to swallow up states' health care reform efforts. In now-infamous language, ERISA subsection 514(a) announces the scope of federal preemption of state law in broad terms: ERISA regulation "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described [in the Act]."³⁴ Interpretation of section 514 has turned on the contours of the phrase "relate to," and nearly thirty years of jurisprudence illustrate the difficulty of defining the scope of that term.

The overbroad language of subsection 514(a) is complicated by a series of exceptions (and exceptions to the exceptions) that have important implications for health insurance benefits. First, subsection 514(b), known as the "savings clause," importantly narrows the law's preemptive scope by saving from preemption "any State [law] which regulates insurance, banking, or securities."³⁵ Recognizing the potentially broad reach of the preemption language, Congress carved out a few distinct spheres where state regulation would be permitted—insurance, banking, and securities. But in the next subparagraph, known as the "deemer clause," Congress immediately and sharply limited the extent of the insurance/banking/securities exception. That language declares that no "employee benefit plan . . . shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company" that is subject to a state's insurance, banking, and security regulations.³⁶ Put more concretely, the deemer clause says that if an ERISA-regulated employee benefit plan does things that make it "look like" an insurance company or a bank, it is nonetheless exempt from state regulation in this area. The most relevant example is large employers who "self-insure" their employees. The self-insurance fund is covered by the statute as an ERISA plan. Thus, although these ERISA plans perform exactly the same functions as a health insurance company (paying for some but not all employee/enrollee medical expenses), the deemer clause exempts them from state regulations that apply to the rest of the insurance market.³⁷

state and federal requirements simultaneously (e.g., state law requires pension information to be presented by union representatives, but federal law requires the information be provided only by the employer). Field preemption refers to situations where it is technically possible to comply with both state and federal law, but courts determine that the federal government intended to occupy the entire "field" and displace state law (e.g., state law requires pensions to vest after a term of ten years or less, federal law requires pensions to vest after a term of fifteen years or less—while it is possible to satisfy the state law without violating the federal law, field preemption principles might dictate that the federal law ought to override the state). These concepts often overlap; for example, an express preemption clause that speaks to some but not all issues can be used to guide courts in understanding the proper scope of field preemption.

34. 29 U.S.C. § 1144(a) (2006).

35. *Id.* § 1144(b)(2)(A).

36. *Id.* § 1144(b)(2)(B).

37. See generally Russell Korobkin, *The Failed Jurisprudence of Managed Care*, 51 UCLA L.

To further complicate the statutory scheme, section 514 contains a number of other exceptions and clarifications, most of which are not relevant here.³⁸ In 1982, Congress added an important exemption applicable only to the State of Hawaii: After the Supreme Court held that Hawaii's pay or play health care reform program was ERISA preempted,³⁹ Congress specifically exempted the Hawaiian law from preemption.⁴⁰ The exemption is narrow, however, and only covers the Hawaii law as it existed in 1974, when ERISA was first enacted.⁴¹

Finally, ERISA's broad preemption language is, quite logically, not applicable to plans that are not regulated by ERISA. Section 403(b)(3) of the Act explicitly excludes from regulation any plan "maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws."⁴² In this provision, Congress recognized that, while some employers voluntarily provided generous benefits associated with workplace injuries or layoffs, state governments were actively involved in ensuring a minimum level of protection through workers' compensation or unemployment benefit schemes. Thus, ERISA regulation does not apply to plans maintained "solely" to comply with these state law requirements, and the relevant state laws are not ERISA preempted. This "compliance plan" exception is decidedly under-theorized, but is nonetheless a part of the ERISA preemption landscape.⁴³

With this background in the statutory framework, I turn to ERISA preemption as it has been shaped by the Supreme Court. The discussion briefly illustrates the Court's initial approach, then offers a description of recent jurisprudence.

REV. 457, 486-88 (2003) (discussing the problem of "self-insured employers").

38. "[G]enerally applicable criminal law[s]" are not preempted by the broad language of 514(a), nor are "qualified domestic relations orders" or state tort actions dealing with the recoupment of some funds under Medicaid programs. 29 U.S.C. § 1144(b)(4), (b)(7), (b)(8) (2006).

39. See *Agsalud v. Standard Oil Co. of Cal.*, 454 U.S. 801 (1981), *summarily aff'g* *Standard Oil Co. of Cal. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980).

40. See Pub. L. No. 97-473, § 301, 96 Stat. 2605, 2611 (1983) (codified at 29 U.S.C. § 1144(b)(5) (2006)).

41. See 29 U.S.C. § 1144(b)(5)(B)(ii) (2006).

42. 29 U.S.C. § 1003(b)(3) (2006).

43. A Westlaw search for works in the legal academy discussing the section of the code revealed several dozen articles discussing the existence of the compliance plan exception, mostly in the context of entities that are exempt from malpractice litigation, but only one article exploring this section of the preemption clause as a potential policy tool. See James E. Holloway, *Revisiting Cooperative Federalism in Mandated Employer-Sponsored Health Care Programs Under the ERISA Preemption Provision*, 8 QUINNIPIAC HEALTH L.J. 239, 268-69 n.207 (briefly discussing the compliance exemption and listing the handful of relevant cases).

1. Early Preemption Doctrine

ERISA preemption analysis begins with the statute's broad displacement of state laws that "relate to" ERISA-regulated benefits. Indeed, the first fifteen years of the Supreme Court's ERISA preemption jurisprudence were characterized by a rather literal interpretation of the phrase "relate to" that rendered preemption of state law "nearly automatic."⁴⁴ In 1981, the Court decided its first case, *Alessi v. Raybestos-Manhattan, Inc.*, which involved a New Jersey law that prevented employers from reducing pension plan benefits because of a workers' compensation award.⁴⁵ A unanimous Court easily concluded that the law was preempted.⁴⁶ But, foreshadowing decades of unpredictable and often bizarre jurisprudence, the Court acknowledged that the "relate to" language engendered "some confusion" when the state law at issue affects ERISA plans only indirectly.⁴⁷

In *Shaw v. Delta Air Lines, Inc.*, the Court held that ERISA preempted a state law requiring that employee benefit plans cover pregnancy disability.⁴⁸ The Court expounded on the scope of preemption when state law had an indirect effect on ERISA-regulated subjects, saying, "A law 'relates to' an employee benefit plan . . . if it has a *connection with* or *reference to* such a plan."⁴⁹ It is not abundantly clear that "connection with" provides substantially more guidance to lower courts than 514(a)'s "relate to" language, but the "connection with or reference to" test quickly became black letter law.⁵⁰ Importantly, the *Shaw* Court acknowledged that a law "may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant" preemption,⁵¹ carving out a possible exception to their otherwise broad holding.

Nonetheless, in subsequent cases the Court relied on the "connection with or reference to" standard to conclude that numerous state laws were preempted by the federal scheme. State laws mandating coverage of mental health benefits,⁵² providing a cause of action for bad faith claim denials,⁵³ regulating benefit plan

44. Edward A. Zelinsky, *Travelers, Reasoned Textualism, and the New Jurisprudence of ERISA Preemption*, 21 CARDOZO L. REV. 807, 808 (1999).

45. 451 U.S. 504 (1981).

46. *Id.* at 505.

47. *Id.* at 523.

48. 463 U.S. 85 (1983).

49. *Id.* at 96-97 (emphasis added).

50. See LANGBEIN ET AL., *supra* note 32, at 770.

51. *Shaw*, 463 U.S. at 100 n.21.

52. *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724 (1985). The Court held that the law at issue "relate[d] to" ERISA plans, but was nonetheless saved by the insurance exemption. *Id.* at 746.

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

treatment of tort suit awards,⁵⁴ and governing benefit provision to workers' compensation beneficiaries⁵⁵ were held preempted. A handful of state laws were saved from ERISA preemption, including a generally applicable state garnishment statute⁵⁶ and a state law requiring one-time severance payments to laid-off workers.⁵⁷

The Court's opinion in *Ingersoll-Rand Co. v. McClendon*⁵⁸ is emblematic of its post-*Shaw* jurisprudence. The plaintiff in that case claimed that his employer discharged him only to prevent his pension plan from vesting, which would constitute wrongful termination under state law. The Court held that the state common law claim was preempted by ERISA.⁵⁹ The holding reaffirmed the idea that a state law that only indirectly affected an ERISA-plan could nonetheless be preempted.⁶⁰ Additionally, the Court emphasized that the state law claim depended on the *existence* of a plan in order to determine liability.⁶¹ The state law was not the kind of "generally applicable statute that . . . functions irrespective of . . . an ERISA plan,"⁶² because the law only made sense in a world of employee benefit plans. Therefore, even though the state law did not place burdens on plans *qua* plans, and instead imposed burdens on employers who had plans, it was still the kind of state requirement that manifested an inappropriate "connection with or reference to" ERISA.

In sum, under the Court's initial approach, section 514 broadly preempted state law. One scholar has characterized the tortured scope of ERISA preemption, noting that state law was preempted "even if such laws [were] 'not specifically designed to affect' ERISA plans, [and] even if the effect . . . '[was] only indirect.'"⁶³ As the cases described above illustrate, ERISA section 514 presented "one of the broadest preemption clauses ever enacted by Congress."⁶⁴

54. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

55. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992).

56. *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988). In a rather ironic holding, the Court applied the "reference to" test to preempt a small portion of the state statute. Georgia, in language clearly designed to avoid ERISA preemption, announced that the law did not apply to a "plan or program subject to ERISA," but the Court concluded this clause was preempted as an impermissible reference. *Id.* at 829-30.

57. *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987). The Court held that this one time payment was not a "plan" within the meaning of ERISA.

58. 498 U.S. 133 (1990).

59. *Id.* at 137.

60. *Id.* at 139.

61. *Id.*

62. *Id.*

63. *Zelinsky*, *supra* note 44, at 829 (quoting *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992)).

64. 953 F.2d 543, 545 (9th Cir. 1992) (citing *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437,

2. Travelers and Recent Jurisprudence

Throughout the early- and mid-1990s, commentators,⁶⁵ lower courts,⁶⁶ and even Supreme Court Justices⁶⁷ began to express frustration with the state of ERISA preemption jurisprudence. By 1995, the Court was prepared to revisit its approach to section 514.

In *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, the Court fundamentally altered its interpretation of section 514.⁶⁸ Justice Souter's unanimous opinion admitted some frustration with "uncritical literalism" in applying the "connection with or reference to" test, but did not technically overrule or even limit *Shaw*, *Ingersoll-Rand*, or any of the Court's prior section 514 decisions.⁶⁹ Nonetheless, *Travelers* is widely understood to have created a "sea change" in ERISA preemption doctrine.⁷⁰

At issue in the case was a New York state law that levied surcharges against all payers of hospital bills, except Blue Cross/Blue Shield plans.⁷¹ The law undoubtedly had an indirect effect on employee benefit plans, since their employees' medical costs were subject to the surcharge if the employer's ERISA plan self-insured or used conventional commercial insurance, but not if the plan elected Blue Cross/Blue Shield coverage. Yet the Court upheld the New York law.⁷² While the surcharge had "an indirect economic effect" on ERISA plans, it did not actually "bind plan administrators" to a particular design choice.⁷³ Nor did it "preclude uniform administrative practice"⁷⁴ since the administrative burden fell to the hospitals, not the plan. Thus, there was no impermissible connection with an ERISA plan in the law.

1439 (9th Cir. 1990)).

65. See, e.g., Gabrielle Lessard, *Conflicting Demands Meet Conflict of Laws: ERISA Preemption of Wisconsin's Family and Medical Leave Act*, 1992 WIS. L. REV. 809, 822-23.

66. See, e.g., *Gast v. State*, 585 P.2d 12, 23 (Or. Ct. App. 1978).

67. In a 1992 dissent, Justice Stevens encouraged the Court "to take a fresh look" at ERISA preemption. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 135 (1992) (Stevens, J., dissenting).

68. 514 U.S. 645 (1995).

69. *Id.* at 656.

70. See, e.g., *Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr.*, 154 F.3d 812, 815 (8th Cir. 1998) (internal quotation marks omitted); see also Robert F. Rich, Christopher T. Erb & Louis J. Gale, *Judicial Interpretation of Managed Care Policy*, 13 ELDER L.J. 85, 92 (2005) ("[I]n the seminal case of *Travelers* the Court initiated what many today perceive to be a sea change in ERISA preemption policy and interpretation.").

71. *Travelers*, 514 U.S. at 649-50.

72. *Id.* at 650.

73. *Id.* at 659.

74. *Id.* at 660.

Subsequent cases generally followed this approach, and in particular picked up on the *Travelers* emphasis on state laws that “bind plan administrators” to particular choices. In *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, the Court considered a state law affecting apprenticeship programs, which are ERISA plans.⁷⁵ California allowed contractors to pay lower wages to apprentices in state-approved programs, thereby creating an incentive for apprenticeship programs to seek state approval. The *Dillingham* Court insisted that the state law was no more than an incentive and was not preempted by ERISA; it did not “bind ERISA plans to anything,” nor was it “tantamount to a compulsion.”⁷⁶ In much-quoted language, the Court concluded that the law was permissible because it “alters the incentives, but does not dictate the choices” of ERISA plans.⁷⁷

The Court’s next ERISA case dealt with a state law that acted directly (as opposed to indirectly) on an ERISA plan. In *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, the Court upheld a New York law that imposed a general tax on health care facilities.⁷⁸ The law was challenged by an ERISA plan that administered its own health care facility subject to the tax.⁷⁹ Acknowledging that this law certainly had “some [direct] effect on the administration of ERISA plans,” the Court nonetheless concluded that it was not preempted by 514(a).⁸⁰ The Court described the statute as “one of myriad state laws of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not relate to them.”⁸¹ In the context of the relevant state statute and the accumulated ERISA jurisprudence, there may be some logic to this formulation. But it makes clear the linguistic absurdity in the post-*Travelers* cases: it is truly remarkable to conclude that a “burden” is “unrelated” to the object that shoulders it.⁸²

The descriptions above highlight only a few of the Court’s recent section 514 cases, and they neglect a great deal of nuance in the cases presented. But they do illustrate several themes that are important for understanding preemption of state “pay or play” laws. First, consider the Court’s emphasis on “alter[ing] the incentives” versus “dictat[ing] the choices facing ERISA plans,” which was most

75. 519 U.S. 316 (1997).

76. *Id.* at 332, 333.

77. *Id.* at 334.

78. 520 U.S. 806 (1997).

79. *Id.* at 809.

80. *Id.* at 816.

81. *Id.* at 815 (internal citations and quotation marks omitted).

82. *Cf. Zelinsky, supra* note 44, at 808 (deploring ERISA preemption jurisprudence that shows no “regard for the terms of the statute”).

clearly articulated in *Dillingham* but has its conceptual origin in *Travelers*.⁸³ Indeed, this formulation of the “test” for ERISA preemption has received a great deal of attention in the legal literature,⁸⁴ including the literature on preemption of pay or play schemes.⁸⁵ Under this approach, state laws are evaluated based on the extent to which they coerce, rather than merely incentivize, ERISA plans in order to promote desired outcomes.

But a second theme, less prominently articulated but similarly originating in *Travelers*, also underlies these cases: the locus and nature of the administrative burden associated with the state law is important. Thus, in *Travelers* the Court emphasized that New York’s hospital surcharge law did not interfere with “uniform administrative practice” for ERISA plans.⁸⁶ The law’s administrative burden instead fell to hospitals, not to an ERISA-covered entity. Justice Thomas has built on this theme, emphasizing that one impermissible law required ERISA plans to be changed to comply with the state’s requirement.⁸⁷ Clearly, that action might impair national uniformity.⁸⁸ In this view, state laws are evaluated based on the extent to which they actually “touch” ERISA plans, regardless of whether those touches are “coercive.” Indeed, this sort of analysis begins to look more like implied preemption jurisprudence, essentially ignoring the preemption clause and instead focusing on the actual effect that fifty unique state regimes might have on a federally-regulated entity.⁸⁹

83. See *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 334 (1997); *N.Y. Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659 (1995) (“An indirect economic influence, however, does not bind plan administrators to any particular choice . . .”).

84. See, e.g., Jeffrey A. Brauch, *Municipal Activism v. Federal Law: Why ERISA Preempts San Francisco-Style Domestic Partner Ordinances*, 28 SETON HALL L. REV. 925, 947, 962 (1998); Larry J. Pittman, *ERISA’s Preemption Clause: Progress Towards a More Equitable Preemption of State Laws*, 34 IND. L. REV. 207, 214-20 (2001); Alice T. Armstrong, Comment, *ERISA Preemption of “Any Willing Provider”: The Eighth Circuit Got It Right*, 7 GEO. MASON L. REV. 753, 769-73 (1999); Meridith H. Bogart, Note, *State Doctrines of Substantial Compliance: A Call for ERISA Preemption and Uniform Federal Common Law Doctrine*, 25 CARDOZO L. REV. 447, 465-66 (2003).

85. See, e.g., Monahan, *supra* note 18, at 1209-10; Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption and Experimentation*, 49 WM. & MARY L. REV. 229, 251-52 (2007).

86. *Travelers*, 514 U.S. at 660.

87. See *Egelhoff v. Egelhoff*, 532 U.S. 141, 150-51 (2001).

88. *Id.* at 152.

89. Justice Scalia and Justice Ginsburg, in a pair of concurring opinions, have called upon the Court to do exactly this—abandon much of the section 514(a) jurisprudence, and hold that the statute’s preemptive scope is precisely congruent with traditional field and conflict preemption. *Id.* at 152 (Scalia, J., concurring); *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr.*,

Finally, these cases underscore that the “connection with or reference to” framework survived the *Travelers* revolution. *Travelers*, *Dillingham*, and *DeBuono* all open by affirming this approach.⁹⁰ Thus, while *Shaw*’s “nearly automatic” approach to preemption is no longer good law, section 514 cases still develop quite deliberately by looking for “connections” and “references.” Moreover, much of the pre-*Travelers* thinking is still reflected and cited.⁹¹ For this reason, cases like *Ingersoll-Rand* are relevant to the preemption landscape, even if their precise interpretative approaches no longer reflect the Court’s thinking.⁹²

To summarize, ERISA preemption jurisprudence began with a decade in which state laws that had only the most indirect and tangential effects on ERISA-regulated subject matter were nonetheless held preempted. The Court changed course in 1995 with *Travelers*, and began to chaotically and somewhat unpredictably scale back on the scope of federal preemption. In subsequent cases, the Court appeared to focus on two kinds of issues—the extent to which state law compelled (rather than merely encouraged) ERISA plans to operate in particular ways, and the magnitude and locus of the administrative burdens. Indeed, in the last fifteen years, ERISA preemption has changed drastically, though the Court has yet to formally renounce its earlier decisions.

C. ERISA Preemption of Pay or Play Programs

These broad outlines frame potential ERISA preemption of state pay or play laws. And there is reason to be pessimistic: some observers have flatly concluded that it is “hard to envision significant state experimentation with medical coverage that does not run afoul” of ERISA’s preemption clause,⁹³ and that all employer mandates “are preempted by ERISA.”⁹⁴ Indeed, as explained below, despite the Court’s somewhat relaxed post-*Travelers* approach, it is fairly clear that state attempts to mandate employer health insurance programs generally constitute impermissible and ERISA-preempted governance of employee benefit plans.

N.A., Inc., 519 U.S. 316, 334 (1997) (Scalia, J., concurring). For a discussion of field and conflict preemption, see *supra* note 33.

90. See *Egelhoff*, 532 U.S. at 149; *Dillingham*, 519 U.S. at 323; *Travelers*, 514 U.S. at 623.

91. See generally Robert N. Covington, *Amending ERISA’s Preemption Scheme*, 8 KAN. J.L. & PUB. POL’Y 1, 9 (1999) (“Is there really a new order under ERISA? Answer: ‘Yes, BUT . . .’”).

92. See, e.g., *Egelhoff*, 532 U.S. at 149-50 (citing *Ingersoll-Rand* for the proposition that fifty dissimilar state laws would pose too steep an administrative burden on ERISA plans).

93. See Zelinsky, *supra* note 85, at 286.

94. Michael H. Bernstein & John T. Seybert, *You Can’t Get There from Here: Erisa Preemption of State Laws Mandating Employer Healthcare Contributions*, 3 ABA HEALTH ESOURCE, Mar. 2007, <http://www.abanet.org/health/esource/Volume3/07/bernstein-seybert.html>.

Courts have addressed ERISA preemption of four of the seven state and local statutes described above. Laws in Suffolk County and Maryland have been held ERISA preempted,⁹⁵ and the Supreme Court's holding that Hawaii's law was preempted led to a special congressional exception.⁹⁶ In the only ERISA opinion that has been favorable to a pay or play law, the Ninth Circuit held that San Francisco's program survived ERISA preemption; the case has been appealed to the Supreme Court.⁹⁷ New York City's law has not been challenged and remains on the books, but has not been enforced due to conflict between the mayor and city council regarding the permissibility of the statute under ERISA.⁹⁸ Meanwhile, the Massachusetts and Vermont laws have not been subject to judicial review and are currently being implemented.

As explained above, the Court's ERISA preemption jurisprudence has been anything but coherent. Therefore, it is useful to trace a number of themes that appear in the pay or play cases: exploring the dictated choices versus altered incentives framework, locating administrative burdens, and relying on the existence of an ERISA plan. These themes repeatedly appear in the reported opinions that have considered ERISA preemption of pay or play laws, and the laws that have escaped preemption challenges are vulnerable along the same dimensions.

1. Controlling the Level of Benefits: Choices and Incentives

The Court's first foray into ERISA preemption emphasized the importance of ensuring that "private parties, not the Government, control the *level of benefits*" provided under an ERISA plan.⁹⁹ Post-*Travelers*, the federal courts have attempted to define exactly what it means for a state statute to "control the level of benefits," and they have largely settled on the test articulated in *Dillingham*, distinguishing between laws that "alter[] the incentives" and laws

95. See *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007), *aff'g* 435 F. Supp. 2d 481 (D. Md. 2006); *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403 (E.D.N.Y. 2007).

96. See 29 U.S.C. § 1144(b)(5)(B)(ii) (2000) (creating an exception to ERISA preemption for Hawaii); HAW. REV. STAT. ANN. § 393-2 (LexisNexis 2004) (Hawaii's pay or play law); *Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd. mem.*, 454 U.S. 801 (1981) (holding the statute ERISA preempted).

97. *Golden Gate Rest. Ass'n v. San Francisco*, 546 F.3d 639 (9th Cir. 2008).

98. See N.Y., N.Y., ADMIN. CODE § 22-506 (2009), available at <http://public.leginfo.state.ny.us> (follow "Laws of New York" hyperlink, then follow "ADC" hyperlink, then navigate to Title 22, Section 506). The official codification notes that the law's validity is "currently a subject of disagreement between the mayor and the city council."

99. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981) (emphasis added).

that “dictate the choices” of ERISA plans.¹⁰⁰ Until recently, this framework has not been charitable to employer mandates.

Perhaps the best example of how this test has been applied to relevant state laws appears in the Fourth Circuit’s discussion of the Maryland “Walmart” statute. In that case, Maryland insisted that the law did not “mandate” that employers provide benefits under an ERISA plan, because employers had a choice between spending at least eight percent of their payroll on health benefits, or spending less than eight percent and paying any difference as an assessment to the state.¹⁰¹ In this view, the law was merely a *Dillingham*-like incentive, encouraging but not requiring employers to take certain actions with respect to ERISA-governed plans. The courts unequivocally rejected this view. The district court described the statute as providing a “Hobson’s choice,” since there was not “a single reason why the employer would pay the state.”¹⁰² The Fourth Circuit continued, “The only rational choice employers have . . . is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold.”¹⁰³

Courts have also relied on legislative intent in crafting pay or play statutes, focusing on legislative sponsors’ statements regarding the consequence of the law. A court reviewing the Suffolk County statute emphasized legislators’ hope that the statute would force “Wal-Mart and the big box stores” to offer health benefits.¹⁰⁴ Similarly, the Fourth Circuit insisted that supporters “understood the [Maryland Fair Share] Act as *requiring* Walmart to increase its healthcare spending.”¹⁰⁵ Thus, even though these pay or play statutes technically offer employers a “choice,” courts have based their ERISA inquiry on the general goals underlying the pay or play statutes. Indeed, one observer has advised legislators seeking to avoid ERISA preemption to explicitly “remain neutral regarding whether employers offer health coverage or pay the tax” in order to prevent preemption.¹⁰⁶ Thus, attempts to achieve coverage expansions through employer mandates are often ERISA-preempted because they do not offer employers a meaningful choice between “paying” and “playing.”

100. Cal. Div. of Labor Standards Enforcement v. *Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 334 (1997).

101. See Retail Indus. Leaders Ass’n v. *Fielder (Fielder I)*, 435 F. Supp. 2d 481, 497 (D. Md. 2006).

102. *Id.*

103. Retail Indus. Leaders Ass’n v. *Fielder (Fielder II)*, 475 F.3d 180, 193 (4th Cir. 2007).

104. See Retail Indus. Leaders Ass’n v. Suffolk County, 497 F. Supp. 2d 403, 407-08 (E.D.N.Y. 2007).

105. *Fielder II*, 475 F.3d at 194.

106. See BUTLER, *supra* note 11, at 6-7. It is noteworthy that this advice was given *before* the decisions described above.

It is particularly instructive to consider this issue in the context of the Massachusetts and Vermont reform legislation, which have yet to be challenged on ERISA grounds. Recall that both laws require employers to make a “reasonable” contribution to precisely defined employee health care benefits, or pay a relatively small “assessment” or “fee” to the state—less than \$400 per employee per year.¹⁰⁷ Recent estimates suggest that it costs nearly \$4500 to provide annual health insurance for a single employee;¹⁰⁸ therefore, it may be easier for a court to conclude that these statutes actually do offer a choice to employers and ERISA plans. Indeed, Professor Monahan recently concluded that Massachusetts’ requirements “survive preemption [because] there is a relatively modest financial disincentive” associated with paying rather playing.¹⁰⁹ While this approach may seem plausible, in fact, Professor Zelinsky and others have persuasively argued that the modest assessment does not immunize these laws from ERISA preemption.¹¹⁰ For these statutes do not simply require states to spend a certain amount on health care or pay a much smaller fee to the state. Instead, they require employers to provide health benefits that meet certain substantive standards, like including primary care benefits, if they wish to avoid paying the fee. In this way, then, pay or play laws “regulat[e] the substance of [ERISA] plans” in an impermissible way.¹¹¹ Indeed, the laws “dictate the choices” by “expressly regulat[ing] employers and the type of benefits they provide employees.”¹¹² In other words, the Massachusetts and Vermont statutes may offer employers a choice between paying and playing. But for employers who do choose to offer health benefits, the laws impermissibly “dictate” the way in which the benefit must be provided.

Thus, pay or play statutes will often “dictate the choices” and therefore manifest an impermissible “connection” with ERISA plans. They go too far towards shaping the way employers provide benefits to employees—either by creating too stiff a penalty for failing to offer health benefits, or by impermissibly regulating how employers structure their benefits.

2. Administrative Burden

Another aspect of the “connection with” test that has survived—and even

107. See An Act Providing Access to Affordable, Quality, Accountable Health Care § 47, 2006 Mass. Acts 77, 115; STATE OF VT. AGENCY OF ADMIN., *supra* note 28, at 38.

108. See KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2007 ANNUAL SURVEY 1-2 (2007), available at <http://www.kff.org/insurance/7672/index.cfm>.

109. Monahan, *supra* note 18, at 1216.

110. See, e.g., Bernstein & Seybert, *supra* note 94; Zelinsky, *supra* note 85, at 234.

111. Zelinsky, *supra* note 85, at 257.

112. Standard Oil Co. of Cal. v. Agsalud, 633 F.2d 760, 766 (9th Cir. 1980).

flourished—in the aftermath of *Travelers* is an inquiry into the administrative burdens associated with the state law.¹¹³ Of course, by forcing employers to comply with substantive or minimum spending requirements in the provision of health benefits, pay or play statutes create substantial administrative burdens.¹¹⁴ The laws force employers and ERISA plans to alter their benefit structures in order to either spend a certain amount on health care expenditures or comply with substantive regulations, and these alterations impede the “uniform administrative scheme” that ERISA allegedly envisions.¹¹⁵ Administrative complexity underlay the Court’s concern about Hawaii’s employer mandate—in a subsequent ERISA case the Court observed that “if Hawaii could demand the operation of a particular benefit plan, so could other States, which would require that the employer coordinate perhaps dozens of programs.”¹¹⁶ Indeed, courts have gone beyond the structural burdens imposed by pay or play laws and concluded that even the recordkeeping requirements associated with these laws constitute an impermissible administrative burden.¹¹⁷

The administrative complexity question has taken on particular significance in the context of employer mandates enacted by cities and counties, including the Suffolk County and San Francisco statutes. The New York district court emphasized that the Suffolk County law “would require that Wal-Mart make a different expenditure for employees in Suffolk County” and would thus “inhibit the administration of a uniform plan nationwide.”¹¹⁸ Similarly, one court was concerned with employers needing to “keep an eye on the minimum health care spending requirements in each locality.”¹¹⁹

But even in the statewide context, administrative complexity is a major concern of the courts. The Maryland law applied only to very large employers and operated statewide, but the courts found that the law impermissibly interfered with plan administration.¹²⁰ The Massachusetts and Vermont laws arguably

113. *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) (explaining that administrative uniformity was one of the statute’s “principal goals”).

114. *Retail Indus. Leaders Ass’n v. Fielder*, 435 F. Supp. 2d 481, 495 (D. Md. 2006).

115. *Egelhoff*, 532 U.S. at 148 (citing *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)).

116. *Fort Halifax*, 482 U.S. at 13.

117. *See Golden Gate Rest. Ass’n v. San Francisco (Golden Gate I)*, 535 F. Supp. 2d 968, 976 (N.D. Cal. 2007), *rev’d*, 546 F.3d 639 (9th Cir. 2008) (“[T]he requirements of the Ordinance have an impermissible connection with employee benefit plans because they impose on employers specific recordkeeping, inspection and other administrative burdens related to the administration of their private healthcare expenditures.”).

118. *Retail Indus. Leaders Ass’n v. Suffolk County*, 497 F. Supp. 2d 403, 418 (E.D.N.Y. 2007).

119. *Golden Gate I*, 535 F. Supp. 2d at 970, *rev’d*, 546 F.3d 639 (9th Cir. 2008).

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

impose even greater administrative burdens because they regulate substantive aspects of the benefit plan, not just total expenditures. Because they seek substantive changes in employer-provided health care benefits, pay or play laws go to the core of ERISA preemption analysis by creating unacceptable administrative burdens that interfere with “nationally uniform plan administration.”¹²¹

3. *The Existence of an ERISA Plan*

In *Ingersoll-Rand*, the Court called attention to state laws that are premised on the “existence” of an ERISA plan,¹²² concluding that a statute that would not function in the absence of ERISA-governed benefits was, in effect, an impermissible “reference to” a covered plan. The *Dillingham* Court reiterated this theme, condemning statutes “where the existence of ERISA plans is essential to the law’s operation.”¹²³ Despite tortured state attempts to avoid assuming the existence of ERISA plans, pay or play programs run afoul of this requirement.

Employer mandates, by definition, require the state or municipality to determine if an employer has made a statutorily adequate contribution to employee health care. Certainly, a state law which defined its requirements specifically in terms of ERISA’s “employee welfare benefit plans” would be preempted because it specifically “references” and assumes the “existence” of ERISA entities. However, as states have taken more creative approaches to defining what constitutes “playing,” courts have taken a more functional approach to preemption. For example, some state laws that require employers to spend a fixed amount on “employee health care” also include a long definition of qualified health care expenses, which include ERISA and non-ERISA expenditures. Maryland included Health Savings Accounts and on-site employee health clinics,¹²⁴ while Suffolk County also included employers’ charitable contributions to local community health centers.¹²⁵ The Fourth Circuit essentially ignored the Health Savings Account and on-site clinic components of the statute, observing that they “simply would not be a serious means” by which employers would choose to comply with the law.¹²⁶ In reviewing the Suffolk County statute, the district court similarly found that it was “unreasonable” to expect employers

121. *Egelhoff v. Egelhoff*, 532 U.S. 141, 142 (2001).

122. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990).

123. *Cal. Div. Labor Standards & Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1996).

124. *See* MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to -107 (LexisNexis 2006); 2005 Md. Laws 3 (codified as amended at MD. CODE ANN., HEALTH-GEN. § 15-142 (LexisNexis 2007)).

125. *See Retail Indus. Leaders Ass’n v. Suffolk County*, 497 F. Supp. 2d 403, 416 (E.D.N.Y. 2007) (describing the Suffolk County law).

126. *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 196-97 (4th Cir. 2007).

to contribute to a community health center in place of an employee health plan, thus the statute relied on the existence of, and therefore impermissibly referenced, ERISA plans. The California district court nicely summarized this approach, focusing on the “undeniable fact . . . that the vast majority of any employer’s healthcare spending occurs through ERISA plans.”¹²⁷ In this view, any state law that attempts to assess health expenditures necessarily references ERISA plans. Given courts’ functional approach to the “reference to” portion of the preemption inquiry, most pay or play statutes impermissibly depend on ERISA spending in order to determine employer liability.

4. *The Ninth Circuit’s Opinion in Golden Gate Restaurant Ass’n*

As described above, most courts addressing the issue have held that pay or play statutes are barred by ERISA. The only exception is a 2008 decision in the Ninth Circuit, concluding that San Francisco’s employer mandate was not preempted.¹²⁸ In that opinion, Circuit Judge Fletcher overturned a lower court decision holding the statute preempted by ERISA. He also offered a detailed analysis of the program, which required employers to spend \$1.76 per hour per employee, or \$3500 per year for full time employees.

The court first addressed the argument that San Francisco’s law had an impermissible “connection with” employers’ ERISA-covered plans.¹²⁹ Quoting extensively from *Travelers* and emphasizing that the law did not “bind plan administrators to any particular choice,” the court rejected this assertion.¹³⁰ The court did not focus on the ways in which the statute might influence employers’ decisions about whether or not to adopt ERISA-covered health plans, which had been at the heart of the Fourth Circuit’s analysis of this issue.¹³¹ Instead, the Ninth Circuit highlighted the fact that the San Francisco ordinance had only a minimal impact on employers’ decisions about what to do *inside* their health insurance plans. San Francisco did not require or encourage particular forms of coverage, and in that respect “the influence exerted by the [San Francisco]

127. *Golden Gate Rest. Ass’n v. San Francisco (Golden Gate I)*, 535 F. Supp. 2d 968, 976 (N.D. Cal. 2007), *rev’d*, 546 F.3d 639 (9th Cir. 2008).

128. *Golden Gate Rest. Ass’n v. San Francisco (Golden Gate III)*, 546 F.3d 639 (9th Cir. 2008). This decision followed an earlier 2008 opinion in which Judge Fletcher stayed the district court’s decision overturning the ordinance. *Golden Gate Rest. Ass’n v. San Francisco (Golden Gate II)*, 513 F.3d 1112 (2008).

129. *Golden Gate III*, 546 F.3d at 654.

130. *Id.* at 656.

131. *See Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180 (4th Cir. 2007). The Ninth Circuit distinguished the Fourth Circuit case by emphasizing the fact that under the San Francisco law, benefits actually could accrue to employers who chose to pay, rather than play, which was not the case under Maryland’s Walmart law. *Golden Gate III*, 546 F.3d at 659-61.

Ordinance is even less direct than the influence in *Travelers*.¹³² More broadly, because San Francisco only cared about the level of payment, not the type of benefits, there was no preemption.

The court then rejected the claim that the law's administrative burdens rendered it ERISA-preempted. Relying on Ninth Circuit precedent, Judge Fletcher insisted that the burdens fell "on the *employer* rather than on an ERISA plan" and were thus irrelevant to the preemption inquiry.¹³³

Finally, the Ninth Circuit considered whether San Francisco's ordinance made a "reference to" ERISA plans.¹³⁴ Using the *Ingersoll-Rand* test, which looks to a statute's reliance on the "existence of an ERISA plan," the court concluded that the law did not assume the existence of ERISA-governed benefits.¹³⁵ Indeed, the opinion eschewed the functional inquiry described above and instead concluded simply that employers could pay the tax to the city, and therefore the statute could "have its full force and effect even if no employer in the City has an ERISA plan."¹³⁶ Furthermore, to the extent the San Francisco law "referenced" anything, it was a permissible "reference to the *payments* provided by the employer to an ERISA plan," and not an impermissible "reference to the level of *benefits* provided."¹³⁷

The Ninth Circuit analysis is certain to draw criticism, and some have argued that it would not withstand Supreme Court scrutiny.¹³⁸ Yet, even if the reasoning is durable, the core conclusion is that San Francisco's law is permissible because it looks at nothing more than the dollar value of employers' health care expenditures. This reasoning gives state and local governments only the bluntest tool with which to craft health care reform and does not enable a broader array of experimentation. As a simple example, states may wish to expand their safety net health care services for youth, while creating soft employer incentives to cover their employees' children.¹³⁹ Perhaps more to the

132. *Golden Gate III*, 546 F.3d at 656.

133. *Id.* at 657 (emphasis added).

134. *Id.* at 658.

135. *Id.* at 652.

136. *Id.* at 657.

137. *Id.* at 658 (emphasis added).

138. See, e.g., Sharon Jacobs, *The Ninth Circuit Gives San Francisco's Health Care Security Ordinance the Green Light (For Now)*, 36 J.L. MED. & ETHICS 431, 433 (2008).

139. In the events surrounding the 2007 negotiations over SCHIP, the Centers for Medicare and Medicaid Services (CMS) issued a "Dear State Health Official" letter to states that had requested permission to expand their CHIP programs. In the letter denying the states' request, CMS emphasized that states must not expand CHIP without taking steps to prevent children with existing employer-provided coverage from being shifted into the public program. In the letter, CMS suggested states take several steps, including enacting laws that "[p]revent[] employers from changing dependent coverage policies that would favor a shift to public coverage." See Letter from

point, Massachusetts's employer mandate explicitly requires a "group health plan" and would undoubtedly be impermissible under the Ninth Circuit's approach.

Nor is the problem limited to the pivot points in the Ninth Circuit's analysis. In the seven statutes described above, legislators have gone to absurd lengths in their attempts to survive preemption. The Maryland legislature thought it could escape ERISA preemption by including expenditures on "workplace clinics" as a qualified health care cost. Yet it is difficult to imagine that encouraging employers to provide free Band-Aids and cough syrup ought to be a crucial component of the health reform agenda. Suffolk County chose to include employer contributions to local community health centers, but, again, mandated corporate charity hardly seems like a stable solution for the forty-seven million uninsured. And Massachusetts believed it had to cap the employer payment at less than ten percent of the cost of health insurance, which will ultimately limit the effectiveness and may jeopardize the solvency of their project. In other words, states are engaged in legislative contortions to escape ERISA preemption, and courts have regularly concluded that even that is not enough.

If state and local pay or play laws are going to be a viable component of health care reform, governments must be able to avoid these absurdities and confidently design pay or play programs to meet their legitimate health system needs. Therefore, it is important to amend ERISA section 514, giving states the freedom to realistically explore their options, balance incentives, and creatively design programs. The next Part considers options for amending the statute, particularly in the context of a national health care initiative.

II. AMENDING ERISA

Despite extensive discussion of the difficulties associated with ERISA preemption jurisprudence, very little attention has been paid to the contours of a potential legislative change to section 514. Even within the growing body of literature addressing preemption of state pay or play laws, little has been said about how the federal statute might be amended. However, as a window of reform opportunity opens, it is imperative to have solutions on the table. Therefore, building on the above explanation of ERISA preemption, this Part discusses a number of approaches for amending the statute, exploring ways to restructure statutory preemption and allow state and local health insurance reform to flourish.

Dennis G. Smith, Director, Centers for Medicare and Medicaid Services, to State Health Officials (Aug. 17, 2007), *available at* <http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf>. However, it seems that any state law that complied with this term would almost certainly risk ERISA preemption.

This conversation is particularly timely, as serious discussion about national health care reform resumes for the first time in nearly fifteen years. National legislation may impose some type of federal mandate requiring employer health insurance contributions,¹⁴⁰ but it may also create, exacerbate, or simply ignore problems that states or even localities can tackle through their own programs. There will undoubtedly be gaps in the categories of employers and employees included in the federal reform and in the type of care covered. A prolonged phase-in period or a broad set of exceptions will create a larger space where state and local governments may wish to take action. States will need to mediate the relationship between any federal programs or mandates and Medicaid and other state safety net programs. A truly comprehensive program is simply not on the horizon, and there remains an important role for states and localities to play.

Furthermore, negotiations surrounding health care reform provide an ideal legislative vehicle.¹⁴¹ The nascent health care reform conversations already involve state and local governments, employers, unions, and insurance companies—all key actors in the ERISA landscape.¹⁴² This moment, then, provides a unique opportunity to amend ERISA to allow state and local governments to experiment with their own health care reform agendas.

In general, there are three different policy paths that would achieve this result. First, federal legislation could drastically alter the preemption clause and eliminate most of the current jurisprudence by repealing the “relate to” language in its entirety. Second, section 514 could be amended to carve out a narrower exception that would permit state and local employer mandates, but would, in some other respects, leave the preemption scheme largely intact. As discussed below, this could take a number of forms, relying on existing components of the statute to craft an exception. Finally, broad and continuing “relate to” preemption could be supplemented by special exceptions—legislative or administrative—for particular state or local laws.

Before turning to these options, it is useful to briefly recall the structure of ERISA section 514, the preemption clause. Subsection 514(a) contains the infamous “relate to” language, while subsection 514(b) contains a list of exemptions from preemption—the insurance/banking/securities exception and the associated “deemer clause,” the special exception for Hawaii’s employer

140. Amol Navathe et al., *Barack Obama’s Plan for a Healthy America*, Context: Pol’y & Prac., http://www.contextjournal.org/category5.php?article_id=369 (last visited Nov. 12, 2009).

141. *See generally* JOHN W. KINGDON, *AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES* 173-75 (2d ed. 1995) (discussing legislative timing and the importance of a political “window” for proposed reforms).

142. If the failed 1994 health care reform debates taught anything, it is the importance of bringing all stakeholders to the table early.

mandated health insurance law, and many others.¹⁴³

A. Repealing “Relate to”

Perhaps the most obvious approach to prevent ERISA preemption of employer mandates is to simply abandon subsection 514(a)’s “relate to” language. Following this path, courts would be left to apply traditional field and conflict preemption principles to determine the permissibility of laws affecting employee benefits plans. In other words, the Courts would be asked to determine if there were actual conflicts between ERISA’s requirements and a state or local pay or play law (conflict preemption), or alternatively if the law wandered too far into an area that Congress intended to occupy (field preemption).¹⁴⁴ The “connection with or reference to” test in its various iterations would be discarded, and the post-*Shaw* jurisprudence would be obsolete.

Justices Scalia and Ginsburg, in two concurring opinions, have asked the Court to accomplish this result on its own through a narrow construction of the 514(a) language.¹⁴⁵ It is perhaps conceivable that the Court could overrule nearly three decades of ERISA holdings, and Scalia has had some success in convincing Justices Breyer and Stevens of the merits of this argument.¹⁴⁶ However, given the norm of strong statutory stare decisis and Congress’s repeated reliance on the Court’s current approach,¹⁴⁷ specific legislative action seems like a much more appropriate reform tool. Congress could replace the existing “relate to” language in subsection 514(a) with text that clearly indicates the intent Scalia describes. For instance, the statute might be amended as follows:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede ~~any and all~~ State

143. 29 U.S.C. § 1144 (2006). Subsection (d) reiterates that no federal law is preempted and subsection (e) ensures that automatic contribution laws are not prohibited by the states.

144. *See supra* note 33.

145. *Egelhoff v. Egelhoff*, 532 U.S. 141, 152 (2001) (Scalia, J., concurring); *Cal. Div. Labor Standards & Enforcement v. Dillingham Constr., Inc.*, 519 U.S. 316, 336 (1997) (Scalia, J., concurring) (“I think it would greatly assist our function of clarifying the law if we simply acknowledged that our first take on this statute was wrong; that the ‘relate to’ clause of the pre-emption provision is meant, not to set forth a *test* for pre-emption, but rather to identify the field in which ordinary *field pre-emption* applies—namely, the field of laws regulating employee benefit plans . . .”) (internal citation and quotation marks omitted).

146. *See Egelhoff*, 532 U.S. at 153 (Breyer, J., dissenting) (“Like Justice Scalia, I believe that we should apply normal conflict pre-emption and field pre-emption principles where, as here, a state statute covers ERISA and non-ERISA documents alike.”).

147. *See generally* Richard Sorian & Judith Feder, *Why We Need a Patients’ Bill of Rights*, 24 J. HEALTH POL. POL’Y & L. 1137 (1999) (describing how the proposed Patients’ Bill of Rights legislation relied on the Court’s current interpretations of ERISA preemption).

laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title that conflict with or otherwise impede the operation of this subchapter, subchapter II of this chapter, or subchapter III of this chapter.¹⁴⁸

One might argue that it would be better to simply repeal section 514, leaving ERISA without an express preemption clause, and relying on the courts to apply field and conflict preemption on their own. However, such an approach creates serious problems given the exceptions to preemption carved out in subsection 514(b) and the other preemption guidance appearing in subsections 514(d) and (e).¹⁴⁹ Indeed, despite the confusing “relate to” language, other parts of ERISA preemption clause offer sensible instructions and should be left intact. Therefore, it is wise to use an amended subsection 514(a) to set a general tone for preemption and allow the remainder of the statute to build around that.

Still this approach poses significant drawbacks. To begin, ERISA plans have legitimate concerns regarding administrative uniformity. In a labor market that is increasingly freed from geographic limitations, the administrative costs of complying with myriad state and local laws (reaching well beyond health benefits) could be tremendous. Field preemption principles would provide some limit to state regulation, especially within a statute that clearly evinces the need for administrative simplicity,¹⁵⁰ but there would undoubtedly be tremendous uncertainty. For instance, states would obviously be barred from regulating appeals from pension denials, since there is a large body of ERISA law on the subject, but appeals related to health insurance denial would be in uncertain waters. Furthermore, uncertainty itself is an important drawback to this approach. Preemption jurisprudence is notoriously unpredictable. Inviting a new generation of state law in a field that has been largely closed to state regulations for more than thirty years will cause confusion. On balance, these drawbacks may be outweighed by a legislative conclusion that “relate to” preemption was a failed experiment, but it is important to explore more limited alternatives.

B. A Statutory Space for Pay or Play

Rather than eliminating “relate to” and all of the associated jurisprudence, it may be more feasible or more desirable to simply carve out a narrower exception that allows state and local governments to experiment with pay or play statutes. There are three potential ways to create such an exception—bifurcating subsection 514(a) to separate pension plans and welfare benefit plans, expanding

148. *See* 29 U.S.C. § 1144(a) (2006).

149. *Id.* § 1144(b), (d)-(e).

150. *See* *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (“The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans.”).

the insurance/banking/securities exception in subsection 514(b), or expanding the “compliance plan” exception. Each of these approaches is discussed below.

1. Pensions Plans and Welfare Benefit Plans

One way to create an exception for state employer mandates would be to focus on the different kinds of benefits regulated under the statute. Recall that ERISA regulates two broad categories: pension plans and welfare benefit plans. Pension plans provide post-retirement income to former employees and therefore require a complex set of rules governing how benefits accrue and vest over the course of an employee’s career. Indeed, ERISA’s 1974 enactment was motivated by the desire to create comprehensive national standards to ensure that pension funds were sustainably and fairly administered, and to provide a federal guarantee of pension plans’ solvency.¹⁵¹ Welfare benefit plans, on the other hand, include temporary benefits like health insurance and life insurance. While there was certainly some perceived need for federal regulation in this area, the substantive provisions of ERISA place far fewer burdens on welfare benefit plans than they do on pension plans.¹⁵²

Yet, section 514’s preemption scheme applies equally to pension and welfare benefit plans. The Third Circuit has reasoned that “it is unlikely that Congress intentionally created this so called ‘regulatory vacuum,’ in which it displaced state-law regulation of welfare benefit plans while providing no federal substitute.”¹⁵³ Professor Conison has offered a convincing account of the origins of this approach.¹⁵⁴ Conison argues that Congress was primarily concerned with fiduciary issues like pension plan vesting and funding, but the inclusion of welfare benefit plans in the broad preemption language was nonetheless intentional.¹⁵⁵ In particular, a 1974 state court ruling in Missouri affecting welfare benefit plans and subjecting them to state insurance regulation¹⁵⁶ sensitized ERISA’s drafters to the “potential for state interference with the proposed law.”¹⁵⁷ Thus, Congress was aware of the impact that subsection 514(a) would have on regulation of welfare benefit plans and deliberately elected such an approach.

Despite original congressional intent, however, it is relatively easy to build a

151. See LANGBEIN ET AL., *supra* note 32, at 77-89.

152. *Id.* at 90-92.

153. *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 467 (3d Cir. 2003) (Becker, J., concurring).

154. Jay Conison, *ERISA and the Language of Preemption*, 72 WASH. U. L.Q. 619 (1994).

155. *See id.* at 646-650.

156. *State ex rel. Farmer v. Monsanto Co.*, 517 S.W.2d 129, 133 (Mo. 1974).

157. Conison, *supra* note 154, at 648.

case for treating non-federal regulation of pension plans and welfare benefit plans differently. Imagine an employee who begins a twenty-year career with a single employer in Ohio, spends fifteen years working in Michigan, and transfers to Florida eighteen months before retirement. When this employee retires, disparate pension regulations in Ohio, Michigan, and Florida could cause profound uncertainty and conflict over the terms of his pension benefits, creating a strong imperative for federal preemption. However, when the employee seeks an annual physical under his employer-sponsored health insurance in Ohio, Michigan, or Florida, there is no conflict.¹⁵⁸ His health benefits are only subject to the regulations of one state at a time, and his transfer out of Michigan terminates any effect that Michigan law might have on his coverage.

Following this logic, subsection 514(a) could be amended to apply broad “relate to” preemption to pension plan benefits, but not employee welfare benefit plans. New language might read:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee *pension* benefit plan described in section ~~1003(a)~~ 1002(2) of this title and not exempt under section 1003(b) of this title.

With no explicit preemption language affecting ERISA’s welfare benefit plans, traditional field and conflict preemption principles would apply. Functionally, this approach may be indistinguishable from an effort to remove the “relate to” language from the statute entirely. All of the major ERISA preemption cases have considered laws that allegedly “relate to” welfare benefits, not pensions, and the supremacy of the comprehensive federal scheme in pension benefit regulation is largely undisputed. Nonetheless, approaching preemption reform in this way might be more palatable to key ERISA stakeholders, including employers and plan administrators, because it continues federal preemption in important parts of the market.

It is important to distinguish this approach from the “reasoned textualism” approach to preemption under the current statute that has been advocated by Professor Zelinsky.¹⁵⁹ He focuses attention on the distinction between pension and welfare benefit plans, but he does so in order to draw the preemption analyses closer together, rather than to separate them from one another. In particular, a “reasoned textualist” approaches preemption as follows:

[I]f ERISA affirmatively regulates a particular facet of pension plans (e.g., the employees who must be covered by such plans), the combination of section 514

158. Cf. LANGBEIN ET AL., *supra* note 32, at 118-19 (providing a similar example).

159. See Zelinsky, *supra* note 44, at 808.

and ERISA's silence on that subject as to welfare plans consigns that subject to employer autonomy. Thus, as to a state law impacting upon the substance of welfare plans, the Court should ask whether such law intrudes upon the zone of employer autonomy defined by reference to ERISA's regulation of pension plans. If the challenged state law intrudes upon the zone of employer autonomy so defined, the law is ERISA-preempted and the zone thereby preserved from state as well as federal regulation.¹⁶⁰

In other words, the "relate to" language is used to broadly define the field of regulation occupied by ERISA with respect to welfare plans. If Congress chose to regulate an aspect of pension benefits but left welfare benefits unregulated in that area, then any state or local law touching on welfare benefits in that way must be ERISA preempted. On the other hand, if the law affects an aspect of welfare benefit plans for which Congress is also silent with respect to pension benefits, the law is permissible. This "reasoned textualist" approach, whatever its merits, undoubtedly leaves most pay or play laws preempted.¹⁶¹ These laws mandate employer contributions to certain benefit plans and therefore impermissibly affect employer action. By contrast, the approach described above detangles pension and welfare benefit plan preemption, focusing the inquiry only on the way in which Congress separately regulates each type of benefit, and creates broader space for pay or play legislation.

2. Insurance/Banking/Securities Exception

Separating pensions from welfare benefit plans, while technically leaving the "relate to" language partially intact, still creates a tremendously large exception for regulation of all welfare benefit plans. A narrower change to ERISA's preemption language might focus more specifically on employers' health insurance benefits. A logical approach begins with subsection 514(b)(2)'s insurance/banking/securities exception. This language allows states to "regulate[] insurance, banking, or securities," but with one important caveat—no ERISA-covered plan shall *itself* be subject to state regulation of insurance, banking, or securities.¹⁶² This limitation, codified in the "deemer clause," has created a surprisingly large loophole, allowing employers to "self-insure" rather than purchase insurance products, thus exempting them from state insurance regulation. Without digressing too far into the health insurance and HMO controversies of the late 1990s and early 2000s, it is worth noting that ERISA and its deemer clause played a central role in states' early inability to effectively

160. *Id.* at 840.

161. *See id.* at 845-46 (discussing *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992)); *see also Zelinsky, supra* note 85, at 232.

162. *See* 29 U.S.C. § 1144(b)(2) (2006).

regulate HMOs in the face of consumer complaints.¹⁶³ The proposed federal “Patients Bill of Rights” was one reaction to this gap in regulation, but subtle, post-*Travelers* changes in ERISA jurisprudence eventually alleviated some, though not all, of this tension.¹⁶⁴ This conflict undoubtedly lies in the background of any attempt to rework subsection 514(b)(2).

Nonetheless, carefully targeted modifications could extend this statutory language to include pay or play statutes. Combined with changes to section 514’s definitional section, the subsection could be amended as follows:

(b) Construction and application (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities, *or which requires provision of health care benefits*. (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. . . .

(c) Definitions. For purposes of this section (3) *The term “health care benefits” shall include benefits provided under an employee benefit plan described in section 1003(a) of this title, only insofar as those benefits affect the protection or maintenance of a beneficiary’s health or wellness.*

This language allows states to do two things. First, they can require that employers make minimum health care expenditures or provide a minimum guarantee of health care coverage. This sort of revision does indeed create a broad safe harbor for employer mandates, allowing broad and creative state experimentation. At the same time, this language also reaches a very different kind of state regulation. Under the proposal, states can require that employers cover certain benefits, like pregnancy or vaccinations—requirements that have long been applied to standalone insurers, but that self-insured employers have been able to avoid through ERISA’s deemer clause.¹⁶⁵ While this is certainly a controversial extension of states’ regulatory power, this approach creates a sensible expansion.

The language above does include important limitations on states’ new

163. See LANGBEIN ET AL., *supra* note 32.

164. See Covington, *supra* note 91, at 6.

165. See LANGBEIN ET AL., *supra* note 32, at 770.

authority. First, the proposed language exempts only state laws that “require the provision of” health benefits, not laws which “regulate” those benefits, thus limiting the extent to which states can affect plan conduct. Furthermore, the proposed revision leaves the actual text of the deemer clause intact, even while neutralizing some of its effects. Nonetheless, under this scheme, self-insured employers continue to be exempt from state regulations affecting the “business” of health insurance (e.g., solvency requirements),¹⁶⁶ and states are only able to reach the substantive content of self-insured health plans in the same way that they regulate standalone insurance. At the same time, the definitional language in subsection 514(c)(3) could be narrowed, perhaps excluding mental health benefits and eschewing the controversial debate over mental health parity (e.g., “protection or maintenance of a beneficiary’s *physical* health or wellness”), or otherwise limiting the scope of the exception. Finally, note that, unlike solutions described above, this language applies only to states, not localities, and schemes like the one in San Francisco would continue to risk ERISA preemption.

Further, the interests lined up to support the deemer clause—large employers and most insurers—are substantial, and narrowing the loophole subjects them to a vast body of state regulation. While this may be entirely justifiable from a policy perspective, it may be politically infeasible, or it may simply be a battle that reformers choose not to fight. In that case, there is a third approach that would extend an even narrower safe harbor to certain kinds of employer mandates. As discussed below, this proposal does not rely on an amendment to section 514 and instead proceeds from the “compliance plan” exception in ERISA’s general definitional section.

3. *Compliance Plan Exception*

Broadly speaking, not all kinds of employee benefits are regulated under ERISA. Laws affecting benefits that are unregulated are therefore not preempted, for they do not “relate to” any ERISA-governed subject matter.¹⁶⁷ For instance, “excess benefit plans,” which provide benefits beyond some ERISA requirements, are outside the regulatory scheme;¹⁶⁸ governments are free to regulate these plans as they choose.¹⁶⁹ Leveraging this feature of the statute relies on amending ERISA so that benefits provided to comply with state and local pay

166. Regulation on the “business” of health insurance includes provisions creating minimum asset requirements or creating fiduciary responsibilities, exactly the sort of regulation ERISA was meant to preempt.

167. *See generally* 29 U.S.C. § 1144(a) (2006) (preempting state laws that “relate to any employee benefit plan described in section 1003(a) of this title *and not exempt* under section 1003(b) [ERISA section 403(b)] of this title”) (emphasis added).

168. *See id.* §§ 1002(36), 1003(b)(5).

169. *See id.* § 1144(a).

or play laws are not considered regulated welfare benefits. While this may seem improbable, given that health insurance benefits are a central ERISA-governed welfare benefit plan, the Act does open up a narrow opportunity for action.

Specifically, subsection 403(b)(3), known as the “compliance plan” exception, provides:

(b) The provisions of this subchapter shall not apply to any employee benefit plan if . . . (3) such plan is maintained solely for the purpose of complying with applicable workmen’s compensation laws or unemployment compensation or disability insurance laws¹⁷⁰

This language leaves the states and localities free to design workers compensation and unemployment benefit schemes, with mandated employer contributions, without risking ERISA preemption. Pay or play laws could potentially be worked into this framework, though the result would necessarily limit the form of state and local regulation. Following this approach, subsection 403(b)(3) could be amended to read as follows:

(b) The provisions of this subchapter shall not apply to any employee benefit plan if . . . (3) such plan is maintained solely for the purpose of complying with applicable workmen’s compensation laws, ~~or~~ unemployment compensation or disability insurance laws, *or health care contribution laws*

Under this exception, governments could design stand-alone “health care contribution” programs and require employer provision of benefits without coming under ERISA’s umbrella. However, this sort of scheme would look very different from employer mandates that state and local governments have recently enacted. Note that the exception applies only to plans that are maintained “solely” to comply with relevant laws. Pay or play laws, on the other hand, have tended to look to employer contributions under existing ERISA-covered health care benefit plans. If non-federal health care reform is going to escape preemption through the compliance plan exception, then new forms of employer mandates will need to be developed.

The Massachusetts health care reform statute suggests one design that may be effective. Under that law, employers who choose to “pay” are not assessed a fixed per-employee fee, but are instead required to compensate the state for a percentage of the uncompensated health care sought *by their employees*.¹⁷¹ A statute that placed a similar assessment on employers across the state could be designed so that contributions were funneled into a plan “maintained solely for

170. *Id.* § 1003(b) (2006).

171. *See* An Act Providing Access to Affordable, Quality, Accountable Health Care § 44, 2006 Mass. Acts 77, 111-13.

the purpose of complying.”¹⁷² Thus, while not technically creating an employer mandate, this approach would accomplish the same result, since individuals generally seek uncompensated care only if they lack employer-provided insurance.

Approaching pay or play preemption in this way has tremendous practical advantages—it creates a narrow exception that only reaches a very specific kind of statute. Yet it also drastically limits how governments design their reform programs, potentially placing off-limits many innovative public-private partnership approaches providing expanded access to health insurance. By requiring that pay or play statutes operate from an employer benefit that exists “solely” to comply with state or local law, new regulation might arguably be more disruptive by requiring the establishment of new kinds of benefits.

C. Case by Case De-Preemption

None of the narrow approaches described above are entirely satisfactory—the more expansive safe harbors may be impossible to enact and may risk intolerable uncertainty, while the more limited approaches may be too restrictive to allow effective experimentation. Similarly, repealing the “relate to” language may prove unwise or insurmountably challenging. The third potential policy path, case by case de-preemption of particular laws, certainly does not escape these concerns. Instead, it may recombine the trade-offs in a different way, thus creating an alternative set of opportunities for reformers.

This Section describes two somewhat related tools for achieving such case by case de-preemption, where federal actors evaluate particular state and local pay or play laws and exempt them from ERISA preemption at their discretion. It begins by describing a purely legislative approach based on ERISA’s exception for the state of Hawaii and then explores how this approach might be modified in light of the Clean Air Act’s scheme for establishing fuel economy standards for consumer vehicles. It then sketches the outline of a more comprehensive and flexible scheme based on federal agency discretion.

1. The Hawaii Route

In 1974, shortly before ERISA was enacted, Hawaii’s state legislature passed the Prepaid Health Care Act of 1974, effectively requiring employers to pay at least fifty percent of their employees’ health care costs.¹⁷³ The Hawaii statute reaches beyond even the most ambitious proposals in the modern debate, covering any employee working more than twenty hours a week, and capping

172. 29 U.S.C. § 1003(b)(3) (2006).

173. HAW. REV. STAT. ANN. § 393-13 (LexisNexis 2004).

employee contributions to insurance premiums at 1.5% of their salary.¹⁷⁴ In a 1980 decision that was affirmed by the Supreme Court per curiam, the Ninth Circuit held the statute preempted by ERISA.¹⁷⁵ Two years later, after an aggressive campaign by Hawaii's congressional leadership,¹⁷⁶ Congress amended ERISA's preemption clause to specifically exclude the Hawaii statute.¹⁷⁷ The exception only extends to the statute as crafted in 1974 and does not allow Hawaii to modify its program in any way.¹⁷⁸ Therefore, Hawaii employers are still required to comply with the state's broad health care coverage mandate; however, any other state attempting to replicate the program would face certain ERISA preemption.

Some have argued that Massachusetts should explore a similar legislative exception for its own health care reform program.¹⁷⁹ While the state's program has not been challenged in federal court, and observers continue to argue that the law is effectively tailored to escape ERISA preemption, the threat of preemption litigation still hangs over administration of the state law. A statutory exception like Hawaii's would eliminate this concern. Of course, given Massachusetts's tortured efforts to escape ERISA preemption—limiting employers' assessments to \$295 per year and tracking employer data for uncompensated care patients—it would be ironic to find that these compromises were moot. More importantly, a Hawaii-like provision would lock Massachusetts into its current program design, flying in the face of rhetoric touting the program as an experiment in need of tinkering and modification.¹⁸⁰ And, perhaps most significantly, an exception for the state of Massachusetts would do nothing to promote employer mandates in San Francisco, Vermont, and other states and cities contemplating reform. In fact, a legislative exception for Massachusetts would actually undermine the argument that other programs were not ERISA-preempted.

Some of these concerns can be better understood by looking to an entirely unrelated area of federal law: the Clean Air Act's Corporate Average Fuel

174. *Id.* § 393-3, -13; see also Sylvia A. Law, *Health Care in Hawai'i: An Agenda for Research and Reform*, 26 AM. J.L. & MED. 205, 206-07 (2000) (attributing Hawaii's broad coverage to numerous factors, including decades of Democratic political control and the state's unique cultural history).

175. *Standard Oil Co. of Cal. v. Aghsalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981).

176. Shelley K. Hubner, *State "Pay or Play" Employer Mandates: Prescribed or Preempted?*, HEALTH L., Aug. 2008, at 15, 19.

177. See 29 U.S.C. § 1144(b)(5) (2006).

178. See *id.* § 1144(b)(5)(B)(ii).

179. David A. Hyman, *The Massachusetts Health Plan: The Good, the Bad, and the Ugly*, 55 U. KAN. L. REV. 1103, 1110 (2007). The same logic certainly applies to programs in Vermont, San Francisco, and other places.

180. See *id.* at 1116-17.

Efficiency (CAFE) Standards, governing fuel efficiency standards for automakers.¹⁸¹ In 1970, Congress created the first federal standards for consumer automobiles. In the process, legislators were forced to grapple with the fact that California had already adopted its own more stringent standards for cars sold within its boundaries.¹⁸² The compromise that emerged allowed California to keep its own standards, and to amend those standards subject to approval by the Environmental Protection Agency.¹⁸³ Furthermore, other states were free to adopt the California standards if they chose; they could not, however, create their own fuel economy standards.¹⁸⁴

By analogy, imagine how the ERISA preemption scheme could adopt some of these features. The statute could be amended to, first, de-preempt the Massachusetts law; second, give Hawaii and Massachusetts the option of seeking federal approval for changes to their statutes; and third, allow other states to adopt wholesale the Hawaii or Massachusetts programs. But even this brief thought experiment exposes profound flaws with such an approach in the context of health care reform. To begin, fuel efficiency standards create a single-variable regulatory scheme and the core cost-benefit calculation is clear: the cost of dirtier air against the expense of more efficient cars. Pay or play statutes, on the other hand, are comprehensive programs that involve dozens, or even hundreds, of decision points and weigh a daunting array of interests. Fuel efficiency standards are simply a number, but employer mandate-based health reform affects an entire system, and an either/or approach in this context is difficult to justify. Additionally, in the context of CAFE standards, California has some non-arbitrary claim to special status—it is a large state and its consumers purchase enough cars to garner substantial market power.¹⁸⁵ No similar logic applies in the health care reform debate; Hawaii and Massachusetts are only advantaged

181. See 49 U.S.C. § 32,902 (2006).

182. See Patrick Parenteau, *Lead, Follow, or Get Out of the Way: The States Tackle Climate Change with Little Help from Washington*, 40 CONN. L. REV. 1453, 1466-67 (2008).

183. Until recently, EPA approval was largely considered a rubber-stamp process, and the EPA had never denied a waiver to California; however, the Bush Administration denied the most recent application in 2007. See Press Release, Environmental Protection Agency, America Receives a National Solution for Vehicle Greenhouse Gas Emissions (Dec. 19, 2007), available at <http://www.epa.gov/newsroom/newsreleasese.htm> (follow “By Date” hyperlink, then follow “2007” hyperlink, then navigate to 12/19/2007). In the first week of the new administration, President Obama ordered the EPA to reconsider the issue. See John M. Broder & Peter Baker, *Obama’s Order Is Likely to Tighten Auto Standards*, N.Y. TIMES, Jan. 25, 2009, at A1.

184. 42 U.S.C. § 7543(a) (2006).

185. See generally Thomas W. Merrill, *Preemption and Institutional Choice*, 102 NW. U. L. REV. 727, 732-33 (2008) (discussing the business community’s preference for preemption because of the way it simplifies trade across state lines). Were Nebraska to attempt similar legislation, one could imagine that automakers would simply refuse to sell cars in the state.

because of their first-mover status, and there is no particular reason to think that these programs would work well in other states.¹⁸⁶ Finally, in the health care context, this approach would largely eliminate the broad and creative experimentation that is needed to find meaningful health care reform options.

Indeed, none of this is to suggest that the CAFE model should be seriously explored in the context of ERISA reform. But it does highlight an alternative to the statutory reforms discussed in the preceding Section, which attempt to define a specific sandbox in which non-federal actors can create pay or play structures. Instead, there are models in the modern administrative system that begin by preempting state law but nonetheless allow states and localities to advance their own regulatory interests on a federally-controlled playground. The next Subsection explores a different, more apt analogy in administrative law and uses that to trace an approach for amending ERISA section 514.

2. A Role for Federal Agencies

A more workable model would provide state and local governments a flexible way to seek ERISA de-preemption of health care reform legislation. Starting with a presumption of today's broad (though somewhat uncertain¹⁸⁷) ERISA preemption of pay or play statutes, states and localities could apply to a federal agency, which would then review their program and grant an exception from preemption. Such a system would give governments the ability to design flexible programs, while allowing a federal actor to assess the administrative burden placed on employers. Thus, Massachusetts's comprehensive and carefully administered statewide reform program could be treated differently than the haphazard New York City law applying only to employers with more than 12,500 square feet of retail grocery sales.¹⁸⁸ Moreover, employers would be provided with clear notice of any non-federal law that may affect their provision of health care benefits, arguably lessening the administrative complexity for multi-state employers.

In fact, a 1976 Food and Drug Administration (FDA) statute, the Medical Device Amendments,¹⁸⁹ operates in a very similar way. The statute provides a

186. See Sidney D. Watson et al., *The Road from Massachusetts to Missouri: What Will It Take for Other States To Replicate Massachusetts Health Reform?*, 55 U. KAN. L. REV. 1331 (2007) (explaining the myriad ways that health reform must vary state-to-state).

187. Cf. *Golden Gate Rest. Ass'n v. San Francisco*, 546 F.3d 639 (9th Cir. 2008) (constituting the only decision upholding a pay or play law).

188. See N.Y., N.Y., ADMIN. CODE § 22-506 (2009), available at <http://public.leginfo.state.ny.us> (follow "Laws of New York" hyperlink, then follow "ADC" hyperlink, then navigate to Title 22, Section 506).

189. See Medical Device Amendments of 1976, Pub. L. No. 94-295, 90 Stat. 539 (codified as amended at 15 U.S.C. § 55 and in scattered sections of 21 U.S.C.).

comprehensive federal regulatory scheme for medical devices, and in broad language preempts any state law governing the “safety or effectiveness” of a regulated device.¹⁹⁰ However, the statute also provides that the FDA may exempt laws from preemption, “[u]pon application of a State or a political subdivision” and review by the agency.¹⁹¹ Today, the *Code of Federal Regulations* contains a long list of exempted state laws.¹⁹² Like the fuel efficiency standards compromise, this legislative scheme was born of an era when states entered a regulatory field before the federal government, and legislators were forced to design a system that would allow federal supremacy while accommodating existing state law.¹⁹³

There are a number of unresolved questions and substantial problems with using this approach to create an ERISA de-preemption scheme. First, which agency would be responsible for administering the program? ERISA largely falls under the purview of the Department of Labor, but that agency has very little special expertise in the complex issues affecting employer provision of health care. Some even argue that the Department’s own engagement in ERISA cases is at least partly responsible for today’s complicated ERISA jurisprudence.¹⁹⁴ Another choice might be the Centers for Medicare and Medicaid Services (CMS), an office within the Department of Health and Human Services that is responsible for assessing state compliance with the federal Medicaid statute.¹⁹⁵ States are accustomed to seeking CMS approval for changes to their Medicaid programs,¹⁹⁶ and pay or play reforms are often coupled with expansion of or alterations to the state’s health care safety net services.¹⁹⁷ Thus, states may

190. 21 U.S.C. § 360k(a)(2) (2006).

191. *Id.* § 360k(b) (2006).

192. *See* 21 C.F.R. § 808.1 (2009).

193. *Cf.* Robert Adler, *The 1976 Medical Device Amendments: A Step in the Right Direction Needs Another Step in the Right Direction*, 43 FOOD DRUG COSM. L.J. 511, 526 (1988) (discussing the history of the MDA).

194. *See, e.g.*, William N. Eskridge, Jr. & Lauren E. Baer, *The Continuum of Deference: Supreme Court Treatment of Agency Statutory Interpretations from Chevron to Hamdan*, 96 GEO. L.J. 1083, 1113-14 (2008) (discussing the Supreme Court’s deference to the Department of Labor in ERISA cases). *But see* *Golden Gate Rest. Ass’n v. San Francisco*, 546 F.3d 639 (9th Cir. 2008) (lower court did not defer to the Department of Labor).

195. *See* Centers for Medicare & Medicaid Services, Overview, <http://www.cms.hhs.gov/History> (last visited Nov. 12, 2009).

196. All states must have a Medicaid “State Plan” on file with CMS, and states must seek approval for all changes, either as “State Plan Amendments” or federal “waivers.” *See generally* Julia Gilmore Gaughan, *Institutionalization as Discrimination*, 56 U. KAN. L. REV. 405, 408-12 (2008) (providing a description of the Medicaid state plan process).

197. *See* Mark E. Douglas, *An Overview of the Recent State Rally for Health Care Reform*, 5 IND. HEALTH L. REV. 277, 291-93 (2008) (describing how the Massachusetts reform plan interacts

already be working with CMS to obtain approval for their reform legislation, and expanding that process to cover ERISA de-preemption could be a starting point. However, CMS has no expertise in employee benefits, the private insurance market, state insurance regulation, or other related issues, making it difficult to imagine putting the entire process in their hands. One could also envision a hybrid scheme where CMS evaluates the program and makes a recommendation to the Department of Labor, in much the same way that the Department of Justice and Department of Health and Human Services collaborate on the “scheduling” of drugs under the Controlled Substances Act.¹⁹⁸

Yet even if one resolves the question of agency authority, there is still the vexing concern of inappropriate agency politicization of these decisions. After all, both of the de-preemption schemes discussed above—CAFE standards and the MDA—have been thrust into newspaper headlines and federal courts in recent years, as state and private actors allege that the agency involved has asserted its authority in impermissible ways.¹⁹⁹ One of the goals of pay or play reforms is to fill gaps at the interstices of federal health care reform, and inserting the federal bureaucracy into these decisions may frustrate this aim.

Finally, any system of federal agency de-preemption would require statutory criteria by which state or local programs could be evaluated. This forces a conversation about the specific goals of ERISA preemption, and reaching a consensus may be even more politically challenging than the legislative reforms discussed above. Furthermore, statutory criteria would need to draw boundaries around the type of state or local law that would be eligible for de-preemption. If the option is targeted to only reach the archetypal employer mandate, experimentation may be unnecessarily closed, but a broader focus may make de-preemption administratively impossible. Nonetheless, despite all of these concerns, an administrative de-preemption scheme creates a possible alternative and may allow more middle ground than a purely statutory change.

CONCLUSION

This Note has argued that most state and local pay or play laws are preempted by ERISA. Even when health care reform is tailored to survive a challenge, the preemption jurisprudence places such hurdles in front of program design that it impedes the ability to create flexible and creative reform structures. As health care reform is thrust into the national spotlight, legislators are

with the Medicaid program).

198. See 21 U.S.C § 811(b) (2000).

199. See *Riegel v. Medtronic*, 128 S. Ct. 999, 1012 (2008) (Stevens, J., concurring) (discussing the MDA and FDA’s de-preemption authority); Broder & Baker, *supra* note 183 (discussing the California CAFE controversy).

presented with an opportunity to amend ERISA's preemption clause as part of a health care reform bill, yet little attention has been paid to the contours of such legislative reform. Thus, this Note has proposed and analyzed a number of specific amendments that would allow health care reform at the state and local level.

One obvious possibility is to simply remove the controversial "relate to" language from the statute and leave ERISA to traditional field and conflict preemption principles.²⁰⁰ Another approach continues expansive "relate to" preemption for ERISA regulation of pension plans, but leaves state and local law affecting welfare benefit plans without an express preemption clause.²⁰¹ Alternatively, reforms could graft new exceptions onto existing components of ERISA's preemption clause—the insurance/banking/securities exception,²⁰² or the compliance plan exception.²⁰³ State and local governments could also seek specific congressional amendments exempting their particular employer mandates, as Hawaii did in 1982.²⁰⁴ Finally, the Note explored a proposal for ERISA de-preemption moderated by a federal agency.²⁰⁵

Each of these proposals has different advantages. Abandoning the "relate to" language, in its entirety or as applied to welfare benefit plans, is the only alternative that offers states and localities complete flexibility in program design. Yet these approaches may place intolerable administrative burdens on employers and may be politically impossible. At the same time, more targeted and politically palatable reforms—including modification of the compliance plan exception or agency-based de-preemption—may so constrain the design of pay or play reforms that they are hardly better than the current scheme. Administrative de-preemption is further hampered by program complexity and important questions about its feasibility, but if successfully implemented, it could provide a compromise option that promoted state and local experimentation while satisfying some employer concerns.

Perhaps the best alternative is to add health care reform to the insurance/banking/securities exception. The types of employer mandates covered by this change are reasonably broad, but employers are exposed to state regulation in a more narrow and predictable area. This proposal has the further advantage of mitigating some of the more pernicious concerns associated with employers' use of the "deemer clause" to escape state regulation of health

200. See *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 335 (1997) (Scalia, J., concurring); *supra* Section II.A.

201. See *supra* Subsection II.B.1.

202. See *supra* Subsection II.B.2.

203. See *supra* Subsection II.B.3.

204. See *supra* Subsection II.C.1.

205. See *supra* Subsection II.C.2.

insurance benefits,²⁰⁶ though that fact in and of itself may pose political difficulties.

Indeed, it is hardly obvious where negotiations to amend ERISA's preemption clause will lead. The process will have to tackle concerns that reach well beyond the context of pay or play health care reform, and those topics are outside the scope of this Note. But if nothing else, this begins a conversation about how ERISA can be amended by placing possibilities on the table and providing a sense of the trade-offs and concerns in play. And the time for action is now: presented with a once-in-a-generation opportunity to reform our health care system, national leaders can make it possible for states to pick up where their efforts leave off. Through swift action, Congress can ensure that state and local governments are empowered to create successes from whatever small failures the national health reform project is forced to endure.

206. *See supra* notes 35-37 and accompanying text.

