NOTES

OF STATE LABORATORIES AND LEGISLATIVE ALLOYS: HOW "FAIR SHARE" LAWS CAN BE WRITTEN TO AVOID ERISA PREEMPTION AND INFLUENCE PRIVATE SECTOR HEALTH CARE REFORM IN AMERICA

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INTRODUCTION

> To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory ....[1]

Justice Brandeis's famous dissent in *New State Ice Co. v. Liebmann* remains apt today, particularly when viewed through the prism of America's developing health care crisis. As health care costs rapidly rise,[2] state and federal deficits increase,[3] and the uninsured rolls swell,[4] the importance of finding new avenues for public and private funding of health care assistance becomes increasingly salient.

In keeping with long-standing tenets of federalism, in recent years several states have taken the lead in trying to solve some of health care's impending difficulties.[5] One prevailing notion has been to use "pay or play" legislation[6] to shift some of the burden of

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1. New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

2. For a thorough discussion of the increase in health insurance premium prices, see Kaiser Family Found., *Snapshots: Comparing Projected Growth in Health Care Expenditures and the Economy*, May 2006, http://www.kff.org/insurance/snapshot/chcm050206oth2.cfm.

3. *See* ELIZABETH C. MCNICHOL & IRIS J. LAV, CTR. ON BUDGET & POLICY PRIORITIES, STATE BUDGETS: ON THE EDGE? (2006), http://www.cbpp.org/5-4-06sfp.pdf (discussing the often unstable, sometimes dire nature of many state fiscal budgets); Letter from Peter R. Orszag, Dir., Cong. Budget Office, to Hon. Robert C. Byrd, Chairman, Senate Comm. on Appropriations (Mar. 2, 2007), *available at* http://www.cbo.gov/ftpdocs/78xx/doc7836/03-02-Prelim_Analysis.pdf (stating the CBO's estimate that the federal deficit, under the President's budget, will total $226 billion, or 1.6 percent of GDP in 2008).

4. *See* CTR. ON BUDGET & POLICY PRIORITIES, THE NUMBER OF UNINSURED AMERICANS CONTINUED TO RISE IN 2004 (2005), http://www.cbpp.org/8-30-05health.pdf (noting how U.S. Census Bureau data from 2004 showed that 45.8 million Americans were without health insurance, up from 45 million in 2003 and 39.8 million in 2000).

5. *See, e.g.*, Retail Indus. Leaders Ass'n v. Fielder (*RILA II*), 475 F.3d 180, 198 (4th Cir. 2007) (Michael, J., dissenting) ("Innovative ideas for solving the [Medicaid] funding crisis are required, and the federal government, as the co-sponsor of Medicaid, has consistently called upon the states to function as *laboratories* for developing workable solutions." (emphasis added)); Edward A. Zelinsky, *Maryland's "Wal-Mart" Act: Policy and Preemption*, 28 CARDOZO L. REV. 847, 874 & n.125 (2006) ("It is a truism of contemporary federalism that states should serve as laboratories of experimentation.").

6. For a survey of the landscape of "pay or play" bills entered into state assemblies in 2006, categorized by state, bill number, number of employees/mandated percentage, status,

financing health insurance to the private sector through America's competitive, efficient, and highly imaginative capitalist economy.[7]

One such state is Maryland, whose General Assembly passed a statute[8] in January 2006 requiring all for-profit, non-governmental employers with more than 10,000 employees in the state to spend at least 8 percent of total payroll wages on health insurance costs for employees.[9] Any noncompliant employer that fell under the purview of the "Fair Share Health Care Fund Act" ("Fair Share Act" or "FSA" or "the Act") was required to pay the state the difference between the percentage of their health care expenditures and the 8 percent rate required by the law.[10] Any revenues collected from the assessment were to be deposited into a special fund that would be used to supplement the State's Medicaid program.[11]

FSA opponents, primarily in the retail and commerce communities, dubbed the Act the "Wal-Mart Law" because the three other in-state employers to which the law could apply were exempted for reasons explained below.[12] The Retail Industry Leaders Association challenged the Fair Share Act in federal court, alleging that the Act

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sponsor(s), and date of introduction, see Retail Indus. Leaders Ass'n, Pending State Health Care Mandate Matrix, http://www.retail-leaders.org/new/resources/matrix.pdf (last visited Mar. 10, 2008).

7. Already four states (Maine, Massachusetts, Vermont, and Hawaii) have attempted to secure near universal health coverage for their citizens. *See* Nat'l Conference of State Legislatures, 2007 Universal Health Care Legislation: Health Reform Bills, http://www.ncsl.org/programs/health/universalhealth2007.htm (last visited Mar. 10, 2008). In January 2007, Governor Arnold Schwarzenegger of California proposed a $12 billion plan to provide health coverage for all of the state's 36 million residents. *See* Jennifer Steinhauer, *California Plan for Health Care Would Cover All*, N.Y. TIMES, Jan. 9, 2007, at A1. If approved, the plan would extend Medi-Cal, the State's Medicaid program, to children as well as to adults who earn as much as 100 percent above the federal poverty line. *See id.* In addition to requiring 2 percent or 4 percent revenue contributions from doctors and hospitals, respectively, another provision of the plan would require businesses that choose not to offer health coverage to pay 4 percent of their total Social Security wages to a state fund created to subsidize the purchase of coverage by the working uninsured. *See id.* The cost of such coverage would be measured on a sliding scale depending on what an employee earned; and, employees would be able to pay for it using pre-tax dollars. *See id.* For the official proposal, see GOVERNOR'S HEALTH CARE PROPOSAL (2007), http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf.

8. MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to -107 (LexisNexis 2007).

9. For non-profit companies, the benchmark was 6 percent of total payroll wages. *Id.* § 8.5-104(a).

10. *Id.* § 8.5-104(b).

11. *Id.* § 8.5-107(3) ("The secretary shall ... (3) pay the revenue from the payroll assessment into the fund created under § 15-142 of the Health-General Article.").

12. *See infra* Part I.A.

was preempted by federal law.[13] A federal district court held that the Maryland Fair Share Act was preempted by the federal Employment Retirement Income Security Act of 1974 (ERISA),[14] and the court's decision was upheld on a 2-1 ruling by the Fourth Circuit Court of Appeals in early 2007.[15]

This Note examines Maryland's preempted statute and the United States District Court case that granted its opponents declaratory relief. After reviewing the Fair Share Act, the federal ERISA statute,[16] and the significant changes in Supreme Court jurisprudence concerning ERISA preemption in the past decade, this Note will offer new approaches through which states can modify the analytical framework outlined by the Fair Share Act to achieve improvements in the state financing of Medicaid through large private employers.[17] The goal of this Note is to analyze ways to fit future fair share legislation within the non-preempted confines of ERISA.

The proposed modifications include: (1) rewriting fair share laws as unequivocal, non-regulatory Medicaid taxes from which compliant employers may become exempt;[18] (2) dulling the sharp edge of the FSA's punitive texture by decreasing the 100 percent shortfall tax to 35-50 percent;[19] (3) a state-initiated higher minimum wage for very large employers, with an incentivized exemption provision allowing an employer to revert back to the higher of the state or federal government's general minimum wage if the employer spends a certain percentage of payroll wages on employee health insurance;[20] (4) expanding employers' options for "outlets" that meet the 8 percent health expenditure benchmark, such as through an increase in non-medical fringe benefits, which would give the

13. Retail Indus. Leaders Ass'n v. Fielder (*RILA I*), 435 F. Supp. 2d 481 (D. Md. 2006).

14. *Id.* at 484 (citing ERISA § 514, 29 U.S.C. § 1144 (2006)). When ERISA became law in 1974, it was codified as part of Title 29 of the United States Code. Although it may be correctly cited solely by its U.S.C. provisions, it can also be cited solely by its specific ERISA provisions. For purposes of clarity, this Note will cite both.

15. *RILA II*, 475 F.3d 180 (4th Cir. 2007). For a discussion of the Fourth Circuit Court of Appeals' decision, see *infra* Part III.C.

16. ERISA § 514, 29 U.S.C. § 1144 (2006).

17. *See infra* Parts IV-VII.

18. *See infra* Part V.

19. *See infra* Part V.C.

20. *See infra* Part VI.A.

statute a less coercive feel;[21] and (5) a "total package" benefits approach analogous to unpreempted ERISA prevailing wage cases.[22]

Part I of this Note will describe the legislative history and passage of the Maryland Fair Share Act, as well as Wal-Mart's role in the retail sector nationally and in Maryland specifically. Part II will provide a brief background of ERISA. Subsections within Part II will discuss early Supreme Court jurisprudence regarding ERISA, as well as the Court's interpretive changes to ERISA since the landmark *Travelers* decision in 1995. Part III treats *RILA v. Fielder* (*RILA I*), giving particular attention to the rationale employed by Judge Frederick Motz with respect to the Tax Injunction Act and ERISA preemption. Additionally, the Fourth Circuit's 2-1 affirmance (*RILA II*) will be briefly discussed.

Part IV introduces modifications for future "fair share" legislation, and Part V proposes an approach focused on rewriting the law as a Medicaid tax, rather than a legislative regulatory mandate. Part V stresses the importance of (1) the statutory language, (2) a Medicaid financing purpose, (3) a reduction in the shortfall tax, (4) the means of collection of the tax, and (5) the statute's legislative record. Part VI then offers a second approach: the introduction of employer size-specific minimum wages and "total package" benefit statutes that provide additional incentivized means for employers to meet their minimal expenditure requirements.

Finally, Part VII discusses a concern voiced by Judge Motz in *RILA I*: the perceived strain on employers' reporting requirements and uniform plan administration. This Part argues that large employers such as Wal-Mart, with a massive workforce and a multitude of health insurance plan offerings, have regularly collected, accessible payroll and personnel data, as well as a plan of administration that cannot be described as uniform.

Lastly, the Note concludes by summarizing the approaches described, and stressing the long-term federal interest in allowing states to act as laboratories by shifting to the free market some of the burden of grappling with enlarging Medicaid costs.

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21. *See infra* Part VI.B.
22. *See infra* Part VI.B.2.

I. THE MARYLAND FAIR SHARE ACT

A. The Law and Its Background

In 2005, the state legislature of Maryland passed Senate Bill 790[23] and House Bill 1284,[24] the "Fair Share Health Care Fund Act."[25] Though vetoed by Governor Robert L. Ehrlich, Jr., the Maryland General Assembly overrode the veto on January 12, 2006,[26] enacting the law that would have taken effect on January 1, 2007.[27] The FSA created a fund to assist the operations of Maryland's Medicaid program[28]—Maryland's public health insurance program that is jointly funded by the states and the federal government, and which serves eligible low-income parents, children, seniors, and people with disabilities.[29] The fund was created, in part, as a response by the Maryland legislature after learning that "between fiscal years 2003 and 2006, annual expenditures on [Maryland's Medicaid and children's health programs] increased from $3.46 billion to $4.7 billion."[30]

The FSA's fund was to be replenished through a health care "payroll assessment" on large employers who did not spend at least 8 percent of their total payroll on health insurance costs.[31] Underpaying employers with more than 10,000 in-state employees[32] were required to pay the difference between their payroll health insurance costs and the 8 percent target set by the statute.[33] The

23. S.B. 790, 2005 Leg., 420th Sess. (Md. 2005).

24. H.B. 1284, 2005 Leg., 419th Sess. (Md. 2005).

25. MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to -107 (LexisNexis 2007).

26. *See* John J. Sweeney & Fred Mason, Letter to the Editor, *Wal-Mart's Agenda*, WASH. POST, Jan. 13, 2006, at A20.

27. MD. CODE ANN., LAB. & EMPL. § 8.5-103(a)(1) (LexisNexis 2007). Because the FSA was held preempted in July 2006, the law was never enacted.

28. *Id.* § 8.5-107(3); *see also* MD. CODE ANN., HEALTH-GEN. § 15-142 (LexisNexis 2007).

29. *See* Kaiser Family Found., Medicaid Fact Sheet for Maryland and United States, http://www.statehealthfacts.org/medicaid.jsp (follow "MD" hyperlink) (last visited Mar. 11, 2008). For an excellent statistical analysis of health insurance, Medicare, and Medicaid expenditures in all fifty states as compared to the United States as a whole, see *id.* (select the state to compare from the drop down box and click "Go").

30. *RILA II*, 475 F.3d 180, 183 (4th Cir. 2007).

31. MD. CODE ANN., LAB. & EMPL. § 8.5-104(b) (LexisNexis 2007).

32. *Id.* § 8.5-102.

33. *Id.* § 8.5-104(b).

FSA also required such employers to report annually to the Secretary of Labor, Licensing, and Regulation their total number of in-state employees, the amount spent by the employer on health insurance, and the percentage of payroll spent by the employer on health insurance costs.[34] As defined by the FSA, "health insurance costs" included payments for "medical care, prescription drugs, vision care, medical savings accounts, and any other costs to provide health benefits[35] as defined in § 213(d) of the Internal Revenue Code."[36]

In Maryland, only four employers have 10,000 or more employees: Johns Hopkins University, Northrop Grumman Corporation, Giant Food Inc., and Wal-Mart. Northrop Grumman was exempt because it had successfully lobbied for a FSA provision permitting employers to exclude, for purposes of calculating the percentage of payroll spent on healthcare, compensation paid to employees above the state's median household income.[37] Johns Hopkins, a nonprofit organization, met the lower 6 percent benchmark set by the FSA for nonprofits,[38] and Giant Food Inc.'s health care expenditures already exceeded 8 percent of the total wages it paid to its in-state employees.[39]

The only institution affected by the Fair Share Act was Bentonville, Arkansas-based Wal-Mart Stores Inc., which employed 14,301 individuals in Maryland according to the FSA's 2005 General Assembly Fiscal and Policy Note.[40] The Fiscal and Policy Note (FPN) commented that some states claim that:

> [M]any Wal-Mart employees end up on public health programs such as Medicaid. A survey by Georgia officials found that more than 10,000 children of Wal-Mart employees were enrolled in the state's children's health insurance program (CHIP) at a cost [to the State] of nearly $10 million annually. Similarly, a North

34. *Id.* § 8.5-103.

35. *Id.* § 8.5-101(d).

36. *Id.* (referencing 26 U.S.C. § 213(d) (2000 & Supp. 2004)).

37. *See id.* § 8.5-103(b); *RILA I*, 435 F. Supp. 2d 481, 485 (D. Md. 2006).

38. MD. CODE ANN., LAB. & EMPL. § 8.5-104(a) (LexisNexis 2007).

39. *RILA I*, 435 F. Supp. 2d at 485.

40. SEN. LAWLAH et al., MD. DEP'T OF LEGIS. SERVS., FISCAL AND POLICY NOTE (REVISED), S.B. 790, at 3 (2005), *available at* http://mlis.state.md.us/2005rs/fnotes/bil_0000/sb0790.pdf [hereinafter FISCAL AND POLICY NOTE].

> Carolina hospital found that 31% of 1,900 patients who said they were Wal-Mart employees were enrolled in Medicaid, and an additional 16% were uninsured.[41]

The FPN reflects the view held by many that, as the largest private employer in the United States, providing work for over 1.36 million people in 4,091 stores,[42] Wal-Mart should not set subpar standards in labor practices and wages. Many argue that Wal-Mart has done just that.[43] In Maryland alone, at the end of fiscal year 2004, Wal-Mart paid its 14,301 employees $270 million in total wages, while Giant Food paid $536 million to its 18,902 employees.[44] A 2003 Harvard Business School study estimated that Wal-Mart spent an average of $3,500 per employee per year on health insurance, whereas the average spending per employee in the wholesale/retail sector was $4,800, and $5,600 per employee for U.S. employers in general.[45] As the FPN also notes, "Wal-Mart officials say the company provides health coverage to about 537,000 people [nationwide], or 45% of its total work force. As a matter of comparison, Costco Wholesale provides health insurance to 96% of eligible employees."[46]

Although focused on Wal-Mart as the quintessential "very large" employer, this Note genuinely does not intend to malign that company. Rather, Wal-Mart and its employee health care policies are being cited because Wal-Mart is an example of the type of

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41. *Id.* at 2.

42. *See* Wal-Mart Facts, United States Operational Data Sheet–August 2007, http://www.walmartfacts.com/articles/5231.aspx (last visited Mar. 10, 2008).

43. *See* Anthony Bianco & Wendy Zellner, *Is Wal-Mart Too Powerful?*, BUS. WK., Oct. 6, 2003, at 100, 102 (stating that average wages for full-time Wal-Mart associates in fiscal year 2001 were less than $14,000 per year, despite a federal poverty line of $14,630 for a family of three). In Maryland, the average wage for regular, full-time hourly associates is $10.26 per hour. *See* Wal-Mart Facts, Maryland Community Impact, http://www.walmartfacts.com/StateByState/?id=20 (last visited Mar. 10, 2008) [hereinafter Maryland Community Impact].

44. FISCAL AND POLICY NOTE, *supra* note 40, at 3. As of February 2008, the total number of Wal-Mart associates in Maryland was 17,806. *See* Maryland Community Impact, *supra* note 43.

45. *See* Pankaj Ghemawat, Stephen Bradley & Ken Mark, *Wal-Mart Stores in 2003*, at 13 (Harvard Bus. Sch. Case Study 9-704-430, rev. Jan. 30, 2004); *see also* Bernard Wysocki, Jr. & Ann Zimmerman, *Wal-Mart Cost-cutting Finds a Big Target in Health Benefits*, WALL ST. J., Sept. 30, 2003, at A1 (reporting that Wal-Mart spends 40 percent less on health benefits per covered employee than the average for all U.S. corporations).

46. FISCAL AND POLICY NOTE, *supra* note 40, at 3.

company whose behavior "pay or play" legislation, like the Fair Share Act, is intended to influence. Although Wal-Mart is the only applicable large employer in Maryland that pays less than 8 percent of payroll wages towards health insurance, other states have similarly large employers.[47] The important point is that, in passing legislation such as the FSA, state legislatures have begun to announce that employers whose policies have unfavorable effects on state public health insurance budgets may now be expected to mitigate the resulting situations by either paying more to their employees' health insurance, or by paying more to the state to offset the cost to the state's Medicaid funds—and by proxy, its taxpayers.

To fully understand the contentious reaction of some to the Maryland Fair Share Act and, more broadly, to any state attempt to require employers to augment their health care expenditures, one must understand the pervasive influence of ERISA, the federal statute intended to solely regulate how employer health benefit plans operate.

II. EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

A. The Law and Its Background

ERISA is a complex federal statute designed to "supersede any and all State laws"[48] that "relate to"[49] employee benefit plans (EBPs). By virtue of the Supremacy Clause of U.S. Constitution Article VI, Congress may, by statute, expressly preempt state law.[50] An expansive, voluminous piece of legislation, ERISA deals with the administration of "employee pension benefit plans" and "employee

47. For a listing of the largest for-profit and nonprofit employers in each state, see America's Career Info Net, http://www.acinet.org/acinet/select_state.asp (last visited Mar. 10, 2008) (select a state from the list; press continue; follow the hyperlink under State Information, "Largest Employers"). For example, in Colorado, Allstate Insurance Co. employs 17,000 workers; in New York, Merrill Lynch & Co. Inc. employs 15,000 workers; and, in Pennsylvania, Motorola, Inc. employs 12,000 workers. *Id.*

48. ERISA § 514(a), 29 U.S.C. § 1144(a) (2006).

49. *Id.*

50. U.S. CONST. art. VI, cl. 2.

welfare benefit plans."[51] The statute itself defines an "employee welfare benefit plan" as:

> [A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness ....[52]

ERISA was initially enacted to "protect ... the interests of participants in employee benefit plans and their beneficiaries" by setting out substantive regulatory requirements for EBPs and to "provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts."[53]

ERISA's purpose was thus to provide a predictable, uniform regulatory regime over employee benefit plans. To this end, Congress included broad preemption provisions[54] that were intended to ensure that EBP regulation would be "exclusively a federal concern."[55] ERISA imposes a variety of administrative requirements on employee welfare plans with respect to such matters as reporting,[56] disclosure,[57] participation and vesting requirements,[58] funding standards,[59] and fiduciary responsibility.[60] Although the statute does not regulate the terms of employee benefit plans, it does preempt their regulation by state or local governments.[61]

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51. ERISA § 3(3), 29 U.S.C. § 1002(3) (2006).

52. *Id.* § 3(1), 29 U.S.C. § 1002(1).

53. *Id.* § 2(1), 29 U.S.C. § 1001(b).

54. *See id.* § 514(a), 29 U.S.C. § 1144(a).

55. Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004) (quoting Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523 (1981)).

56. ERISA §§ 101-111, 29 U.S.C. §§ 1021-1031 (2006).

57. *Id.*

58. *Id.* §§ 201-211, 29 U.S.C. §§ 1051-1061.

59. *Id.* §§ 301-308, 29 U.S.C. §§ 1081-1086.

60. *Id.* §§ 404-414, 29 U.S.C. §§ 1101-1114.

61. *See* JOHN H. LANGBEIN & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW 894 (3d ed. 2000).

B. Early Supreme Court Interpretation of ERISA

1. Health Benefit Mandates

In the first two decades after ERISA's passage, the Supreme Court took a very narrow view of the extent to which state laws could survive ERISA preemption challenges. Throughout the late 1970s and 1980s, the Supreme Court adopted such a broad view of ERISA that preemption of state statutes became essentially routine.[62] One discernible "trigger" for preemption came from state laws that mandated health care benefits.[63] In *Shaw v. Delta Air Lines*,[64] the Court held that § 514(a) of ERISA[65] preempted state laws that "relate to" employee benefit plans. The Court found that a law "relates to" an EBP if "it has a connection with or reference to such a plan."[66]

Consequently, the Court in *Shaw* found the New York Human Rights Law[67] forbidding EBPs from discriminating on the basis of pregnancy, as well as the Disability Benefits Law,[68] requiring employers to pay sick-leave benefits to employees unable to work because of pregnancy or other non-occupational disabilities, sufficiently "related to" employee benefit plans such that they were struck down.[69] The *Shaw* Court did, however, sow a discrete, yet important, jurisprudential seed that would later take on increased significance:

> Some state actions may affect employee benefit plans in *too tenuous, remote, or peripheral a manner* to warrant a finding that the law "relates to" the plan .... [This case] does not present a borderline question, and we express no views about where it would be appropriate to draw the line."[70]

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62. *See id.* at 892.

63. *See, e.g.*, N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 649 (1995).

64. 463 U.S. 85 (1983).

65. 29 U.S.C. § 1144(a) (2006).

66. *Shaw*, 463 U.S. at 96-97.

67. N.Y. EXEC. LAW §§ 290-301 (McKinney 1982).

68. N.Y. WORKERS' COMP. LAW §§ 200-242 (McKinney 1965).

69. *See id.* at 96.

70. *Id.* at 100 n.21 (citations omitted) (emphasis added); *see also* District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 130 n.1 (1992) (holding that ERISA preempts state

Although vague, this aspect of the *Shaw* holding would figure prominently in the Court's reasoning in the later *Travelers* decision.[71]

C. The New Paradigm: The Travelers*,* Dillingham*, and* De Buono *Trilogy*

The lessons gleaned from the trilogy of Supreme Court ERISA preemption cases from the late 1990s are instructive and factor into some of the proposals for future fair share legislation set forth in this Note.[72] For this reason, a brief overview of each case is helpful to analyze present ERISA jurisprudence and to discuss potential fair share modifications.

1. Travelers

If Supreme Court case law for the first two decades following ERISA's enactment may be described as broad in its preemptive scope, then precedent from the last twelve years must be described as more nuanced and less reflexive. One watershed 1995 case in particular "narrow[ed] [the Court's] interpretation of the scope of ERISA preemption" and "adopted a pragmatic approach" to determining whether a state law "relates to" an employee benefit plan.[73] This case, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.* (*Travelers*),[74] established a new framework for preemption analysis because, in the words of Justice Souter, the *Shaw* analysis did not give the Court "much help [in] drawing the line" for where the phrase "relates to" ends.[75]

In *Travelers*, the unanimous Court examined a New York statute[76] that required hospitals to collect surcharges on hospital bills from patients covered by commercial insurers, but not from

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and local workers' compensation laws that require employers who provide health insurance for their employees to provide equivalent health insurance coverage for injured employees eligible for workers' compensation benefits).

71. *See infra* Part II.C.1.

72. *See infra* Parts V & VI.

73. Coyne & Delany Co. v. Selman, 98 F.3d 1457, 1466-68 (4th Cir. 1996).

74. 514 U.S. 645 (1995).

75. *Id.* at 655.

76. N.Y. PUB. HEALTH LAW § 2807-c(1)(b) to (c) (McKinney 2007).

patients insured by Medicare or Empire Blue Cross/Blue Shield (BC/BS) plans. Many of the commercial insurance patients had insurance purchased through employee health care plans that were governed by ERISA.[77] The statute also subjected most health maintenance organizations (HMOs) to surcharges that varied with the number of Medicaid recipients that they enrolled.[78] The revenue collected by these 9 percent to 24 percent surcharges was used to subsidize the State's Medicaid program.[79]

The Court began its analysis by stating clearly that questions of preemption must start with the presumption that Congress does not intend to supplant state law.[80] Because preemption claims turn on Congress's intent, the Court examined ERISA's language and history. Justice Souter remarked:

> The governing text of ERISA is clearly expansive.... [O]ne might be excused for wondering, at first blush, whether the words of limitation ("insofar as they ... relate") do much limiting. 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." But that, of course, would be to read Congress's words of limitation as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality.[81]

The Court rejected any argument that the New York statute "related to" an employee benefit plan by the "reference to"[82] factor, because the surcharges were imposed upon patients and HMOs regardless of whether the commercial coverage was secured by an ERISA plan.[83]

The Court next took up whether the statute "related to" an EBP through a "connection with"[84] such a plan. Stating that "[f]or the

77. *Travelers*, 514 U.S. at 650.
78. *Id.* at 649.
79. *Id.* at 650.
80. *Id.* at 654.
81. *Id.* at 655 (internal citations omitted).
82. *See* Shaw v. Delta Air Lines, 463 U.S. 85, 96-97 (1983).
83. *Travelers*, 514 U.S. at 656.
84. *See Shaw*, 463 U.S. at 96-97.

same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections."[85] The Court declared that it had to "go beyond the unhelpful text [of § 514(a)] 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."[86]

Noting that a primary goal of ERISA's passage was "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law,"[87] and thus "minimize the administrative and financial burden of complying with conflicting directives among States,"[88] the Court differentiated the New York surcharge statute from prior preemption cases.

Noting that even though the surcharges from which BC/BS plan holders were exempt exerted an "indirect economic effect" on commercial insurance buyers and ERISA plans—by making BC/BS more attractive competitively—the Court significantly held that:

> An indirect economic influence, however, *does not bind plan administrators to any particular choice* and thus function as a regulation of an ERISA plan itself.... *Nor does the indirect influence of the surcharges preclude uniform administrative practice* ... if a plan wishes to provide one. It simply bears on the costs of benefits and the relative costs of competing insurance to provide them. It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges.[89]

As such, although the surcharges had an indirect economic influence on ERISA plans, they were not preempted by ERISA because they neither sufficiently "related to" employee benefit plans nor adopted "acute"[90] schemes of coverage that effectively restricted an ERISA plan's choice of insurers.

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85. *Travelers*, 514 U.S. at 656.
86. *Id.*
87. *Id.* (citing Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990)).
88. *Id.*
89. *Id.* at 659-60 (emphasis added).
90. *Id.* at 668.

Justice Souter concluded his analysis in *Travelers* by writing that to read § 514(a)'s[91] preemption provision as nullifying all state laws that affect the costs and charges of EBPs, simply because they "indirectly relate"[92] to ERISA plans, "would effectively read the limiting language in § 514(a) out of the statute, a conclusion that would violate basic principles of statutory interpretation"[93] and go against the previously enunciated principle that "[p]re-emption does not occur ... if the state law has only a tenuous, remote, or peripheral connection with covered plans."[94] Having examined ERISA, the Court found that "nothing in the language of the Act or the context of its passage indicate[d] that Congress chose to displace general health care regulation, which historically has been a matter of local concern."[95]

2. Dillingham

Building on its decision in *Travelers*, the Supreme Court further refined its ERISA preemption analysis in *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.* (*Dillingham*).[96] In *Dillingham*, the Court dealt with a California prevailing wage statute[97] that required contractors on public works projects to pay their workers the local prevailing wage—typically the local union wage—except that apprentices in state-approved apprenticeship programs could be paid less than the prevailing wage.[98]

An employee benefit plan under ERISA includes apprenticeship programs.[99] Despite this, under the California statute an approved apprenticeship program did not necessarily need to be an employee benefit plan, because the program's "costs [could] be defrayed out of

91. 29 U.S.C. § 1144(a) (2006).

92. *Travelers*, 514 U.S. at 661.

93. *Id.*

94. *Id.* (quoting Shaw v. Delta Air Lines, 463 U.S. 85, 100 n.21 (1983); District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 130 n.1 (1992)).

95. *Travelers*, 514 U.S. at 661.

96. 519 U.S. 316 (1997).

97. CAL. LAB. CODE § 1771 (West 1989).

98. *Dillingham*, 519 U.S. at 319.

99. ERISA § 3(1), 29 U.S.C. § 1002(1) (2006).

that employer's general assets."[100] Thus, because the prevailing wage law was facially and technically "indifferent"[101] to the funding of the apprenticeship program and any ERISA coverage, Justice Thomas, writing for a unanimous Court, found that the statute did not make "reference to" ERISA plans.[102]

Turning next to the question of whether the wage law had a "connection with" ERISA plans, the Court found that "in every relevant respect, California's prevailing wage statute [wa]s indistinguishable from New York's surcharge program."[103] Like New York hospital surcharges in *Travelers*, the Court believed that the wages paid on state public works projects had long been regulated by the states[104] and that the wages to be paid to apprentices on such projects were quite remote from the areas of reporting, disclosure, and fiduciary duty with which ERISA is expressly concerned.[105] Reiterating the view from *Travelers* that a reading of ERISA preemption supplanting "traditionally state-regulated substantive law in those areas where ERISA has nothing to say would be 'unsettling,'"[106] the Court held that the lack of positive indications from Congress that it intended to supersede the states' historic police powers was sufficient to sustain the law.[107]

The Court also found that the statute's effect—a wage differential that made state-approved apprentice program members economically more attractive to employers because of their lower labor costs—did "not bind ERISA plans to anything."[108] Justice Thomas noted that the statute's effect on ERISA apprenticeship programs was "merely to provide some measure of *economic incentive to comport with the State's requirements*, at least to the extent that those programs seek to provide apprentices who can work on public works projects at a lower wage."[109] The Court stated that the "added

100. *Dillingham*, 519 U.S. at 326.
101. *Id.* at 328.
102. *Id.*
103. *Id.* at 330.
104. *Id.*
105. *Id.*
106. *Id.* at 330-31 (quoting N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 665 (1995)).
107. *Id.* at 331.
108. *Id.* at 332.
109. *Id.* (emphasis added).

inducement created by the wage break"[110] was not demonstrated to be "tantamount to a compulsion upon apprenticeship programs,"[111] and thus the law was legal.

3. De Buono

The final case in the *Travelers* trilogy is *De Buono v. NYSA-ILA Medical and Clinical Services Fund* (*De Buono*).[112] *De Buono* dealt with a state statute[113] that imposed a tax on gross receipts for patient services at hospitals, residential health care facilities, and diagnostic treatment centers.[114] The tax applied equally to medical centers that were owned and operated by an ERISA plan. The revenue raised from the tax, called the Health Facility Assessment (HFA), would become part of the state's general revenues.[115] According to the Court, the statute came about because, in 1990, the New York General Assembly was "faced with the choice of either curtailing its Medicaid program or generating additional revenue to reduce the program deficit,"[116] a choice similar to Maryland's today. The New York General Assembly chose the latter.[117]

The respondents in the case were the trustees of a fund that administered a self-insured, multi-employer welfare benefit plan, and which owned three medical centers.[118] Respondents argued that, because they paid HFA assessments totalling $7,066 based on their hospitals' patient income of $1,177,670, the law "related to" the fund within the meaning of § 514(a) of ERISA,[119] and was therefore preempted, as it applied to the practice of hospitals being run by ERISA plans.[120]

The Court was unpersuaded. Again citing the "historic police powers of the State[,] includ[ing] the regulation of matters of health

110. *Id.* at 333.
111. *Id.*
112. 520 U.S. 806 (1997).
113. N.Y. PUB. HEALTH LAW § 2807-(1)(a) (McKinney 1997).
114. *De Buono*, 520 U.S. at 809-10.
115. *Id.*
116. *Id.* at 809.
117. *Id.*
118. *Id.* at 810.
119. 29 U.S.C. § 1144(a) (2006).
120. *De Buono*, 520 U.S. at 810.

and safety,"[121] Justice Stevens found that the Health Facility Assessment was a revenue raising measure that clearly operated in a field traditionally occupied by the States.[122] The Court did not find that the Respondents had met their "considerable burden of overcoming the 'starting presumption that Congress does not intend to supplant state law.'"[123] The state tax on hospital gross receipts was likened to the state laws of general applicability in *Travelers* and *Dillingham*, which "impose[d] some burdens on the administration of ERISA plans but nevertheless d[id] not 'relate to' them within the meaning of the governing statute."[124]

Finding that the HFA was a tax on hospitals, most of which are not owned by ERISA plans or funds, the Court declared that "[a]ny state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute."[125] As such, the state tax that was intended to raise revenue for New York's Medicaid program was held to be valid.[126]

With this discussion of historic and recent Supreme Court ERISA jurisprudence in mind, contextualizing the Maryland General Assembly's passage of the Fair Share Act over Governor Ehrlich's veto is now possible. Likewise, the rationale and legal reasoning employed by Judge Motz in *RILA I*[127] are now understandable within the ERISA preemption framework outlined by the High Court.

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121. *Id.* at 814.

122. *Id.*

123. *Id.* (quoting N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654 (1995)).

124. *Id.* at 815.

125. *Id.* at 816. The Court also found that:

> As we acknowledged in *Travelers*, there might be a state law whose economic effects, intentionally or otherwise, were so acute 'as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers' and such a state law 'might indeed be pre-empted under § 514.' That is not the case here.

Id. at 816 n.16 (citations omitted).

126. *Id.* at 816.

127. 435 F. Supp. 2d 481 (D. Md. 2006).

III. RETAIL INDUSTRY LEADERS ASSOCIATION V. FIELDER

On July 19, 2006, the United States District Court for the District of Maryland held in *RILA I*[128] that the Maryland Fair Share Act was preempted by the federal Employment Retirement Income Security Act of 1974.[129] Two major issues posed by the Maryland law—the federal Tax Injunction Act and ERISA preemption—were treated in the opinion.[130]

A. Tax Injunction Act

The court's discussion of taxes and regulatory fees is germane to any future prescriptive offering to other states about how to structure "pay or play" legislation. Maryland argued that the FSA's "payroll assessment" was in fact a "payroll tax" on covered employers. It did this, seemingly, because of the Tax Injunction Act[131] (TIA). In its entirety, the Tax Injunction Act reads: "The district courts shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State."[132] Because Maryland state courts could serve as an adequate forum for a "plain, speedy and efficient remedy," the State argued that the Fair Share Act was a payroll tax in order to, in the words of Judge Motz, "strip[] this [federal] court of jurisdiction to hear the case."[133]

Although the court ultimately found that the Fair Share Act was not a tax,[134] the reasoning employed by Judge Motz is nonetheless instructive. In ascertaining whether the FSA was a tax—which would trigger the Tax Injunction Act and remove the case to state court—or a regulatory fee—which would not—the court looked to prior case law dealing with attempts to differentiate between taxes

128. *Id.*
129. *Id.* at 494.
130. Judge Motz's discussion of standing and his dismissal of RILA's equal protection discrimination claim will not be discussed, as they are beyond the scope of this Note.
131. 28 U.S.C. § 1341 (2006).
132. *Id.*
133. *RILA I*, 435 F. Supp. 2d at 490.
134. *Id.* at 492-93.

and regulatory fees.[135] The court cited an opinion by then-Chief Judge Stephen Breyer stating that:

> The classic "tax" is imposed by a legislature upon many, or all, citizens. It raises money, contributed to a general fund, and spent for the benefits of the entire community. The classic "regulatory fee" is imposed by an agency upon those subject to its regulation. It may serve regulatory purposes directly by, for example, deliberately discouraging particular conduct by making it more expensive. Or, it may serve such purposes indirectly by, for example, raising money placed in a special fund to help defray the agency's regulation-related expenses.[136]

Judge Motz additionally opined, "in close cases 'the most important factor becomes the purpose behind the statute, or regulation, which imposes the charge.'"[137]

The District Court found problematic the fact that, under the FSA, the responsibility for collecting any payments from for-profit employers not meeting the 8 percent "health insurance costs" benchmark was placed upon the Department of Labor, Licensing, and Regulation, instead of the state treasurer (here, the Comptroller of Maryland).[138] In the eyes of Judge Motz, "[t]his [wa]s not merely a formal matter," but rather it "reflect[ed] the underlying reality that the potential assessment imposed by the Act ... [was] part and parcel of a regulatory process designed to implement a health care mandate."[139]

The court reviewed whether the statute's purpose was to raise revenue or to punish large employers. Looking to the legislative history behind the Fair Share Act, in which no FSA sponsor ever referred to the assessment as a "tax," and in which Wal-Mart seemed to be targeted by certain legislators, the court concluded that "the General Assembly neither intended nor contemplated that

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135. *Id.* at 490-92.

136. *Id.* at 490 (quoting San Juan Cellular Tel. Co. v. Pub. Serv. Comm'n, 967 F.2d 683, 685 (1st Cir. 1992) (citations omitted)).

137. *Id.* at 491 (quoting Valero Terrestrial Corp. v. Caffrey, 205 F.3d 130, 134 (4th Cir. 2000)).

138. *Id.* The treasurer or comptroller is typically the individual whose primary duty is to collect taxes. *See, e.g.*, Comptroller of Maryland's Homepage, Comptroller of Maryland Duties, http://www.comp.state.md.us/comptroller/duties.asp (last visited Mar. 10, 2008).

139. *RILA I*, 435 F. Supp. 2d at 491.

the Act would raise any revenue for the State. To the contrary, its purpose was to force Wal-Mart to increase the level of its health care benefits."[140] As such, Judge Motz held that the Fair Share Act fell under the penumbra of a "regulatory fee," and, thus, the Tax Injunction Act did not divest the federal court of jurisdiction.

B. ERISA Preemption

The District Court began its preemption analysis by stating that it found that the FSA had a "connection with" an ERISA plan, and was thus preempted on that basis.[141] Judge Motz recalled from *Travelers* that "the main objective of ERISA's preemption clause is to 'avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.'"[142]

The court found that the Fair Share Act created health care spending requirements that were either not applicable for multi-state employers in other jurisdictions, or came into conflict with fair share legislation in other states.[143] It held that the "intended effect"[144] of the FSA was to "force Wal-Mart to increase its contribution to its health benefit plan, which is an ERISA plan, and the actual effect of the Act will be to coerce Wal-Mart into doing so."[145] Asserting that the State of Maryland "over-read" the *Travelers* trilogy on which it relied, Judge Motz said he found nothing in those cases suggesting that the Supreme Court "would now uphold a state statute or local ordinance mandating that an employer provide a

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140. *Id.* at 493.

141. *Id.* at 494.

142. *Id.* (quoting N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995)).

143. *Id.* at 494-95; *see*, *e.g.*, N.Y. COMP. CODES R. & REGS. tit. 22, § 506(c)(2) (2006); SUFFOLK COUNTY, N.Y., REG. LOCAL LAW § 335-3(A) (2006) (requiring Wal-Mart to spend an amount annually on health care, as determined by an administrative agency); H. FILE 3143, 84th Leg., Reg. Sess. (Minn. 2006) (calculating total wages, from which an employer's minimum spending level is determined, with reference to Minnesota's median house income); H.B. 2678, 50th Leg., 2d Sess. (Okla. 2006) (providing for an almost identical regime to Maryland's Fair Share Act; not yet voted on at the time of this writing); *see also supra* note 7 for a listing of fair share laws circulating in state legislatures during 2006.

144. *RILA I*, 435 F. Supp. 2d at 495.

145. *Id.*

certain type or monetary level of welfare benefits in an ERISA plan."[146]

To specifically refute any analogy to the statutes described in the *Travelers*, *Dillingham*, and *De Buono* cases, the District Court argued that these cases "lie at the periphery of ERISA analysis, not (as does the Fair Share Act) at its core."[147] After briefly describing the state laws at issue in those cases, Judge Motz contrasted them with the Fair Share Act. He contended that the FSA was "not merely tangentially related to ERISA plans but [wa]s focused upon them."[148] Drawing upon the FSA's legislative history, Judge Motz said that the law was targeted directly at a single employer's ERISA plan, the effect of which was direct because it would require Wal-Mart to increase its in-state health care benefits and administer its plan in a manner that would ensure that the statutory spending required by the FSA was met.[149] This was seen as violating ERISA's purpose of providing for uniform national benefits and administration.

The District Court of Maryland also took issue with the State's argument that the Fair Share Act was not a mandate. Although the Secretary maintained that employers could comply with the law without increasing its health care benefits by (1) contributing to Health Savings Accounts (HSAs), (2) spending 8 percent of payroll on first aid facilities (as allowed in the FSA's text), or (3) simply paying a sum equaling 8 percent of payroll wages to the State without increasing health care expenditures, the court was not swayed.[150] Faulting the HSA proposal because the employees must initiate these accounts, rejecting the first aid facilities suggestion as unrealistic, and saying that the payment of equal funds to the State rather than employees would be irrational,[151] Judge Motz viewed the Fair Share Act as "imposing a substantive mandate"[152] that had a "connection with"[153] an ERISA plan, and was thus preempted.

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146. *Id.*
147. *Id.*
148. *Id.* at 496.
149. *Id.*
150. *Id.* at 497-98.
151. *Id.*
152. *Id.* at 497.
153. *See* Shaw v. Delta Air Lines, 463 U.S. 85, 96-97 (1983).

C. The Fourth Circuit Court of Appeals' Decision

In many ways, the opinion and dissent in the Fourth Circuit's *RILA II*[154] decision were merely a rehashing of the respective arguments of Wal-Mart and the State of Maryland. In his affirming opinion for the Circuit, Judge Niemeyer wrote that "[a] state law that directly regulates the structuring or administration of an ERISA plan is not saved by inclusion of a means for opting out of its requirements."[155] This dispatched with the notion that just because affected employers had the option of not paying higher amounts to their employees' ERISA-governed plans but instead paying the difference to the State, the FSA represented a non-coercive choice that did not implicate ERISA. Further, arguing that the Fair Share Act specifically targeted Wal-Mart, the majority found that unlike *Travelers* and *Dillingham*, the Maryland law in question "*directly* regulate[d] employers' structuring of their employee health benefit plans. This tighter causal link between the regulation and employers' ERISA plans ma[de] the Fair Share Act much more analogous to the regulations at issue in *Shaw* and *Egelhoff*, both of which were found preempted by ERISA."[156]

Judge Michael's dissent, however, found the Act to be an appropriate and legal response by the State to "wrestl[e] with explosive growth in the cost of Medicaid."[157] For the sole dissenter in this 2-1 decision, the fact that the FSA offered covered employers the option of paying an assessment into a state fund to support Medicaid, thus offering a means of compliance that did not impact ERISA—because an ERISA plan technically did not need to exist to comply with the law—was determinative.[158] Judge Michael was likewise unpersuaded by the argument that the Act would impede large employers'

154. 475 F.3d 180 (4th Cir. 2007).

155. *Id.* at 192 (citing Egelhoff v. Egelhoff, 532 U.S. 141, 150-51 (2001) (holding that ERISA preempted a Washington State law voiding the designation of a spouse as the beneficiary of a nonprobate asset, such as a life insurance plan, if the plan was governed or related to ERISA)).

156. *Id.* at 195-96.

157. *Id.* at 198 (Michael, J., dissenting).

158. *Id.* at 201 ("An employer can comply with the Act either by paying assessments into the special fund or by increasing spending on employee health insurance. The Act expresses no preference for one method of Medicaid support or the other. As a result, the Act is not preempted by ERISA.").

ability to administer ERISA plans, because the FSA did not dictate a plan's system for processing claims, paying benefits, or determining beneficiaries,[159] and because the Act's reporting requirements to the secretary were normal calculations of the cost of benefits and the number of payees employers such as Wal-Mart already regularly recorded.

IV. MODIFICATIONS FOR FUTURE "FAIR SHARE" LEGISLATION

Having reviewed ERISA, the Fair Share Act, and the federal district court case that tackled the two, this Note will now turn to the ways in which other states can draft legislation that avoids some of the pitfalls of Maryland's ill-fated statute. As delineated by Judge Motz in *RILA I*, sometimes the pitfalls were relatively minor: suspect aspects of the legislative record, or the title of the individual whose job was to oversee the collection of revenues. Other times, the deficiencies were more serious: unrealistic alternate avenues for non-health insurance expenditures or uniform administration of plans. The following Parts seek to offer potential remedies to some of the ailments endemic in the Fair Share Act, in hopes of elucidating for other states how to craft workable fair share legislation.

V. APPROACH #1: REWRITE THE LAW AS A MEDICAID TAX, NOT A REGULATORY MANDATE

The first approach to writing such legislation in a manner that avoids ERISA preemption combines the creation of a Medicaid tax with a judicious legislative record, a specified tax revenue collector, a system of incentivized tax credits, and a reduction in the shortfall tax.

A. Statutory Language and Medicaid Financing Purpose

Under this first approach, future laws hoping to influence employer health care spending must be unambiguously written as Medicaid taxes falling within an "area[] traditionally subject to local

159. *Id.* at 202.

regulation":[160] the financing of public health programs. In this regard, the language and purpose of the statutes must evolve from the Fair Share Act's current position. They can no longer be written as legislative regulatory mandates, implicitly designed to force employers to increase health care benefits; they must instead be written to genuinely aid in the funding of state Medicaid budgets and low-income health insurance programs. Achieving this fundamental step through a revenue-raising tax, and correctly using the language necessary to do so, will greatly alter the interpretation and feel of these laws.

First, the vagueness of terms like "payroll assessment" must be eliminated, replaced with clear language that removes the specter of the gray area between a tax and a regulatory fee. A "Medicaid tax" is not only semantically more direct, but it is also a better description of the law's true purpose, in keeping with Judge Motz's view that "the most important factor [is] the purpose behind the statute, or regulation, which imposes the charge."[161]

The Medicaid tax is designed to ease the burden and facilitate the state's traditional police power to provide for the health and safety of its citizens, and, as such, its only concern must be raising general revenues for the state's Medicaid funds. Moreover, a Medicaid tax for revenue-generating purposes is also much more likely than a payroll assessment to trigger the Tax Injunction Act if challenged,[162] potentially keeping jurisdiction of the lawsuit in state court.

Second, such laws must contain a tax credit and a specific exemption provision for employers that would prefer to comply with the Medicaid tax indirectly by investing in employee health care what they would otherwise pay to the state. Again, the credit and exemption provisions are merely alternatives to the law's main thrust, which is to serve as a revenue-raising Medicaid tax. For instance, one iteration of this scheme would be an across-the-board Medicaid tax of 10 percent of total payroll wages paid by in-state employers with 10,000 or more employees, to be paid directly to the

160. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 668 (1995).

161. *RILA I*, 435 F. Supp. 2d 481, 491 (D. Md. 2006) (quoting Valero Terrestrial Corp. v. Caffrey, 205 F.3d 130, 134 (4th Cir. 2000)).

162. 28 U.S.C. § 1341 (2006). See *supra* Part III.A. for a discussion of the Tax Injunction Act.

state's Medicaid budget. Every employer must consequently pay 10 percent of total payroll wages to the state to satisfy the universal Medicaid tax, but a tax credit could be applied for each percentage that the employer spent on individual employees' health insurance instead. It is thus an option, rather than the transparent requirement, that existed in the Fair Share Act.

Under this scenario, an employer who spends 4 percent of its payroll wages on employee health insurance costs would have an automatic 4 percent tax credit, leaving the employer to pay 6 percent more to the State to meet the Medicaid tax requirement.[163] Likewise, an employer who already spends 10 percent of total payroll wages on health insurance costs would opt out of the Medicaid tax by virtue of its tax credits and thus be exempt. The exemption provision should not, however, be the statute's explicit aim. It must be secondary, existing only to allow employers to generate good will with their employees if they so choose, rather than directly paying the tax to the state, as the law requires.

B. Legislative Record and Collection of the Tax

In *RILA I*, Judge Motz objected to the Wal-Mart references in the Fair Share Act's congressional record and to statements evincing a purpose other than that of raising revenue.[164] These maladies are easily fixable for future legislation. Firstly, General Assembly members and any accompanying Fiscal and Policy Notes should only refer to the bill as what legislators want state and federal courts to consider it: a Medicaid tax. Secondly, the statute's text and the lawmakers discussing it should never single out an individual employer or a certain type of employer (beyond those of a specified in-state workforce size). The actual class sizes for this kind of legislation should be theoretically unlimited, in keeping with the argument that "[a]n assessment imposed upon a broad class of parties is more likely to be a tax than an assessment imposed upon

163. *See infra* Part V.C. for a discussion of the shortfall reduction, which would actually decrease the remaining amount owed by the employer under the Medicaid tax if the employer chose to spend it directly on employee health insurance costs.

164. *RILA I*, 435 F. Supp. 2d at 492-93.

a narrow class."[165] Thirdly, states should consider setting benchmarks for employers of other sizes, so as to dull the perception of singling out only large employers. For example, a 3 percent Medicaid tax rate could be applied to employers with fewer than 10,000 employees in the state.

Another significant modification that may appear at first to be merely cosmetic is the legislative bill's path in committee. Judge Motz expressed his concern that "the House of Delegates referred the bill to the Committee on Health and Government Operations, not to the Ways and Means Committee, which has jurisdiction over 'state and local taxation matters.'"[166] Consequently, lawmakers should ensure that Medicaid tax legislation passes through only those committees that deal with taxes. The Ways and Means Committee, Budget and Taxation Committee, the Finance Committee, and their counterparts in different states, should take the lead in drafting the Medicaid tax and performing markups. Moreover, the law must be codified in the state tax code, rather than something such as the Labor and Employment Code,[167] to underscore its purpose as a legitimate tax to raise revenue for the general public benefit.[168]

Another important feature of the Medicaid tax is the determination of whose eventual responsibility it will be to collect the revenue raised by the tax. In *RILA I*, the court noted that "[i]f the responsibility for administering or collecting the assessment lies with the general tax assessor, it is more likely to be a tax; if this responsibility lies with a regulatory agency, it is more likely to be a fee."[169] Pointing out that under the FSA the Secretary of Labor, Licensing, and Regulation collected payments from non-compliant employers,

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165. *Id.* at 491 (quoting Bidart Bros. v. Cal. Apple Comm'n, 73 F.3d 925, 931 (9th Cir. 1996) (holding that an assessment was more like a regulatory fee because the impacted class was limited to only California apple producers)). *But see* Antosh v. City of College Park, 341 F. Supp. 2d 565, 568 (D. Md. 2004) (holding that a trash-collection charge was more like a tax because the impacted class consisted of all people who lived in single-family rental homes or apartments).

166. *RILA I*, 435 F. Supp. 2d at 493 n.11.

167. *See id.*

168. *See id.* at 492 (stating that "a court ordinarily asks whether ultimately the general public will benefit from the revenue raised or whether the benefits 'are more narrowly circumscribed'" (quoting Valero v. Caffrey, 205 F.3d 130, 134 (4th Cir. 2000))).

169. *Id.* at 491 (quoting Collins Holding Corp. v. Jasper County, 123 F.3d 797, 800 (4th Cir. 1997)).

Judge Motz found that this tended to demonstrate that the law was part of a regulatory process. As such, states drafting Medicaid tax legislation would be well-advised to vest the tax's collection powers with the state treasurer or comptroller. These individuals would then be responsible for transferring the income obtained from the Medicaid tax into the state's respective Medicaid accounts.

With this necessary legislative language and critical features framework in place, the important next step is a reduction in the shortfall tax between the mandatory Medicaid tax threshold and the amount an employer currently pays.

C. Reduce the Shortfall Tax

Under the Fair Share Act, an employer who did not meet the for-profit 8 percent threshold was required to pay 100 percent of the difference between the percentage of its actual total wages paid towards health insurance and the 8 percent mark. In effect, as the law was written, if Wal-Mart did not meet the 8 percent threshold, it would then have to match the shortfall dollar-for-dollar, either to its employees or to Maryland. For this reason, the *RILA I* court found the regulatory mandate to be a "Hobson's choice,"[170] because the law felt coercive and was not a real choice at all.

Concurrent with any Medicaid tax for financing the state's public health assistance programs should be a reduction in the shortfall tax. One possibility is a 35 to 50 percent reduction in the shortfall tax that would indirectly encourage employers to invest their Medicaid tax revenue in their employees rather than the state. As such, whatever the difference is between the employer's present percentage of health care expenditures and the benchmark percentage set forth in the Medicaid tax statute, the employer could either pay the state 100 percent of the difference, or it could pay to its employees 35 to 50 percent of the difference in the form of health insurance costs.

For instance, as in the scenario described *supra* in Part V.A., for a state with a Medicaid tax having a minimum threshold of 10 percent of total wages paid, an employer who already spends 4

170. *Id.* at 497 (quoting N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 664 (1995)).

percent of its payroll wages toward health insurance costs would be required under the Medicaid tax to pay the state the remaining 6 percent. However, with a shortfall tax of 50 percent, rather than the 100 percent found in the Maryland FSA, the employer would be able to spend only 3 percent (that is, 50 percent of 6 percent) of payroll wages on employee health insurance to meet its requirement, rather than paying the full 6 percent to the state. Under this scenario, an economic incentive in the mold of *Dillingham*, the lack of a Hobson's choice would likely change the employer's cost-benefit analysis. After all, although the court in *RILA I* suggested that forcing an employer to choose between paying 100 percent to the state or 100 percent to its employees was no choice at all, here a significant difference exists between a company paying $1 to the state or $.35 to $.50 to its employees.

States should adopt a tax rate on the shortfall that approximates the highest marginal income tax for that state,[171] which usually falls somewhere between 35 and 50 percent. When the rate is higher than that, and especially when it is 100 percent, courts are much more likely to view the statute as patently punitive, a reality that played out in Judge Motz's examination. A 50-percent-and-below rate, however, is a figure that not only looks like a normal tax or surcharge, but it is also in line with the "indirect economic influence" language of *Travelers* and *De Buono*. A reasonable shortfall tax on employer wages, coupled with tax credits for the state's Medicaid financing scheme—a function within traditional state regulation—is less punitive and operates irrespective of whether an employer utilizes ERISA plans.

The result of a legitimate Medicaid tax with (1) a built-in tax credit based on the employers' present health care expenditures, (2) an exemption for employers who prefer to pay the tax funds in full to its employees that it would have paid the state, and (3) a 35 to 50 percent shortfall tax rate, is no longer a coercive legislative mandate. It now becomes a choice and a matter of preference to employers. The Medicaid tax would exert an "indirect economic influence,"[172] as it did in *Travelers*, but this non-acute influence

171. For a listing of state individual income tax rates for tax year 2007, see Federation of Tax Administrators, State Individual Income Tax Rates–2007, http://www.taxadmin.org/fta/rate/ ind_inc.html (last visited Mar. 10, 2008).

172. *Travelers*, 514 U.S. at 659.

would neither "bind plan administrators to any particular choice"[173] nor sufficiently "relate to" employee benefit plans. As in *Dillingham*, the state statute's effect would be "merely to provide some measure of economic incentive to comport with the State's requirements,"[174] here, in the form of a Medicaid tax.

VI. APPROACH #2: MINIMUM WAGE AND "TOTAL PACKAGE" BENEFITS

A. Employer Size-specific Minimum Wages

One very important conclusion from the *Dillingham* case[175] was that where a state law functions independently or irrespectively of an ERISA plan, the state law does not necessarily have a sufficient "connection with" or "refer to" an ERISA plan.[176] In *Dillingham*, both ERISA and non-ERISA covered apprenticeship programs could be approved under the California prevailing wage statute, thus the Court found that the law was "indifferent" to ERISA even though the vast majority of state-approved apprenticeship programs were in fact ERISA plans.[177]

A different avenue for state legislatures that hope to influence large employer behavior, and which varies from the Medicaid tax structuring mentioned above, is to enact employer size-specific minimum wages. The creation in states of industry-neutral minimum wage statutes that apply only to employers of a certain size is also likely to fall into the "traditional state regulation" rubric that played out in *Travelers* and its progeny.

The purpose of such a minimum wage statute would be to have employers put money into the hands of low-income employees who otherwise would be mathematically at risk of needing public health insurance assistance, given subpar employer health coverage. As stated above, the average national wages for full-time Wal-Mart associates in fiscal year 2002 were less than $14,000 per year,

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173. *Id.*

174. Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 332 (1997).

175. *See supra* Part II.C.2.

176. *Dillingham*, 519 U.S. at 325-28.

177. *See id.* at 327 n.5.

versus a federal poverty line of $14,630 for a family of three.[178] Although ensuring that the resources gained from a higher minimum wage would definitely be spent on health care costs would be impossible, it would at the very least put employees in a position to do so. Furthermore, this approach is not coercive because it does not in any way require the employer to interact with ERISA plans, although it may have the direct effect of allowing individual employees to better control their own health care needs.

A size-specific minimum wage would borrow from prevailing wage cases, in which a standard is set for employers to pay employees who work on certain projects or have taken part in certain programs. A state-wide prevailing minimum wage for large employers (e.g., over 10,000 employees) is not irrational, given that many employees for such companies are already paid according to the federal or state minimum wage, and many of these same workers are at a high risk, relative to other workers, of becoming part of the state's Medicaid program. Moreover, it is also quite commonplace for states to enact minimum wages higher than the federal government's, as is the case in Alaska, California, Connecticut, Delaware, Florida, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, New Jersey, New York, Oregon, Rhode Island, Vermont, Washington, and Wisconsin.[179]

In many ways, requiring employers of a certain size to raise their employee wages is not unlike New York's hospital surcharge in *Travelers* or the wage differential created in *Dillingham*. In both of those cases, the state tax or prevailing wage had the effect of providing some measure of indirect economic influence or incentive; but, it did not bind ERISA plans or lead to undue administrative burdens. The same would be true in the case of a statute requiring

178. Bianco & Zellner, *supra* note 43, at 100, 102.

179. To see the specific wages in these states, see Department of Labor, Minimum Wage Laws in the States–January 1, 2008, http://www.dol.gov/esa/minwage/america.htm. Note that thirty-two states have a minimum wage higher than the federal minimum wage. *Id.* A trend is apparent as well, given the number of minimum wage increases that were approved in 2006 through ballot measures in Arizona (66%), Colorado (53%), Missouri (76%), Montana (73%), Nevada (69%), and Ohio (56%). *See* CNN.com – Elections 2006, http://www.cnn.com/ELECTION/2006/pages/results/ballot.measures/ (last visited Mar. 10, 2008).

that, for example, in-state employers of more than 10,000 workers pay $2 more than the state's present minimum wage.[180]

A provision, of course, could be written into the minimum wage statute that would allow employers to be exempt from the higher state minimum wage if a certain percentage of their total wages paid to employees was spent on health insurance costs. So, if the employer met the exemption benchmark set forth in the law, it could revert to the state standard minimum wage. The goal of such an exemption would be to provide an incentive to employers who wish to invest in employee health care the money that they would otherwise be paying to their employees in higher wages. Once again, such an exemption provision would neither bind/refer them to ERISA plans nor burden them. It would merely serve as a possible way to meet a prevailing wage statute that is part of "traditionally state-regulated substantive law in those areas where ERISA has nothing to say."[181]

B. Additional Options for Employers To Meet Minimal Expenditures

1. Clinics and Health Savings Accounts

Under the Maryland Fair Share Act, for-profit employers could meet the requirement of 8 percent of total wages paid to employees on "health insurance costs" without the existence of an ERISA plan.[182] Judge Motz, however, was not persuaded by the avenues for doing so. As mentioned above, he quibbled with the State's contention that on-site first aid facilities would be adequate.[183] The court said that "[w]hile the Secretary's argument may evidence the active

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180. The $2 figure is being offered here only for means of conjecture. In reality, an appropriate minimum wage increase for affected employers would result from a calculation of the average expenditure that the state must pay to subsidize the deficiency from the defaulting employer.

181. *Dillingham*, 519 U.S. at 330-31 (quoting N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 665 (1995)).

182. *See supra* text accompanying notes 8-10.

183. The State's argument derived from 29 C.F.R. § 2510.3-1(c)(2) (2006), excepting from the definition of ERISA plans "[t]he maintenance on the premises of an employer of facilities for the treatment of minor injuries or illness or rendering first aid in case of accidents occurring during working hours." *RILA II*, 475 F.3d 180, 196 (4th Cir. 2007).

imagination of his lawyers, it is utterly out of line with reality."[184] Although Judge Motz may be correct that making up the difference between a large company's present health insurance expenditure percentage and 8 percent solely through the creation of new on-site medical facilities is not practical, the building of these facilities is nonetheless not insignificant. Moreover, although the Fourth Circuit noted that the Department of Labor strictly interprets the definition of such facilities not to cover a facility that treats members of employees' families or more than "minor injuries,"[185] Wal-Mart itself had already begun making such expenditures before the Fair Share Act even took effect. A February 2006 Wal-Mart News Release recounted that the employer intended to open fifty more such clinics in 2006, and that, in the Northwest Arkansas region alone, three clinics had already treated 4,300 patients and administered more than 1,800 flu shots in just six months.[186] Nearly half of all the patients treated at the three clinics cited were uninsured.[187]

Maryland also argued that the spending requirement could be met through contributions to employee Health Savings Accounts (HSAs), tax-advantaged medical savings accounts that were established as part of Section 1201 of the 2003 Medicare Prescription Drug, Improvement, and Modernization Act.[188] The U.S. Department of Labor's Field Assistance Bulletin 2004-1[189] noted HSAs were "established to receive tax-favored contributions by or on behalf of eligible individuals, and amounts in an HSA may be accumulated over the years or distributed on a tax-free basis to pay or reimburse 'qualified medical expenses.'"[190]

In order to establish an HSA, individuals must be covered under a High Deductible Health Plan (HDHP), and no other more

184. *RILA I*, 435 F. Supp. 2d 481, 497 (D. Md. 2006).

185. *RILA II*, 475 F.3d at 196 (citing Labor Dep't Op. No. 83-35A, 1983 WL 22520 (1983)).

186. Press Release, Wal-Mart, Wal-Mart CEO Calls for a "New Commitment" Between Government and Business Leaders (Feb. 26, 2006), http://www.prnewswire.com/cgi-bin/stories.pl?ACCT=109&STORY=/www/story/02-26-2006/0004300659&EDATE=.

187. *Id.*

188. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, 2469-79 (2003).

189. U.S. DEP'T OF LABOR, FIELD ASSISTANCE BULLETIN 2004-1, Apr. 7, 2004, http://www.dol.gov/ebsa/regs/fab_2004-1.html [hereinafter DOL ASSISTANCE BULLETIN 2004-1].

190. *Id.*

comprehensive health plan. This coverage can be made available by the employer or purchased by the employee without establishing an ERISA plan.[191] In fact, the same Department of Labor guide states that:

> [W]e would not find that employer contributions to HSAs give rise to an ERISA-covered plan where the establishment of the HSAs, is completely voluntary on the part of the employees and the employer does not: (i) limit the ability of eligible individuals to move their funds to another HSA ... (ii) impose conditions on utilization of HSA funds ... (iii) make or influence the investment decisions with respect to funds contributed to an HSA ... (iv) represent that the HSAs are an employee welfare benefit plan established or maintained by the employer; or (v) receive any payment or compensation in connection with an HSA.[192]

Wal-Mart itself has said that it offers HSAs to its associates, to "provide yet another option for families to gain access to health insurance and save for future health care needs."[193] "Wal-Mart matches associates' contributions to their HSAs dollar-for-dollar ... and associates own the accounts. (The match ranges from $250 to $1,000, depending on coverage level selected.)"[194]

The District Court objected to this method on the grounds that HSAs fall outside the definition of ERISA plans unless "the establishment of the HSAs is completely voluntary on the part of the employees."[195] Even so, for those employees who do wish to establish HSAs, the spending would be useful and applicable under fair share legislation. Again, although by itself such expenditures may not be independently sufficient to meet the minimum "health insurance costs" requirement, they nonetheless must be included in the definition of very significant non-ERISA options.

In order for fair share legislation to be less coercive and more palatable to employers and courts, new laws must include additional options for meeting mandatory spending levels. The key to expand-

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191. 29 C.F.R. § 2510.3-1(j) (2006).

192. DOL ASSISTANCE BULLETIN 2004-1, *supra* note 189.

193. Wal-Mart Facts, Wal-Mart's Health Care Benefits Are Competitive in the Retail Sector, http://www.walmartfacts.com/articles/1802.aspx (last visited Mar. 10, 2008).

194. *Id.*

195. *RILA I*, 435 F. Supp. 2d 481, 497 (D. Md. 2006) (quoting DOL ASSISTANCE BULLETIN 2004-1, *supra* note 189).

ing the expenditure options that employers have is to present them with numerous coherent, valid choices, but to make health insurance expenditures the most attractive of all the viable avenues. Essentially, the state must present employers with fair options that lead under-providing members of the private sector to invest more in either the health care of their employees or in the public health insurance funds of the state, even if employers are not enamored of the options.

2. "Total Package" Statutes

Logically, the greater the number of mechanisms for meeting the statute's minimum requirements, the more likely employers (and courts) will be to feel that they have choices. For this reason, fair share legislation can again look to the non-ERISA preemption model outlined in prevailing wage cases.

Prevailing wage statutes often contain both a cash component and a benefits component.[196] Under many of these statutes, contracts for public projects must either provide benefits contributions at the level determined in the prevailing wage or a monetary equivalent. As one apposite case noted:

> Appellees suggest this provision creates a preemptible relation to ERISA plans merely by providing the option of complying with part of the minimum [prevailing] wage through benefits contributions. We disagree. The provision does not require or encourage an employer to provide certain benefits, to alter the manner in which it provides benefits, or even to provide any benefits at all. The benefits component only relates to ERISA plans when an employer decides to satisfy it through contributions to ERISA plans instead of cash payments or contributions to non-ERISA benefits. *Where a legal requirement may be easily satisfied through means unconnected to ERISA plans, and only relates to ERISA plans at the election of an employer, it "affect[s] employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan*."[197]

196. *See, e.g.*, 34 PA. CODE § 9.106 (2007) (setting forth standards for "[p]ayment of general prevailing minimum wage rates").

197. Keystone Chapter, Assoc. Builders & Contractors v. Foley, 37 F.3d 945, 960 (3d Cir. 1994) (quoting Shaw v. Delta Air Lines, 463 U.S. 85, 100 n.21 (1983) (emphasis added)) (holding that the State's Prevailing Wage Act did not impede the goals of ERISA or relate to

In one post-*Dillingham* case, a state law allowed employers to meet their prevailing wage liability in any combination of benefit plans or wages. The Second Circuit in *Burgio & Campofelice, Inc. v. New York State Department of Labor* (*Burgio*)[198] examined one such "total package" statute that "require[d] employers to match the total cost of all prevailing supplements. Employers [we]re no longer required to match one-for-one the specific prevailing rate for each prevailing supplement, or even to provide each type of prevailing supplement,"[199] rather, they could meet the supplement benchmarks through a combination of features.

With this in mind, states are able to pass "total package" fair share laws that place a greater emphasis on non-ERISA fringe benefits as an option for compliance.[200] Some of these benefits could include: (1) employee discounts on qualified property or services;[201] (2) payment for employees' business periodicals;[202] (3) membership in professional associations, if the expense could have been deducted as a business expense had the employee paid the dues herself;[203] (4) outplacement services;[204] (5) "ordinary vacation benefits, paid out of an employer's general assets like wages rather than out of a dedicated fund;"[205] (6) employer-paid club dues;[206] (7) employer-paid trips with specific bona fide business purposes;[207] (8) local personal phone calls;[208] (9) occasional parties or picnics for employees and their guests;[209] (10) holiday gifts, other than cash, with a low fair

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such plans in more than an incidental or insignificant way).

198. 107 F.3d 1000 (2d Cir. 1997) (holding that the prevailing wage law in question, when used with a "total package" approach, was not preempted because it did not mandate employee benefit structures or their administration).

199. *Id.* at 1004, 1010.

200. "A working condition fringe is any property or service provided to any employee of an employer to the extent that, if the employee paid for the property or service, the amount paid would be allowable as a deduction under [26 U.S.C. §§] 162 or 167." 26 C.F.R. § 1.132-5(a) (2007).

201. 26 U.S.C. § 132(c)(1) (2006).

202. 26 C.F.R. § 1.132-5(a)(1)(iii) (2007); *id.* § 1.162-1(a).

203. *Id.* § 1.132-5(s)(1).

204. Rev. Rul. 92-69, 1992-2 C.B. 51, 53.

205. *RILA II*, 475 F.3d 180, 190 (4th Cir. 2007) (describing Massachusetts v. Morash, 490 U.S. 107, 115-16 (1989)).

206. 26 C.F.R. § 1.132-5(s)(1) (2007).

207. *See* Townsend Indus., Inc. v. United States, 342 F.3d 890, 893 (8th Cir. 2003).

208. 26 C.F.R. § 1.132-6(e)(1) (2007).

209. *Id.*

market value;[210] (11) tuition reimbursements;[211] (12) flexible spending accounts;[212] (13) employer-paid educational assistance programs;[213] (14) transportation in connection with travel between the employee's residence and the place of employment;[214] and (15) meals furnished on the business premises of the employer.[215] All of these examples represent possible non-medical fringe benefits that could serve as targets for wage supplements under a "total package" approach. This second approach would present large employers with other fair, though perhaps not coveted, options for their expenditures under fair share legislation. A fair share "total package" statute could thus be written such that large employers would be required to spend 10 percent of payroll wages on health insurance. This 10 percent benchmark could then be met through a combination of higher wages, numerous non-ERISA fringe benefits expenditures, the maintenance of on-site medical facilities, and HSAs, as well as by employers who would rather increase their ERISA plan expenditures, or simply pay the difference to the state's Medicaid fund.

VII. REPORTING REQUIREMENTS AND UNIFORM PLAN ADMINISTRATION

As stated above, a primary purpose of ERISA is to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."[216] This does not mean, however, that ERISA preempts any state law that would have any effect on an ERISA employee benefit plan. As the Second Circuit noted in *Burgio*, "preemption does not occur where a state law places on ERISA plans administrative requirements so slight that the law 'creates no impediment to an employer's adoption of a

210. *Id.*

211. *Id.* § 1.127-2 (2007).

212. Rev. Rul. 2003-102, 2003-2 C.B. 559. Flexible spending accounts are tax-advantaged accounts set up through employer cafeteria plans that allow employees to set aside portions of their earnings to pay for medical and dependent care expenses. The most common of these plans is similar to a Health Savings Account.

213. 26 C.F.R. § 1.127-2 (2008).

214. *Id.* § 1.132(f)(1)(A)-(C).

215. 26 U.S.C. § 119 (2006).

216. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995).

uniform benefit administration scheme.'"[217] After all, "ERISA plan expenditures are considered in the calculation of an employer's total level of health insurance spending, but this factor does not create an impermissible connection with an ERISA plan."[218]

The vastness of a company like Wal-Mart's health insurance plans aside,[219] any requirements resulting from the fair share legislation proposals outlined above would be a product of the relationship between the employer and the state, and they would function regardless of whether the employer even used an ERISA plan in that state. Indeed, multi-state employers assume the risk of being subject to individual state laws when they do business there. Moreover, as one post-*Travelers* case noted: "[I]nformation such as a list of plan participants, payroll lists, the amount of an employer's contributions and the names of people for whom the employer made contributions are appropriate areas of inquiry substantially similar to the record production we approved in *Burgio*."[220]

Other courts have made clear that very large employers such as Wal-Mart already keep extensive records of payroll and personnel data,[221] and that ERISA does not preempt two-tier state prevailing wage laws just because they require ongoing calculations to determine cash wages and total contributions to employee benefit plans.[222] For this reason, and because of the fact that Judge Motz in *RILA I* did not find the FSA reporting requirements objectionable enough to establish a "connection with" employee benefit plans, limited reporting requirements related to employers seeking to meet

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217. Burgio & Campofelice, Inc. v. N.Y. State Dep't of Labor, 107 F.3d 1000, 1009 (2d Cir. 1997) (quoting Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1, 14 (1987)).

218. *RILA II*, 475 F.3d 180, 201-02 (4th Cir. 2007) (Michael, J., dissenting).

219. According to Wal-Mart's 2004 I.R.S. Form 5500, the Wal-Mart Associates Health and Welfare plan utilized nearly fifty insurance companies in different states to provide benefits. *See* FreeErisa.com, http://www.freeerisa.com/5500/CompanyDetail.asp?company=WAL%20MART+STORES+INC (last visited Mar. 11, 2008).

220. HMI Mech. Sys. v. McGowan, 266 F.3d 142, 151 (2d Cir. 2001) (citing *Burgio*, 107 F.3d at 1009).

221. *See, e.g.*, Dukes v. Wal-Mart Stores, Inc., 222 F.R.D. 137, 180 (N.D. Cal. 2004) (discussing, in the context of a class action gender discrimination suit, Wal-Mart's "extraordinarily sophisticated information technology system" that allows users to "create detailed reports of individual work histories" with respect to salaries, social security numbers, and payroll data).

222. *See* WSB Elec. v. Curry, 88 F.3d 788, 790-91 (9th Cir. 1996) (rejecting a public works contractor's challenge to a California prevailing wage law that adopted a two-tier system that calculated a cash wage and a total contribution to benefit plans).

a Medicaid Tax exemption or a "total package" prevailing wage statute should not trigger preemption by ERISA under any reporting requirements or uniform plan administration challenges.

CONCLUSION

This Note proceeds from the belief that *RILA I* should be read as a veiled guide for private sector health care reform in America. In other words, it may be seen more as a shot in the arm rather than as a shot in the foot for health care advocates. Rather than the case being seen as a setback for efforts to influence large employers to provide their employees with greater access to affordable health care, the Fair Share Act and the case that preempted it should be viewed for the subtle opportunities they elucidate that can be built upon.

One such subtlety that should not get lost in translation is the efficacy of rewriting fair share legislation as state Medicaid taxes falling under the purview of an area traditionally subject to local regulation: public health and safety. An affirmative Medicaid tax on large employers, designed solely for funding the state's public health assistance programs, provisioned with tax credits and possible exemptions for those employers who wish to invest in employee health care what they would otherwise pay to the state, appears very promising based on relevant Supreme Court case law. Moreover, the reduction to a 35 to 50 percent shortfall tax on the difference between what an employer would be required to pay the state, and what it could instead spend on its employees in health care costs, would give employers reasonable indirect economic incentives to increase their employee health expenditures while not directly "relating to" or having "connection with" ERISA plans.

Likewise, employer size-specific minimum wages have the potential to serve as the connective tissue between indirectly influencing large employer behavior and increasing the financial resources available to low-income employees for their health care expenses. Statutory exemption clauses allowing for a reversion to the standard state minimum wage for those employers who meet a certain percentage of payments towards health insurance costs would also facilitate this process. Similarly, an increase in the viable options that employers have for meeting spending requirements, whether through HSAs, on-site medical facilities, or non-

ERISA fringe benefits, would detract from the argument that so few options under the Fair Share Act lead to a Hobson's choice. Coupled with a "total package" scheme and a prevailing wage and benefits statute, this approach to fair share legislation could be very formidable.

Medicaid taxes, minimum wage laws, and "total package" arrangements can thus be conceived of as metals, the alloy of which states as "laboratories"[223] can employ to catalyze the process of lessening their public health burden, while encouraging large employers to contribute a greater proportion to employee health care. As this prominent debate continues in political and policy circles nationwide, it will be interesting to watch in the years ahead as states inevitably devise new fair share proposals to shift some of the burden of health care maintenance from the state and individual taxpayers to the private sector. What will perhaps be even more fascinating, however, is seeing how the innovative free market in America will respond to these proposals, most likely creating workable solutions that preempt, in practice, the very fair share proposals that spawned them.

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223. New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

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