Note title: The Relationship Between ERISA, State and Local Health Care Experimentation, and the Need for National Health Care Reform

Abstract: The Employee Retirement Income Security Act of 1974 (ERISA), provides a comprehensive federal scheme for the regulation of employee benefit plans, which include employee welfare benefit plans. Under Section 514(a) of ERISA, any state law that relates to employee benefit plans is preempted by ERISA. Judicial decisions have generally interpreted the scope of ERISA preemption to be fairly expansive; however, some recent decisions have narrowed the scope of Section 514(a) to some degree. Nonetheless, ERISA's preemption clause continues to significantly limit state and local efforts at health care reform. Several states and localities have experimented with fair share laws, which seek to increase access to health care and provide a means by which to finance such expansion. Employer spending mandates under such laws have been subject to legal challenges as expressly preempted by ERISA. To date, only San Francisco's fair share law has survived its ERISA challenge. More importantly, the debate over the relationship between ERISA preemption and fair share laws implicates significant issues with respect to health care reform at the local, state, and national levels. In addressing these issues, Congress should strongly consider amending ERISA to allow controlled experimentation at the state and local level. This course of action would not only enhance the federal government's ability to develop a national model for health care reform but also start to make noticeable progress toward bridging the gap between the uninsured and access to health care.

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I. Introduction

The Employee Retirement Income Security Act of 1974 (ERISA), provides a comprehensive federal scheme for the regulation of employee benefit plans, which include employee welfare benefit plans. By definition, employee welfare benefit plans generally provide for hospital, medical, surgical, sickness, accident, disability, death, unemployment, severance, or similar benefits; thus, health care benefit plans fall within the scope of ERISA. Under Section 514(a) of ERISA, any state law that relates to employee benefit plans is preempted by ERISA. In general, judicial decisions have interpreted the scope of ERISA preemption to be fairly expansive; however, some more recent decisions have narrowed the scope of Section 514(a) to some degree. Nonetheless, ERISA's preemption clause continues to significantly limit state and local efforts at health care reform.

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

Notwithstanding these laudable goals, such state and local health care reform initiatives have been subject to legal challenges on the grounds that ERISA expressly preempts fair share laws in general and their employer spending mandates in particular. Specifically, Maryland, Suffolk County, NY, and the city of San Francisco all enacted their own versions of fair share laws; in each instance, however, trade associations representing affected employers attacked the laws as preempted by

ERISA. In both Maryland and Suffolk County, the courts sided with the trade associations, concluding that ERISA preempted the challenged fair share laws. In stark contrast, however, the San Francisco fair share law has survived its legal challenge to date. Absent intervention by the U.S. Supreme Court and a decision finding that San Francisco's fair share law is preempted by ERISA, San Francisco will be permitted to continue operating its program, including the employer spending mandate. More importantly, the debate over the relationship between ERISA preemption and fair share laws implicates significant issues with respect to health care reform at the local, state, and national levels. In addressing these issues, Congress should strongly consider amending ERISA to allow controlled experimentation at the state and local level. This course of action would not only enhance the federal government's ability to ultimately develop a national model for health care reform but also start to make noticeable progress toward bridging the gap between the uninsured and access to health care.

II. Employee Retirement Income Security Act of 1974 (ERISA)

A. Introduction

By enacting ERISA, Congress established a regulatory framework that applies to all employee benefit plans. Although the primary purpose of ERISA was to regulate pension plans, health benefit plans also fall within the scope of the act.[1] The goals of ERISA are to "establish uniform national standards, safeguard employee benefits from loss or abuse, and to encourage employers to offer those benefits."[2] While ERISA does not mandate that employers offer benefit plans, in the event that such plans are provided to employees, plan administrators are subject to strict requirements.[3]

Currently, Hawaii is the only state that has received an exemption from ERISA.[4] This is primarily due to the fact that Hawaii enacted the Prepaid Health Care Act of 1974 (PHCA) shortly before congressional passage of ERISA in 1974.[5] Under the PHCA, Hawaii included an employer

mandate that required all employers to provide a standard health package and pay for seventy-five percent of its premium.[6] In 1981, the Supreme Court ruled that ERISA preempted Hawaii's legislation[7]; however, Congress responded in 1983 by amending ERISA and granting Hawaii's PHCA an express and limited exemption from ERISA.[8]

B. Preemption Under ERISA Section 514(a)

By enacting ERISA, Congress' principal goal was to create a uniform set of standards for employee benefit plans, thereby protecting employees by eliminating the need for employers to adhere to inconsistent state and local regulations.[9] In order to achieve this goal of uniformity, ERISA includes an express preemption provision, Section 514(a), which states that ERISA shall "supersede any and all State laws insofar as they now or hereafter *relate to* any employee benefits plan."[10] As a result, ERISA generally preempts state regulation of employment-based health insurance and, in effect, established the "federal government as the primary regulator of private-sector employee benefit plans."[11]

Despite this broad preemption, ERISA Section 514 also includes a savings clause and a deemer clause. Section 514(b)(2)(A), ERISA's savings clause, explicitly preserves states' rights to regulate the business of insurance.[12] Specifically, ERISA will not "be construed to exempt or relieve any person from any law of any State which regulates insurance."[13] Therefore, a state insurance law might relate to employee benefit plans but nonetheless will not be preempted by ERISA. Effectively, this provision protects state laws that directly regulate insurance from federal preemption, thereby reinforcing the states' authority to regulate insurance under the McCarran-Ferguson Act of 1945.[14] Section 514(b)(2)(B), ERISA's deemer clause, narrows the potential scope of the savings clause.[15] In general, the deemer clause provides that no employee benefit plan will be deemed to be an insurer or in the insurance business (among other things) in order to make such plans subject to state law and therefore avoid ERISA preemption. As a result, the deemer clause

restricts the extent to which state insurance regulation can impact employee benefit plans and prevents states from circumventing federal preemption under ERISA through the pretext of regulating insurance.[16]

C. Judicial Interpretation of ERISA Preemption

With respect to preemption under ERISA, the critical inquiry is determining whether, or to what extent, a state law "*relate[s] to* an employee benefits plan."[17] As noted by the U.S. General Accounting Office, "ERISA preemption language was sufficiently ambiguous that courts have had to elaborate on its scope . . . [and] tried to delineate how closely state laws must relate to employer health plans to be preempted."[18] A series of recent U.S. Supreme Court cases has attempted to develop an analytical framework for determining whether state or local law sufficiently "relates to" employee benefit plans so as to cause such laws to be preempted by ERISA. Early cases interpreting Section 514(a) of ERISA applied the provision very broadly. In *Shaw v. Delta Airlines, Inc.*, one of the first cases to consider the scope of Section 514(a), the Supreme Court interpreted the "relate to" language to include any provision having either a "connection with or reference to" an employee benefits plan.[19] A "reference to" a benefits plan that will result in ERISA preemption arises "[w]here a State's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the [State] law's operation."[20] Alternatively, a "connection with" an employee benefits plan that gives rise to preemption under ERISA requires an examination of "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, [and] . . . the nature of the effect of the state law on ERISA plans."[21] The "connection with or reference to" test adopted by the Supreme Court in *Shaw* assumes a very literal and expansive view of preemption under Section 514(a) of ERISA. Although this view has maintained much of its vitality over time, subsequent cases interpreting and applying Section 514(a) have narrowed its scope to some degree and signaled that its reach is not limitless.

Most notably, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*,[22] "finally recognized the limits of ERISA preemption."[23] In *Travelers*, the Supreme Court concluded that Section 514(a) did not preempt a New York law requiring hospitals to charge different rates to insured, HMO, and self-insured plans. Taking a noticeable step back from its traditionally expansive interpretation of ERISA preemption, the court reaffirmed the traditional principle recognized in other areas of law that there is a "presumption that Congress does not intend to supplant state law."[24] To determine whether Congress intended to preempt state law, the court examined the "structure and purpose of the act."[25] With respect to federal preemption generally, where federal law is said to bar state action in fields of traditional state regulation, the Supreme Court assumes that federal law does not supersede states' historic police powers unless Congress clearly manifests such a purpose in its legislation.[26] In *Travelers*, the court specifically identified health care as an area of traditional state regulation and suggested that a congressional intent to preempt state law should not be presumed unless it was "clear and manifest."[27] This examination led the court to conclude that "nothing in the language of the act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."[28] Defining the purpose of ERISA as freeing employee benefit plans from conflicting state and local regulations,[29] the court held that Congress intended ERISA to preempt only state and local laws that operated *directly* on the structure or administration of employee benefit plans.[30] Laws that only *indirectly* affected employee benefit plans should not be preempted by ERISA.[31] Therefore, while the "decision did not delineate fully between state actions that preempted and those that are not,"[32] it seemed to indicate that state regulation would be permissible where it did not (1) conflict with the underlying objectives of ERISA or (2) impact employee benefit plans too greatly.[33] As the first Supreme Court case narrowing the scope of ERISA preemption, the U.S. General Accounting Office suggested that the ruling would not only make states "likely to perceive that they have more

options and greater flexibility than previously recognized" in drafting laws affecting employee benefit plans but also that such laws would "have to be judged individually on the facts and circumstances in each case.[34]

While *Travelers* scaled back the scope of ERISA preemption to some degree,[35] the decision did not provide a bright-line test as to when federal law would preempt state or local law. Two years later, in *DeBuono v. NYSA-ILA Medical Services Fund*, the Supreme Court permitted the state of New York to impose a tax on gross receipts for patient services performed by medical providers on a hospital owned and operated by an ERISA plan.[36] Similar to *Travelers*, the court noted that the law regulated health and safety matters, a field traditionally occupied by the states.[37] In addition, the court concluded that nothing in New York's law suggested it was the type of law that Congress intended ERISA to supersede.[38] Ultimately, *DeBuono* rejected an expansive, literal interpretation of Section 514(a), holding that the tax at issue was one of "general applicability."[39] While the court acknowledged that the challenged law "impose[d] some burdens on the administration of ERISA plans," the statute nevertheless had only an incidental effect on employee benefit plans and did not "relate to [ERISA plans] within the meaning of" ERISA; therefore, the challenged law did not affect ERISA's objectives.[40] When read in conjunction with the *Travelers* decision, the *DeBuono* opinion implies that a state or local law may survive ERISA preemption, even if it imposes burdens of administration on ERISA plans, so long as the challenged law is a law of general applicability and not the type of law that Congress intended for ERISA to supersede.

In *Kentucky Ass'n of Health Plans, Inc. v. Miller*,[41] the most recent Supreme Court case addressing ERISA preemption, a trade association brought a suit challenging Kentucky's "any willing provider" law (AWP law). This law prohibited insurers from discriminating against a health care provider willing to meet the insurer's criteria for participation in the health plan by requiring health insurers and managed care organizations to reimburse all licensed physicians or health

professionals as long as they were willing and qualified to participate in the insurer's network.[42] In the Sixth Circuit, a three-judge panel concluded that although Kentucky's AWP law "related to" employee benefit plans, the AWP law only applied to directly insured plans; therefore, ERISA's savings clause prevented federal preemption.[43] The Supreme Court subsequently affirmed the Sixth Circuit ruling, holding that a state law is deemed to regulate insurance under Section 514(b)(2)(B) if it satisfies the following requirements: the state law must (1) be "specifically directed toward entities engaged in insurance" and (2) "substantially affect the risk pooling arrangement between the insured and the insurer."[44] This new two-part test departed from the traditional approach taken by the Supreme Court in interpreting Section 514(b)(2)(A),[45] significantly clarifying and expanding, the scope of ERISA's savings clause. Effectively, the court "abandoned its earlier precedents and crafted a new approach to interpreting the savings clause." Under the analytical framework articulated by the Supreme Court in *Kentucky Ass'n*, ERISA's savings clause would appear to protect any state law that requires insurers to provide particular benefits.[46]

The Supreme Court decisions in *Travelers, DeBuono,* and *Kentucky Ass'n* indicate a gradual shift toward a more narrow judicial interpretation of ERISA preemption. Nonetheless, Section 514(a) is generally considered to still broadly preempt state and local law, and ERISA remains "a significant barrier to state health care reform."[47] In effect, the expansive reach of Section 514(a) has constrained experimentation with health care reform at the state and local level. In particular, ERISA preemption has proved to be a formidable challenge to fair share laws enacted by state and local governments in Maryland, Suffolk County, NY, and San Francisco, CA in an effort to provide uninsured residents with access to health care.

III. Uninsured & Access to Health Care

In 2007, an estimated 45 million Americans under the age of 65 did not have health insurance.[48] According to the Congressional Budget Office, approximately 1-in-6 nonelderly people

in the United States will be without health insurance at any given time during 2009.[49] The incremental cost of health insurance for low-wage workers is relatively high; therefore, those most likely to be uninsured will be least able to pay for their own health care.[50] Whether the uninsured receive health care will depend upon a combination of where each uninsured patient lives, the care needed, and what organizations are willing to pay for such care.[51] Rising health care costs have made health care coverage less affordable or even prohibitively expensive for many individuals and employers, contributing to both the growing number of uninsured as well as a decreased level of access to care.[52] In 2007, employer-sponsored health insurance accounted for the majority of insured individuals;[53] however, many businesses do not offer health benefits to their employees.[54] In addition, the number of employers offering employer-sponsored coverage has either stalled or declined over the past decade.[55] With respect to the relationship between the uninsured and access to care, studies indicate that lack of health care coverage reduces access to care and results in unmet need for such care, regardless of the length of time that one is uninsured.[56]

During the economic downturn at the start of the decade, "nonelderly Americans with employer-sponsored health insurance decreased for the first time since 1993, dropping from sixty-six percent in 2000 to sixty-one percent by 2004." As suggested by historical experience, a declining economy will result in a greater number of individuals becoming unemployed, self-employed, or working in smaller firms; under all of these scenarios, the number of uninsured will presumably increase. According to a recent study by the Kaiser Commission on Medicaid and the Uninsured, a one percent increase in the unemployment rate in 2008 would result in a 1.1 million increase in the number of uninsured.[57] Similarly, a downward shift in incomes associated with falling economic conditions will result in a greater number of low-income individuals, "where uninsured rates are the highest."[58] Since the number of uninsured will undoubtedly continue to multiply at increasing rates in the near-term, the need to institute health care reform that addresses the twin problems of the

uninsured and access to health care is critical. Notwithstanding this pressing need, ERISA serves as a formidable obstacle to state and local efforts to expand health care coverage.

IV. Fair Share Laws

A. Introduction

Several state and local governments have turned to fair share laws as one possible solution to the problem of the uninsured and the failure to achieve comprehensive health care reform at the national level. Fair share laws generally require employers to pay into a state fund if employers (1) pay less than a specified percentage of their payroll toward employee health benefits or (2) do not provide any health insurance coverage for their employees.[59] As a result, such laws require employers to either provide a minimum level of health benefits for their employees or help to offset the cost of public health care coverage provided by the state or locality.[60]

For example, in April 2006, Massachusetts enacted a law that required all residents of the state to have health insurance.[61] The Massachusetts program is funded in part by an employer spending mandate; employers with eleven or more employees must either provide health insurance coverage for their employees or contribute up to $295 annually per employee to the state.[62] So far, no ERISA preemption suit has been brought against Massachusetts' health care reform statute and its employer spending mandate.[63] The lack of a legal challenge may be attributable to the strong support from leading business groups for the state's reform initiative; alternatively, it might be due to the fact that the minimum health care expenditure amount imposed by Massachusetts' law is much smaller relative to other fair share programs.[64] Nonetheless, speculation persists as to whether Massachusetts' employer spending mandate will be subject to an ERISA challenge and, if so, whether it would survive such a challenge.[65]

Notwithstanding the notable absence of an ERISA preemption suit against Massachusetts' health care reform law, other states and localities have not been as fortunate. In particular, Maryland

and Suffolk County, NY both attempted to implement their own fair share laws. However, in each instance, a retail trade association brought a suit challenging the law under ERISA, and the court ultimately found that ERISA preempted the fair share law in question.

B. Maryland – Fair Share Health Care Fund Act

In January 2006, Maryland enacted the Fair Share Health Care Fund Act (Fair Share Act).[66] This legislation required for-profit employers with 10,000 or more employees in Maryland to either spend at least eight percent of total payroll costs on employee health insurance costs[67] or pay the state the amount that those employers' spending fell short of that threshold percentage.[68] However, shortly after the Fair Share Act was enacted, the Retail Industry Leaders Association (RILA), a trade association that included Wal-Mart as a member, brought a suit challenging the law on the grounds that it was preempted by ERISA.[69] Ultimately, the Fourth Circuit affirmed the district court decision, which concluded that Section 514(a) of ERISA preempted the Fair Share Act.[70]

The state made two arguments in defense of upholding the Fair Share Act: (1) the law was a statute of general applicability and (2) did not have a "connection with" employee benefit plans. Presumably, under *DeBuono*, a law of general applicability may survive an ERISA preemption challenge. In support of this argument, the state contended that the revenue obtained under the minimum spending requirement would fund the Fair Share Health Care Fund, which was established under the Fair Share Act and would be used to offset costs under the Maryland Medical Assistance Program.[71] With regard to whether the Fair Share Act had a "connection with" employee benefit plans, the state argued that no such connection existed because employers could act in ways that did not involve employee benefit plans but satisfied the minimum spending requirement imposed by the Fair Share Act.[72] For example, an employer could establish on-site medical clinics, contribute more money to employees' health savings accounts, or not increase benefits under any ERISA plan and simply pay the difference between existing ERISA benefit spending and the eight

percent required under the Fair Share Act.[73]

The Fourth Circuit rejected both arguments presented by the state and concluded that ERISA preempted the Fair Share Act. One critical issue with respect to the Fair Share Act is the extent to which it directly impacted Wal-Mart while not affecting either large nonprofit employers or other for-profit employers operating within the state. Under Maryland's law, Wal-Mart would have been the only for-profit employer in the state subject to the Fair Share Act requirements.[74] Before enacting the Fair Share Act, state legislators considered testimony that reported rising costs within the Maryland Medical Assistance Program, which provided access to health care for Maryland's low income residents.[75] In addition, the General Assembly reviewed information showing Wal-Mart failed to provide adequate health benefits to its employees. For example, Wal-Mart employed 16,000 workers in Maryland, many of whom received inadequate health care coverage or no coverage at all.[76] This led many Wal-Mart employees and dependents to enroll in Medicaid and the Maryland's children's health insurance program.[77] Based on the legislative history of the act, the court found that the Fair Share Act "could hardly be intended to function as revenue act of general application," rejecting the state's argument in that regard.[78]

Similarly, the Fourth Circuit found the Fair Share Act had an impermissible "connection with" employee benefit plans. In *Travelers*, the Supreme Court upheld the law at issue, finding that it merely created an "*indirect* economic influence"[79] on employers with respect to employee benefit plans. In contrast, the Fourth Circuit concluded that the Fair Share Act "*directly* regulate[d] employers' structuring of their employee health benefit plans."[80] As a result, "the only rational choice" for an employer subject to the Fair Share Act requirements was "to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold."[81] Alternatives to increase spending suggested by the state were not sufficient to avoid ERISA preemption. The options provided by Maryland's law were "not *meaningful* alternatives"[82] by which an employer could increase

health care spending to comply with the Fair Share Act without affecting its ERISA plans. In the court's opinion, it was unrealistic and impractical to assume that employers would be able to differentiate between ERISA and non-ERISA health care spending as isolated and unrelated costs. Since "[d]ecisions regarding one would affect the other and thereby violate ERISA's preemption provisions," a prohibited "connection with" ERISA plans existed under Maryland's law.[83]

Having lost at both the district court and appellate court levels, Maryland's Attorney General concluded a reversal was highly unlikely and decided not to seek review of the Fourth Circuit decision by the Supreme Court.[84] Post-*Fielder*, it would seem clear that "a direct mandate requiring employers to offer specified coverage to their employees is out of the question."[85]

C. Suffolk County, NY – Fair Share for Health Care Act

In October 2005, Suffolk County, NY passed the Suffolk County Fair Share for Health Care Act (Suffolk County Act).[86] As originally enacted, the Suffolk County Act required certain large retail stores selling groceries[87] to make "health care expenditures"[88] equivalent to not less than $3.00 per hour worked by employees in Suffolk County, NY.[89] Four categories of non-ERISA health care expenditures could satisfy the employer spending mandate: (1) contributions by the employer to a health savings account, (2) reimbursement by the employer of health care expenses incurred by an employee or its family members, (3) expenditures incurred by the employer to provide a health clinic or any health-related services in the workplace, or (4) contributions by the employer to any federally funded health center or other community center.[90] If covered employers failed to satisfy the mandated expenditures, the Suffolk County Act required such employers to pay a civil penalty to the county.[91] The act was later amended, redefining the "health care expenditures" requirement as equivalent to the "public health care cost rate multiplied by the total number of hours worked" by employees in Suffolk County, NY. The "public health care cost rate" is defined under the law as "a rate that approximates the cost to the public health care system of providing health care to one

uninsured employee."[92]

Similar to the *Fielder* decision, the legislative history of the Suffolk County Act and its particular impact on Wal-Mart played a critical role in the disposition of the Suffolk County case. The act "expressly acknowledge[d] a legislative intent to protect small retailers in Suffolk County from large employers who do not provide health care for employees."[93] In addition, Wal-Mart met the definition of a "covered employee" under the Suffolk County Act because it operated stores in Suffolk County in which groceries and other foods were sold for offsite consumption and had total annual revenue over $1 billion with at least twenty percent of that revenue produced by grocery sales.[94] Several sponsors of the Suffolk County Act expressed a desire not only to protect small businesses but also to have a direct effect on Wal-Mart's operations in Suffolk County.[95] Most notably, Legislator Foley expressed concerns "about the looming threat of Wal-Mart type stores that have wreaked havoc in a number of communities."[96] Similarly, in dramatic fashion, Legislator Tonna described a scene from a movie where an entire town had collapsed as a result of one individual's actions and suggested that "if you look around the communities of the United States, you see that's what Wal-Mart has done."[97] It is no surprise that almost immediately after the Suffolk County Act was enacted, RILA challenged the law on the basis of ERISA preemption.[98]

In defense of its law, Suffolk County argued that a local law is not preempted by ERISA where the existence of an ERISA plan is not necessary to be in compliance with the local law.[99] The county contended that the existence or modification of an ERISA plan was not necessary under the Suffolk County Act due to the fact that employers could achieve compliance with the law through four categories of non-ERISA expenditures expressly identified under the law as satisfying the employer spending mandate.[100] In addition, the county asserted that the primary purpose of its law was to reduce the county's financial burden of subsidizing health care for residents; since containing health care costs is a traditional area of state regulation, the county maintained that ERISA did not

preempt its fair share law.[101]

The district court commented that it was not bound by the Fourth Circuit's decision in *Fielder* several months earlier; nonetheless, the district court noted that the Suffolk County Act was substantially similar to Maryland's Fair Share Act.[102] Thus, stating that it was "in accord with the Fourth Circuit's well reasoned and comprehensive analysis"[103] in *Fielder*, the district court held that ERISA preempted Suffolk County's fair share law.[104] The district court asserted that the only rational choice for covered employers was "to structure their ERISA health care benefit plans to meet the minimum spending threshold" required by the Suffolk County Act.[105] Despite the Suffolk County Act providing alternatives by which employers could satisfy the minimum spending requirement, the district court found these options did not constitute "meaningful alternatives," maintaining that the alternative options were unrealistic and would be difficult for covered employers to actually utilize.[106] Once those options for compliance with the Suffolk County Act were eliminated, "all that [was] left [was] for covered employers . . . to increase contributions to ERISA plans."[107] Much like *Fielder*, the district court also noted that the legislative history made it clear that the Suffolk County Act was targeted at Wal-Mart, concluding that "Suffolk County enacted [its law] in order to mandate that covered employers and, specifically, Wal-Mart, increase spending on healthcare coverage for Suffolk County employees."[108] The district court also expressed concern that the Suffolk County Act would disrupt uniform plan administration, resulting in differing state regulations and "impos[ing] precisely the burden that ERISA preemption was intended to avoid."[109] Based on the aforementioned factors, the district court found that the Suffolk County Act obviously had a prohibited connection with employee benefit plans and was therefore preempted by Section 514(a) of ERISA.[110]

V. San Francisco – Healthy San Francisco

A. Introduction

San Francisco has had a long history of seeking to improve the health care delivery system for its uninsured residents.[111] Beginning in the mid-1990's the city launched initiatives to provide high quality medical care to the largest possible number of low-income residents.[112] Shortly thereafter, in 1998, San Francisco voters approved an initiative encouraging health care expansion to the city's uninsured residents.[113] In February 2006, the city established the multi-disciplinary Universal Healthcare Council (UHC) to explore options to expand health care access to all of San Francisco's uninsured residents.[114] Ultimately, the UHC developed a framework for implementing such a program, and in July 2006, the city of San Francisco adopted its own fair share law.[115] Thus, San Francisco became the first city in the United States to implement a program designed to provide all of its uninsured residents with universal access to health care.[116] Initially referred to as the San Francisco Health Access Program, the program has come to be known as Healthy San Francisco.[117]

Unlike many other health care reform efforts, Healthy San Francisco is not health insurance.[118] Instead, the program provides each participant with the following: (1) a "medical home;" (2) a primary care provider; and, (3) access to specialty care, urgent and emergency care, mental health care, substance abuse services, laboratory, inpatient hospitalization, radiology, and pharmaceuticals.[119] In order to receive care, a participant must be a resident of the city of San Francisco and is limited to receiving care through the Healthy San Francisco program within the city.[120] Healthy San Francisco began by targeting the most vulnerable segment of San Francisco's uninsured population. Residents whose income was at or below 100 percent of the Federal Poverty Level (FPL) were the first to be eligible to enroll in Healthy San Francisco.[121] As of January 2008, eligibility was expanded to include San Francisco residents whose income was at or below 300 percent of the FPL.[122] The Healthy San Francisco program started by enrolling several hundred

patients at two Chinatown clinics in July 2007; since that time, the program has expanded to include twenty-seven participating clinics and has added roughly 2,000 participants per month.[123] When Healthy San Francisco was enacted, San Francisco had an estimated uninsured population of 82,000 residents;[124] as of March 2009, more than 38,000 residents had enrolled in Healthy San Francisco.[125] Of the 82,000 residents initially identified as uninsured, approximately 46,000 of those residents were employed but lacked health insurance.[126] Based on a study conducted by the San Francisco Health Plan,[127] the majority of employed individuals without health care coverage cited their employer not offering health benefits as the reason for being uninsured.[128] Other reported reasons included either not being eligible for coverage[129] or declining to accept coverage offer by an employer,[130] presumably due to the high cost of contribution to the employer's health plan.

At the time of enactment, Healthy San Francisco was expected to cost approximately $200 million per year or slightly more than $2,400 per year for each uninsured resident.[131] In order to finance universal access to health care for San Francisco's uninsured residents, Healthy San Francisco relies on a combination of four major funding sources:[132] city funds,[133] state funds,[134] individual premiums and copayments,[135] and mandatory employer contributions.[136] Payments made by covered employers pursuant to Section 14.3 of the Health Care Security Ordinance cover about a quarter of Healthy San Francisco's annual cost.[137] Essentially, under the Healthy San Francisco definition for "covered employer,"[138] any for-profit business operating in San Francisco and employing twenty or more people or any nonprofit corporation operating in San Francisco and employing fifty or more people is required to either provide health care coverage for its employees or pay a fee to the city to help finance the Healthy San Francisco program.[139] If an employer chooses to provide health care coverage for its employees, then it must meet a minimum spending requirement established by Healthy San Francisco. In particular, smaller companies are required to spend roughly $200 per employee per month, and larger companies are required to spend roughly

$300 per employee per month.[140] In the event that a covered employer decides not to provide health care coverage for its employees at the minimum amounts established by the ordinance, then such employers must pay fees ranging from $1.23 per employee per hour for medium-sized businesses and $1.85 per employee per hour for large businesses.[141] A "medium-sized business" is defined as "an employer for which an average of between twenty (20) and ninety-nine (99) persons per week perform work for compensation during a quarter"[142] and a "large business is defined as "an employer for which an average of one hundred (100) or more persons per week perform work for compensation during a quarter."[143]

An employer subject to Healthy San Francisco's requirements must only make required health care expenditures on behalf of its covered employees.[144] Such expenditures must be made quarterly and are calculated based on the total number of hours worked by covered employees multiplied by the health care expenditure rate.[145] Similar to the Suffolk County Act, certain expenditures are expressly identified under Healthy San Francisco as complying with a covered employer's required health care expenditures.[146] Qualifying health care expenditures include the following: (1) employer contributions to a health savings account, (2) employer reimbursement of employee expenses incurred in purchasing health care services, (3) employer payments to a third party for the purpose of providing health care services for employees, (4) costs incurred by an employer in the direct delivery of health care to its employees, or (5) employer payments to the city of San Francisco to be used on behalf of its employees.[147] In addition to the health care expenditure requirements, a covered employer must also satisfy certain record keeping and reporting requirements under Healthy San Francisco.[148]

B. Small Business Opposition to Healthy San Francisco

Similar to other health care reform efforts attempting to implement fair share laws, Healthy San Francisco has not come without challenges from affected employers.[149] The mandatory

employer contribution component has faced fierce opposition from the San Francisco business community in general and small businesses in particular.[150] Small businesses have argued that Healthy San Francisco forced them to bear an unfair share of financial responsibility for the program and "would force them to lay off employees, raise prices, cut salaries, or go out of business," all of which would be detrimental to the city of San Francisco.[151] The 900-member Golden Gate Restaurant Association (GGRA),[152] in particular, alleged that compliance with Healthy San Francisco would raise restaurant operating costs by five percent, significantly reducing historically small profit margins.[153] On November 8, 2006, shortly after the enactment of Healthy San Francisco, the GGRA sued the city of San Francisco in an effort to overturn the employer spending mandate on the grounds that it was preempted by ERISA.[154]

C. Legal Challenge to Healthy San Francisco – Northern District of California

As if expecting an ERISA challenge, Section 14.6 of the San Francisco Health Care Security Ordinance states "[n]othing in this Chapter shall be interpreted or applied so as to create any power, duty or obligation in conflict with, or *preempted* by, *any Federal* or State law."[155] Nevertheless, on December 27, 2007, Judge White entered judgment in favor of the GGRA on the grounds that Section 514(a) of ERISA preempted the San Francisco Health Care Security Ordinance.[156] In reaching this result, Judge White analyzed the extent to which San Francisco's ordinance "relate[d] to" an employee benefit plan by applying the two-part test established in *Shaw*, whereby satisfaction of either prong results in preemption under Section 514(a) of ERISA.

Applying the first prong of the *Shaw* test, Judge White concluded that San Francisco's law had a prohibited connection with employers' ERISA-regulated plans. Specifically, Healthy San Francisco (1) affected ERISA plan administration, (2) imposed ongoing administrative burdens upon employers, including record keeping and reporting, that directly affected the scheme of providing health care benefits, (3) both directly and indirectly affected the structure and

administration of ERISA plans, and (4) interfered with national uniform plan administration.[157] Similarly, Judge White found that San Francisco's law also failed the second prong of the *Shaw* test by making an unlawful reference to employee benefit plans in two ways. First, Judge White interpreted Healthy San Francisco as implicitly referencing the existence of ERISA plans in its expenditure requirements provisions.[158] Second, he concluded that liability under Healthy San Francisco was determined exclusively with reference to employer-sponsored health benefits that are predominantly provided under existing ERISA plans.[159] In Judge White's opinion, a covered employer could only determine its liability under Healthy San Francisco by ascertaining how much it paid for employee health coverage under existing plans. Therefore, "under either analysis, [Healthy San Francisco was] preempted because it [had] both a connection with and reference [to] ERISA plans."[160] Due to the fact that Healthy San Francisco "fail[ed] to withstand the expansive test of ERISA preemption," the district court enjoined the implementation and enforcement of the program.[161]

D. Legal Challenge to Healthy San Francisco – Ninth Circuit Court of Appeals

Despite Judge White's ruling, the city of San Francisco immediately filed a motion with the district court seeking a stay of the injunction pending an appeal to the Ninth Circuit Court of Appeals. Although the district court denied the motion,[162] on January 9, 2008, a unanimous three-judge panel of the Ninth Circuit ordered a stay of the district court order pending an appeal by the city of San Francisco.[163] In reaching this decision, the Ninth Circuit panel noted the legal standard for granting a stay constitutes a continuum, which requires an assessment of the probability of success on the merits at one end and, at the other end, whether the balance of hardships tipped sharply in favor of the party seeking the stay.[164] Under this analytical framework, the court held that not only did a strong likelihood of success on the merits exist but also that the balance of hardships tipped sharply in favor of the city of San Francisco.[165] In addition, the panel found that public

interest supported granting the stay.[166] On February 7, 2008, the GGRA filed an application to the U.S. Supreme Court, seeking to lift the Ninth Circuit's ruling.[167] However, on February 21, 2008, acting in his capacity as Circuit Justice for the Ninth Circuit, Justice Kennedy denied the GGRA request.[168] Thus, Healthy San Francisco and its employer spending requirement remained in effect pending the city of San Francisco's appeal of the district court decision. On September 30, 2008, the Ninth Circuit's three-judge panel issued an opinion reversing the district court's ruling and upholding Healthy San Francisco's employer spending requirement.[169] In response to this ruling, on October 22, 2008, the GGRA petitioned for a rehearing en banc before the Ninth Circuit.[170] Nonetheless, on March 9, 2009, the Ninth Circuit denied the request for rehearing en banc, upholding the panel's decision that ERISA did not preempt the Healthy San Francisco program.[171] The Ninth Circuit's denial of an en banc rehearing elicited both dissenting and concurring opinions, which is relatively uncommon in terms of federal appellate procedure.[172]

Joined by seven other judges, Judge Smith voiced his belief that "the San Francisco Ordinance [was] clearly preempted by ERISA Section 514(a)" and strongly dissented on several grounds.[173] Specifically, Judge Smith asserted that the Ninth Circuit's decision (1) created a circuit split with the Fourth Circuit Court of Appeals, (2) rendered the *Shaw* test meaningless and ignored ERISA preemption guidelines established by Supreme Court precedent,[174] and (3) "most importantly, flout[ed] the mandate of national uniformity in the area of employer-provided healthcare" that was at the core of ERISA's enactment.[175] In relation to the issue of national uniformity, the dissenting opinion raised a more overarching policy concern with respect to the Ninth Circuit's decision, suggesting that the decision to allow San Francisco to implement Healthy San Francisco created a roadmap for other state and local governments to circumvent ERISA preemption.[176] "[S]imilar laws [would] become commonplace," undermining the congressional goal of minimizing the administrative and financial burdens imposed on employee benefit plan

administrators and resulting in "adverse consequences to employers and employees alike."[177]

With respect to the creation of a circuit split between the Ninth Circuit and Fourth Circuit, the dissent argued that the employer spending requirements imposed by Healthy San Francisco and Maryland's Fair Share Act were functionally indistinguishable.[178] The issue was not whether employers had a "meaningful alternative" through which to make non-ERISA payments; rather, "[c]overed employers under San Francisco's Ordinance must coordinate their non-ERISA payments with their ERISA plans in the very manner the *Fielder* court deemed impermissible."[179] Essentially, a non-complying covered employer in San Francisco faced the same choice as a non-complying covered employer in Maryland; the employer could either "[m]ake a payment to the government or change its current ERISA plan."[180] Regardless of which payment the employer decides to make, the practical effect is to impose a penalty upon the employer rather than to provide a meaningful alternative for compliance.[181] Therefore, by allowing Healthy San Francisco to impose its employer spending requirement, the dissent contended that the Ninth Circuit "create[d] a circuit split on the issue of whether ERISA preempt[ed] 'fair share' or 'play-or-pay' ordinances."[182]

In addition, the dissent alleged that the Ninth Circuit chose to disregard Supreme Court precedent establishing ERISA preemption principles, conflicting with decisions in both *Egelhoff v. Egelhoff* and *District of Columbia v. Greater Washington Bd. of Trade*.[183] Emphasizing the fact ERISA was enacted to eliminate the burden of conflicting obligations on employers operating in multiple jurisdictions,[184] the dissent cited *Egelhoff* for the proposition that states and localities cannot avoid preemption by offering employers a theoretical means by which to avoid changing existing ERISA plans.[185] Under the dissent's interpretation of *Egelhoff*, an employer's ability to "opt out" of the state law did not prevent it from having an impermissible "connection with" ERISA plans.[186] In this manner, the dissent analogized *Egelhoff* to San Francisco's ordinance, asserting that covered employers who have not achieved the minimum spending requirement face one of the two following

choices: they can either (1) increase or maintain health care expenditures under existing plans or (2) pay San Francisco an amount equal to the mandated minimum.[187] However, under the dissent's interpretation of Section 514(a) and Supreme Court precedent, either choice bears a prohibited "connection with" employer's employee benefit plans, preempting Healthy San Francisco under ERISA. In addition, notwithstanding the choices available to employers in complying with San Francisco's requirement, allowing such a law would require plan administrators to potentially contend with such provisions in every state; the necessary burden of monitoring, accounting for, and complying with a multitude of state and local laws was "exactly the burden ERISA [sought] to eliminate."[188]

Similarly, the dissent analogized the employer spending mandate under Healthy San Francisco to the Washington, D.C. law challenged in *Greater Washington Bd. of Trade*.[189] Washington, D.C.'s ordinance required employers to provide the same medical coverage to injured employees as non-injured, active employees. Under that law, employers could provide benefits to injured employers through a separate non-ERISA plan; nonetheless, the court found the law was preempted by ERISA on the grounds that it impermissibly referred to an ERISA plan.[190] This prohibited reference arose because the benefits for each class of employees had to be equal, which necessarily required a comparison to the existing ERISA plan.[191] Similarly, while covered employers might not have to amend their ERISA plans in order to comply with San Francisco's ordinance, whether covered employers are in compliance with the spending requirement can only be determined by using such employers' current ERISA plans as a reference.[192] Consequently, the dissent flatly rejected the notion that the issue could be framed in terms of obligations measured by reference to payments provided by the employer to an ERISA plan or another entity under Healthy San Francisco versus obligations measured by reference to the level of benefits provided by the ERISA plan to an employee in *Greater Washington*.[193]

"[M]ost importantly, [Judge Smith] dissent[ed] because this case concerns an issue of exceptional national importance, i.e., *national uniformity* in the area of employer-provided healthcare."[194] The dissent insisted that the Ninth Circuit decision ignored ERISA's preemption goals, focusing instead on ERISA's objective of protecting against misuse of employee benefit plan funds, despite the fact that preemption, and not misuse, was central to ERISA's implementation.[195] Without uniformity, multi-state employers face significant hardships; such employers cannot offer all similarly situated employees the same benefits nor can they achieve continuity in their respective benefit programs.[196] As an example, the dissent noted that employees of a national restaurant chain operating in Oakland and San Francisco would receive different benefits, and the employer would be subject to different requirements, notwithstanding their geographic proximity.[197] While complying with San Francisco's law may not be particularly onerous on a small scale, "if we consider the possibility of numerous cities, counties and states enacting similar laws, the burden this places on employers is potentially very great, thereby encouraging affected employers to drop their ERISA plans as a cost saving measure."[198] By allowing San Francisco's health access program, the Ninth Circuit provided a roadmap for other states and localities to institute employer spending requirements, leading to "health care expenditure balkanization," which is exactly what ERISA was meant to prevent.[199]

Having written the original Ninth Circuit panel decision, Judge Fletcher concurred in the court's decision not to rehear the matter en banc and drafted a concurring opinion to respond to the dissent's arguments. In particular, Judge Fletcher systematically rejected the dissent's contentions that the Ninth Circuit's decision (1) "create[d] a circuit conflict with *Retail Industry Leaders Ass'n v. Fielder,*"[200] (2) conflicted with Supreme Court precedent,[201] and (3) that ERISA "required national uniformity in the provision of health care."[202] Addressing the potential split with the Fourth Circuit's decision in *Fielder*, Judge Fletcher suggested that the two cases can be distinguished on the

issue of "meaningful choice."[203] Maryland's Fair Share Act required "employers with 10,000 or more Maryland employees to spend at least eight percent of their total payrolls on employees' health insurance costs or pay the amount their spending falls short to the State of Maryland."[204] Any employer subject to the minimum spending threshold did not receive anything in return for itself or its employees as a result of payments made to the state; due to the employer size threshold, the only employer covered by the law was Wal-Mart. Since the practical effect of Maryland's law was to *require* Wal-Mart to increase its ERISA coverage of employees,[205] the law was impermissibly related to ERISA.[206]

In contrast, under San Francisco's health access program, covered employees "are entitled to obtain health care benefits . . . at reduced rates."[207] According to Judge Fletcher, rather than "imposing a de facto obligation," this structure presented a "meaningful choice" to covered employers between either (1) meeting the minimum spending threshold imposed by Healthy San Francisco or (2) paying the tax to San Francisco in exchange for its employers receiving access to health care services provided by the city.[208] In addition, Judge Fletcher argued that San Francisco's fair share law does not require covered employers to coordinate non-ERISA payments imposed by the minimum spending requirement with their existing ERISA plans. Under the Maryland law, "Wal-Mart's use of the non-ERISA spending option would *necessarily produce a change* in its ERISA plans."[209] In Judge Fletcher's opinion, no change in any ERISA plan resulted from a covered employer's paying the tax imposed by Healthy San Francisco; however, Judge Fletcher makes this broad statement without any additional discussion or comparison.[210]

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

an option to plan administrators; however, the court rejected this argument and held that the law bound plan administrators to a particular choice of rules for determining beneficiary status.[211] By forcing administrators to either follow the state's beneficiary designation scheme or alter the terms of their ERISA plans, the challenged statute forced plan administrators to make a change to their ERISA plans one way or another and was therefore preempted by Section 514(a). Relying upon his analysis in relation to *Fielder*, Judge Fletcher maintained that San Francisco's ordinance did not require any change to an ERISA plan and was therefore distinguishable from the result in *Egelhoff*.[212]

While *Egelhoff* dealt with the issue of a state law imposing changes upon ERISA plans, *Greater Washington Bd. of Trade* analyzed the determination of the requisite level of benefits under an employer mandate. In *Greater Washington Bd. of Trade*, Washington, D.C. implemented a law that determined the requisite level of benefits by "reference to" existing health insurance coverage provided by employers; according to the court, this calculation constituted an impermissible reference to an ERISA plan.[213] In contrast, Judge Fletcher argued that Healthy San Francisco's required payments are determined by reference to hours worked by an employee rather than by reference to benefits provided by an ERISA plan.[214] A covered employer's required payments can be reduced or eliminated by making payments to, among other things, an employee's ERISA plan;[215] however, the "amount of the reduction is determined by reference to the *amount* of money paid" on behalf of the employee in reference to the number of hours worked.[216] For this reason, Judge Fletcher argued that Healthy San Francisco is distinguishable from *Greater Washington Bd. of Trade*. Notwithstanding the closely related issues raised in *Egelhoff* and *Greater Washington Bd. of Trade*, Judge Fletcher maintained that the Ninth Circuit's decision was not inconsistent with existing Supreme Court precedent due to the particular facts and circumstances related to Healthy San Francisco's structure and implementation.[217]

Finally, Judge Fletcher rejected the dissent's position that "ERISA responds to the 'need for

nationally uniform plan administration' and a 'uniform regulatory system.'"[218] Citing the Supreme Court's decision in *Fort Halifax Packing Co. v. Coyne*,[219] Judge Fletcher argued that the purpose of ERISA was not to require national uniformity in the provision of health care but rather to ensure administrative practices of a benefit plan are governed only by a single set of regulations.[220] Assuming that nothing in San Francisco's plan required employers to establish an ERISA plan or to alter an existing ERISA plan, Judge Fletcher concluded that "nothing in the Ordinance interfere[d] in any way with the uniformity of ERISA regulations."[221]

At least one thing is clear from the Ninth Circuit's final decision – its members have distinctly different viewpoints on the permissibility of Healthy San Francisco and whether ERISA preemption affords any opportunity for health care reform through state or local fair share laws. Whether the Supreme Court will ultimately weigh in on this matter remains to be seen. On March 18, 2009, the GGRA filed an application to the Supreme Court for an emergency injunction, seeking to prevent San Francisco from continuing to impose the employer spending requirement while the GGRA appeals the Ninth Circuit decision to the Supreme Court.[222] However, on March 30, 2009, Justice Kennedy once again denied the GGRA's request for an emergency stay.[223] Accordingly, Healthy San Francisco and its employer spending requirements remain in effect for all covered employers.[224]

VI. Conclusions

Regardless of whether the Supreme Court ultimately decides to intervene in *Golden Gate Restaurant Ass'n*, the more interesting issue is what effect a decision to uphold or reject the Ninth Circuit decision will have on employee benefit plans and health care reform.[225] In the event that San Francisco's ordinance is upheld, it will likely result in the proliferation of state and local health care reform initiatives that emulate Healthy San Francisco. In 2006, at least thirty state legislatures were considering laws that "require[d] employers either to provide minimum levels of health care to their

employees or to pay the shortfall into public programs."[226] Effectively, Healthy San Francisco would provide state and local governments with a guide to enacting health care reform initiatives while circumventing ERISA. Likewise, permitting San Francisco's law will firmly establish employer mandates as another source of financing available to fund state and local initiatives to expand access to health care for the uninsured.

Alternatively, if the Ninth Circuit's decision is rejected by the Supreme Court, that would seem to suggest most fair share laws are presumptively invalid under ERISA. By assuming a more expansive interpretation of Section 514(a), there would be very little, if any, room for state and local governments to institute health care reform that addresses the problem of providing the uninsured with access to health care without being subject to ERISA preemption. Overturning the Ninth Circuit's decision would firmly establish a common law barrier to state and local level experimentation with health care reform and could potentially "increase the already significant clamor for a federal solution to the [nation's] health care crisis."[227]

"Although ERISA's legislative history makes clear that Congress intended to craft a broad preemption provision, it is far from clear that Congress anticipated the extent of the law's impact on health care regulation."[228] Effectively, in enacting ERISA, members of Congress failed to consider the breadth of Section 514(a) and the "effect such a broad preemption clause would have on the ability of states to regulate in fields even remotely related to employee benefit plans"[229] Advocates for amending ERISA contend that ERISA's preemption provision unduly constrains comprehensive health insurance reform at state and local levels by preventing state and local governments from regulating employment-based group health plans.[230] Instead of judicial action further narrowing the scope of ERISA preemption, another option would be for Congress to provide relief in some way.

With ERISA preemption as it stands now, health care policy in the U.S. finds itself in a position where "ERISA legally may block state initiatives while simultaneously acting as a political

roadblock to federal reform."[231] At the state and local level, Section 514(a) of ERISA significantly constrains any effort to expand coverage that includes an employer financing component. Certainly, these governments could implement health care reform without employer assistance, but this would eliminate a critical source of financing and place even more of the financial burden on state and local governments. As state budget deficits increase, it is unlikely that they will be willing to expand coverage without some portion being financed by employers. At the federal level, ERISA preemption functions as a shield that protects employers from additional requirements with respect to employee benefit plans. Employers and industry leaders would undoubtedly be reluctant to relinquish this protection and would lobby heavily against any legislation attempting to alter ERISA. Many employers also argue that ERISA preemption is necessary in order to provide equal benefits to all employees, regardless of where the employees work or live.[232] Notwithstanding these obstacles to amending ERISA, there are several ways in which Congress could provide relief from ERISA.

One alternative would be for Congress to amend ERISA to establish minimum standards for health care plans and make employer-sponsored plans mandatory, including a requisite level of employer financing. Or, closely related, Congress could enact its own federal version of a fair share law, which would establish a minimum level of health care expenditures and allow employers to choose between providing coverage for employees, paying into a government fund for such coverage, or a combination of both. This approach would effectively capture the structure of San Francisco's ordinance. Presumably, both of these approaches would elicit substantial opposition from employers and industry leaders. At the other end of the spectrum, it has been suggested that Congress could eliminate Section 514(a) entirely and allow principles of implied preemption to guide judicial interpretation with respect to the proper balance between state and federal law.[233] Such action would be far too drastic, however, and would seem to promote more, rather than less,

litigation and uncertainty. Eliminating Section 514(a) does nothing to create better-defined, transparent boundaries for permissible state and local initiatives aimed at reforming health care. At this point, such a move would probably create even more confusion with regard to an obviously complex area of law.

Finally, Congress could modify ERISA to expressly allow limited and targeted experimentation at the state and local level. Under this approach, for purposes of discussion, Congress could select ten states and localities, such as San Francisco and Massachusetts, which have already begun experimentation with health care reform or have new programs in the pipeline. This would enable state and local governments to take the reins in designing programs that expand coverage in the most efficient and practicable way possible. At the same time, such an approach would allow for incremental health care reform. Congress is obviously averse to making any bold moves with respect to health care reform; therefore, this option might be more politically palatable since greater responsibility would belong to state and local governments. To the extent that certain experiments prove more successful than others, Congress could then incorporate the key features into a unified national plan for health care aimed at reforming its structure and financing. In the absence of national health care reform in the short run, such an amendment might be the best solution to overcoming the impasse between ERISA preemption and experimentation with health care reform at the state and local level while benefitting national health care reform in the long run.

As evidenced by litigation in Maryland, Suffolk County, NY, and San Francisco, ERISA significantly constrains experimentation with health care reform initiatives at the state and local level. At first impression, one might argue that this result is wholly undesirable. On the one hand, state and local experimentation allows for regulations to take local circumstances and preferences into consideration. For example, statistics show that between 2006 and 2007, employer-sponsored health insurance covered approximately seventy percent of nonelderly residents nationwide while an almost

eighteen percent of such residents were uninsured.[234] Hawaii, Massachusetts, Minnesota, and Wisconsin all reported over sixty-eight percent of nonelderly residents insured under employer-sponsored programs while less than ten percent of such residents were uninsured. Thus, these four states significantly outperformed the national average at both ends of the spectrum. In contrast, Arizona, California, Florida, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas all significantly underperformed the national averages. Each of these states reported less than fifty-six percent of nonelderly residents insured under employer-sponsored programs while more than twenty percent of such residents were uninsured. These figures highlight the significant variation in the distribution of nonelderly residents covered under employer-sponsored insurance versus those without any coverage at the state level.[235] Differences in the distribution of state coverage suggest that allowing state and local governments to experiment could be beneficial to the extent that states are able to recognize local circumstances or preferences and modify or adapt programs aimed at health care reform accordingly.

Similarly, it might be advantageous to allow state and local governments to serve as incubators for health care reform. In this respect, both the federal government and local governments, ranging from states to municipalities, could look to existing state and local experiments for information and guidance. Taking the specific needs and characteristics of a particular government's population into account, federal and local governments could assess what has succeeded elsewhere in deciding how best to develop their own health care programs. Furthermore, allowing state experimentation could have an immediate impact on reducing the number of uninsured in the United States.

Notwithstanding these potential arguments in favor of permitting state and local experimentation, unfettered freedom to regulate health care outside the federal level of government could have considerable adverse consequences. First, allowing greater experimentation might create

a race to the bottom between states. Employers seeking to avoid increased costs imposed by state or local health care legislation may move to other locations that have not implemented such legislation.[236] Second, and perhaps more importantly, opening the door to state and local health care experimentation without any limits could lead to the "balkanization of health care expenditures," which is one of the core concerns raised by the Ninth Circuit dissent in *Golden Gate Restaurant Ass'n.* Faced with the burden of complying with multi-jurisdictional requirements imposed by health care reform aimed at expanding coverage, affected employers might abandon existing ERISA plans altogether. Thus, instead of reducing the number of uninsured, the existing problem might actually intensify. Employers currently provide the majority of health insurance coverage in the United States; however, the financial and administrative responsibility may shift to state and local governments if too much experimentation is allowed.

Arguments have been made in favor of Congress "permit[ting] the San Francisco experiment, and others like it, to proceed, either to confirm such concerns or to allay them."[237] Allowing such experimentation certainly has informational advantages. Observations from state and local experiments could be used to identify the most feasible proposals to achieve health care reform on a larger scale. Nevertheless, authorizing state and local experimentation without any qualifications or limitations fails to account for potentially negative long-term effects. At present, the extent of state and local experimentation is relatively limited. However, at the extreme end of the spectrum, if every state develops its own health care reform program, navigating the different health care structures will become *nearly* impossible; perhaps even worse, eventually incorporating and integrating such different health care structures into a unified national scheme will become *certainly* impossible. The potential for proliferation of state and local health care experimentation is further complicated by the fact that the longer such program are in operation, the harder they will become to unwind, if necessary, as they become intertwined in the existing health care structure and

more individuals come to depend upon them. In fact, the Ninth Circuit panel expressed this very concern as a justification for denying the GGRA's request for an injunction, suggesting that enjoining Healthy San Francisco would adversely affect not only enrollees in the program but also individuals connected to those enrollees.

Arguably, the optimal solution would be to implement comprehensive national health care reform. Nonetheless, national health care reform is obviously an extremely complex issue fraught with numerous obstacles.[238] Achieving such national reform has been, and will continue to be, a long and contentious process; whether policymakers are able to design a national framework for health care reform remains to be seen. However, until national reform can be implemented, Congress should act to allow a very limited level of targeted state and local experimentation free from the constraining effect of ERISA preemption. A market obviously exists for developing expanded health care coverage, as indicated by the desire to institute such reform in Maryland, Suffolk County, NY, San Francisco, and Massachusetts. If Congress is eventually able to develop a unified national program for health care reform, these selected state and local experiments could then be assimilated into the larger federal scheme.[239] Such controlled experimentation seems to offer an acceptable compromise; it would not only enhance the federal government's ability to ultimately develop a national model for health care reform but also start to make noticeable progress toward bridging the gap between the uninsured and access to health care.

VII. Appendix

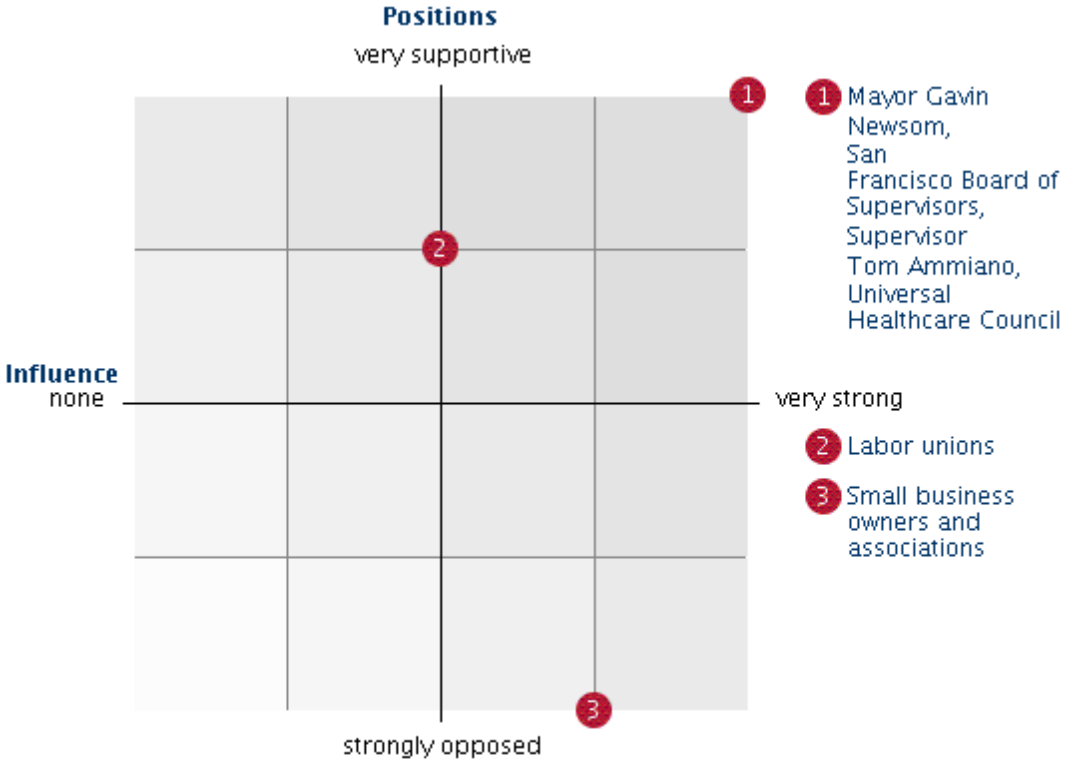
A. Figure 1 – Healthy San Francisco, Projected Annual Sources of Funding at Full Rollout[240]

Funding Source	Amount (In millions)	Comment
City and County of San Francisco	$111	Existing funds to SFDPH to provide care to indigent and uninsured adults.
Federal Allocation	$ 24	Federal Health Care Coverage Initiative funding for three years totaling $73.12 million. This reimbursement-based funding is part of the California five-year Section 1115 Medi-Cal Hospital/ Uninsured Care Demonstration. Funding supports a subset of HSF participants.
State	$45	Realignment and other funding sources.
Fees from employer/employee participation fees for those participating in HSF via the Employer Spending Requirement	$12	Estimate based on likely participation of employers in HSF option starting Spring 2008.
Participant fees	$8	Assumes sliding scale of share of quarterly participant contribution based on Federal Poverty Level.

B. Figure 2 – Healthy San Francisco, Employer Spending Requirement by Employer Size[241]

Business Size		Rate Schedule		
		1/9/08	4/1/08	1/1/09
Large	100+ employees	1.76/hour		$1.85/hour
Medium	50-99 employees	$1.17/hour		$1.23/hour
	20-49 employees	Not Applicable	$1.17/hour	$1.23/hour
Small`	1-19 employees	Not Applicable		

C. Figure 3 – Healthy San Francisco, Levels of Support and Influence by Interested Parties[242]



D. Figure 4 – Health Insurance Coverage of the Nonelderly by State, 2006-2007[243]

	Nonelderly	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
	(thousands)[a]	Employer	Individual	Medicaid	Other[b]	
United States	260,724	60.9%	5.5%	13.7%	2.4%	17.5%
Alabama	3,943	63.8%	4.1%	13.7%	3.0%	15.4%
Alaska	608	58.1%	4.0%	12.3%	6.7%	18.9%
Arizona	5,603	53.6%	4.5%	17.3%	2.8%	21.8%
Arkansas	2,435	53.5%	5.1%	17.2%	4.3%	19.9%
California	32,291	54.7%	7.4%	16.0%	1.5%	20.4%
Colorado	4,355	62.4%	7.6%	8.6%	3.0%	18.5%
Connecticut	3,003	70.4%	4.6%	12.5%	1.8%	10.7%
Delaware	745	68.9%	3.4%	12.1%	2.3%	13.4%
District of Columbia	511	58.6%	6.2%	22.0%	1.6%	11.6%
Florida	15,099	56.1%	6.1%	10.3%	3.0%	24.4%
Georgia	8,538	60.5%	4.0%	12.8%	3.5%	19.3%
Hawaii	1,060	71.2%	3.8%	11.5%	4.0%	9.5%
Idaho	1,295	62.0%	7.3%	11.8%	2.2%	16.7%
Illinois	11,238	65.6%	4.9%	12.2%	2.0%	15.2%
Indiana	5,557	69.2%	4.3%	11.8%	1.7%	13.0%
Iowa	2,546	67.9%	6.5%	13.1%	1.1%	11.4%
Kansas	2,356	63.0%	7.2%	12.8%	2.7%	14.2%
Kentucky	3,637	59.3%	4.7%	15.6%	4.0%	16.4%
Louisiana	3,645	52.5%	5.3%	16.8%	2.3%	23.1%
Maine	1,118	61.5%	5.6%	19.6%	2.7%	10.6%
Maryland	4,912	69.1%	4.4%	9.2%	1.9%	15.5%
Massachusetts	5,496	68.3%	5.0%	16.7%	1.0%	8.9%
Michigan	8,633	67.0%	4.4%	14.2%	2.0%	12.4%
Minnesota	4,543	69.5%	7.1%	12.1%	1.4%	9.9%
Mississippi	2,556	51.0%	5.0%	18.7%	3.2%	22.1%
Missouri	5,024	62.4%	6.4%	13.4%	3.0%	14.8%
Montana	811	55.6%	9.2%	13.2%	3.3%	18.7%
Nebraska	1,548	65.5%	8.2%	9.5%	2.4%	14.4%
Nevada	2,233	65.0%	4.9%	6.9%	2.4%	20.7%
New Hampshire	1,148	73.7%	5.1%	6.8%	1.9%	12.4%
New Jersey	7,488	68.6%	3.8%	8.5%	1.5%	17.6%
New Mexico	1,697	48.0%	5.6%	17.1%	3.6%	25.7%
New York	16,552	59.9%	4.0%	19.5%	1.2%	15.4%
North Carolina	7,863	57.4%	5.5%	13.9%	3.7%	19.5%
North Dakota	536	64.2%	11.5%	9.3%	2.3%	12.7%
Ohio	9,898	66.4%	4.8%	14.0%	2.5%	12.4%
Oklahoma	3,029	55.0%	4.5%	14.8%	4.5%	21.2%
Oregon	3,263	59.6%	7.0%	11.6%	2.1%	19.7%
Pennsylvania	10,483	67.6%	6.1%	13.3%	1.7%	11.3%
Rhode Island	915	64.7%	4.6%	17.7%	2.0%	11.0%
South Carolina	3,746	58.8%	4.8%	14.4%	3.5%	18.5%
South Dakota	666	63.4%	9.5%	10.8%	3.5%	12.8%
Tennessee	5,176	58.0%	5.8%	15.8%	4.1%	16.2%
Texas	20,887	52.1%	4.9%	12.9%	2.6%	27.5%
Utah	2,378	64.9%	7.6%	9.8%	1.5%	16.3%
Vermont	537	61.9%	4.1%	19.6%	2.1%	12.3%
Virginia	6,658	66.2%	4.4%	8.2%	5.4%	15.8%
Washington	5,651	64.6%	5.7%	13.5%	3.3%	13.0%
West Virginia	1,561	59.8%	2.3%	17.7%	4.3%	15.9%
Wisconsin	4,811	69.5%	6.0%	13.1%	1.8%	9.6%
Wyoming	447	62.7%	7.8%	10.3%	2.9%	16.2%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

[1] ERISA regulates "employee welfare benefit plans," which include employer health plans. As defined under ERISA, a welfare benefit plan generally provides for hospital, medical, surgical, sickness, accident, disability, death, unemployment, severance, or similar benefits. *See* ERISA §2; codified at 29 USCA §1001; *see also* Senate Subcommittee on Labor of the Committee on Labor and Public Welfare, *Legislative History of the Employee Retirement Income Security Act of 1974,* Washington, D.C.: U.S. Government Printing Office, 1974:3456. ERISA does not regulate health insurance purchased by individuals as individuals, including self-employed individuals or health benefits not provided through employment-related group plans.

[2] Peter D. Jacobson and Scott D. Pomfret, *ERISA Litigation and Physician Autonomy*, 283 J. AM. MED. ASS'N 921, 921 (2000); *see also* 29 USCA §1001.

[3] In particular, ERISA regulates reporting and disclosure, participation and vesting, funding, and performance of fiduciary obligations. *See* ERISA §§101-11, 201-11, 301-305, 401-414; codified at 29 USCA §§1021-1031, 1051-1061, 1081-1085, 1101-1114.

[4] *See* ERISA §514(b)(5); codified at 29 USCA §1144(b)(5).

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

[6] As part of Hawaii's "Prepaid Health Care" system, PHCA requires all employers to offer a health insurance plan to its employees that covers at least a minimum set of specified benefits. Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, Box 2-3, 50 (Dec. 2008); *see also* United States General Accounting Office, *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*, GAO/HEHS-95-167, 33 (Jul. 1995); BARRY R. FURROW, ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS, 340 (Thompson West)(abridged 6th ed. 2008).

[7] Standard Oil Co. v. Agsalud, 454 U.S. 801 (1981).

[8] Congressional Budget Office, *supra* note 6, at 50. According to Congressman Erlenborn, the ERISA exemption granted to Hawaii was not to "be considered a precedent with respect to extending similar treatment to any other State law." Council of Hawaii Hotels, 594 F. Supp. At 456 n. 9.

[9] *See* 120 Cong. Rec. H29,197 (1974) (statement of Rep. Dent) ("With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation."); *Id.* at 29,933 (statement of Sen. Williams) ("It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions . . . are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans."); *Id.* at 29,942 (statement of Sen. Javits) ("[T]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required . . . the displacement of State action in the field of private employee benefit programs.").

[10] ERISA §514(a); codified at 29 USCA §1144(a) (emphasis added).

[11] William Pierron & Paul Fronstin, *ERISA Pre-emption: Implications for Health Care Reform and Coverage*, Employee Benefit Research Institute, Issue Brief 314, 6 (February 2008).

[12] ERISA §514(b)(2)(A); codified at 29 USCA §1144(b)(2)(A). Although not directly applicable to the issue of state health care reform, the savings clause also applies to state laws that regulate banking or securities. *Id.*

[13] ERISA §514(b)(2)(A); codified at 29 USCA §1144(b)(2)(A).

[14] Pierron & Fronstin, *supra* note 11, at 6.

[15] ERISA §514(b)(2)(B); codified at 29 USCA 1144(b)(2)(B).

[16] United States General Accounting Office, *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*, GAO/HEHS-95-167, 32 (Jul. 1995).

[17] ERISA §514(a); 29 USCA §1144(a) (emphasis added).

[18] United States General Accounting Office, *supra* note 16, at 6.

[19] Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983).

[20] Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., 519 U.S. 316, 324 (1997).

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

[22] 514 U.S. 645 (1995).

[23] FURROW, *supra* note 6, at 337.

[24] Travelers, 514 U.S. at 654.

[25] *Id.* at 655.

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

[27] *Id.* at 655.

[28] *Id.* at 661.
[29] *Id.* at 656-57.
[30] *Id.* at 657-58.
[31] *See generally*, *id.* at 658-64.
[32] United States General Accounting Office, *supra* note 16, at 7.
[33] Travelers, 514 U.S. 645.
[34] United States General Accounting Office, *supra* note 16, at 7.
[35] The Supreme Court's "post-*Travelers* preemption cases suggest that the [Supreme Court] in fact turned a corner in *Travelers,*" as the Supreme Court has rejected ERISA preemption in the majority of cases post-*Travelers* but typically had not done so pre-*Travelers*. FURROW, *supra* note 6, at 337.
[36] 520 U.S. 806 (1997).
[37] *Id.* at 814-16.
[38] *Id.* at 814 (citing Travelers, 514 U.S. at 654).
[39] DeBuono, 520 U.S. at 815-16; *see also*, Travelers, 514 U.S. at 668.
[40] DeBuono, 520 U.S. at 815-16 (internal quotations omitted).
[41] 538 U.S. 329 (2003).
[42] Kentucky Ass'n, 538 U.S. at 332-34. Kentucky's AWP law required reimbursement regardless of whether an insurer actually had a contractual relationship with the licensed physician or health care professional.
[43] Kentucky Ass'n of Health Plans, Inc. v. Nichols, 227 F.3d 352 (6th Cir. 2000).
[44] Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 342 (2003). According to the court, Kentucky's AWP law satisfied both prongs of this test and, therefore, was not preempted by ERISA.
[45] Historically, to determine whether the savings clause protected a state law from ERISA preemption, the Supreme Court had applied a "common sense test" and also examined whether the challenged law regulated the "business of insurance" under the McCarran-Ferguson Act's multi-factored test. A state law regulates the business of insurance if it (1) has the effect of transferring or spreading the policyholder's risk, (2) is an integral part of the policy relationship between the insurer and the insured, and (3) is limited to entities within the insurance industry that could be included under the savings clause. *See, e.g.,* Metropolitan Life Insurance v. Massachusetts, 471 U.S. 724, 740-44 (1985); Pilot Life v. Dedeaux, 481 U.S. 41 (1987).
[46] FURROW, *supra* note 6, at 338; *see also*, Matthew Gatewood, *The New Map: The Supreme Court's New Guide to Curing Thirty Years of Confusion in ERISA Savings Clause Analysis*, 62 WASH. & LEE L. REV. 643 (2005).
[47] FURROW, *supra* note 6, at 340.
[48] Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer – Key Facts About Americans Without Health Insurance*, 1 (October 2008)[hereinafter *Kaiser Uninsured Primer*]. Between 2003 and 2007, the number of uninsured individuals in the United States increased from increased approximately 1.6%. PricewaterhouseCoopers Health Research Institute, *Top Nine Health Industry Issues in 2009: Outside Forces Will Disrupt the Industry*, 2 (2009)[hereinafter *PWC Industry Issues 2009*].
[49] Congressional Budget Office, *supra* note 6, at 27.
[50] Jean Fraser, *Covering San Francisco: Private and Public Coverage and the Gaps*, San Francisco Health Plan Presentation to the San Francisco Universal Health Care Council (February 23, 2006).
[51] PricewaterhouseCoopers Health Research Institute, *Healthcare Policy in an Obama Administration: Delivering on the Promise of Universal Coverage*, Washington National Tax Service, 14 (November 2008)[hereinafter *PWC Healthcare Policy*].
[52] The Henry J. Kaiser Family Foundation, *Health Care Costs: A Primer – Key Information on Health Care Costs and Their Impact*, 1 (March 2009)[hereinafter *Kaiser Health Care Costs Primer*]; Kaiser Uninsured Primer, *supra* note 49, at 8.
[53] In 2007, 159 million Americans, or sixty-one percent of the nonelderly population, were covered by employer-sponsored health insurance. Kaiser Uninsured Primer, *supra* note 49, at 15.
[54] Small firms, in particular, are generally less likely to provide coverage in comparison to larger firms. *Id.* at 15-16.
[55] Employer-sponsored health insurance is especially sensitive to changes in the economy and health insurance premiums. The economic downturn in early 2001, combined with double-digit inflation in health insurance premiums, resulted in a decrease in employer-sponsored coverage. More recently, growth of health insurance premiums has slowed, but the percentage of individuals covered by employer-sponsored insurance has not increased. *Id.* at 15.
[56] *Id.* at 8.
[57] Stan Dorn, Bowen Garrett, John Holahan, & Aimee Williams, Kaiser Commission on Medicaid and the Uninsured, *Medicaid, SCHIP, and Economic Downturn: Policy Challenges and Policy Responses*, 5 (April 2008).
[58] Kaiser Uninsured Primer, *supra* note 49, at 13.

[59] Pierron & Fronstin, *supra* note 11, at 12.

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

[61] 2006 Mass. Act Ch. 58. According to a study by PricewaterhouseCoopers LLP, Massachusetts' health care reform has resulted in the nation's lowest uninsured rate in the country. In particular, Massachusetts recently reported that its uninsured rate dropped to three percent compared with 15 percent nationally. *See* PWC Healthcare Policy, *supra* note 51, at 11.

[62] Pierron & Fronstin, *supra* note 11, at 13.

[63] PWC Healthcare Policy, *supra* note 51, at 17; *see also*, Mary Ann Chirba-Martin & Andrés Torres, *Universal Health Care in Massachusetts: Setting the Standard for National Reform*, 35 FORDHAM URB. L. J. 409 (2008).

[64] John McDonough, Michael Miller & Christine Barber, *A Progress Report on State Health Access Reform*, Health Affairs – Web Exclusive, w114, *available at* http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.2.w105v1 (Jan. 29, 2008). "It is possible that employers saw sufficient potential benefit to them from reform that they decided not to challenge it or that the burdens imposed by the Massachusetts law were not sufficiently great to justify the expense of litigation." Phyllis Borzi, *There's Private and Then There's "Private": ERISA, its Impact, and Options for Reform*, 36 J. L. MED. & ETHICS 660, 666 n. 51 (2008).

[65] *See, e.g.*, Joan Rigdon, *Universal Health Care?*, WASHINGTON LAWYER (Jul./Aug. 2008).

[66] 2006 Md. Laws 1.

[67] "Health insurance costs" means the "amount paid by an employer to provide health care or health insurance to employees in [Maryland] to the extent the costs may be deductible by an employer under federal tax law." Md. Code Ann., Com. Law §8.101(d)(1).

[68] *Id.* at §8.101-107.

[69] *See* Retail Industry Leaders Assoc v. Fielder, 435 F. Supp. 2d 481 (D. Md. 2006).

[70] *See* Retail Industry Leaders Ass'n v. Fielder, 475 F.3d 180 (4th Cir. 2007). In addition, the U.S. Dept. of Labor filed an amicus brief in November 2006 in support of RILA and ERISA preemption of the Fair Share Act. *See* Brief of the Secretary of Labor as Amicus Curiae Supporting Plaintiff-Appellee and Requesting Affirmance, RILA v. Fielder, 475 F. 3d 180 (4th Cir. 2007)(No. 06-1840, 06-1901).

[71] Fielder, 475 F.3d at 190.

[72] *Id.* at 194-95.

[73] *Id.* at 195.

[74] *Id.* at 185. Other for-profit employers with at least 10,000 employees in Maryland either satisfied the eight percent spending threshold or were exempted from the Fair Share Act.

[75] *Id.* at 183.

[76] *Id.* at 184.

[77] *Id.*

[78] *Id.* at 194. "[L]egislators and interested parties uniformly understood the Act as requiring Wal-Mart to increase its healthcare spending. If this is not the Act's effect, one would have to conclude, which we do not, that the Maryland legislature misunderstood the nature of the bill that it carefully drafted and debated. For these reasons, the amount that the Act prescribes for payment to the State is actually a fee or penalty that gives the employer an irresistible incentive to provide its employees with a greater level of health benefits." *Id.*

[79] *Id.* at 195 (citing Travelers, 514 U.S. 645, 659)(emphasis added).

[80] Fielder, 475 F.3d at 195 (emphasis added).

[81] *Id.* at 193.

[82] *Id.* at 196 (emphasis added).

[83] *Id.* at 197.

[84] *Maryland Attorney General Will Not Seek Supreme Court Review of "Fair Share" Law*, Daily Lab. Rep. (BNA) No. 73 (Apr. 17, 2007).

[85] FURROW, *supra* note 6, at 345.

[86] Retail Industry Leaders Association v. Suffolk County, 497 F. Supp. 2d 403, 417 (E.D. N.Y. 2007).

[87] Specifically, "covered employers" are defined as "any person that operates at least one retail store located in Suffolk County where groceries or other foods are sold for off-site consumption and where either (1) twenty-five thousand square feet or more of the store's selling area floor space is used for the sale of groceries or other foods for off-site consumption, or (2) three percent or more of the store's selling area floor space is used for the sale of groceries or other foods for off-site consumption and the store contains at least 100,000 square feet of selling area floor space,

or (3) [the retail store] had total annual revenues of $1 billion or more in the most recent calendar year and the sale of groceries comprise more than twenty percent of a company's revenue." *Id.* at 407; *see also*, Suffolk County Reg. Local Law §352-2.

88 "Health care expenditures" are defined as "any amount paid by a covered employer to employees or to another party for the purpose of providing health care services or reimbursing the cost of such services for employees or family of employees." Suffolk County, 497 F. Supp. 2d at 407.

89 *Id.* at 406-407.

90 *Id.* at 407.

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

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

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

94 *Id.*

95 *Id.*

96 *Id.*

97 *Id.*

98 *Id.*

99 *Id.* at 409-10.

100 *Id.* at 410.

101 *Id.*

102 *Id.* at 416.

103 *Id.*

104 *Id.* at 418.

105 *Id.* at 417.

106 *Id.* at 417-18.

107 *Id.* at 418.

108 *Id.* at 417.

109 *Id.* at 417 (citing Egelhoff v. Egelhoff, 532 U.S. 141, 150 (2001)).

110 Suffolk County, 497 F. Supp. 2d at 418.

111 Healthy San Francisco, *Healthy San Francisco: Program in Depth*, 3, *available at* http://www.healthysanfrancisco.org/files/PDF/HSF_Program_In-Depth.pdf [hereinafter *HSF Program in Depth*].

112 Most notably, the city and county of San Francisco established the San Francisco Health Plan in 1997, which initially served the Medi-Cal population in a managed care setting; however, the plan was created with a vision toward helping to provide high quality medical care to the largest possible number of low-income residents in the city and county of San Francisco. *Id.*

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

114 *Id.*

115 *See* San Francisco Administrative Code, San Francisco Health Care Security Ordinance, §14.1-8.

116 Elena Conis & Carol Medlin, *San Francisco Health Access Program Update*, Health Policy Monitor, April 2008, available at http://www.hpm.org/en/Downloads/Half-Yearly_Reports.html; *see also*, HSF Program in Depth, *supra* note 111, at 6.

117 Under San Francisco's administrative code, the program is officially titled the San Francisco Health Care Security Ordinance. *See* San Francisco Administrative Code, San Francisco Health Care Security Ordinance, §14.1(a); *see also*, HSF Program in Depth, *supra* note 111, at 3.

118 HSF Program in Depth, *supra* note 111, at 3; *see also*, San Francisco Administrative Code, San Francisco Health Care Security Ordinance, §14.2(a).

119 San Francisco Administrative Code, San Francisco Health Care Security Ordinance, §14.2(e)-(f).

120 *See* San Francisco Administrative Code, San Francisco Health Care Security Ordinance, §14.1-8.

121 HSF Program in Depth, *supra* note 111, at 4.

122 *Id.*

123 *Id.*

[124] San Francisco Universal Healthcare Council, Final Report to Mayor Gavin Newsom, *San Francisco Health Access Program: Serving Uninsured Adults*, 3 (Jun. 23, 2006)[hereinafter *SFUHC report*]

[125] Healthy San Francisco, Program Stats, *available at* http://www.healthysanfrancisco.org/about_us/Stats.aspx# (Mar. 28, 2009).

[126] San Francisco Health Plan, *About the Numbers: A Profile of Uninsured Adults in San Francisco*, Prepared for the San Francisco Universal Health Care Council, 6 (Feb. 2006)[hereinafter *SFHP About the Numbers*]

[127] San Francisco Health Plan is a city-sponsored City- health plan that provides health insurance for approximately 55,000 residents of San Francisco, separate and apart from Healthy San Francisco. *See* San Francisco Health Plan, *available at* http://www.sfhp.org/about_us/who_we_are/.

[128] Sixty-nine percent of uninsured workers cited this as the reason for being uninsured. SFHP About the Numbers, *supra* note 126, at 8.

[129] This reason accounted for fifteen percent of uninsured workers in San Francisco. *Id.*

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

[131] These figures are based on the estimated cost of SFHAP in 2006 dollars and the number of uninsured residents as of 2006. SFUHC report, *supra* note 124, at 4.

[132] *Id.* at 9-10; *see also,* Appendix, Figure 1 – Projected Annual Sources of Funding for Healthy San Francisco at Full Rollout.

[133] A portion SFHAP's cost is covered by the $104 million per year that the city previously paid to provide emergency care and other services to its uninsured residents. Conis & Medlin, *supra* note 116; *see also*, San Francisco Administrative Code, San Francisco Health Care Security Ordinance, §14.2(d).

[134] In 2007, SFHAP received an award of $73 million from the state health department to be apportioned over three years. Conis & Medlin, *San Francisco Health Access Program Update*, Health Policy Monitor, April 2008, available at http://www.hpm.org/en/Downloads/Half-Yearly_Reports.html.

[135] Enrollees are required to pay quarterly participant fees and point of service fees at rates determined by their level of income. Conis & Medlin, *supra* note 116; *see also*, San Francisco Administrative Code, San Francisco Health Care Security Ordinance, §14.2(d).

[136] San Francisco Administrative Code, San Francisco Health Care Security Ordinance, §14.2(d).

[137] Conis & Medlin, *supra* note 116.

[138] "Covered employer" means any medium-sized or large business engaging in business within the city of San Francisco. In the case of a nonprofit corporation, "covered employer" means an employer for which an average of fifty or more persons per week perform work for compensation during a quarter. Small businesses are not "covered employers" and are therefore exempt from the health care spending requirements under Section 14.3 of the Health Care Security Ordinance. "Large business" means an employer for which an average of one hundred or more persons per week perform work for compensation during a quarter, while "medium-sized business" means an employer for which an average of between twenty and ninety-nine persons per week perform work for compensation during a quarter. *See* San Francisco Administrative Code, San Francisco Health Care Security Ordinance, §14.1(b)(3), (b)(11)-(12).

[139] Self-employed individuals, independent contractors, employers with 19 or fewer employees total (including any employees located outside of San Francisco), and nonprofits with 49 or fewer employees total (including any employees located outside of San Francisco) are not covered by the Health Care Security Ordinance. San Francisco Administrative Code, San Francisco Health Care Security Ordinance, §14.1(b)(3); *see also*, Office of Labor Standards Enforcement, *Health Care Security Ordinance*, *available at* http://www.sfgov.org/site/olse_index.asp?id=45168 [hereinafter *OLSE*].

[140] Conis & Medlin, *supra* note 116. SFHAP spending per enrollee is estimated to be approximately $200 per month.

[141] The initial health care expenditure rate was set at $1.06 per employee per hour for medium-sized businesses and $1.60 per hour for large businesses from the effective date of the ordinance through June 30, 2007; thereafter, the health care expenditure rate increased by five percent over the calculated expenditure for the previous year. The first increase incurred on July 1, 2007, followed by subsequent increases on January 1 of each following year. As of January 1, 2010, the health care expenditure rate will be determined annually based upon an annual ten-county survey of the "average contribution" for a full-time employee to the City Health Service System. *See* San Francisco Administrative Code, San Francisco Health Care Security Ordinance, §14.1(b)(8); *see also*, Appendix, Figure 2 – Employer Spending Requirement by Employer Size.

[142] San Francisco Administrative Code, Health Care Security Ordinance, §14.1(b)(12).

[143] San Francisco Administrative Code, Health Care Security Ordinance, §14.1(b)(11).

[144] Under the San Francisco Health Care Security Ordinance, "covered employee" includes any person, regardless of residence, who works in San Francisco for a covered employer, either full time or part time, for at least 8 hours per

week (as of January 1, 2009), and for at least 90 days. The term "covered employee" does not include certain classes of employees, such as managerial or supervisorial employees (subject to certain conditions not being satisfied). *See* San Francisco Administrative Code, Health Care Security Ordinance, §14.3(b)(2). In addition, although Healthy San Francisco became operative as of July 1, 2007, the employer spending requirement did not go into effect until January 1, 2008. *See* San Francisco Administrative Code, Health Care Security Ordinance, §14.8.

145 San Francisco Administrative Code, Health Care Security Ordinance, §§14.1(b)(8), 14.3(a).

146 San Francisco Administrative Code, Health Care Security Ordinance, §§14.1(b)(7).

147 San Francisco Administrative Code, Health Care Security Ordinance, §§14.1(b)(7)(a)-(e).

148 San Francisco Administrative Code, Health Care Security Ordinance, §§14.3(b).

149 HSF Program in Depth, *supra* note 111, at 6.

150 *Id.* at 5-6; *see also* Appendix, Fig. 3, Levels of Support and Influence by Interested Parties.

151 Conis & Medlin, *supra* note 116.

152 Similar to RILA, the GGRA is a non-profit trade association. The GGRA's goals are to promote, extend, and protect the interests of restaurant industry members in the San Francisco Bay Area. *See* Golden Gate Restaurant Association, *available at* http://www.ggra.org/About.aspx.

153 Conis & Medlin, *supra* note 116.

154 The GGRA sought a permanent injunction against the employer spending requirements imposed by Healthy San Francisco. *See* Golden Gate Restaurant Ass'n v. City and County of San Francisco, Complaint for Declaratory Relief and Injunction, 2006 WL 3853281 (Trial Pleading) (N.D. Cal. Nov. 8, 2006).

155 San Francisco Administrative Code, Health Care Security Ordinance, §14.6 (emphasis added). Similarly, the ordinance includes a severability provision, such that if any section, subsection, clause, phrase, or portion of the ordinance is held invalid or unconstitutional by any court or Federal or State agency for any reason, such portion shall be deemed a separate, distinct, and independent provision and such holding shall not affect the validity of the remaining portions of the ordinance. San Francisco Administrative Code, Health Care Security Ordinance, §14.5.

156 Golden Gate Restaurant Ass'n v. City and County of San Francisco, 535 F. Supp. 2d 968, 970 (N.D. Cal. 2007).

157 *Id.* at 975-77.

158 *Id.* at 978; *see also*, San Francisco Administrative Code, Health Care Security Ordinance, §14.1(b)(7) (calculating employer liability by looking at "amounts paid by a covered employer to its covered employees or to a third party . . . for the purpose of providing health care services for covered employees.").

159 Golden Gate Restaurant Ass'n, 535 F. Supp. 2d at 978.

160 *Id.* at 979.

161 *Id.* at 980.

162 Golden Gate Restaurant Ass'n v. City and County of San Francisco, 2007 WL 4591729 (N.D. Cal. Dec 28, 2007).

163 Golden Gate Restaurant Ass'n v. City and County of San Francisco, 512 F. 3d 1112 (9th Cir. 2008).

164 *Id.* at 1119.

165 *Id.*

166 *Id.*

167 OLSE, *supra* note 139.

168 Justice Kennedy did not issue an opinion explaining the reasons for denying the request. *Id.*; *see also*, *Justice Kennedy Denies Request for Order to Block San Francisco Fair Share Health Law*, 8 Pens. & Ben. Daily (BNA) No. 36 (Feb. 25, 2008).

169 This ruling was made by the same panel that issued the stay of the district court's decision. Golden Gate Restaurant Ass'n, 546 F.3d 639 (9th Cir. 2008)(reversing and remanding the district court decision and ordering summary judgment in favor of the city of San Francisco).

170 Golden Gate Restaurant Ass'n v. City and County, 2008 WL 4918566, Petition for Rehearing En Banc (9th Cir. 2008).

171 Golden Gate Restaurant Ass'n, 558 F.3d 1000, 1001 (9th Cir. 2009).

172 More typically, such a denial is purely procedural, resulting in neither concurring nor dissenting opinions.

173 Golden Gate Restaurant Ass'n, 558 F.3d at 1009-10.

174 *Id.* at 1004 (citing Egelhoff v. Egelhoff, 532 U.S. 141 (2001) and District of Columbia v. Greater Washington Board of Trade, 506 U.S. 125 (1992)).

175 Golden Gate Restaurant Ass'n, 558 F.3d at 1004.

176 *Id.* (citing *Egelhoff*, 532 U.S. at 149-50).

177 Golden Gate Restaurant Ass'n, 558 F.3d at 1004.

178 *Id.* at 1006-7.

179 *Id.* at 1006.

[180] *Id.* at 1006-7.
[181] *Id.* at 1007.
[182] *Id.*
[183] *Id.* (citing Egelhoff v. Egelhoff, 532 U.S. 141 (2001) and District of Columbia v. Greater Washington Bd. of Trade, 506 U.S. 125 (1992)).
[184] Golden Gate Restaurant Ass'n, 558 F.3d at 1007 (citing Egelhoff, 532 U.S. at 151).
[185] Golden Gate Restaurant Ass'n, 558 F.3d at 1007 (citing Egelhoff, 532 U.S. at 147-48).
[186] Golden Gate Restaurant Ass'n, 558 F.3d 1000 at 1007.
[187] *Id.*
[188] *Id.* (citing Egelhoff, 532 U.S. at 151).
[189] Golden Gate Restaurant Ass'n, 558 F.3d at 1008.
[190] *Id.* (citing Greater Washington, 506 U.S. 125, at 130).
[191] Golden Gate Restaurant Ass'n, 558 F.3d at 1008.
[192] *Id.*
[193] *Id.*
[194] *Id.*(emphasis added).
[195] *Id.* at 1009.
[196] *Id.*
[197] *Id.*
[198] *Id.*
[199] *Id.*
[200] *Id.* at 1001.
[201] *Id.* at 1003.
[202] *Id.* at 1001.
[203] *Id.* at 1002.
[204] Retail Industry Leaders Ass'n v. Fielder, 475 F. 3d 180, 183 (4th Cir. 2007).
[205] According to *Fielder*, healthcare benefits represent a portion of an employee's total compensation. By increasing healthcare benefits and therefore total compensation, an employer receives consideration for this payment in the form of improved retention and performance of current employees and the ability to attract and recruit potential future employees; in contrast, the employer receives no consideration by making a payment to the state for which it receives nothing in return. Effectively, "the only rational choice employers have under the [Maryland law] is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold." *Id.* at 183.
[206] *Id.* at 198.
[207] Golden Gate Restaurant Ass'n, 558 F.3d at 1002.
[208] *Id.*
[209] *Id.* at 1003.
[210] *Id.*
[211] *See* Egelhoff, 532 U.S. 141, at 147, 150.
[212] Golden Gate Restaurant Ass'n, 558 F.3d at 1003.
[213] Greater Washington, 506 U.S. 125, at 30.
[214] Golden Gate Restaurant Ass'n, 558 F.3d at 1003; *see also*, San Francisco Administrative Code, San Francisco Health Care Security Ordinance, §14.1(b)(8).
[215] Golden Gate Restaurant Ass'n, 558 F.3d at 1003; *see also*, San Francisco Administrative Code, San Francisco Health Care Security Ordinance, §14.3.
[216] Golden Gate Restaurant Ass'n, 558 F.3d at 1003 (emphasis added).
[217] Golden Gate Restaurant Ass'n, 558 F.3d at 1003.
[218] *Id.* at 1004 (quoting the dissent at 1008-9).
[219] 482 U.S. 1, 11 (1987)
[220] Golden Gate Restaurant Ass'n, 558 F.3d at 1003.
[221] *Id.*
[222] OLSE, *supra* note 139.
[223] As with GGRA's first request for an emergency injunction, Justice Kennedy did not issue an opinion explaining the reasons for denying the request. *See, e.g.,* Bob Egelko, *High Court Denies Restaurants' Stay Request*, San Francisco Chronicle, *available at* http://sfgate.com/cgi-bin/article.cgi?f=/c/a/2009/03/31/BACR16PK6H.DTL (Mar. 31, 2009).

[224] The GGRA has not yet filed its appeal to the Supreme Court but has announced plans to do so. OLSE, *supra* note 139. The GGRA is confident that the Supreme Court will grant certiorari in the matter. Kevin Westyle, executive director of the GGRA, stated that "the issue of affordable health care has become such a national debate that the Supreme Court is likely to take on the issue." *See* Bren Bagin, *SF Restaurant Group Loses Health Plan Appeal*, *available at* http://www.sfexaminer.com/local/SF-restaurant-group-loses-health-plan-apepal-40995187.html (March 10, 2009). Similarly, David Bacon, a Nixon Peabody partner representing the GGRA, commented that there is "a very dramatic dissent here with eight judges, including Chief Judge Alex Kozinski" and thinks that "the stage is very clearly set for a Supreme Court showdown." Evan Hill, *San Francisco Health Care Law Survives 9th Circuit but May Face High Court*, The Recorder, *available at* http://www.law.com/jsp/article.jsp?id=1202428929836 (March 10, 2009).

[225] The Supreme Court could expressly uphold the Ninth Circuit decision by granting certiorari and then issuing an opinion affirming the Ninth Circuit decision. Alternatively, the court could implicitly uphold the Ninth Circuit decision by denying certiorari.

[226] Sharon Jacobs, *On the Mend: The Ninth Circuit Gives San Francisco's Health Care Security ordinance the Green Light (For Now)*, 36 J. L. MED. & ETHICS 431, 433 (2008).

[227] *Id.*

[228] *Id.* (citing Stephen Befort and Christopher Kopka, *The Sounds of Silence: The Libertarian Ethos of ERISA Preemption*, 52 U. FLA. L. REV. 1, 26-29 (2000)).

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

[230] Pierron & Fronstin, *supra* note 11, at 13.

[231] Borzi, *supra* note 63, at 666.

[232] Pierron & Fronstin, *supra* note 11, at 13.

[233] Since the legislative history of ERISA clearly expresses an intent to preempt the field of pension plan administration, removing Section 514(a) would not allow state laws that conflict with ERISA's purposes to survive. Griffen, *supra* note 230, at 503.

[234] Appendix, Figure 4 – Health Insurance Coverage of the Nonelderly by State, 2006-2007; *see also*, *id.* at 29.

[235] For purposes of comparison, only the percent of nonelderly residents covered by employer-sponsored insurance and the percent of such residents with no insurance coverage are identified here. The percentage of nonelderly residents covered under other forms of private and public insurance, including Medicaid and private individual insurance, also varies significantly by state. *See generally*, Appendix, Figure 4 – Health Insurance Coverage of the Nonelderly by State, 2006-2007; *see also*, Kaiser Uninsured Primer, *supra* note 49, Table 5 at 29.

[236] Competition among states may result in a race to the top, however, that is far less likely. While competing for employees in terms of health care coverage will be beneficial to a particular state or locality, such competition will to no avail without the necessary employers to provide job opportunities.

[237] Edward Zalinsky, *Golden Gate Restaurant Association: Employer Mandates and ERISA Preemption in the Ninth Circuit*, Benjamin N. Cardozo School of Law, Jacob Burns Institute for Advanced Legal Studies, Working Paper No. 219, 5, *available at* http://ssrn.com/abstract=1090122 (2008).

[238] Admittedly, advocating national health reform is one thing, and providing a tangible framework for such reform is an entirely separate, more daunting task. However, providing such a framework is beyond the scope of this paper.

[239] Even if these selected state and local programs are not incorporated into a national health care reform program, assuming one is realized, the relative burden of a handful of different state and local programs plus a federal program would be infinitely less than if a multitude of states, counties, and municipalities enacted their own legislation expanding health care coverage.

[240] HSF Program in Depth, *supra* note 111, at 16.

[241] *Id.* at 5.

[242] Conis & Medlin, *supra* note 116.

[243] Kaiser Uninsured Primer, *supra* note 49, Table 5 at 29.