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Mary Ann Chirba-Martin

Boston College Law School

Andres Torres

Boston College Law School

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UNIVERSAL HEALTH CARE IN MASSACHUSETTS: SETTING THE STANDARD FOR NATIONAL REFORM

Mary Ann Chirba-Martin* & Andrés Torres**

I. INTRODUCTION

Health care reform in the United States has proven to be one of the most complex challenges facing lawmakers and private citizens today. Although there is widespread agreement that the system is in disarray and in dire need of fundamental reform, the core problems of affordability and access continue to steadily worsen. The extent of the national health care crisis is reflected in the fact that although health care annually consumes some sixteen percent of the nation's GDP (or \$2.0 trillion),¹ 46.5 million Americans under the age of sixty-five are currently uninsured.² Notwithstanding the astronomical resources devoted to health care, the number of uninsured nationwide is expected to rise if skyrocketing costs and other barriers to access are not systematically addressed. Despite this national crisis, the country's political and economic leadership continues to debate while avoiding any real action. Compounding the lack of political consensus and will is the specter of record budget deficits as a considerable road block to systemic reform.³

Facing this dearth of national leadership, a growing number of states, including Vermont, Wisconsin, and California, are undertak-

* Associate Professor of Legal Reasoning, Research, and Writing, Boston College Law School; Boston College Law School, J.D.; Harvard School of Public Health, M.P.H.

** Boston College Law School, J.D.

1. Aaron Catlin et al., *National Health Spending in 2005: The Slowdown Continues*, 26 HEALTH AFF. 142 (2007).

2. KAISER COMM'N ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER 1 (2007).

3. In the 1990s, the "managed competition" model, which seeks to lower costs and increase access, became a central strategy to health care reform in the United States. See generally Alain E. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF. (SUPPLEMENT) 24 (1993). The Clinton Administration attempted to apply these principles to national health care reform via the Health Security Act, but Congress voted down the Act in 1994. See Jonathan Oberlander, *Learning from Failure in Healthcare Reform*, 357 NEW ENG. J. MED. 1677, 1677-79 (2007). Having learned from that experience, the Massachusetts plan applies a refined managed competition model at the state level.

ing health care reform at the state level. Of all the state reforms, none has received more attention than Massachusetts' newly enacted health care reform law. This landmark legislation entitled, *An Act Providing Access to Affordable, Quality, Accountable Health Care* (the "Act"), was passed on April 12, 2006.⁴ Having taken effect on July 1, 2007, it is to date the boldest plan for achieving universal coverage, especially with its aggressive timetable of being fully implemented in just three years.⁵

The plan has garnered much attention for its innovative design, but is equally noteworthy for the political process behind the plan's adoption and implementation. In early 2006, a broad-based coalition of over eighty private and public interest groups teamed with a Democratic state legislature and a Republican governor to enact the most comprehensive state health care reform bill in the nation.⁶ That such a disparate group of supporters agreed to any state-wide health care reform proposal is remarkable. Even more impressive, however, is that such depth and breadth of support have coalesced for a plan that is largely untested. Given the profound importance of achieving universal coverage and the political and financial stakes involved, all eyes are on Massachusetts. The nation waits to see what lessons will unfold from a plan which may or may not be practically feasible and economically sustainable. No one, however, is watching more intently than the people of Massachusetts, whose lives may hang in the balance.

The new law seeks to provide universal health care coverage to all residents of the Commonwealth.⁷ Its key provisions mandate coverage, emphasize personal responsibility, and create incentives for employers, particularly small businesses, to provide insurance. It also reorganizes the insurance market to foster competition and choice, and expands subsidized assistance without raising taxes.⁸ This Article examines the plan's strategy for achieving its fundamental objective of providing all residents with universal access to affordable, quality, and accountable health care. Part II begins by describing the health care challenges that have confronted Massachusetts given the Commonwealth's fiscal and political climate as well as its demographic make-up. It then analyzes the plan's pri-

4. 2006 Mass. Acts ch. 58.

5. *Id.*

6. See CELIA WCISLO ET AL., 1199 SEIU UNITED HEALTHCARE WORKERS E., LESSONS LEARNED TO DATE FROM MASSACHUSETTS HEALTHCARE REFORM 10-11 (Aug. 2007).

7. See generally 2006 Mass. Acts ch. 58.

8. See *id.* §§ 1-2A.

many components, paying particular attention to the costs and benefits of expanding Medicaid coverage, the use of health care mandates, and the newly-created Commonwealth Health Insurance Connector Board (the so-called “Connector”). The extent to which the Massachusetts Health Care Plan can achieve its goals is discussed in Part III, especially in light of what has proved to be the bane of even incremental state reform for too many years: ERISA preemption of state law.

II. HEALTH CARE IN MASSACHUSETTS AND THE ROAD TO REFORM

A. Background: A State of Challenges and Opportunities

Massachusetts faces many of the same challenges and deficiencies that trouble every state in the nation in terms of financing and delivering health care. According to the Commonwealth, some 550,000 Massachusetts residents lacked health care coverage prior to reform.⁹ Without decisive action, that number was sure to rise since premium costs would continue to increase at double-digit rates and increasing costs would incite more small and medium-sized businesses to drop employee health benefits.¹⁰ Declining employer coverage, coupled with over a half-million uninsured residents was clearly detrimental to the families and individuals directly affected. In Massachusetts, it also imposed a significant strain on state finances, businesses, and working families who inevitably funded the Commonwealth’s \$1 billion per-year Free Care Pool that reimbursed hospitals for providing uncompensated care.¹¹

Despite the significant challenges facing the Commonwealth, it was in a stronger position than most states to enact broad reform.

9. COMMONWEALTH OF MA. CONFERENCE COMM., HEALTH CARE ACCESS AND AFFORDABILITY REPORT, Mass. Leg., 184th Sess., at 6 (2006), [hereinafter HEALTH CARE ACCESS AND AFFORDABILITY REPORT] available at <http://www.mass.gov/legis/summary.pdf> (discussing “a bridge between principles in the House and Senate bills, H 4479 and S 2282). See also KAISER COMM’N ON MEDICAID AND THE UNINSURED, Henry J. Kaiser Family Found., Key Facts: Massachusetts Healthcare Reform Plan 1 (Apr. 2006), [hereinafter KAISER COMM’N, KEY FACTS] available at <http://www.allhealth.org/briefingmaterials/Kaiser-MAHealthCareReformPlan-239.pdf>.

10. Tim Murphy, Mass. Exec. Off. of Health & Human Servs., Remarks at Alliance for Health Reform Conference “The Massachusetts Health Plan: How Did They Do It?” 5-6 (May 8, 2006) [hereinafter Murphy, “How Did They Do It?”], available at http://www.allhealth.org/briefingmaterials/050806_Transcript_mass-164.pdf.

11. Vikki Valentine & Richard Knox, *Q & A: Governor Romney on Universal Healthcare*, NATIONAL PUBLIC RADIO, Apr. 8, 2006, <http://www.npr.org/templates/story/story.php?storyId=5330792>.

Although the half-million or so residents without health care represented roughly 10% of the state's population, this percentage was significantly lower than the 16% national average. Plus, a notably higher percentage of Massachusetts residents benefited from employer-provided insurance. In Massachusetts, 68% of residents received insurance through their employer, compared to the national average of 61%.¹² While the 12.7% of insured residents in Massachusetts receiving coverage through Medicaid was on par with the 12.8% national average, it is important to note that 20% of those who were uninsured in Massachusetts before implementation of the new law—about 106,000 people—were eligible for Medicaid but were not enrolled.¹³

In addition to its comparatively lower number of uninsured, the Commonwealth's tax structure and its access to millions in federal resources from Medicaid offered unique opportunities to fund the projected \$1.2 billion reform without imposing additional state taxes. In Massachusetts, like other states, hospitals have provided emergency and other medical services to thousands of uninsured patients. In other parts of the country especially, this has been a significant driver of premium cost escalation. States frequently use hospital surcharges or other techniques to generate revenues from patients who have coverage in order to cross-subsidize hospitals for caring for those who lack coverage. Massachusetts applies an explicit tax to insurance companies and businesses to fund the Commonwealth's Free Care Pool for the uninsured.¹⁴ Insurance companies typically pass these added costs on to the insured by way of premium hikes that effectively function as an implicit tax.¹⁵ As a result, before enactment of the reform statute, hospitals would pay the full costs of uninsured patients upfront; the Commonwealth would then reimburse them for medical services through its \$1 billion uncompensated care pool.¹⁶ In essence, this amounted to a \$1 billion per year subsidy for the uninsured that had become a financial headache for the insurance industry and a glaring liability for the state in securing federal Medicaid funding.

Facing shortfalls in funding the Free Care Pool by relying on employer-sponsored and other private insurance, Massachusetts had

12. KAISER COMM'N, KEY FACTS, *supra* note 9, at 1.

13. Murphy, "How Did They Do It?", *supra* note 10, at 7.

14. See Lauren Klepac & Robert Gutierrez, *Dr. Jonathan Gruber: Professor of Economics at MIT*, HEINZ SCH. REV., Vol. 3, Issue 2, Oct. 2006, available at <http://journal.heinz.cmu.edu/articles/interview-dr-jonathan-gruber>.

15. *Id.*

16. *Id.*

increasingly used federal Medicaid dollars to support its hospital reimbursement transfers.¹⁷ In 2006, it became clear that the strategy of borrowing from Medicaid funds was on borrowed time. By that point, the federal government was threatening to withhold \$385 million in Medicaid funding unless Massachusetts developed a plan to apply federal resources more strategically.¹⁸ Facing such a considerable loss of federal resources made it clear to legislators and stakeholders alike that the time to act had arrived.

Just as the federal government's threat to withhold Medicaid funds was at the core of the immediate funding crisis, the reallocation of uncompensated care funds was at the heart of the new plan. Seeking to maximize and capitalize upon the millions available in federal dollars, the new law converted the Free Care Pool from a hospital reimbursement fund into a premium assistance support resource for the uninsured.¹⁹ This change allowed the state to renew its Medicaid waiver under § 1315 of the Social Security Act,²⁰ and secure an additional \$385 million federal transfer.²¹ These amounts, combined with the \$1 billion in state funds, laid the financial foundation to increase access to coverage and reduce costs by transforming the overall insurance market.

Putting a financing plan in place enabled policymakers to analyze the characteristics of the uninsured and design a largely consumer-driven program based on personal responsibility. Identifying and enrolling the estimated 20% of the uninsured in Massachusetts who are eligible for Medicaid into MassHealth—the state's Medicaid program—should be, at least in theory, fairly straightforward to accomplish using administrative resources already in place.²² However, dealing with the remaining 80% of the uninsured who are not eligible for Medicaid poses far greater legislative, financial, and political complexities. At the time of reform, approximately 150,000 to 200,000 uninsured individuals in Massa-

17. See JOHN HOLAHAN ET AL., URBAN INST., *CARING FOR THE UNINSURED IN MASSACHUSETTS: WHAT DOES IT COST, WHO PAYS, AND WHAT WOULD FULL COVERAGE ADD TO MEDICAL SPENDING?* 32 (2004), available at http://www.bcb-smafoundation.org/foundationroot/en_US/documents/roadmapReport.pdf.

18. Edmund Haislmaier, *The Significance of Massachusetts Health Reform*, HERITAGE FOUND., at 3, Apr. 11, 2006, <http://www.heritage.org/Research/HealthCare/wml1035.cfm?renderforprint=1>.

19. *Id.*

20. 42 U.S.C.A. § 1315 (West 2000) (allowing states to receive federal Medicaid funding while they experiment or implement pilot programs to provide health services to low income groups).

21. See Klepac & Gutierrez, *supra* note 14.

22. See Murphy, *supra* note 10, at 7.

chusetts earned too much to be covered through Medicaid, but also earned less than 300% of the federal poverty level, or \$29,412 per person per year, and could not afford basic premiums.²³

Equally significant were the roughly 200,000 individuals who earned more than 300% of the federal poverty level, but still could not—or would not—purchase insurance due to high costs, poor value, little consumer choice, or overly-restrictive risk pools, among others reasons.²⁴ Taking into consideration available state financing, the various needs of the uninsured and the characteristics of the market, the authors of the new Massachusetts plan devised a multi-faceted strategy for achieving universal coverage by 2009. Adopting a thesis of shared responsibility, it requires everyone, from the poorest individual to the wealthiest corporation, to play a part in accomplishing this goal.

B. Insurance Coverage for Low-income Groups: The Individual Mandate and MassHealth Expansion

Perhaps one of the most controversial, and surely one of the most innovative aspects of the Massachusetts law is that it required all Medicaid ineligible residents eighteen years and older to purchase private health care insurance if the Connector deemed them able to afford coverage. July 2007 was the initial deadline for obtaining coverage, but it was subsequently extended to December 30, 2007. Representatives of the Connector indicate that no further extensions will be granted and penalties will be assessed for those who remain uninsured in 2008.²⁵ Although subject to a hardship waiver, any person not insured by the deadline is subject to penalty,²⁶ starting with the loss of their personal tax exemption followed by increasingly severe penalties in subsequent years.²⁷ The statute provides that the actual amount of the penalty shall be set by the state's Department of Revenue, but it can be as high as one half of what the individual's minimum monthly premium would be if coverage were to be obtained through the Connector.²⁸ For the 2007 tax year, the individual penalty is \$210, an amount which many of those affected have already expressed a preference

23. *Id.* at 14-15.

24. *Id.* at 2-3.

25. Audio file: Comments of Jon Kingsdale, "Your Call: Health Care—The Show", (Dec. 18, 2007), <http://www.wbur.org/weblogs/commonhealth/?9=312>.

26. MASS. GEN. LAWS ch. 111M, § 2(b) (2006) *reprinted in* 2006 Mass. Acts ch. 58, § 13.

27. *Id.*

28. *Id.*

for, rather than the thousands of dollars that are needed to obtain coverage. In response, the Department of Revenue has indicated that for the 2008 tax year, it will increase the individual penalties for those earning above 150% of the poverty level. Depending on income, penalties will range from \$210 to as high as \$912 per year and are subject to adjustment each year thereafter.²⁹ At first glance, the individual mandate may seem to place an impossible burden upon lower-income families, but it is a cornerstone to increasing access while reforming the insurance market. In deciding to mandate individual coverage, Massachusetts has ostensibly altered the manner in which the Commonwealth and hospitals will provide medical attention to the uninsured. As noted earlier, the Commonwealth previously subsidized hospitals by directly reimbursing expenditures incurred in attending the uninsured. The new plan will gradually transform the Free Care Pool from a hospital financial assistance program into a financial resource for assisting individuals in purchasing private health care. In this way, the law seeks to ensure a more sustainable use of public finances while simultaneously increasing access to coverage. Although hospital reimbursements will undoubtedly continue until universality is achieved, the law envisions a steady reduction in hospital subsidization as coverage continually expands.

Key to implementing this financial reallocation is the newly created Commonwealth Care Insurance Program.³⁰ Its primary function is to subsidize the approximately 200,000 residents who earn too much to be covered through Medicaid, but whose low earnings make it difficult, if not impossible to purchase the mandated coverage without financial assistance.³¹ Commonwealth Care is intended to enable the state to provide subsidies on a sliding scale to those individuals who earn up to 300% of the federal poverty level.³² Notably, individuals earning less than 133% of the federal poverty level are not required to pay any premiums.³³ For exam-

29. Mass. Dept. of Revenue, Draft Technical Information Release 07-18: Individual Mandate Penalties for Tax Year 2008, [http://www.mass.gov/?pageID=dorterminal&L=7&L0=Home&L1=Businesses&L2=Help+%26+Resources&L3=Legal+Library&L4=Technical+Information+Releases&L5=TIRs+-+By+Year\(s\)&L6=2007+Releases&sid=Ador&b=terminalcontent&f=dor_rul_reg_tir_tir_07_18_draft&csid=Ador](http://www.mass.gov/?pageID=dorterminal&L=7&L0=Home&L1=Businesses&L2=Help+%26+Resources&L3=Legal+Library&L4=Technical+Information+Releases&L5=TIRs+-+By+Year(s)&L6=2007+Releases&sid=Ador&b=terminalcontent&f=dor_rul_reg_tir_tir_07_18_draft&csid=Ador) (last visited Mar. 10, 2008).

30. Murphy, *supra* note 10, at 14.

31. *Id.*

32. MASS. GEN. LAWS. ch. 118E, § 9A (2006) *reprinted in* 2006 Mass. Acts ch. 58, §15.

33. See 130 MASS. CODE REGS. § 505.002 (2008). See also KAISER COMM'N ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., Key Facts:

ple, an individual making up to \$14,700 per year, or 150% of the poverty line, is required to pay an \$18 monthly premium towards private coverage while a person earning \$29,412 per year will pay \$106 per month.³⁴ It must be emphasized that the Commonwealth Care Insurance Program is *not* an insurance plan. Rather, it simply facilitates the purchase of coverage. All insurance plans under this program must be purchased, free of deductibles, from private insurance companies. In the first three years of implementation, only those insurance companies that currently offer plans through Medicaid are permitted to compete in this sector of the insurance market.³⁵

In addition to improving access to coverage through the partially subsidized individual mandate, the law also increases eligibility and benefits under the Medicaid program itself. Eligibility for MassHealth is raised to cover all children who fall within 300% above the federal poverty line.³⁶ It is hoped that this adjustment will expand Medicaid coverage to an estimated 90,000 children.³⁷ Whether it will succeed is another matter, especially given President Bush's vetoes of Congress's attempts to expand the federally funded State Children's Health Insurance Program ("SCHIP").³⁸ Those earning within 133% of the poverty line will continue to have premium-free access to health care.³⁹ The Act also restores dental and vision benefits to all MassHealth beneficiaries.⁴⁰ Through the end of 2006, the Commonwealth had signed up 29,000 individuals who had been eligible for these benefits but had not previously enrolled, and by December 2007, estimates of the newly insured ranged from 200,000⁴¹ to 300,000 people.⁴² Of these, ap-

Massachusetts Healthcare Reform Plan: An Update 1 (June 2007), <http://www.kff.org/uninsured/upload/7494-02.pdf> [hereinafter KAISER COMM'N, KEY FACTS UPDATE].

34. Editorial, *What's With This Health Law?*, BOSTON GLOBE, Dec. 29, 2006, at A14.

35. Murphy, *supra* note 10, at 14.

36. MASS. GEN. LAWS ch. 118H, § 3 (2006) *reprinted in* 2006 Mass. Acts ch. 58, § 45.

37. KAISER COMM'N, KEY FACTS, *supra* note 9, at 2.

38. See Susan Milligan, *Patrick Blasts Romney for Medical Aid Stance*, BOSTON GLOBE, Sept. 29, 2007, at A7.

39. See 130 MASS. CODE REGS. § 505.002 (2008). See also KAISER COMM'N, KEY FACTS UPDATE, *supra* note 33, at 1-2.

40. HEALTH CARE ACCESS AND AFFORDABILITY REPORT, *supra* note 9, at 3.

41. CHRISTINE BARBER & MICHAEL MILLAR, CMTY. CATALYST, INC., REVISITING MASSACHUSETTS HEALTH REFORM: 18 MONTHS LATER 6 (Dec. 2007), http://www.communitycatalyst.org/doc_store/publications/revisiting_MA_health_reform_dec07.pdf.

proximately one third are thought to be privately insured with the remainder being fully or partially subsidized by the state.⁴³

Lawmakers fully anticipated the political opposition and financial obstacles that would greet the individual mandate, and considered a variety of issues in justifying this aspect of the new reform plan. The legislature and governor agreed that without subsidies and market reforms, forcing individuals to purchase insurance in the current market would be impossible for most and unfair to all. Nevertheless, the state was already subsidizing the uninsured through inefficient, if not wasteful, hospital reimbursements. If subsidies were to be paid, the plan's architects reasoned, those funds would be better spent on bringing all persons into the insurance market. Thus, it became apparent to all that subsidizing low-income consumers and transforming the market to offer affordable insurance options were critical to ending the status quo. As a result, the law mandates premium rates according to income levels and contemplates a variety of market reforms to increase consumer options while reducing premiums to more accessible levels.

While the overall logic has been widely accepted, many believe that the mandated rates and out-of-pocket expenses required for low income families remain unaffordable and must be substantially lowered in order for the plan to succeed. For example, the Greater Boston Interfaith Organization ("GBIO") conducted an early analysis of how the individual mandates would affect those families eligible for subsidized assistance under Commonwealth Care. It found that 46.1% of families that fell between 100% and 300% of the federal poverty level could not afford the premiums under the approved payment scheme, and that 38% of those surveyed reported negative monthly earnings.⁴⁴

If it is true that nearly half of the 200,000 or so individuals living between 100% and 300% of the poverty line are unable to afford insurance at the subsidized rates, the basic premise of the program may be crippled. The law makes clear that if the mandated premiums have been miscalculated and are unaffordable, they become

42. See Commonwealth Connector, About the Connector: Overview, <http://www.mahealthconnector.org/portal/site/connector> (follow "About Us" hyperlink) (last visited Mar. 10, 2008).

43. *Id.*

44. GREATER BOSTON INTERFAITH ORG., MANDATING HEALTH CARE INSURANCE: WHAT IS *Truly* Affordable for Massachusetts Families? 1 (Dec. 2006) http://www.gbio.org/maint/affordability_report.doc [hereinafter GBIO, MANDATING HEALTH CARE INSURANCE].

unenforceable.⁴⁵ As a result, if a portion of beneficiaries were unable to purchase insurance, the Commonwealth would be forced to continue bankrolling hospitals while also paying millions in subsidies to those covered. Funding the mandated subsidies while also paying considerable hospital reimbursements would exacerbate an already untenable burden for the state. Plus, it would not only increase inefficient government spending but would do so while leaving thousands uncovered—an outcome that would dramatically and possibly fatally undermine the law's objectives.

The viability of the individual mandate along with its intended impact on the overall insurance market demands that affordable plans be available. It was therefore paramount for lawmakers and insurers to reach consensus in defining affordability. This seemed unlikely in early 2006, as Governor Mitt Romney initially insisted that average monthly costs could total around \$200, while insurers continually argued that average premiums would hover around \$320 per month.⁴⁶

The inability of state regulators and insurance companies to agree on affordable premium rates seemed destined to impede the law's successful implementation. However, on March 3, 2007, the Connector Board and the seven participating insurers reached a compromise, which has kept the program on solid ground. At least for now, monthly premium rates are reduced to an average of \$175 per month, while out-of-pocket expenses will be permitted to fluctuate according to particular plans. This breakthrough is a step in the right direction, especially because the low premiums include benefits such as prescription drugs, office visits, and outpatient surgery. It is important to note, however, that lower premiums were obtained by permitting higher co-payments and deductibles. As a result, total payments for medical attention could potentially nullify or at least minimize the intended effect of having relatively affordable premiums.⁴⁷ It also remains to be seen whether low income individuals and families will be able to pay even these modest premiums and related expenses.⁴⁸

Obviously, health care reform in Massachusetts will not be sustainable if it is not affordable, and affordability is a mounting

45. MASS. GEN. LAWS ch. 111M, § 4 (2006) *reprinted in* 2006 Mass. Acts ch. 58, § 12.

46. *See* Robert Steinbrook, *Healthcare Reform in Massachusetts—A Work in Progress*, 354 NEW ENG. J. MED. 2095, 2097 (2006).

47. *See* GBIO, MANDATING HEALTH CARE INSURANCE, *supra* note 44, at 14.

48. *See id.* at 18.

worry with regard to subsidizing the individual mandate. Early reports indicate that the state grossly underestimated its own costs in covering the previously uninsured.⁴⁹ In 2006, projected enrollment in the state subsidized Commonwealth Care program ranged from 140,000 to 160,000, but by January 2008, 169,000 had joined; by 2011 enrollment may surge to 342,000 with an attendant cost to the state of \$1.35 billion.⁵⁰ Lawmakers are considering raising needed revenues through new cigarette taxes and raising employer penalties which would surely jeopardize the employer support that the Massachusetts law has enjoyed so far.⁵¹

C. Employer Responsibility for Uninsured Workers

In addition to the individual mandate and expanded Medicaid coverage, the law also emphasizes employer responsibility. At the time of the law's enactment, over 200,000 Massachusetts residents were estimated to earn more than 300% of the federal poverty rate but were unable or unwilling to purchase private insurance.⁵² Many of these individuals work for small and medium-size businesses that do not offer health benefits. In addressing this segment of the uninsured population, the Massachusetts law established important provisions for businesses with eleven or more full time employees and those with ten or more full and part-time workers.

Under reform, employers with eleven or more full time workers must make a "reasonable contribution" towards employee insurance plans by enrolling at least 25% of workers in employer-sponsored health insurance, or contributing 33% towards the cost of individual health plans for all full-time employees.⁵³ Any company with eleven or more full time workers that chooses not to contribute directly to a worker's private health benefits must make a yearly \$295 per employee "fair share contribution" to the uncompensated care pool.⁵⁴ Furthermore, businesses with eleven or more full time equivalent employees were required to adopt Internal Revenue Code section 125 "cafeteria" plans—initially by July 1, 2007 and subsequently by January 1, 2008.⁵⁵ Basically, a cafeteria

49. Alice Dembner, *Undercount of Uninsured Attributed to Flawed System*, BOSTON GLOBE, Feb. 3, 2008, at A15.

50. *Id.*

51. Alice Dembner, *DiMasi, Murray Mull Increase in Cigarette Tax: Funds Would Help Cover Healthcare Costs*, BOSTON GLOBE, Feb. 6, 2008, at B1.

52. See Murphy, *supra* note 10, at 7.

53. 114.5 MASS. CODE REGS. § 16.03 (2006).

54. MASS. GEN. LAWS ch. 149, § 188 (2006).

55. 956 MASS. CODE REGS. § 4.00 (2006).

plan allows employees to choose between taxable benefits (such as cash) and at least one “qualified” benefit on a pre-tax basis, such as accident or health insurance, group term life insurance, or adoption assistance.⁵⁶ Cafeteria plans are intended to be attractive to businesses and employees alike, as they allow workers to pay for health coverage on a pre-tax basis and provide them with greater choice in selecting health plans, while also allowing companies to save on Federal Insurance Contribution Act (“FICA”) taxes.⁵⁷ Companies that fail to offer cafeteria plans will be charged a “free-rider” penalty to help fund employees who seek uncompensated care on multiple occasions. The exact amount of the surcharge will vary depending upon a variety of factors, including number of employees, the number of state funded visits, and the total costs to the state.⁵⁸ It is hoped that the modest “fair share” contribution and the section 125 fiscal benefits will encourage small businesses in particular to contribute to employee coverage, as they are less likely to offer direct coverage to their workers.⁵⁹

Because employers were given through the end of 2007 to comply with the new law, it is too soon to know how aggressively the Commonwealth will impose penalties and how employers will respond. Early indications are that employers have been remarkably cooperative, exceeding the Connector’s initial projections. Even with full compliance, however, the impact on workers can be significant and in some cases, burdensome. For example, a Burger King franchisee that had previously covered only senior staff expanded coverage to include all full-time workers, but did so by halving its own contribution to the cost of that coverage.⁶⁰ Other firms that had previously covered part-time employees have tightened eligibility by increasing the minimum hours needed to qualify for coverage. Under either approach, some workers received access to

56. INTERNAL REVENUE SERV., FAQs FOR GOVERNMENT ENTITIES REGARDING CAFETERIA PLANS, <http://www.irs.gov/govt/fslg/article/0,,id=112720,00.html> (last visited Mar. 10, 2008).

57. THE COMMONWEALTH CONNECTOR, EMPLOYER HANDBOOK 4 (Nov. 1, 2007), <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/Employer/Overview/Employer%20Handbook.pdf>.

58. *Id.* at 5.

59. See Robert Moffit & Nina Owcharenko, *Understanding Key Parts of the Massachusetts Health Plan*, HERITAGE FOUND., Apr. 20, 2006, <http://www.heritage.org/Research/HealthCare/wm1045.cfm>.

60. See Alice Dembner, *Firms Find Ways Around State Health Law*, BOSTON GLOBE, Dec. 23, 2007, at A1.

previously unavailable coverage, but others lost a significant means of paying for that coverage.⁶¹

Unfortunately, but not unpredictably, there are employers that have dropped coverage altogether. In these instances, the cost of covering all eligible workers may prove to be too burdensome, especially when compared with the less-expensive option of paying \$295 per-worker to the state. At least one employer has opted to avoid state requirements entirely by establishing separate corporations of less than the eleven full time workers needed to trigger the employer mandate.⁶² Still others are expected to circumvent the law by converting employees to independent contractor status. Again, given that this is the first year in which compliance is required, it is too early to appreciate fully how employers will behave and how state regulators will respond.

Despite the strong consensus surrounding the evolution and enactment of this law, the employer mandate has been strongly criticized by both liberals and conservatives. Critics are quick to point out that the term “employer provided health care” is a misnomer, and reject the implicit assumption that employers pay for health care. Because health coverage is actually a component of an employee’s overall compensation package, it is the worker who actually pays for the insurance. Consequently, any funds transferred from a company to an insurance provider on the employee’s behalf are proportionately reflected in decreasing salaries.⁶³ Some conservatives also argue that the required contribution amounts to a second tax upon business. In their view, it overly burdens businesses that already contribute to the uncompensated pool through the state health insurance premium tax.⁶⁴ Because increased business taxation can be particularly difficult for small companies, this could lead to downsizing or migration to other states.⁶⁵ The potential loss of jobs could instigate further increases in the ranks of uninsured individuals in the Commonwealth.

In contrast, many business leaders, reform advocates, and state lawmakers insist that the \$295 penalty is too lenient for private

61. *Id.*

62. *Id.*

63. Nina Owcharenko & Robert E. Moffit, *The Massachusetts Health Plan: Lessons for the States*, HERITAGE FOUND., at 7, July 18, 2006, <http://www.heritage.org/Research/HealthCare/bg1953.cfm>.

64. *Id.*

65. See Anna D. Sinaiko, *Employers’ Responses To A Play-Or-Pay Mandate: An Analysis Of California’s Health Insurance Act Of 2003*, HEALTH AFF., Oct. 13, 2004, at W4-474, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.469v1>.

companies and assert that the law should demand more of employers.⁶⁶ The Smaller Business Association of New England, a non-profit organization with 700 members, has argued that most of its members already contribute 50% to 80% of their workers' health care premiums. Member-companies reason that although they have the financial wherewithal to continue paying for employee premiums and many are willing to continue, the new low annual figure of \$295 actually provides them with a financial incentive to stop.⁶⁷ In response to this argument and similar arguments made by Affordable Care Today, a Massachusetts advocacy organization, State Senator Mark Montigny recently submitted a bill entitled, An Act Strengthening Health Reform. Among other key provisions, it would require that companies pay at least 50% of individual premiums.⁶⁸

D. The Commonwealth Connector & Insurance Market Reform

Debate over the individual and employer mandates has revealed significant reservations about the law—at least among certain stakeholders—especially with regard to affordability. One aspect of the law that might alleviate at least some of these concerns is its call for insurance market reforms since these will hopefully reduce premiums for the uninsured while expanding consumer choice. At the heart of this feature of overall reform is the newly created Commonwealth Health Insurance “Connector” which sets affordability standards, assists low-income groups in paying for coverage, and provides tools to help individuals and employers find affordable health insurance coverage. The Connector is an independent public authority, which is administered by the Commonwealth Health Insurance Connector Authority and overseen by a ten-member board of representatives from the public and private sectors.⁶⁹ It basically functions as a centralized clearinghouse that matches insurance buyers with sellers. As such, it is the glue that holds the entire health care reform plan together. Often compared to a stock exchange for health insurance, the Connector brings together willing providers and consumers into one centralized mar-

66. See, e.g., Jeffrey Krasner, *Business Leaders Suggest Health Law Too Easy on Firms*, BOSTON GLOBE, Feb. 2, 2007, at C1.

67. *Id.*

68. S. 661, 185th Sess. (Mass. 2007).

69. Commonwealth Connector, About the Connector: Leadership, <http://www.mahealthconnector.org/portal/site/connector/> (follow “About Us” hyperlink; then follow “Leadership” hyperlink) (last visited Feb. 26, 2008).

ketplace intended to facilitate consumer-driven competition.⁷⁰ Like the stock market, the underlying assumption is that economic efficiency can be increased through a central mechanism that promotes competition and, therefore, facilitates information-sharing, communication, and the collection and transmission of payments.

The Connector is considered by many to be the most innovative mechanism of the Massachusetts program. In addition to electronically linking buyers and sellers by facilitating information exchange through one centralized source, the Connector is structured to increase access and reduce costs by pooling consumers, thus increasing consumer leverage and bargaining power. Prior to the law's enactment, insurance markets in Massachusetts were deeply fragmented between individual and group markets. Lacking the leverage of group plans, persons not covered through their employer were typically limited to plans that cost substantially more and offered considerably less. To assuage this disparity, the Massachusetts Legislature was determined to make the Connector marketplace accessible to purchasers consisting of both individuals and small businesses (which the law defines as having fifty or fewer employees). By merging the small business and individual markets, the Connector—at least in theory—expands consumer choice and increases consumer bargaining power while helping to reduce individual premiums by an estimated 24%.⁷¹

Employer participation in the Connector is not mandatory, but the law offers important incentives for small businesses to insure their employees through this mechanism. For those companies that previously did not offer coverage to their employees, the Connector provides an affordable and administratively simple alternative. Now, whether or not a small business is new to the health insurance market, it can look to the Connector for help in establishing its group plan as the Connector facilitates information regarding options from which small business can choose. Equally important, the Connector can enable small businesses already providing group insurance to free themselves of the administrative burdens associated with employee coverage.

While the Connector framework offers clear benefits to employers, its flexibility and consumer-driven focus makes it especially attractive to individual purchasers. Unlike most employer-sponsored programs, the Connector allows eligible employees to select the products and options that best suit their needs and financial re-

70. See Haislmaier, *supra* note 18, at 2.

71. KAISER COMM'N, KEY FACTS, *supra* note 9, at 1.

sources. Because private companies will vie for buyers in this new market model and consumers are free to choose from a variety of policies, market principles suggest that premium costs will decline as competition increases. By promoting consumer choice, this aspect of the plan will hopefully benefit both insurers and individual purchasers. In theory at least, private insurance companies are given the opportunity to generate new business while consumers can now demand more quality and value.

A key feature of the Connector is its role in supporting workforce mobility by facilitating consumer portability. Once consumers select and purchase an insurance plan, they are free to move to different jobs without the threat of losing the insurance benefits already obtained through the Connector.⁷² This should be considered one of the plan's greatest innovations. Prior to reform, workers with employer-sponsored insurance were often discouraged from exploring more promising or suitable career opportunities for fear of losing benefits. By ensuring portability, however, the Connector mechanism reinforces worker autonomy and levels the playing field between employers and employees. Along these lines, the legislation also preserves employee tax benefits by excluding employer or worker contributions from taxable income, allows double-income families to combine employer contributions toward the plan of their choice, and permits part-time workers to combine payments from various employers.⁷³

In addition to strengthening competition and consumer autonomy, the Connector also expands quality coverage for segments of the population with low coverage rates.⁷⁴ In Massachusetts and elsewhere, nineteen to twenty-six year olds are often reluctant or unable to seek individual coverage. In that age group, salaries are generally low; plus, many younger residents place a low priority on purchasing health insurance given their financial constraints and their statistically lower risk of needing health care. Yet their health status, at least as a demographic group, is the precise reason why their presence is so important for spreading risk—and costs—in insurance risk pools. In recognition of this, the law mandates that this age group be covered,⁷⁵ and provides a variety of mechanisms for achieving coverage. The Connector offers individual coverage

72. See 2006 Mass. Acts ch. 58, §§ 96-100, as amended by Technical Corrections Act of 2006, 2006 Mass. Acts ch. 324, § 52.

73. See Haislmaier, *supra* note 18, at 3.

74. See Technical Corrections Act of 2006, 2006 Mass. Acts ch. 324, § 34.

75. *Id.*

at reduced rates to young adults through the age of twenty-six who lack their own employer-sponsored health benefits and are not covered by a parent's family plan. The law also requires family health plans to cover children for two years after they become independent from their parents or reach the age of twenty-five.⁷⁶ This is a sizeable gain for those who would previously have been cut off from family coverage at approximately age twenty-one or earlier if not full-time students.

The Connector's role, however, extends beyond simply matching willing buyers with sellers. Its ten-person Connector Authority also determines the required coverage that insurance companies must offer in order to participate in the Connector-administered market. In addition, the board sets the affordability standard for subsidized monthly premiums under the individual mandate, and negotiates deductible costs with insurance companies. Finally, the board administers the Commonwealth Care Program for residents with incomes below 300% the federal poverty level.⁷⁷

While the Connector represents an important innovation in the expansion of health insurance and is widely recognized as such, it is not without its detractors. As previously discussed, the Connector's success or failure will largely depend upon the affordability of plans offered. Assuming that reasonably priced options are made available, critics argue that the Connector may increase general access to care, but will do little to equalize access to, or increase consumer choice of quality coverage.⁷⁸ Thomas Miller of the American Enterprise Institute indicates that the Connector's ability to promote competition among providers is merely illusory since consumer choice for those with incomes between 100% and 300% of the federal poverty level remains limited to the four current Medicaid operators.⁷⁹

Perhaps the Connector's most fundamental and, therefore, troubling limitation is that despite the obvious merits of expanding coverage, it does too little to contain administrative costs and does nothing to address other cost drivers, such as overall utilization patterns and specific consumption of technology and prescription drugs. Increasing coverage, and thus utilization of health care,

76. MASS. GEN. LAWS ch. 175, § 108 (2006).

77. MASS. GEN. LAWS ch. 118H (2006) *reprinted in* 2006 Mass. Acts ch. 58, § 45.

78. See Deborah White, *Pros and Cons of Massachusetts Mandatory Health Insurance Program*, ABOUT.COM, <http://usliberals.about.com/od/healthcare/i/MassHealthIns.htm> (last visited Mar. 10, 2008).

79. Thomas Miller, *Massachusetts: More Mirage than Miracle*, 25 HEALTH AFF. W451 (2006), available at <http://content.healthaffairs.org/cgi/reprint/25/6/w450>.

without addressing such key components of overall expenditures will make sustaining such a plan difficult without additional tax revenues.⁸⁰ The Massachusetts Medical Society is already reporting a shortage of primary care physicians for the second consecutive year.⁸¹ This shortage may continue and potentially worsen as more people gain coverage and use more care. Although significant delays in accessing care have not yet become a problem, the increasing number of enrollees and the dwindling number of available doctors could pose serious challenges.

The basic logic of Massachusetts' approach to health care reform has obvious appeal: reduce uncompensated care by lowering the cost of coverage by "managing" the competition among insurance carriers for a larger and more risk-diverse pool of purchasing dollars. Despite its theoretical strengths, the plan has already faced obstacles to implementation. On April 13, 2007, the Connector Board made perhaps its most strategic decision yet by voting to exempt 20% of uninsured residents from the individual mandate while also increasing access to MassHealth for those earning up to 133% of the federal poverty level.⁸² The decision was made largely in response to the tenacious lobbying efforts of a coalition of civic organizations concerned about affordability and fairness. As a result of this decision, some 60,000 low and moderate income residents unable to afford insurance at the reduced rates will not be penalized for a failure to obtain coverage. Clearly, this temporarily detracts from true universality. More importantly, however, the Connector Board's action in this instance reveals that it correctly recognizes the need to work closely with different constituencies in addressing practical necessities and to be flexible in making key modifications as needed. It also demonstrates that health care affordability and, indeed, the viability of overall health care reform, must be continually reevaluated with adjustments being made according to evolving circumstances.

80. See Steinbrook, *supra* note 46, at 2095-96.

81. Doug Trapp, *Massachusetts Health Reform Builds Momentum, But Will a Physician Shortage Lead to Long Waits for Enrollees in State's New Insurance Plan?*, AMNews, Oct. 1, 2007, <http://www.ama-assn.org/amednews/2007/10/01/gvsb1001.htm>.

82. See 130 MASS. CODE REGS. § 505.002 (2008); see also Julie Appleby, *Mass Health Plan Finds Cost is too High for 20% of People*, USA TODAY, Apr. 13, 2007, available at http://www.usatoday.com/money/industries/health/2007-04-13-mass-usat_N.htm.

III. ERISA PREEMPTION: AN ENDURING THREAT TO SUCCESSFUL STATE REFORM

Massachusetts' universal coverage plan follows years of frustration among the states arising out of dramatic spikes in both costs and the number of uninsured, as chronic gridlock blocked meaningful federal action. While congressional intransigence has forced states to take the reins of health care reform, it has also erected formidable obstacles to doing so. Of the many daunting challenges facing any state health care reform plan, preemption by the Employee Retirement Income Security Act ("ERISA") of 1974 is potentially the most onerous.

A. ERISA's § 514 Preemption Clause

Congress passed ERISA⁸³ to protect employee benefit plan participants and their beneficiaries by federalizing regulation of plan administration "to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government."⁸⁴ While fraud and mismanagement in the pension context inspired ERISA's enactment, health benefits were swept within its purview.⁸⁵ The statute does not require employers to offer benefits,⁸⁶ but instead controls the administration of benefit plans through detailed provisions concerning plan design and administration, including reporting and disclosure requirements,⁸⁷ participation and vesting provisions,⁸⁸ funding standards,⁸⁹ and plan administrator fiduciary obligations.⁹⁰ Such detailed directives evidence Congress' preoccupation with pension benefits, and contrast starkly with ERISA's virtual silence about health benefits.

To prevent unduly complicated and potentially contradictory state regulation of the administration of employee benefits plans, ERISA also contains a three-part "conflict" preemption provi-

83. Pub. L. No. 93-406, 88 Stat. 829 (codified at 29 U.S.C. § 1001 *et seq.* (2008)).

84. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).

85. ERISA applies to employee welfare and pension benefit plans that provide "medical, surgical, or hospital care or benefits" for plan participants and their beneficiaries "through the purchase of insurance or otherwise." 29 U.S.C.A. §1002(1) (West 2008).

86. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 651 (1995).

87. 29 U.S.C.A. §§ 1021-1031 (West 2008).

88. *See id.* §§ 201-211.

89. *See id.* §§ 301-308.

90. *See id.* §§ 1131-1145.

sion.⁹¹ Section 514(a) states that ERISA shall “supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”⁹² The “relate to” clause is limited by the “saving” clause, which saves or excludes from preemption those state laws that would satisfy the relate to clause but nevertheless qualify as, *inter alia*, state insurance law.⁹³ The saving clause is itself limited by the “deemer” clause which precludes states from “deeming” a law to constitute insurance regulation for the purpose of “saving” a law which would otherwise “relate to” a plan so as to be preempted. The convoluted structure of § 514 is exacerbated by the absence of any statutory definition of “relate to” or explanation of what constitutes state insurance law for the purposes of the saving and deemer clauses.

Preemption of state remedies under the relate to clause leaves only those remedies available under ERISA’s § 502’s civil enforcement scheme which allows equitable relief, but does not include monetary damages, even in instances where equitable relief is clearly inadequate.⁹⁴ By preempting state law and granting such limited relief, ERISA effectively provides no remedy or recourse to patients or providers who try to challenge—or states which attempt to regulate—the conduct of employer sponsored benefit plans. This result seems at least facially at odds with Congress’ original intent that ERISA would be an employee-protective statute. Nevertheless, ERISA has preempted patient complaints of perceived inadequacies in plan coverage and accountability⁹⁵ and stalled, if not derailed, state efforts to regulate the finance and delivery of health care.⁹⁶

91. Section 502 of ERISA, which articulates the statute’s exclusive remedies, is frequently characterized as a second preemption provision in that it has been held to completely preempt plan beneficiaries’ claims which amount to alternative claims for benefits, or challenges to the quality of benefits received. *See, e.g., Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004).

92. 29 U.S.C.A. § 1144(a). State laws subject to possible preemption include “all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.” *Id.* § 1144(c)(1).

93. *Id.* § 1144(a).

94. *See, e.g., Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993) (monetary damages unavailable); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) (unavailability of extracontractual, compensatory, or punitive damages under § 502).

95. *See, e.g., Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

96. *See generally, e.g., Mary Ann Chirba-Martin & Troyen A. Brennan, The Critical Role of ERISA in State Health Reform*, 13 HEALTH AFF. 2, 142 (1994).

B. Judicial Interpretation of § 514 Preemption

Given its combination of structural complexity and definitional ambiguity, § 514 has engendered three decades of generally expansive and unpredictable Supreme Court case law. The result is a sad pattern of states struggling to regulate around ERISA, but usually seeming powerless to do so. The next chapter of § 514 case law seems destined to reveal what, if anything, states can do to enlist employers in their efforts to rein in health care costs while expanding coverage. The key to resolving this will be the United States Supreme Court's 1995 decision in *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,⁹⁷ which involved a New York hospital rate setting statute that required hospitals to impose a series of surcharges on the bills of patients who were covered by commercial payors.⁹⁸ Unlike the "fair share" or "play or pay" laws of Maryland, New York's Suffolk County and Massachusetts,⁹⁹ it created no direct requirements or incentives for employers or employer-sponsored benefits plans. This did not stop plans from arguing that by increasing plan costs, the surcharges had the kind of "connection with or reference to" plan administration that had demanded § 514 preemption since *Shaw v. Delta Air Lines*.¹⁰⁰

A unanimous Supreme Court disagreed,¹⁰¹ reasoning that "[if] 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for [r]eally, universally, relations stop nowhere."¹⁰² Thus, instead of following its prior expansive—and self-admittedly confusing—interpretations of the relate to clause, the Court in *Travelers* returned to a classical preemption analysis by engaging a "starting presumption that Congress does not intend to supplant state law."¹⁰³ It emphasized that this presumption is particularly strong where the state law in question involves the exercise of a state's police power in an area traditionally left to state control, such as health care.¹⁰⁴ Preemption of such traditionally state laws will not occur unless it is determined to be "the clear and manifest

97. 514 U.S. 645 (1995).

98. N.Y. PUB. HEALTH LAW § 2897-c (Gould 1993).

99. See *infra* notes 114-15 and accompanying text.

100. 463 U.S. 85 (1983).

101. *Travelers*, 514 U.S. at 647.

102. *Id.* at 655.

103. *Id.* at 654-55 (citing *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981)).

104. *Id.* at 655.

purpose of Congress.”¹⁰⁵ Consequently, a state law that expressly references benefits plans would directly conflict with ERISA’s text and thereby trigger § 514 preemption.¹⁰⁶ Since the New York statute made no mention of ERISA plans, there was no “reference.”

To determine whether the surcharge statute had a sufficient “connection” with ERISA plans so as to merit preemption, the Court stressed in now oft-quoted language:

[H]ere, an uncritical literalism is no more help than in trying to construe “relate to.” For the same reasons that infinite relations cannot be the measure of preemption, neither can infinite connections. We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.¹⁰⁷

Congress’ intent that ERISA would secure nationally uniform plan administration did not erase the strong starting presumption against preemption because the hospital rate setting law fell within the state’s traditional area of health care quality oversight.¹⁰⁸ Absent any clear congressional intent to immunize health plans from this type of state financing legislation, it did not warrant relate to preemption.¹⁰⁹ Rather, Congress intended relate to preemption to displace those state laws which would overtly or effectively regulate actual plan administration. As a result, the Court reasoned, § 514’s relate to clause preempts laws which directly mandate or indirectly bind the choices of plan administrators or otherwise interfere with uniform plan administration.¹¹⁰ The New York surcharge statute, however, only imposed an indirect economic cost on plans which could affect—but would not bind—the plans’ “shopping decisions” concerning the administration and delivery of benefits.¹¹¹ Moreover, relate to preemption of “medical care quality standards” in the face of congressional silence would be “unsettling” and do “grave violence” to the presumption against preemption.¹¹² Underscoring that “nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically

105. *Id.*

106. *Id.* at 656.

107. *Id.*

108. *Id.*

109. *Id.* at 655.

110. *Id.* at 659.

111. *Id.*

112. *Id.* at 660.

has been a matter of local concern,”¹¹³ it stated that preempting hospital rate setting legislation “would be all the more startling” since measures of this kind were in existence when ERISA was enacted.¹¹⁴ The absence from both text and legislative history of “so much as a hint . . . that Congress intended to squelch these state efforts” further confirmed for the Court that Congress intended to leave this type of state law intact.¹¹⁵

While certainly not the most recent Supreme Court decision to wrestle with ERISA preemption, the *Travelers* opinion will surely be important to, if not determinative of, how the new generation of “play or pay” and “fair share” state laws fare. Early indications are that, based on the *Travelers* rationale, § 514 will continue to preempt most wide scale reform at the state level because such laws go beyond creating the kind of indirect economic costs that have evaded preemption. At the dawn of 2007, for example, Maryland’s “Fair Share” legislation succumbed to relate to preemption in *Retail Industry Leaders Ass’n v. Fielder*.¹¹⁶ Just a few months later, a fair share initiative in New York’s Suffolk County collapsed on similar grounds in *Retail Industry Leaders Ass’n v. Suffolk County*.¹¹⁷ Despite significant differences between those laws and the Massachusetts statute, *Fielder* and *Suffolk County* portend a serious threat of ERISA preemption of at least some portions of the Commonwealth’s plan for achieving universal coverage by 2009.

Unlike Massachusetts, Maryland took a narrow approach to address the growing numbers of the uninsured and resulting increases in uncompensated care and Medicaid claims.¹¹⁸ Yet like Massachusetts, Maryland was responding to an upsurge in the state’s Medi-

113. *Id.* at 661 (citations omitted).

114. *Id.* at 665.

115. *Id.* *Travelers’* effort to balance relate to preemption with deference to state health care oversight continued in *DeBuono v. NYSA-ILA Medical & Clinical Services Fund*, which found that a state tax on both ERISA-funded and non-ERISA funded health care providers was simply “one of myriad state laws of general applicability that impose[d] some burdens on the administration of ERISA plans but nevertheless [did] not relate to them within the statute’s meaning.” 520 U.S. 806, 807 (1997). Decided on the same day and completing the “*Travelers* trilogy,” *California Division of Labor Standards Enforcement v. Dillingham* rejected ERISA preemption of a state labor law, and again emphasized that courts must presume that Congress never intended to override State police powers absent clear evidence of an intent to do so. 519 U.S. 316, 335 (1997).

116. 475 F.3d 180, 183 (4th Cir. 2007).

117. 497 F. Supp. 2d 403, 418 (E.D.N.Y. 2007).

118. See generally Fair Share Health Care Fund Act, MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to -107 (West 2006).

caid expenditures, a problem plaguing most states. Congress originally envisioned Medicaid as a limited program in which government would be “the payor of last resort.”¹¹⁹ With joint federal and state expenditures nearing \$320 billion, however, it has increasingly become the payor of first resort as enrollments and costs surge. In Maryland, for example, the state’s portion of Medicaid costs approximately \$5 billion per year, consume some 17% of annual spending and created a budgetary shortfall of \$130 million in 2006 alone.¹²⁰ Declines in employer coverage have played a key roll in escalating costs, and Wal-Mart has earned the dubious honor of having more employees and dependents receive publicly subsidized health care than any other employer in the nation.¹²¹ An internal Wal-Mart memorandum showed that 37% of its employees’ children were on Medicaid and that another 19% had no insurance at all.¹²² According to one study, Georgia alone pays \$10 million per year to insure 10,000 children of Wal-Mart employees.¹²³ By not covering its workers, Wal-Mart and similar employers not only impose burdens on the public fisc, but also create a competitive disadvantage for smaller companies that do cover their workers.

In Maryland, Wal-Mart employed 16,000 workers, many of whom received inadequate coverage or no coverage at all.¹²⁴ Struggling to fund Medicaid while grappling with the growing ranks of the uninsured and rising uncompensated care costs, Maryland passed the “Fair Share Act”¹²⁵ in 2006. Basically, the law required employers of 10,000 or more Maryland employees to spend at least 8% of their total payrolls on employees’ health care or health insurance costs. Despite the facial neutrality of the statute’s “play or pay” language, the Act’s legislative history showed that Wal-Mart’s pattern of relying on public assistance to pay for the health care of its employees and their dependents was a critical, if not the sole, impetus for the plan.¹²⁶

119. See *Fielder*, 475 F.3d at 198 (citing S. REP. NO. 99-146, at 312-13 (1985), as reprinted in 1986 U.S.C.C.A.N. 42, 279-80) (Michael, J., dissenting).

120. *Id.* at 199.

121. *Id.* at 184; see also Robert Wood Johnson Foundation, *Nationwide Protests Assail Wal-Mart and Other Companies’ Health Benefits*, Apr. 26 2006, <http://www.rwjf.org/programareas/features/digest.jsp?id=3426&pid=1132&gsa=1>.

122. See *Fielder*, 475 F.3d at 184.

123. See *id.*

124. *Id.*

125. Fair Share Health Care Fund Act, MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to 107.

126. *Fielder*, 475 F.3d at 183-85.

Claiming, *inter alia*, that ERISA preempted Maryland's "Fair Share" law, the Retail Industry Leaders Association ("RILA") essentially sued on Wal-Mart's behalf,¹²⁷ although amicus briefs supporting its position were submitted by other business trade groups.¹²⁸ RILA's basic position was that this "fair share" or "play or pay" statute exposed benefits plan administrators to inconsistent state directives. Forcing an employer to play or pay created the kind of employer mandate that undermines ERISA's uniform administration. Pursuant to *Travelers*, then, it would be preempted by ERISA's relate to clause.¹²⁹ In response, Maryland contended that the law was not an impermissible employer mandate since, rather than meet the 8% spending requirement by providing more generous benefits, on-site medical clinics, or contributions to employee health savings accounts, the employer could simply pay the difference between current spending and 8% of total payrolls to the state's Medicaid fund.¹³⁰ In this way, the state argued, the law was a generally applicable revenue statute that merely created the kind of indirect economic impact that survived § 514 preemption under *Travelers*.¹³¹

The state's logic failed to persuade the U.S. Court of Appeals for the Fourth Circuit. Unlike New York's hospital rate setting statute in *Travelers*, which may have affected plan costs but was aimed squarely at providers, Maryland's law directly targeted large employers. Therefore, fundamentally, the statute was not generally applicable since it had been carefully designed to target particular employers, most notably Wal-Mart.¹³² Furthermore, the law went

127. The court found that RILA had "associational standing" under *Hunt v. Washington State Apple Advertising Comm'n*, 432 U.S. 333, 343 (1977), because "(a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." That only one of the association's members faced immediate or threatened harm in this case was nevertheless sufficient to support standing under *Warth v. Seldin*, 422 U.S. 490, 511 (1975). *Id.* at 186.

128. A variety of patient advocacy groups filed amicus briefs supporting the state, including the AARP Foundation, Medicaid Matters! Maryland, the Maryland Citizens' Health Initiative Education Fund, Inc., the National Federation of Independent Business Legal Foundation. Amici in support of RILA included the United States Department of Labor, the National and Maryland Chambers of Commerce, The Society for Human Resource Management, The H.R. Policy Association, and the American Benefits Council. *Id.* at 182.

129. *See id.* at 191 (citing *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658-59 (1995)).

130. *Id.* at 195.

131. *Id.*

132. *Id.* at 194.

beyond creating the kind of revenue scheme that would only affect plan administration indirectly.¹³³ Giving affected employers the choice of making a “free rider” payment to the state instead of setting up a benefits plan was simply not an indirect cost. Plus, it really was no choice at all since “an employer would gain nothing in consideration of paying a greater sum of money to the State [and, by becoming known as a free rider] might suffer from lower employee morale and increased public condemnation.”¹³⁴ As a result, the law effectively interfered with plan administration by forcing the employer to restructure its plan to offer a state-imposed minimum level of health benefits, alter its accounting practices, and comply with the statute’s reporting requirements.¹³⁵ That such administrative burdens would upset ERISA’s goal of uniformity was more than a hypothetical risk given similarly intended laws in Minnesota and two New York counties with differing financial and reporting requirements.¹³⁶ Thus, despite the lack of any express reference to ERISA plans, the statute established the kind of connection with the plan that triggered § 514 relate to preemption.¹³⁷ Because the law was preempted, the Court of Appeals saw no need to evaluate the defendant’s equal protection challenge to the statute.¹³⁸

The *Felder* dissent was far more willing to view the statute as analogous to the hospital surcharge statute at issue in *Travelers*. Again, in *Travelers*, a New York hospital surcharge statute designed to cross-subsidize uncompensated care survived preemption because it only imposed indirect economic costs on payors and therefore lacked the connection with or reference to a plan needed to justify § 514 preemption.¹³⁹ Maryland uses a similar approach in its “all payor” program by factoring uncompensated care costs into the state’s determination of permissible charges for patients with coverage. As a result, such “all payor” rates—which affect even

133. The statute did qualify as a revenue statute, however, as opposed to a tax measure. For this reason, the court rejected RILA’s claim that a federal court’s approval of the statute would violate the federal Tax Injunction Act, 28 U.S.C.A. § 1341 (West 2008). See *id.* at 189.

134. See *id.* at 193.

135. See *id.* at 193-94.

136. *Id.* at 194 (citing N.Y.C. Admin. Code § 22-506(c)(2); Suffolk County, N.Y., Reg. Local Laws § 325-3; and Minnesota’s pending H.F. 3143, 84th Leg. Sess. (Minn. 2006)).

137. *Id.* at 197.

138. *Id.* at 198.

139. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 662 (1995).

Medicaid as a payor—will rise and fall with the number of patients who lack employer sponsored health insurance.¹⁴⁰ The dissent stated that this was highly analogous to having an employer contribute to Maryland’s Medicaid program to fulfill its Fair Share obligations since, as recognized in *Travelers*, a law that merely changes incentives or even costs without dictating choices does not pose the kind of threat to uniformity that § 514 prevents.¹⁴¹ The law instead responded to the federal government’s charge to states to experiment in finding ways to bridge the gap between escalating Medicaid costs and shrinking employer-based coverage.¹⁴²

The *Felder* dissent’s logic not only failed to rescue the Maryland statute from preemption, but also failed to prevail in a similar challenge to a Suffolk County, New York law in *Retail Industry Leaders Ass’n v. Suffolk County*.¹⁴³ Imposing reporting obligations that were virtually identical to its Maryland counterpart, the Suffolk County Fair Share for Health Care Act¹⁴⁴ set an annual “public health cost rate” to reflect the county’s cost in covering uninsured workers. It then directed large, non-unionized retailers to spend at least this amount on the health benefits of each employee for each hour worked regardless of their full or part-time status.¹⁴⁵ Alternatively, affected employers—which, again, essentially amounted to Wal-Mart—could fulfill the statute’s financial requirement by making a lump sum payment to a community health center equal to the number of hours worked by employees multiplied by the public health cost rate.¹⁴⁶ The *Suffolk County* court agreed completely with *Felder*’s determination that the payment alternatives provided no real choice other than to restructure benefits plans. This impermissible interference with plan administration was the kind of connection with an ERISA plan that necessitated preemption under § 514’s relate to clause.¹⁴⁷

140. *Felder*, 475 F.3d at 199 (Michael, J., dissenting) (citing MD. CODE ANN., HEALTH-GEN. §§ 19-211, 214, 219).

141. Judge Michael observed that “[a] statute that ‘alters the incentives, but does not dictate the choices, facing ERISA plans’ is not preempted.” *Id.* at 202 (quoting Calif. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., 519 U.S. 316, 334 (1997)). He also noted that “[t]he ERISA preemption provision allows for uniformity of administration and coverage, but ‘cost uniformity was almost certainly not an object of pre-emption.’” *Id.* (citing *Travelers*, 514 U.S. at 662).

142. *Id.* at 203-04.

143. 497 F. Supp. 2d 403, 418 (E.D.N.Y. 2007).

144. Suffolk County, N.Y., Reg. Local Law §§ 325-1 to 7 (2005).

145. *Suffolk County*, 497 F. Supp. 2d. at 406-07.

146. *Id.* at 410.

147. *Id.* at 418.

In July 2006, San Francisco enacted its “Health Care Security Ordinance” mandating that covered employers doing business within the city make quarterly “required health care expenditures to or on behalf of” covered employees.¹⁴⁸ Just four months later, the Golden Gate Restaurant Association (“GGRA”) challenged the ordinance on ERISA § 514 “relate to” preemption grounds. Remarkably, it obtained a favorable decision from the federal district court just a few weeks later.¹⁴⁹ The city immediately appealed and, within two weeks, managed to obtain a stay of the lower court’s injunction pending a full disposition of the merits by the Court of Appeals for the Ninth Circuit.¹⁵⁰ What is most surprising about the stay is that the three-judge panel found a likelihood that the city would succeed in defending the ordinance against preemption.¹⁵¹ The GGRA has indicated that should the city prevail at the circuit level, it will seek review by the U.S. Supreme Court.¹⁵²

C. The Massachusetts Act’s Chances of Surviving Preemption

In terms of state efforts to reform health care, Massachusetts has adopted a more comprehensive approach than the one preempted in Maryland, partly because targeting a particular employer raises both § 514 and equal protection concerns, but largely because the reasons for rising costs and shrinking coverage are far more complex than the actions of any one type of employer or employment sector. Instead of targeting a particular source of uninsured workers, therefore, it relies on a blend of insurance market reforms, individually mandated insurance purchases, and employer “play or pay” incentives to achieve universal coverage by 2009. Nevertheless, while its language and design attempt to avoid creating the sort of employer “mandate” that will trigger ERISA preemption, its use of employer “play or pay” provisions are potentially just as vulnerable to § 514 preemption as Maryland’s and Suffolk County’s reliance on similar measures.

148. S.F. ADMIN. CODE § 14.3(a) (2007). Whether employers are covered by the regulation depends on the employer’s average number of covered employees during a quarter. Whether an employee is covered will turn on weekly hours and overall length of employment. *See id.*

149. *See Golden Gate Restaurant Ass’n v. City and County of San Francisco*, 535 F. Supp. 2d 968 (N.D. Cal. 2007).

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

151. *See id.*

152. *See* Press Release, Golden Gate Restaurant Ass’n, Employer Mandated Health Care (Jan. 21, 2008), <http://www.ggra.org/news.asp?newsid=16046&menuid=1248&submenuid=1794>.

The Commonwealth's individual mandate is most likely to withstand preemption. As previously discussed, the most obvious worry regarding the individual mandate is that it may not be economically sustainable. Even after extensive debate and negotiation of plans and premiums, fears linger that premiums may be too high for the insured, too low for the insurer and will therefore require too much in the way of state subsidies. Conceivably, however, an employer could argue that another problem with the individual mandate is that it is preempted under ERISA § 514 due to its impact on employers. Employers that do sponsor coverage will now need to offer a plan that satisfies the law's minimum coverage requirements for individuals or pay the consequences. According to this logic, the individual mandate essentially serves as an employer mandate that has an impermissible connection with an employee benefits plan under *Shaw*.

Yet the *Shaw* test was curtailed in *Travelers* precisely because conceivably, through an endless cascade of impacts and consequences, any legislative action can influence the decisions of an employer sponsored benefits plan. To allow this to trigger preemption would make § 514 even more expansive than it already is and potentially subvert any kind of state health care law. The *Travelers* Court refused to go this far when it stated, “[f]or the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections.”¹⁵³ Given the state's traditional primacy in state health care regulation, it is unlikely that a court would read ERISA as precluding states from requiring its individual citizens to obtain coverage. Thus, while time may prove them to be financially infeasible, individual mandates should evade § 514 preemption.

The “play or pay” provisions directed at employers, however, are unlikely to fare as well given § 514 preemption of far more incremental measures in Maryland and Suffolk County.¹⁵⁴ For example, like Suffolk County's effort to impose a per worker “public health cost” on large retailers, the Massachusetts plan requires large, medium, and small employers of eleven or more workers to make a “fair and reasonable” contribution to employee health care.¹⁵⁵ Massachusetts does offer options—again, of covering at least one quarter of its workers, paying for at least one third of the total cost

153. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995).

154. See *supra* notes 114-45 and accompanying text.

155. See MASS. GEN. LAWS ch. 149, § 188(a) (2006).

of its employees' individual plans, or making the annual "fair share" contribution to the Free Care Pool of \$295 per full time worker.¹⁵⁶ Unlike the "no reasonable alternatives" of the Maryland and Suffolk County laws, perhaps these options will be more attractive to employers given other insurance market reforms. The \$295 per worker fair share contribution will undoubtedly be characterized by the Commonwealth as a simple funding measure that only imposes the kind of indirect economic impact that evaded § 514 preemption in *Travelers*. That \$295 appears, at least to some, to be a modest figure could lead many employers to go along with the plan instead of launching a preemption challenge. For some, however, paying \$295 per worker per year might be difficult. For others, the thought of any charge at any amount is intolerable, especially at this early stage of wide scale state health reform. And for all, significant resources may be consumed in fulfilling the statute's record keeping and reporting requirements. Since the courts have focused on the kinds of measures used, and not the costs of those measures, the per worker fee, no matter how slight, might be preempted as an impermissible interference with plan administration.

Most significantly, these alternatives may devolve to false choices and, accordingly, effective mandates similar to the Maryland and Suffolk County "play or pay" provisions in *Felder* and *Suffolk County*. That employers have an array of alternatives is not likely to avoid preemption of measures that impermissibly mandate benefits and/or interfere with plan administration even if those alternatives are more attractive than those used by Maryland and Suffolk County. As the United States Supreme Court emphasized in *Egelhoff v. Egelhoff*, a state law "is not any less of a regulation of the terms of ERISA plans simply because there are two ways of complying with it . . . [particularly where] simple noncompliance with the statute is not one of the options available to plan administrators."¹⁵⁷ Employers have a strong argument that the Massachusetts law does more than influence a plan's "shopping decisions" in the way that the New York surcharge statute did in *Travelers* since, in *Travelers*, there was no statutory compulsion to shop. Rather, the New York law left employers free to stay out of the health care benefits mall completely. In contrast, "play or pay" and "fair share" provisions force employers to comply with at least one statutory option for covering health benefits or paying into a

156. See *id.* § 188(b), (c)(10).

157. 532 U.S. 141, 150-51 (2001).

state fund. By definition, these laws refuse to let employers stay out of the market and, as such, will probably continue to trigger relate to preemption as they did in *Felder* and *Suffolk County*.

Another aspect of the Massachusetts Act that raises preemption concerns is its requirement that employers of eleven or more full or part time employees offer Internal Revenue Code § 125 “cafeteria plans” that would enable workers to pay for coverage with pre-tax dollars while also offering tax benefits to the employer.¹⁵⁸ Failure to do so will result in free rider penalties. To date, the Internal Revenue Service has taken the position that a § 125 cafeteria plan does not qualify as an ERISA benefits plan.¹⁵⁹ Although the agency’s ruling would certainly be entitled to heavy deference from the courts, it does not guarantee that a court would necessarily agree with this characterization. Still, whether a cafeteria plan is in and of itself an ERISA plan is not really the point. Even if a cafeteria plan is not an actual benefits plan, requiring its provision could still amount to a § 514 preempted employer mandate.

Although the design of the Massachusetts Act reflects a conscious attempt to circumvent preemption, the law’s chief promoters and detractors have paid scant attention to potential ERISA problems—at least publicly. This does not alter the fact that § 514 inevitably casts a shadow over the law’s basic premise that employers, like individuals and insurers, must share in the responsibility of accomplishing universal coverage. The focus on fostering consumer driven competition in insurance markets and the reliance upon individual mandates make the statute at least appear to be more ERISA-friendly than its Maryland and Suffolk County predecessors. Yet, its employer provisions remain problematic, especially since in attempting to avoid ERISA preemption, its architects may have made the Massachusetts law even more vulnerable to attack than its predecessors in Maryland and Suffolk County.

First, by affecting all employers with eleven or more workers, the Act may be likely to antagonize far more employers than the Wal-Marts of the Commonwealth. Second, as examined earlier, the Act is more elaborate than the Maryland and Suffolk County laws and, in this way, arguably affects employers far more significantly. Accordingly, it may be more likely to have the kind of “connection” with a plan so as to impermissibly relate to a plan under § 514. In

158. See MASS. GEN. LAWS ch. 151F, § 2 (2007); see also THE COMMONWEALTH CONNECTOR, EMPLOYER HANDBOOK, *supra* note 57, at 8.

159. See generally 26 U.S.C.A. § 125 (West 2004).

this respect, the Commonwealth “Connector” may be a most unfortunate choice of terminology in light of the specter of ERISA preemption. A third problem results from the requirement of offering “cafeteria plans” to full and part-time workers in order to avoid paying sizeable portions of uncovered workers’ health care costs as “free rider” penalties. Despite the intended tax benefits for both employer and employee and the I.R.S.’s position that § 125 plans are not ERISA plans, this aspect of the law requires significant costs and administrative adjustments. Additionally, paying “free rider” penalties arguably compels an employer to offer a cafeteria plan when it would not otherwise do so. While an employer’s voluntary decision to provide a cafeteria plan might not implicate ERISA, being compelled to offer one in its benefits package certainly might. Plus, the penalty itself is unlikely to qualify as a reasonable alternative. As the *Fielder* court recognized, choosing the cost and negative label of being a free rider is potentially so pejorative that it is unlikely to be viewed as a reasonable alternative to setting up worker cafeteria plans.

All of these “play or pay” features may be challenged as upsetting Congress’ goal of ensuring national uniformity in plan administration. This leads to the fourth and most fundamental problem for Massachusetts health care reform: some states are already enacting reforms and many more are hoping to learn from the experience of Maryland, Massachusetts, and others in order to craft a suitable plan for their own citizens. These statutes will continue to vary in the details, either to suit a particular economy, reflect the needs of their own population, or simply embrace a different policy choice. There are many reasons why states should want—and need—to experiment in this way. Currently, though, they cannot. As recognized in *Fielder* and *Suffolk County*, and more importantly, by the U.S. Supreme Court in *Travelers, Egelhoff*,¹⁶⁰ and on so many other occasions, uniformity cannot be preserved and, therefore, ERISA’s underlying intent cannot be fulfilled, if employee benefit plans are subject to inconsistent state laws concerning plan administration. Should this new generation of state law be found to satisfy the relate to clause, it is unlikely to be saved from preemption as a state insurance regulation. At least in Maryland, Suffolk County, and Massachusetts, the law targets individuals and employers, not insurers. Plus, the Massachusetts Act is situated in the state’s tax code and will be enforced as such. Tellingly, neither

160. 532 U.S. 141, 148 (2001) (citing *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)).

the Maryland nor Suffolk County Fair Share provisions were even evaluated for saving clause protection once they were found to fall within the relate to clause. It seems then that the only way for the Massachusetts law to remain fully intact is for all employers to voluntarily comply with the Act notwithstanding meritorious § 514 arguments. Since the enactment of this law was marked by an unusual degree of consensus building, perhaps such teamwork will endure throughout its implementation.

Or perhaps not. As the first of its kind, the Massachusetts Act inevitably raises concerns among plan administrators that other states will follow suit by enacting potentially conflicting or at least additional requirements that will complicate plan administration—precisely what ERISA intends to prevent. Any initial impetus to cooperate is further eroded by the numbers, kinds and varying interests and constraints of affected employers, the financial and administrative costs imposed, and the well grounded fears that those costs will escalate in the future. The latter concern is especially troubling since the Act does nothing to contain health care utilization and, with expanded coverage, should drive up utilization and, therefore, costs.

It should come as no surprise, then, that one week before the statute's July 1, 2007 effective date, the U.S. Chamber of Commerce was pondering an analysis of these issues through a presentation entitled "ERISA Preemption and MA Health Care Reform."¹⁶¹ Thus, in all likelihood, at least some of the law's employer components will be challenged and may fail due to § 514 relate to preemption. Since employers had until January 1, 2008 to comply with the law, it is too soon to tell whether the possibility of an ERISA preemption claim will become a reality. Despite the significant degree of support that the new Massachusetts law enjoyed from the employment sector during its negotiation, passage, and first eighteen months of implementation, it would seem that at least some employers will challenge it to discourage more states from enacting reforms and creating conflicting state directives in the process. In this regard, future litigants will undoubtedly rely upon the *Felder* court's statement that:

Were we to approve [Maryland's Fair Share law] solely for its noble purpose, we would be leading a charge against the foundational policy of ERISA, and surely other States and local gov-

161. The presentation was prepared by Andy R. Anderson of Morgan, Lewis & Bockius, a law firm based in Philadelphia, PA., and is available at http://www.morganlewis.com/pubs/Anderson_ERISA_Chamber_of_Commerce21jun071.pdf.

ernments would follow. As sensitive as we are to the right of Maryland and other States to enact laws of their own choosing, we are also bound to enforce ERISA as the “supreme Law of the Land.”¹⁶²

D. The Need for ERISA Waivers

It would seem that, if courts see themselves as institutionally incapable of leading the charge to free cash-strapped states from the binds of ERISA preemption, then Congress must respond. In the absence of any congressional consensus regarding whether and how to improve coverage and control costs, it would at least make sense for Congress to permit state experimentation. Plus, like the State Children’s Health Insurance Program that has proved so successful, allowing states to take the lead in finding the most practical ways to improve coverage would also fit with Congress’s clear preference for acting incrementally, if at all, and for delegating health law matters—at least politically contentious ones such as these—to the states.

And this is precisely what is now under review in Congress. Among the first measures introduced when the Democrats assumed control of the House of Representatives in January 2007 was H.R. 506, the Health Partnership Through Creative Federalism Act.¹⁶³ Sponsored by Representatives Tammy Baldwin (D-WI) and John Tierney (D-MA), it would allow states to apply for ERISA waivers in order to pursue innovative health care reforms without the threat of ERISA preemption. Hearings took place in May 2007 during which representatives of the National Business Coalition on Health and the American Benefits Council, The ERISA Industry Committee, and others were stridently opposed to liberalizing ERISA waivers.

One attorney, testifying as an advocate for large employers and the ERISA Industry Committee, identified the following four reasons for preserving strict adherence to ERISA preemption as follows: (1) preemption is needed to permit innovations that will continue and build upon the success of employer based health care; (2) Congress carefully considered the effect of ERISA preemption on state health reform efforts more than 30 years ago, when ER-

162. *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 198 (4th Cir. 2007) (citing U.S. CONST. art. VI).

163. H.R. 506, 110th Cong. (1st Sess. 2007). The Act’s purpose is “to provide for innovation in health care through State initiatives that expand coverage and access.” *Id.*

ISA was enacted. . . . [and] concluded that preemption was necessary to eliminate the threat of conflicting state and local regulation of employee benefit plans”;¹⁶⁴ (3) unlike, Medicaid waivers, for example, granting ERISA waivers would be too complicated since no waiver approval process currently exists; and (4) “states do not need ERISA waivers” to accomplish needed reforms since the problems the reforms address, such as “insuring the unemployed, providing reliable and accessible information on health care cost and quality, making affordable insurance available to individuals and small groups, are outside the scope of ERISA’s preemption provisions.”¹⁶⁵

That an advocate for large employer interests seeks to preserve preemption comes as no surprise. What is so disturbing, however, is that the grounds asserted are not just self-interested, but also inaccurate or at least naive. First, although many employers have made admirable efforts to bring better coverage to greater numbers at lower costs, this does not mean that they should have free—and sole—reign in deciding how patients and providers are treated or how the uninsured and state payors are affected. Second, Congress did *not* consider preemption’s impact on “state health care reform” when it passed ERISA. That is the key problem at the heart of thirty-five years of ERISA jurisprudence concerning both conflict and complete preemption. In enacting ERISA, Congress was clearly focused on pension plan reform and paid little attention to the full ramifications of preemption on health care finance and delivery issues in an age of managed care which were virtually nonexistent in the early 1980s. That the federal HMO Act contemporaneously had to require employers to offer HMO plans is just one of many indicia that current issues of cost, coverage, and quality were simply not on the congressional radar during the debate and passage of ERISA.¹⁶⁶

Third, arguing that waivers are too complicated because there is no system in place is akin to arguing in the 1930s that income taxes simply could not be levied since there was no system in place yet. The idea simply makes no sense, especially with the Medicaid

164. *Health Care Reform: Recommendations to Improve Coordination of Federal and State Initiatives: Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Education and Labor*, 110th Cong. 3 (2007) [hereinafter *Hearing*] (statement of Amy N. Moore, Covington & Burling LLP), available at <http://edworkforce.house.gov/testimony/052207AmyMooreTestimony.pdf>.

165. *Id.*

166. *See, e.g.*, 42 U.S.C. § 300e (1996).

waiver program as a ready analogue to put an ERISA waiver process in place.

Fourth, the problems of improving quality and expanding coverage which are described as “outside the scope” of ERISA preemption have ironically been placed within that scope by large employers seeking to defeat such state health care reforms. Thirty years of legislative and judicial experience shows that ERISA has been a huge obstacle to everyone but employers, i.e., patients, providers, and states alike. In this regard, congressional hearings on the advisability of expanding ERISA waivers also heard from state officials from Montana, Maryland, and New Jersey who described the many and varied reform initiatives that have been blocked by ERISA preemption, particularly with respect to self-funded plans.¹⁶⁷

Some may see ERISA waivers as the most that can be hoped for from a Congress that has been so reluctant to tackle wide scale health reform. Perhaps, though, waivers are the ideal next step. Allowing state experimentation may offer the best promise for figuring out how to fix the health care system since it is broken in so many places and in so many ways. As explained by Montana’s Insurance Commissioner, health care reform measures that hold great promise in Massachusetts may not fit the economy or geography of Montana. Thus, state by state solutions may be necessary precursors to a rational plan.¹⁶⁸ If nothing else, the Massachusetts Act deserves a chance to succeed or fail on its own merits. Its use of an array of methods for expanding and financing coverage has never been put into practice. Its reliance on aggressive outreach and consensus building has been a textbook example of how to design and implement comprehensive statutory reform. Without ERISA preemption, it might still stumble, but even if it did, there are so many valuable lessons to be learned by *all* states attempting reform. If Congress will not undertake meaningful health care reform, it should at least get out of the way of states like Massachusetts that have invested the time and resources into figuring out how to try.

167. See *Hearing, supra* note 164 (statements of Montana Auditor and Commissioner of Insurance and Securities, Maryland Secretary of Health and Human Hygiene, and New Jersey Commissioner of Banking and Insurance), available at <http://edworkforce.house.gov/hearings/help052207.shtml>.

168. See *Hearing, supra* note 164 (statement of John Morrison, Montana Auditor and Commissioner of Insurance and Securities), available at <http://edworkforce.house.gov/testimony/052207JohnMorrisonTestimony.pdf>.

IV. CONCLUSION

The ability of state actors and civic organizations to find common ground on a variety of difficult issues has been one of the hallmarks of Massachusetts' far reaching state health care initiative. From the earliest stages of the legislative process, the Commonwealth has displayed a remarkable level of political sophistication and leadership by skillfully addressing private and public interests in attacking the state's health care crisis. Its innovation and tenacity in pursuing universal coverage shows that socially conscious, market-based solutions are both necessary and possible. In the increasingly polarized arena of national politics, Massachusetts is also demonstrating that solutions to the thorniest economic and political dilemmas can be reached when both the government and private sector work together.

Undoubtedly, the Massachusetts plan will face significant and ongoing challenges in maintaining affordability standards and quality coverage. The coming years will most likely witness numerous setbacks as anticipated and unexpected problems arise. Among other things, significant time and resources must be—and so far have been—focused on generating public awareness about the law's benefits and requirements. The Commonwealth should also begin to sensitize employers and employees alike to the fact that long-term sustainability may require tax increases or continued reallocation of public resources. Despite these and many more challenges, Massachusetts has remained true to its maverick reputation in taking the lead by launching such a promising reform process with important national implications. Whether other states adopt, borrow from, or dismiss the Massachusetts model, there is no question that the Massachusetts experience will yield important lessons for health care reform at the state and national level.

All of this may be curtailed, however, should the Act be eroded by ERISA preemption. The first few months since the Act took effect have been remarkably quiet in this respect. Public discourse has focused on conducting an aggressive outreach plan to boost enrollments.¹⁶⁹ Media coverage has focused on the plan's long-term affordability for individuals and employers, and on overall sustainability.¹⁷⁰ Perhaps, then, Massachusetts health care reform will evade ERISA preemption because employers, along with

169. See, e.g., Dembner, *supra* note 49; Jeffrey Krasner, *Penalties to Rise for Shunning Insurance*, BOSTON GLOBE, Jan. 1, 2008, at 1A.

170. See Dembner, *supra* note 49.

other stakeholders, understand that the time has come to take this on and make it work. Should ERISA preemption reveal that this is just a transient honeymoon for state health care reform, all fifty states will be thrown back to square one. Since the Massachusetts plan tries just about everything, its preemption under ERISA § 514 would mean unfettered climbing costs, widening coverage gaps, and mounting public frustration. This in turn would unequivocally reveal that the health care crisis will remain “same as it ever was,”¹⁷¹ putting states in a bind that can only be untied by the talking heads of Congress.

171. TALKING HEADS, *Once in a Lifetime*, on *REMAIN IN LIGHT* (Sire Records Co. 1980).