

THE NEW MASSACHUSETTS HEALTH LAW: PREEMPTION
AND EXPERIMENTATION

EDWARD A. ZELINSKY*

ABSTRACT

The Employee Retirement Income Security Act of 1974 (ERISA) preempts major features of the new Massachusetts health law. Although regrettable, this conclusion is mandated by ERISA's statutory terminology and the controlling case law. Other states, in fashioning their health care policies, are looking at elements of the new Massachusetts law. Just as ERISA preempts the individual and business contribution mandates of the Massachusetts statute, ERISA will preempt any similar provisions adopted by other states.

Because state experimentation with health care is particularly desirable today, Congress should, at a minimum, amend ERISA to validate the new Massachusetts health law. More comprehensively, Congress should amend ERISA Section 514 to permit all states to experiment with health care reform insofar as such experiments relate to employer-provided health care. Ideally, Congress should repeal section 514 and thus abolish altogether the jurisprudence of ERISA preemption.

* Edward A. Zelinsky is the Morris and Annie Trachman Professor of Law at the Benjamin N. Cardozo School of Law of Yeshiva University.

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This Article is dedicated to the memory of Judge Seymour F. Simon of the Illinois Supreme Court, whose life was a model of public service, legal professionalism, and personal elegance.

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INTRODUCTION

In recent years, many states have, to use Justice Brandeis's celebrated metaphor,¹ acted as laboratories of experiment in the area of health care. Among the recent experiments, two have attracted particular attention: Maryland's Fair Share Health Care Fund Act, commonly known as the "Wal-Mart" Act,² and the new Massachusetts health law.³ Acting as a severe impediment to this experimentation is the Employee Retirement Income Security Act of 1974 (ERISA)⁴—in particular, ERISA's preemption clause, section 514.⁵

I have recently analyzed the legality of Maryland's Wal-Mart Act under ERISA and have concluded that ERISA preempts that Act as a federally forbidden regulation of employer-provided health care.⁶ The United States Court of Appeals for the Fourth Circuit, affirming the United States District Court for the District of Maryland, has similarly concluded that Maryland's Wal-Mart Act is ERISA preempted.⁷ As a normative matter, this is regrettable because health care is an area in which states should be permitted, indeed encouraged, to explore novel approaches. On the merits, Maryland's Wal-Mart Act is a poorly designed experiment, but the

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

2. Fair Share Health Care Fund Act, 2005 Md. Laws 3 (codified as amended at MD. CODE ANN., HEALTH-GEN. § 15-142 (LexisNexis 2007)); MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to 107 (LexisNexis 2006).

3. 2006 Mass. Acts 58. The original law was subject to a variety of technical amendments in Chapter No. 324-2006, signed by Governor Romney on October 26, 2006.

4. ERISA was originally enacted in 1974 as Pub. L. No. 93-406, 88 Stat. 829 (1974). ERISA has been repeatedly amended over the years, most recently by the Pension Protection Act of 2006. ERISA is codified in parts of the Internal Revenue Code (U.S.C. Title 26), and in Title 29 of the United States Code.

5. ERISA section 514 is codified at 29 U.S.C. § 1144 (2000).

6. See Edward A. Zelinsky, *Maryland's "Wal-Mart" Act: Policy and Preemption*, 28 CARDOZO L. REV. 847 (2006) [hereinafter Zelinsky, *Wal-Mart*]. An earlier version of this article appeared as Edward A. Zelinsky, *Is Maryland's "Wal-Mart" Act Preempted by ERISA?*, 41 ST. TAX NOTES 561 (2006).

7. *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007), *aff'g* 435 F. Supp. 2d 481 (D. Md. 2006). The State of Maryland has announced that it will not seek review of the Fourth Circuit's decision. Karen Setze, *Maryland Won't Seek Supreme Court Review of "Wal-Mart Bill" Ruling*, 2007 ST. TAX TODAY 75-15 (Apr. 18, 2007).

encouragement of experiments includes an acceptance of experiments one thinks will fail.

In substantive terms, the new Massachusetts law is a more ambitious and admirable experiment than Maryland's Wal-Mart Act. Nevertheless, as a matter of ERISA preemption, the two statutes have much in common. In particular, both statutes impact employer-provided health care in a fashion outlawed by ERISA section 514(a).⁸ Thus my conclusion: Just as Maryland's Wal-Mart Act is ERISA preempted, so too major features of the Massachusetts law are ERISA preempted as forbidden regulations of employer-provided health care.

This is a regrettable conclusion, but one mandated by the statute and the controlling case law. ERISA preempts the new law's mandate requiring covered Massachusetts employers to sponsor medical plans for their employees and to make "fair and reasonable" contributions to such plans.⁹ ERISA also preempts the new law's requirement that Massachusetts residents maintain "minimum creditable coverage" for health care, as that requirement effectively mandates the substantive medical coverage Massachusetts employers must offer their employees.¹⁰

Other states, in fashioning their health care policies, are looking at elements of the new Massachusetts law. For example, Governor Schwarzenegger has proposed that, as part of a package of health care reforms, California adopt a Massachusetts-style mandate for businesses to provide medical coverage to their employees as well as a Massachusetts-type mandate requiring individuals to obtain medical insurance for themselves.¹¹ Just as ERISA preempts the individual and business contribution mandates of the Massachusetts law, ERISA will preempt any similar provisions adopted by California or any other state.

8. See 29 U.S.C. § 1144(a) (2000).

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

10. See *infra* Part III.D.

11. Lenny Goldberg, *California Governor Proposes 'Fees' for Universal Health Coverage*, 2007 ST. TAX TODAY 8-3 (Jan. 10, 2007); Laura Mahoney, *California Governor Offers Health Care Reform Plan, Also Calls for Changes to State Tax Laws*, DAILY REP. FOR EXECUTIVES (BNA), Jan. 9, 2007, at H-1; Jennifer Steinhauer, *California Plan for Health Care Would Cover All*, N.Y. TIMES, Jan. 9, 2007, at A1.

Today, employer-provided medical coverage is central to health care in the United States. ERISA section 514(a) prevents the states from enacting legislation which “relate[s] to” such employer-provided coverage.¹² ERISA section 514 thereby precludes the states from experimenting with alternative approaches to health care, like the new Massachusetts health law, that impact employer-provided health care.

Because state experimentation with health care is particularly desirable today, Congress should, at a minimum, amend ERISA section 514 to validate the new Massachusetts health law. On the merits, Massachusetts has a compelling argument for congressional protection from ERISA preemption. As a political matter, Massachusetts is also well positioned to seek such protection, given the bipartisan flavor of the new Massachusetts health law.

More comprehensively, Congress should amend section 514 to permit all states to experiment with health care reform insofar as such experiments relate to employer-provided health care. Even those inclined to defend ERISA preemption as we know it should be troubled by section 514's invalidation of key parts of the Massachusetts health law and, by extension, similar features of laws that other states might enact. We do not know if the new Massachusetts law and its novel provisions will succeed, but they, and other similar experiments, should be given the chance.

Ideally, Congress should repeal section 514 and thus abolish altogether the jurisprudence of ERISA preemption. It would improve the status quo decisively to amend section 514 to immunize from ERISA preemption state laws pertaining to employer-provided health care. However, any such amendment of section 514 will entail knotty issues as to the scope of the immunity that the amendment grants. In contrast, abolishing section 514 would eliminate the definitional and borderline questions attendant to a more limited statutory carve out, which validates for ERISA purposes only state laws relating to employer-provided health care.

In the first Part of this Article, I outline the major features of the new Massachusetts health law: the Massachusetts insurance “connector,” the coverage mandates the new law imposes on

12. 29 U.S.C. § 1144(a) (2000).

individuals and employers, and the new Commonwealth Care Health Insurance Program to subsidize medical insurance for low-income families and individuals. In the second Part, I examine the bipartisan and eclectic nature of the compromises embodied in the Massachusetts health law. In the third Part, I analyze key features of the new law under ERISA section 514 and find that ERISA preempts three of these: the employer mandate requiring covered employers to offer medical coverage to their employees, the employer mandate requiring covered employers to make fair and reasonable contributions for such coverage, and the individual mandate requiring Massachusetts residents to have individual or group medical coverage that constitutes minimum creditable coverage. All of these features regulate employer-provided health care in ways forbidden by section 514.

In the final Part, I place the new Massachusetts health law in the context of our national debate about health care. In this Part, I argue that state experimentation with health care permits each state's regulation to adapt to local conditions and preferences while generating information and alternatives which can be emulated, adapted, or rejected by other states. Consequently I urge, as a minimum, that Congress amend section 514 to permit the Massachusetts experiment to go forward. Even more desirable would be the amendment of section 514 to permit all states to experiment with the regulation of employer-provided health care. Most desirable would be the total repeal of ERISA section 514.

Given the centrality of employer-provided medical coverage to health care in the United States today, ERISA preemption effectively prevents the states from experimenting in the health care arena by blocking state legislation relating to employer-provided health care. Section 514 should be amended—or, ideally, abolished altogether—so that, in this arena, the states can pursue their roles as laboratories of experimentation.

I. KEY FEATURES OF THE NEW MASSACHUSETTS HEALTH LAW

A. *The Connector*

Central to the health care structure implemented by the new Massachusetts law is the state's "health insurance connector,"¹³ a publicly-governed¹⁴ authority¹⁵ which will perform six major functions.

First, the connector will facilitate the purchase of health insurance by "eligible individuals"¹⁶ and "eligible small groups."¹⁷ An "eligible individual" is a Massachusetts resident other than a resident "offered subsidized health insurance by an employer with more than 50 employees."¹⁸ An "eligible small group" is either a business firm that employs fifty or fewer employees or a "labor union, educational, professional, civic, trade, church, not-for-profit, or social organization."¹⁹ The connector will identify those "health benefit plans"²⁰ which deserve the connector's "seal of approval"²¹ by meeting "certain standards regarding quality and value."²² As to these approved plans, the connector will collect premium payments from eligible individuals and small groups purchasing their health insurance through the connector and will remit these premiums to the insurers.²³

Second, the connector will define the criteria that health plans must satisfy to constitute minimum creditable coverage²⁴ for

13. The connector is established in and governed by new chapter 176Q of the Massachusetts General Laws. MASS. GEN. LAWS ch. 176Q (2007). Chapter 176Q was added to the General Laws by section 101 of 2006 Mass. Acts 58. *See id.*

14. *Id.* § 2. The connector authority is governed by a board consisting of appointees of the governor of Massachusetts, appointees of the attorney general of Massachusetts, and various officials of the Commonwealth of Massachusetts who serve *ex officio*. *See id.* § 2(b).

15. *Id.* §§ 1, 2(a).

16. *Id.* § 1.

17. *Id.*

18. *Id.*

19. *Id.* As to the latter groups, the term "small" is a misnomer because there is no statutory limit on the number of members such a group may have. *See id.*

20. *Id.*

21. *Id.*

22. *Id.*

23. *See id.* §§ 6, 7.

24. MASS. GEN. LAWS ch. 111M, § 1(a) (2007).

purposes of the new law's insurance mandate on Massachusetts residents.²⁵ As I discuss *infra*, the new law imposes upon Massachusetts residents the requirement that they must be covered by a satisfactory health care plan. The connector, by defining the standards for minimum creditable coverage, will determine which individual and group health plans satisfy an individual's legal obligation to be covered by mandatory health care.

Third, the connector will administer the Commonwealth Care Health Insurance Program²⁶ established by the Massachusetts law.²⁷ As I discuss *infra*, this program will enable certain low-income Massachusetts residents to purchase health insurance through the connector on a subsidized basis.

Fourth, the connector will certify if an uninsured Massachusetts resident attempts to purchase creditable coverage from among the approved insurance policies available through the connector, but cannot obtain coverage that the connector views as "affordable" for such resident.²⁸ An individual who receives such certification will, by virtue of his unsuccessful attempt to find affordable insurance through the connector, be deemed to have satisfied his obligation to carry health coverage.²⁹

Fifth, the connector will promulgate the rules and regulations for the "cafeteria" plans which, under the new law, each covered employer must maintain for its employees to permit such employees to reduce their currently taxable compensation and thereby pay on a pre-tax basis insurance premiums and, possibly, co-payments and deductibles.³⁰

25. MASS. GEN. LAWS ch. 176Q, § 3(a)(5) (2007).

26. *Id.* § 7.

27. The "[c]ommonwealth care health insurance program" is established by Chapter 118H of the Massachusetts General Laws. MASS GEN. LAWS ch. 176Q § 1 (2007). Chapter 118H was added by section 45 of the Massachusetts law.

28. *Id.* § 3(a)(5).

29. MASS. GEN. LAWS ch. 111M, § 2(b)(iii) (2007). This section was added to the Massachusetts General Laws by section 12 of the Massachusetts statute. Section 13 of the Massachusetts statute amends section 2(b) effective as of January 1, 2008. *See* section 147 of the Massachusetts statute. However, section 2(b)(iii) remains identical.

30. MASS. GEN. LAWS ch. 151F, § 2 (2007). I discuss *infra* the new law's requirement for such cafeteria plans. *See infra* notes 62-68 and accompanying text.

Finally, the connector is designed to address the problem of portability,³¹ that is, the need to provide health care coverage continuity when employees change jobs. Consider, for example, an individual who works for a small employer, obtains medical insurance through his employer's participation in the connector, and switches jobs to work for another small employer that also participates in the connector. In this example, the individual need experience no break in his medical coverage as his new employer can simply continue the payments to the connector for the same coverage the individual had at his former workplace. Connector-based insurance will thus be "portable" within the connector.

The connector is intended to reduce the cost of health insurance while increasing the coverage available to currently uninsured individuals.³² The connector effectively pools individuals and small groups into a state-run consortium for purchasing insurance.³³ As an actuarial matter, this pooling is intended to reduce premiums because policies offered through the connector should be underwritten for the large number of insureds expected to obtain coverage through the connector, rather than separately for insured individuals and each small group.³⁴ Thus, an employer turning to the connector for health insurance coverage for its employees should not pay a premium based on the small number of such employees.³⁵ Rather, the insurer offering a policy through the connector should price that policy based on the total number of insureds the insurer expects in the aggregate from all connector participants.³⁶

In effect, the connector is designed to function as a buying cooperative with lower premiums anticipated from the purchasing

31. Nina Owcharenko & Robert E. Moffit, *The Massachusetts Health Plan: Lessons for the States*, BACKGROUND NO. 1953 (Heritage Found., Washington, DC), July 18, 2006, at 4-5, available at <http://www.heritage.org/research/healthcare/bg1953.cfm>.

32. See *id.* at 6-7. An earlier version of the connector was initially proposed for the District of Columbia. See Lawrence H. Mirel & Edmund F. Haislmaier, *Doing It Right: The District of Columbia Health Insurance Market Reform* (April 6, 2006), in HERITAGE LECTURES NO. 936 (Heritage Found., Washington, DC), May 15, 2006, at 2-4, available at <http://www.heritage.org/research/healthcare/hl936.cfm>.

33. See Mirel & Haislmaier, *supra* note 32, at 2.

34. See *id.*

35. See *id.*

36. See *id.*

power which results from combining many individuals and smaller employers into a single, state-run insurance pool.

Although the connector acts as a pooling device, it is also intended to create and maintain a competitive market among the insurers offering coverage through the connector.³⁷ When an individual—or a small group—turns to the connector to purchase health care coverage, he will select from among one or more of the policies approved by the connector.³⁸ The result, connector advocates anticipate, will be a robust market operated through the connector as insurers compete for business by offering competing policies to the connector's participants.³⁹ The original model for the Massachusetts connector was denominated an "exchange,"⁴⁰ as is at least one subsequent proposal⁴¹ building from the Massachusetts connector. The term "exchange" captures more accurately the vision of a state-sponsored marketplace for insurance which underpins the Massachusetts connector.

As to health insurance that employers purchase through the connector, the design of the connector is intended to permit, for federal income tax purposes, employees to exclude from their respective gross incomes the value of employer premiums which the employers pay to the connector.⁴²

37. Owcharenko & Moffit, *supra* note 31, at 2-3.

38. *Id.*

39. *See id.* at 2.

40. *See* Mirel & Haislmaier, *supra* note 32, at 10.

41. INSTITUTE FOR HEALTH POLICY SOLUTIONS, COVERING CALIFORNIA'S UNINSURED: THREE PRACTICAL OPTIONS 34-38 (2006).

42. The IRS has not formally ruled on the excludability from employees' gross incomes of premiums that employers pay to the connector. However, advocates of the connector model indicate that they have had "extensive discussions" with the Treasury and are confident that insurance premiums paid by employers to the connector will be income tax free to the covered employees. *See* I.R.C. § 106 (West 1986); Mirel & Haislmaier, *supra* note 32, at 7; Robert E. Moffit, *The Rationale for a Statewide Health Insurance Exchange*, WEB MEMO NO. 1230 (Heritage Found., Washington, DC), Oct. 5, 2006, at 1-2, *available at* <http://www.heritage.org/research/healthcare/wm1230.cfm> ("In the case of a statewide health insurance exchange, employers would designate the health insurance exchange itself as their 'plan' for the purpose of the federal and state tax codes. Thus all defined contributions would be tax free, just as they would be for conventional employer-based health insurance."). I believe these advocates are correct. The fact that employer-paid health insurance premiums are channeled through the state-sponsored connector should not impair the tax-free status of those premiums to employees.

The connector is very much a work in progress. Most obviously, a reasonable time must elapse before we will know whether the connector has in practice implemented its sponsors' vision of a large scale marketplace that reduces health insurance premiums and increases the availability of coverage by pooling eligible individuals and employers as insurers compete for their business.

B. The Individual Mandate

The individual mandate imposed on Massachusetts residents is a second major feature of the new Massachusetts law.⁴³ For these purposes, the concept of Massachusetts residency is defined broadly.⁴⁴ Massachusetts residents with "sincerely held religious beliefs" against health insurance are excluded from the law's individual mandate,⁴⁵ as is any individual whom the connector certifies as having attempted to obtain connector-approved insurance but who is unable to obtain coverage "deemed affordable by the connector for said individual."⁴⁶

All other Massachusetts residents over the age of eighteen must, as of July 1, 2007, have creditable coverage for health care.⁴⁷ By statute, certain types of health care coverage are deemed per se creditable coverage and thus satisfy the Massachusetts health care

43. See MASS. GEN. LAWS ch. 111M (2007). Chapter 111M was added to the Massachusetts General Laws by section 12 of the new law. See *id.*

44. See *id.* § 1.

45. *Id.* § 3. First Amendment mavens will recognize a potential issue here: namely, whether the religious exemption from the individual mandate is a constitutional accommodation of the Free Exercise rights of those religiously opposed to insurance or is instead a narrow subsidization of religion that violates the Establishment Clause. For background on the constitutional status of tax-based exemptions for religious actors, see Edward A. Zelinsky, *Are Tax "Benefits" for Religious Institutions Constitutionally Dependent on Benefits for Secular Entities?*, 42 B.C. L. REV. 805 (2001); Edward A. Zelinsky, *Dr. Warren, the Parsonage Exclusion, and the First Amendment*, 95 TAX NOTES 115 (2002), reprinted in 36 TAX EXEMPT ORG. TAX REV. 185 (2002).

46. MASS. GEN. LAWS ch. 176Q 3(a)(5) (2007); see also MASS. GEN. LAWS ch. 111M, § 2(b)(iii) (2007). As noted *supra*, there are two versions of section 2(b) of chapter 111M. See *supra* note 29. Section 2(b)(iii), however, is identical in both versions. See *id.* For proposed regulations addressing the criteria for determining affordability, see 956 MASS. CODE REGS. 6.00 (proposed Apr. 12, 2007), available at <http://www.mass.gov/Qhlc/docs/956%20CMR%206.00%20Final%20060507.pdf>. See also Pam Belluck, *Massachusetts Agency Proposes Health Coverage that Most Can Afford*, N.Y. TIMES, Apr. 12, 2007, at A14.

47. MASS. GEN. LAWS ch. 111M, § 2(a) (2007).

mandate for individuals.⁴⁸ For example, Medicare and Medicaid coverage are automatically creditable for purposes of the individual mandate.⁴⁹ Similarly, “a medical care program of the Indian Health Service or of a tribal organization” constitutes creditable coverage per se.⁵⁰ If a Massachusetts resident is not covered by one of the statutorily identified forms of health care, he must obtain coverage from “an individual or group health plan which meets the definition of ‘minimum creditable coverage’ as established by the ... connector.”⁵¹

The connector has proposed regulations delineating the standards for minimum creditable coverage.⁵² Under the proposed regulations, starting on January 1, 2009, a health plan will satisfy the standards for minimum creditable coverage only if, inter alia, the plan both “provide[s] a broad range of medical benefits, including but not limited to, preventive and primary care, emergency services, hospitalization, ambulatory patient services, prescription drugs, and mental health services,” and complies with a variety of limits on deductibles and co-insurance.⁵³

Each Massachusetts resident will be required on his state income tax return⁵⁴ to indicate whether he had the creditable coverage required by statute, whether he claims religious exemption from the law’s individual mandate,⁵⁵ or whether he has been certified as having unsuccessfully attempted to obtain affordable connector-

48. *See id.* § 1.

49. *Id.*

50. *Id.*

51. *Id.*

52. *See* 956 MASS. CODE REGS. 5.00 (proposed Apr. 12, 2007), *available at* <http://www.mass.gov/Qhic/docs/956%20CMR%205.00%20Final%20060507.pdf>.

53. *Id.* at 5.03(2).

54. This use of the Massachusetts resident income tax return demonstrates the utility of the tax system as an efficient, pre-existing system for communications between the government and the public. Massachusetts could have created a new, separate system for Massachusetts residents to report their compliance with the individual mandate of the new health law. It is more efficient, however, for Massachusetts to use the already existing income tax system instead. *See* Edward A. Zelinsky, *Efficiency and Income Taxes: The Rehabilitation of Tax Incentives*, 64 TEX. L. REV. 973 (1986). Other proposals would have other states emulate Massachusetts’ use of its tax system to enforce individual mandates. *See, e.g.*, George C. Halvorson, Francis J. Crosson & Steve Zatzkin, *A Proposal to Cover the Uninsured in California*, 26 HEALTH AFF. W80 (2007), <http://content.healthaffairs.org/cgi/content/abstract/26/1/W80>.

55. *See* MASS. GEN. LAWS ch. 111M, § 3 (2007).

based coverage.⁵⁶ If a Massachusetts resident who is legally obligated to carry creditable health coverage does not do so, he will be subject to a financial penalty.⁵⁷ For the period from July 1 through December 31, 2007, the penalty will equal the incremental state income tax increase resulting from the disallowance of the uninsured resident's personal exemption.⁵⁸ Starting on January 1, 2008, the penalty for failure to carry mandated health insurance will be assessed monthly up to "50 per cent of the minimum insurance premium for creditable coverage" during such month.⁵⁹ All penalties assessed will go to the Commonwealth Care Trust Fund⁶⁰ which, as discussed below, finances the new Commonwealth Care Health Insurance Program.⁶¹

C. The Employer Mandates

A third major feature of the structure established by the new Massachusetts health law consists of the employer mandates imposed by that law. Every Massachusetts employer with more than ten employees must maintain a cafeteria plan.⁶² To the general public, perhaps the best known version of a cafeteria plan consists of so-called flexible spending accounts (FSA).⁶³ Under section 125 of the Internal Revenue Code, employees who participate in employer-established cafeteria plans may elect to exclude from their respective gross incomes the portion of their compensation used to pay for certain income tax-free fringe benefits.⁶⁴ These elective tax-

56. *Id.* § 2(b).

57. *Id.*

58. *Id.* § 2(b) (as added by section 12 of the new Massachusetts statute).

59. *Id.* § 2(b) (as added by sections 13 and 147 of the new Massachusetts statute).

60. *Id.* § 2(c).

61. *See infra* Part I.D.

62. MASS. GEN. LAWS ch. 151F, § 2 (2007) (as added by section 48 of the new Massachusetts statute).

63. For background on FSAs, see Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 YALE L. J. 451, 489-90 (2004) [hereinafter Zelinsky, *Defined Contribution*]; Edward A. Zelinsky, *Defined Contribution Plans After Enron: Exploring a Paradigm Shift*, in N.Y.U. REV. OF EMP. BENEFITS & EXECUTIVE COMP. §§ 1.01, 1.02[4] (Alvin D. Lurie ed., July 2004) [hereinafter Zelinsky, *Paradigm Shift*].

64. I.R.C. § 125 (2000).

free fringe benefits may include qualifying medical costs like premiums, co-payments and deductibles.⁶⁵

Under the new Massachusetts health law, employers' statutorily mandated cafeteria plans must be filed with the connector and must satisfy "rules and regulations" established by the connector.⁶⁶ The regulations promulgated by the connector provide that Massachusetts employers' cafeteria plans must enable their employees to elect to reduce their taxable compensation to defray on a pre-tax basis the premiums such employees are required to pay under their respective employers' medical plans.⁶⁷ Employers' cafeteria plans may also permit participating employees to defray on a tax-free basis any co-payments and deductibles such employees must pay.⁶⁸

In addition, every employer that "employs 11 or more full-time equivalent employees" in Massachusetts⁶⁹ must make "a fair and

65. I.R.C. § 125(f) (2000).

66. MASS. GEN. LAWS ch. 151F, § 2 (2007).

67. 956 MASS. CODE REGS. 4.00 (2007). In particular, see 956 MASS. CODE REGS. 4.07(3)(a) (2007) ("A Section 125 Cafeteria Plan must, at a minimum, be a premium only plan offering access to one or more medical care coverage options in lieu of regular cash compensation."). Employers that pay the full cost of their employees' medical premiums need not maintain cafeteria plans. *Id.* at 4.05(2)(e).

68. The new Massachusetts law imposes a "free rider surcharge" upon any employer if its employees and their dependents, in any year, use more than \$50,000 "in free care services" financed by Massachusetts. MASS. GEN. LAWS ch. 1186, § 18B (2007). Such employers can avoid this surcharge, however, if they "arrange for the purchase of health insurance, including coverage through the connector." *See id.* § 1 (as amended by section 32 of the new Massachusetts health law); *id.* § 18B (added by section 44 of the new Massachusetts health law).

In practice, any employer complying with the statutory mandate to maintain a cafeteria plan for its employees can thereby avoid the "free rider surcharge" by "arrang[ing]" via the cafeteria plan for employees to buy connector-based insurance with pre-tax salary reductions.

69. MASS. GEN. LAWS ch. 149, § 188(b) (2007) (as added to the General Laws by section 47 of the new Massachusetts statute). By design or oversight, the new Massachusetts health law lacks any requirement that employers under common control be aggregated for purposes of the new law. Consequently, if the same individual is the sole shareholder of two corporations, each employing ten employees, neither corporation is subject to the new law's employer mandates; this is true even though, considered as a single economic unit, these commonly controlled corporations employ twenty persons and would be subject to the law. In contrast, under the Internal Revenue Code, businesses under common ownership are treated as a single entity for pension purposes. *See* I.R.C. §§ 414(b), 414(c), 414(m)(1), 414(n)(1), 414(o) (2000).

reasonable premium contribution”⁷⁰ to “a group health plan”⁷¹ that the employer must “offer”⁷² to its employees. An employer that fails to offer such a plan or that fails to make the required contribution to such a plan must instead pay a “fair share employer contribution”⁷³ to the Commonwealth Care Trust Fund.⁷⁴ For these purposes, the Massachusetts law defines the plan a covered employer must offer by incorporating the definition of “group health plan” promulgated in section 5000(b)(1) of the Internal Revenue Code.⁷⁵ That definition specifically includes an employer’s “self-insured plan.”⁷⁶ A Massachusetts employer’s self-funded plan can thus satisfy the employer’s legal obligations to “offer” medical coverage to its employees and to make fair and reasonable contributions toward such coverage.

Under the Massachusetts law, the Massachusetts division of health care finance and policy defines by regulation the standard of “a fair and reasonable premium contribution.”⁷⁷ Pursuant to its regulatory authority, the division has promulgated two alternative tests for determining whether a Massachusetts employer makes a fair and reasonable premium contribution for its employees.⁷⁸ If at least 25 percent of an employer’s full-time employees are actually enrolled in the employer’s health plan, the employer is deemed to be making a fair and reasonable premium contribution.⁷⁹ Alternatively, if an employer offers to pay at least 33 percent of the premium cost for each full-time employee’s health coverage, the employer is deemed to be making a fair and reasonable premium contribution.⁸⁰

For an employer with eleven or more full-time employees that fails to pay fair and reasonable premium contributions, the director of the Massachusetts Department of Labor will calculate that

70. MASS. GEN. LAWS ch. 149, § 188(a) (2007).

71. *Id.*

72. *Id.*

73. *Id.* § 188(b).

74. *Id.* § 188(d).

75. *See id.* § 188(a).

76. I.R.C. § 5000(b)(1) (2000).

77. MASS. GEN. LAWS ch. 149, § 188(a) (2007).

78. *See* 114.5 MASS. CODE REGS. 16.03(1) (2007).

79. *Id.* at 16.03(1)(a).

80. *Id.* at 16.03(1)(b).

employer's respective portion of the Bay State's costs for its "Uncompensated Care Pool, which reimburses hospitals and community health centers (CHCs) for care provided to lower-income uninsured and underinsured people."⁸¹ As a penalty for failing to satisfy the statutory mandate to make "fair and reasonable" contributions for its employees' medical coverage, the employer must pay to the Commonwealth Care Trust Fund an amount equal to this cost for uncompensated medical care.⁸² Under no circumstances, however, can an employer's annual fair share contribution to the Commonwealth Care Trust Fund exceed \$295 per employee.⁸³

D. The Commonwealth Care Health Insurance Program

The Commonwealth Care Trust Fund finances a fourth major element of the structure created by the new Massachusetts law: the Commonwealth Care Health Insurance Program.⁸⁴ This program will enable low-income Massachusetts residents not receiving health care through other government programs⁸⁵ to purchase subsidized coverage through the connector. For these purposes, a Massachusetts resident is eligible to purchase subsidized, connector-based insurance if he has resided in Massachusetts for at least six months⁸⁶ and has an individual or family income no greater than "300 per cent of the federal poverty level."⁸⁷ If such a low-income resident does not have available adequate work-related medical coverage,⁸⁸ he will be able to purchase health insurance

81. John E. McDonough, Brian Rosman, Fawn Phelps & Melissa Shannon, *The Third Wave of Massachusetts Health Care Access Reform*, 25 HEALTH AFF. W420, W422 (2006), <http://content.healthaffairs.org/cgi/content/abstract/25/6/W420>; see also MASS. GEN. LAWS ch. 149, § 188(c) (2007).

82. MASS. GEN. LAWS ch. 149, § 188(d) (2007).

83. *Id.* § 188(c)(10).

84. The Massachusetts General Laws establish the Commonwealth Care Health Insurance Program in chapter 118H. Chapter 118H was added to the general laws by section 45 of the new Massachusetts health law. See *id.*

85. See *id.* § 3(a)(3).

86. *Id.* § 3(a)(2).

87. *Id.* § 3(a)(1).

88. See *id.* § 3(a)(4).

through the connector “under a sliding-scale premium contribution payment schedule” to be determined by the board of the connector.⁸⁹

From the resources of the Commonwealth Care Trust Fund, the connector will pay “premium contribution payment[s]” to insurers offering coverage through the connector.⁹⁰ These payments will subsidize the health care insurance of eligible low-income individuals purchasing such insurance through the sliding-scale premium contribution schedule established by the connector. If the resources of the trust fund—i.e., penalty payments from individuals and employers failing to maintain mandated health coverage—“are insufficient to meet the projected costs of enrolling new eligible individuals” in the Commonwealth Care Health Insurance Program, the program will be closed to new participants.⁹¹

II. THE NEW LAW AS PARTISAN AND IDEOLOGICAL COMPROMISE

Proponents of the new Massachusetts law universally praise the legislation as cutting across partisan and ideological lines.⁹² Those claims are justified; enacted by a Democratic legislature and signed by a Republican governor, the new law eclectically combines elements from different prescriptions for reforming health care finance.

Particularly evident is the influence upon the Massachusetts law of those who believe in strengthening market forces in the provision of medical insurance.⁹³ The most innovative feature of the new

89. *Id.* § 2; see also 956 MASS. CODE REGS. 3.00 (proposed Apr. 12, 2007), available at <http://www.mass.gov/Qhic/docs/956%20CMR%203.00%20Final%20060507.pdf>.

90. See MASS. GEN. LAWS ch. 118H, §§ 1, 5.

91. See *id.* § 5.

92. See, e.g., McDonough et al., *supra* note 81 (calling the legislation “an unusually bipartisan and bi-ideological flavor”); Elizabeth A. McGlynn & Jeffrey Wasserman, *Massachusetts Health Reform: Beauty Is In the Eye of the Beholder*, 25 HEALTH AFF. W447 (2006), <http://content.healthaffairs.org/cgi/content/abstract/25/6/W447> (asserting that the Massachusetts law embodies “bi-partisan solutions”); Nancy C. Turnbull, *The Massachusetts Model: An Artful Balance*, 25 HEALTH AFF. W453, W453 (2006), <http://content.healthaffairs.org/cgi/content/abstract/25/6/W453> (arguing that the Massachusetts health law “transcends political ideology”).

93. For two recent statements of this position, see JOHN F. COGAN, R. GLENN HUBBARD & DANIEL P. KESSLER, HEALTHY, WEALTHY & WISE: FIVE STEPS TO A BETTER HEALTH CARE SYSTEM 35-38 (2005) (favoring expansion of health savings accounts because “public policy should, whenever possible, allow individual preferences rather than government mandates

Massachusetts law—the health care connector—is envisioned as a large scale marketplace in which individuals and small employers will purchase insurance in a competitive environment. In this environment, market forces, reinforced by the large population expected to be served by the connector, are anticipated to reduce premiums for and increase the availability of health insurance.

The design of the Commonwealth Care Health Insurance Program similarly reflects a market-based approach to medical insurance. This program is the health care analogue of food stamps, a government subsidy that underwrites the recipient's participation in the marketplace. Those low-income individuals eligible for the program will, on a subsidized basis, purchase commercial insurance via the connector's marketplace. The subsidization of their insurance will take the form of lower prices under the income-based sliding scale for premiums, a scale to be established by the board of the connector.

Another interesting, but not widely noted, market-oriented feature of the connector is the ability of nonemployer groups, such as churches, labor unions, and fraternal organizations, to obtain health insurance for their respective members through the connector.⁹⁴ For those seeking to de-emphasize the current link between health care coverage and employment, this feature represents a return to the status quo ante, before employer-provided health insurance became as pervasive as it is today. In that earlier world, or at least a nostalgic reconstruction of that world, individuals as health insurance consumers could shop for health insurance from a variety of alternative sources including unions, churches, and civic organizations sponsoring such insurance. Through the connector, these nonemployer groups will theoretically be able to offer their members competitively priced health insurance.

Given the tax benefits associated with employer-provided medical insurance—employer-paid premiums are excluded from employees'

to determine people's health-insurance arrangements"); SALLY C. PIPES, *MIRACLE CURE: HOW TO SOLVE AMERICA'S HEALTH CARE CRISIS AND WHY CANADA ISN'T THE ANSWER* 96 (2004) (“[A] switch to consumer-driven policies will reduce costs, which in turn will allow health care providers to offer greater quality. The consumer revolution in health will not only bring benefits to patients. It will benefit employers as well.”).

94. See MASS. GEN. LAWS ch. 176a, §§ 1, 4 (2006).

gross incomes⁹⁵—it is unlikely that individuals with the option of employer-based coverage will instead elect coverage through nonemployer groups. However, some uninsured Massachusetts residents without the option of work-based coverage, typically persons who work for employers with less than the eleven employees necessary to trigger the employer mandates,⁹⁶ may find it more attractive to acquire insurance through these nonemployer groups, rather than purchasing such coverage from the connector individually.

No doubt some connector advocates envision the market orientation of the connector going even further than the statute on its face suggests. These connector supporters anticipate that some, perhaps many, of the policies to be offered through the connector will be what are now known as “consumer driven” health care policies.⁹⁷ Among such consumer driven health devices are health savings accounts (HSAs), IRA-like accounts devoted to medical outlays.⁹⁸ An HSA allows the account holder to expend funds under his control from the HSA for routine medical care while high deductible insurance covers the HSA holder for large and unexpected medical events.⁹⁹ In another variant, consumer driven health devices take the form of health reimbursement arrangements (HRAs).¹⁰⁰ HRAs also enable the covered individual to pay for routine medical expenses through the HRA account, rather than relying on insurance or other third party payment.¹⁰¹ Some supporters of the Massachusetts connector likely expect that some, perhaps many, of

95. See I.R.C. § 106 (2000) (excluding from employees' gross incomes the value of employer-provided medical coverage). Individually purchased insurance is effectively nondeductible for most persons because an individual's medical outlays, including insurance premiums, can only be deducted to the extent such outlays exceed 7.5 percent of adjusted gross income. See *id.* § 213(a). Individual payments through an employer's cafeteria plans, however, are made with pre-tax dollars. See *id.* § 125.

96. See MASS. GEN. LAWS ch. 149, § 188(b) (2006).

97. See, e.g., Moffit, *supra* note 42, at 2 (“A properly designed health insurance exchange would function as a single market for all kinds of health insurance plans, including traditional insurance plans, health maintenance organizations, health savings accounts, and other new coverage options that might emerge in response to consumer demand.”).

98. On HSAs, see Zelinsky, *Defined Contribution*, *supra* note 63, at 508-09; Zelinsky, *Paradigm Shift*, *supra* note 63, at § 1.02[8].

99. See Zelinsky, *Defined Contribution*, *supra* note 63, at 508.

100. See *id.* at 506-07; Zelinsky, *Paradigm Shift*, *supra* note 63, at § 1.02[7].

101. See Zelinsky, *Paradigm Shift*, *supra* note 63, at § 102[7].

the policies to be offered through the connector will utilize HSAs or HRAs, thereby driving Massachusetts health care further toward a market-based orientation.

Offsetting the market-based features of the Massachusetts law are the mandates that the new law imposes upon individuals and employers. Among other concerns, these mandates respond to the problem of adverse selection,¹⁰² that is, the concern that under a purely voluntary insurance system, healthy individuals eschew such insurance as not worth the cost. The nonparticipation of these healthy individuals leaves the remaining participants in the insurance pool less fit on average, which in turn elevates premiums.¹⁰³ Higher premiums then trigger a vicious cycle in which yet more healthy individuals make a price-stimulated decision to drop insurance coverage, which further segregates those less robust in the insurance pool, which further increases premiums, *ad infinitum*.¹⁰⁴

The new individual mandate established by the Massachusetts law combats this cycle of adverse selection by forcing all Massachusetts residents to obtain medical coverage.¹⁰⁵ This prevents healthy persons from dropping out of the medical insurance pool. At the same time, the employer mandate guarantees that many, perhaps most, individuals will receive the legally required coverage at the workplace.

Although the design of the new Commonwealth Care Health Insurance Program is market-oriented in critical respects, the program also represents a significant expansion of public subsidy to individuals who are ineligible for Massachusetts Medicaid but have incomes less than three times the poverty level.¹⁰⁶

102. MICHAEL J. GRAETZ & JERRY L. MASHAW, *TRUE SECURITY: RETHINKING AMERICAN SOCIAL INSURANCE* 16 (1999) (defining adverse selection as “the tendency of those at high risk to be overrepresented in the insurance pool”); DAVID A. MOSS, *WHEN ALL ELSE FAILS: GOVERNMENT AS THE ULTIMATE RISK MANAGER* 36 (2002) (characterizing adverse selection as “good risks (i.e., healthy individuals) leaving the insurance pool” with “too many bad risks entering it”).

103. *See* GRAETZ & MASHAW, *supra* note 102, at 16-17.

104. *See id.*

105. *See* MASS. GEN. LAWS ch. 111M, § 2(a) (2007).

106. *See* MASS. GEN. LAWS ch. 118H, § 3(a)(1) (2007).

The compromises embedded in the new Massachusetts law have left some unimpressed. Critics with a libertarian bent have attacked the new law as a step toward “a government-run national health care system.”¹⁰⁷ At the other end of the spectrum, the advocates of a Canadian-style single payer system view the market based features of the new Massachusetts law as moving health care policy in the wrong direction, though the direction they prefer is an expanded role for government.¹⁰⁸

Most of those supporting the compromises embedded in the new Massachusetts law temper their sense of self-congratulation with the more sober recognition that the successful implementation of the new law is by no means assured.¹⁰⁹ Most obviously, the connector is a new and unique device. No one will know if it will work as intended until there is sufficient experience in its actual operation. Similarly, nothing like the new law’s individual and employer mandates has ever been tried before. The practical enforceability of those mandates is very much an open question,¹¹⁰ as is the financing of the new subsidized health care program. Will there be enough funds in the Commonwealth Care Trust Fund to finance significant benefits for low income persons? The new law

107. Patricia Barry, *Coverage for All*, AARP BULLETIN, July-Aug. 2006, at 8, 9 (quoting Michael Tanner of the Cato Institute); see also Grace-Marie Turner, *Universal Health Care: Proceed with Caution*, GALEN INST., Feb. 5, 2007, <http://www.galen.org/statehealth.asp?docID=1002> (“Gov. Romney had a vision of creating a competitive marketplace for affordable health insurance.... But the compromises demanded by the heavily Democratic state legislature are jeopardizing its success.”); Sally C. Pipes, Commentary, *Mass Medical Mess*, WASH. TIMES, Nov. 5, 2006, at B3.

108. Barry, *supra* note 107, at 8-9 (citing Dr. David Himmelstein); see also Dr. Michael Hochman & Dr. Steffie Woolhandler, Op-Ed, *Healthy Skepticism*, BOSTON GLOBE, Oct. 28, 2006, at A11 (“The answer lies in an alternative proposal: single-payer national health insurance. Australia and Canada already use this approach.”).

109. See, e.g., John Holahan & Linda Blumberg, *Massachusetts Health Care Reform: A Look at the Issues*, 25 HEALTH AFF. W432, W442 (2006), <http://content.healthaffairs.org/cgi/content/abstract/25/6/W432> (“The Massachusetts health reform plan is potentially of enormous consequence. If it is implemented successfully....”); John E. McDonough et al., *supra* note 81, at W422-23 (noting the law “will take years to implement and evaluate for its true impact”); Turnbull, *supra* note 92, at W456 (“Health reform in Massachusetts is very much a work in progress.”).

110. See, e.g., Todd Wallack & Mark Hollmer, *Light Fines May Hamper New Health Law*, BOSTON BUS. J., Nov. 11, 2006 (“Experts say penalties are so slight that relatively few additional Bay State companies will start offering health insurance. Similarly, thousands of individuals could refuse to sign up for health insurance, figuring they either can’t afford the premiums or that it’s cheaper to pay the fines.”).

reflects an awareness that the law's penalties might in practice yield inadequate financing because the Commonwealth Care Health Insurance Program will be closed to new enrollees if the trust fund financing the program becomes depleted.¹¹¹ The program is thus not a classic entitlement but rather a first come, first served queue to which will be extended subsidized health coverage through the connector as long as the money does not run out.

III. ERISA PREEMPTION AND THE MASSACHUSETTS HEALTH LAW

A. *ERISA Preemption: An Overview*

A definitive assessment of the new Massachusetts law in terms of health care policy must await the actual implementation of the new law. However, the key legal question presented by the new law can—and should—be confronted now: Did Massachusetts have the authority to enact its new health law? In significant measure, it did not. ERISA preempts the new Massachusetts health law insofar as the Massachusetts law mandates covered employers to offer medical plans and to make “fair and reasonable” contributions to such plans. ERISA also preempts the new statute insofar as the statute effectively requires Massachusetts employers to maintain “minimum creditable coverage” for health care to discharge their employees’ obligations under the individual mandate. These statutory mandates impact employer-provided health care plans in ways forbidden by ERISA section 514(a).

The saga of ERISA preemption is a much-told story,¹¹² which begins with section 514(a), added to ERISA at the very end of a protracted legislative process.¹¹³ With beguiling simplicity, section

111. See MASS. GEN. LAWS ch. 118H, § 5 (2007).

112. For my telling of this story see Edward A. Zelinsky, *Travelers, Reasoned Textualism, and the New Jurisprudence of ERISA Preemption*, 21 CARDOZO L. REV. 807 (1999) [hereinafter *Zelinsky, Reasoned Textualism*]. See also LAWRENCE A. FROLIK & KATHRYN L. MOORE, *LAW OF EMPLOYEE PENSION AND WELFARE BENEFITS* 189 (2004); JOHN H. LANGBEIN, SUSAN J. STABILE & BRUCE A. WOLK, *PENSION AND EMPLOYEE BENEFIT LAW* 758 (4th ed. 2006); JAMES A. WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY* 281-85 (2004).

113. WOOTEN, *supra* note 112, at 281.

514(a)¹¹⁴ states that the provisions of ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan” regulated by ERISA.¹¹⁵ In practice, determining the contours of section 514(a) has been anything but simple.

For over a decade, the U.S. Supreme Court applied section 514(a) capaciously, interpreting that provision as preempting virtually any state law touching upon an employee benefit plan. The Court first articulated this broad understanding of ERISA section 514(a) and its preemptive effect in *Shaw v. Delta Air Lines, Inc.*¹¹⁶ In *Shaw*, the Court held that ERISA section 514(a) invalidated New York state statutes requiring employers to pay pregnancy-related disability benefits on the grounds that such statutes had “a connection with or reference to” ERISA regulated plans, that is, employers’ programs of paying disability benefits to their employees.¹¹⁷

ERISA also embodies an expansive concept of what constitutes an employee benefit plan. Specifically, ERISA defines an “employee welfare benefit plan” as “any plan, fund, or program which ... was established or is maintained for the purpose of providing ..., through the purchase of insurance or otherwise,” enumerated fringe benefits including “medical, surgical, or hospital care or benefits.”¹¹⁸

This combination—the broad *Shaw* standard for ERISA preemption (a state law is preempted if the law has a connection with or reference to an ERISA regulated plan) along with the low threshold for finding an employee benefit plan to exist for ERISA purposes—led the Supreme Court to strike under section 514(a) an array of state laws insofar as such laws touched upon employee benefit plans.¹¹⁹

When the expansive *Shaw* standard proved problematic, the Supreme Court, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,¹²⁰ narrowed its under-

114. ERISA section 514 is codified at 29 U.S.C. § 1144 (2000).

115. ERISA § 514(a), 29 U.S.C. § 1144(a) (2000).

116. 463 U.S. 85 (1983).

117. *Id.* at 96-97.

118. ERISA § 3(1), 29 U.S.C. § 1002(1) (2000).

119. See Zelinsky, *Reasoned Textualism*, *supra* note 112, at 815-27 (citing *Shaw*, 463 U.S. at 96-97).

120. 514 U.S. 645 (1995).

standing of ERISA section 514(a) and its “relate to” terminology.¹²¹ The Court has been unwilling so far to acknowledge fully the tension between *Shaw* and *Travelers*. Even under *Travelers*, however, ERISA preemption retains great force in particular contexts. Specifically, under *Travelers*, state laws that “mandate[] employee benefit structures or their administration” are preempted under section 514(a) as relating to ERISA regulated benefit plans.¹²² A state law need not explicitly mandate employee benefit structures to run afoul of section 514(a). Rather, *Travelers* indicates that a state law is ERISA preempted if that law “produce[s] such acute, albeit indirect, economic effects ... as to force an ERISA plan to adopt a certain scheme of substantive coverage.”¹²³

ERISA section 514(b)(2)(A) protects from ERISA preemption certain categories of state laws, including any state law that “regulates insurance.”¹²⁴ ERISA section 514(b)(2)(B), often called the “deemer clause,”¹²⁵ cabins this protection for insurance regulation by precluding a state from deeming an employer-sponsored benefit plan to be an insurance company and thus subject to state regulation as such.¹²⁶ The deemer clause thereby “exempt[s] self-funded ERISA plans from state laws that ‘regulate insurance.’”¹²⁷

This statutory framework may compel as many as three steps to determine if a particular state law is ERISA preempted. As a first step, under section 514(a) a state law is presumptively ERISA preempted if such law relates to an ERISA regulated plan, such as employer-provided medical coverage.¹²⁸ At the second step, however, an otherwise preempted state law is saved under section 514(b)(2)(A) if it falls into one of the protected categories, including insurance regulation.¹²⁹ At the third stage, an insurance regulation otherwise protected from preemption forfeits such protection if the

121. *See id.* at 655-56.

122. *Id.* at 658.

123. *Id.* at 668.

124. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (2000).

125. *See, e.g., FMC Corp. v. Holliday*, 498 U.S. 52, 56 (1990).

126. *See* ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (2000).

127. *FMC Corp.*, 498 U.S. at 61.

128. *See* ERISA § 514(a), 29 U.S.C. § 1144(a) (2000).

129. *See id.* § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (2000).

regulation also governs self-funded employer plans that eschew insurance.¹³⁰

The upshot of this complex legal structure is adverse for the new Massachusetts health law because key features of the new law relate to employer plans in violation of section 514(a).¹³¹ The new law's employer mandates, requiring covered employers to offer medical coverage to their employees and to make fair and reasonable contributions for such coverage,¹³² relate to employers' ERISA regulated medical plans in ways forbidden by ERISA. Similarly, the new law's individual mandate, via its concept of minimum creditable coverage,¹³³ relates to employers' ERISA regulated medical plans by effectively requiring these plans to constitute such minimum coverage to discharge employees' obligations under the individual mandate.¹³⁴

B. The Employer Contribution Mandate

Consider first the new law's requirement that every employer that "employs 11 or more full-time equivalent employees" in Massachusetts¹³⁵ must make "a fair and reasonable premium contribution"¹³⁶ to "a group health plan"¹³⁷ for its employees. If such an employer fails to make the required contribution for employee health care, the employer must instead pay yearly a "fair share employer contribution"¹³⁸ to the Commonwealth Care Trust Fund¹³⁹ up to \$295 per employee.¹⁴⁰ Under both *Shaw* and *Travelers*, this statutory mandate is ERISA preempted.

130. See *FMC Corp.*, 498 U.S. at 52; see also ERISA § 514(b)(2)(B) (2000).

131. See ERISA § 514(a), 29 U.S.C. § 1144(a) (2000).

132. See *supra* Part I.C.

133. See *supra* Part I.B.

134. As noted *infra*, ERISA does not preempt the new law's requirement that covered employers maintain cafeteria plans for their employees. See *infra* Part III.C.

135. MASS. GEN. LAWS ch. 149, § 188(b) (2007) (as added by Section 47 of the new Massachusetts statute).

136. *Id.* § 188(a).

137. *Id.*

138. *Id.* § 188(b).

139. *Id.* § 188(d).

140. *Id.* § 188(c)(10).

Under the expansive *Shaw* reading of section 514(a) and its “relate to” clause, this statutory mandate is ERISA preempted because the mandate both refers to and has a connection with employers’ ERISA regulated plans for providing medical care.¹⁴¹ Instructive in this regard are an early case in the *Shaw* line, *Metropolitan Life Insurance Co. v. Massachusetts*,¹⁴² as well as the last of *Shaw*’s progeny, *District of Columbia v. Greater Washington Board of Trade*.¹⁴³

In *Metropolitan Life*, insurers challenged as ERISA preempted a Massachusetts statute that requires health insurance policies sold in Massachusetts to encompass prescribed mental health benefits including hospital coverage for mental illnesses and outpatient services for such illnesses.¹⁴⁴ In *Metropolitan Life*, the U.S. Supreme Court held that, per *Shaw*, the Massachusetts statute relates to employers’ medical plans under section 514(a) because the Massachusetts statute “bears indirectly but substantially on all insured benefit plans, for it requires them to purchase the mental-health benefits specified in the statute when they purchase a certain kind of common insurance policy.”¹⁴⁵ However, the Court continued, the Massachusetts statute regulates only insurance contracts and does not reach self-funded employer plans, which eschew such insurance by financing employees’ medical benefits out of employers’ general funds.¹⁴⁶ Hence, at the second step of the analysis under section 514(b), the mental health mandate statute survives ERISA preemption as a regulation of insurance.¹⁴⁷

In two respects, the new Massachusetts health law is different from the Massachusetts statute at issue in *Metropolitan Life*. Both differences indicate that the new law, unlike Massachusetts’ earlier mental health statute, is ERISA preempted. First, the new Massachusetts law constitutes direct regulation of employers’ plans, not indirect oversight of such plans via the insurance policies such

141. See ERISA § 514(a), 29 U.S.C. § 1144(a) (2000).

142. 471 U.S. 724 (1985).

143. 506 U.S. 125 (1992).

144. *Metro. Life*, 471 U.S. at 729-31.

145. *Id.* at 739.

146. *Id.* at 739-47.

147. See *id.*

plans may purchase. The new Massachusetts statute requires all covered employers to offer health plans and to make fair and reasonable premium contributions to such plans.¹⁴⁸ If, under *Metropolitan Life*, the regulation of policies that employer plans may or may not purchase relates to such plans, a fortiori the new law's direct and explicit regulation of employers' plans and the contributions to them also relates to such plans and thus runs afoul of section 514(a) and ERISA preemption.

Second, the Massachusetts health law explicitly applies to employers' contributions to self-funded health plans.¹⁴⁹ In *Metropolitan Life*, the state statute mandating mental health benefits was saved from ERISA preemption because, at the second step under section 514(b), that statute only applied to insurance contracts and thus constituted permitted insurance regulation under section 514(b)(2)(A).¹⁵⁰ In contrast, the new Massachusetts health law mandates fair and reasonable premium contributions to employers' self-funded plans,¹⁵¹ as well as to plans which use insurance. Under section 514, the new mandate's coverage of employers' self-funded arrangements disqualifies the Massachusetts law as insurance regulation, leaving the law ERISA preempted under section 514(a).

Specifically, the new statute's requirement of fair and reasonable premium contributions applies to each covered employer's group health plan as defined by section 5000(b)(1) of the Internal Revenue Code.¹⁵² That code section, in turn, incorporates within its definition of a group health plan any "self-insured plan."¹⁵³ Consequently, a Massachusetts employer with eleven or more full-time employees that purchases no health insurance for its employees and instead fully finances health benefits from the employer's general funds must satisfy the new statute's requirement of fair and reasonable

148. MASS. GEN. LAWS ch. 149, § 188(a) (2007).

149. *See id.*

150. *See Metro. Life*, 471 U.S. at 739-47.

151. *See* MASS. GEN. LAWS ch. 149, § 188(a) (2007). Although it is technically inelegant to refer to "premium[s]" paid to self-funded plans, the import of the statute is clear: Employers that self-fund medical coverage for their employees must make financial contributions for such coverage the same as do employers that provide medical coverage by purchasing insurance. *See id.*

152. *See* MASS. GEN. LAWS ch. 149, § 188(a) (2007).

153. *See* I.R.C. § 5000(b)(1) (2000).

premium contributions to that self-funded plan.¹⁵⁴ Per the deemer clause, section 514(b)(2)(B), the applicability of the new mandate to self-insured plans precludes the protection from ERISA preemption of section 514(b).¹⁵⁵

In short, under *Metropolitan Life* and that decision's application of the *Shaw* standard, the Massachusetts statute's employer mandate—fair and reasonable contributions—regulates employers' medical plans directly and explicitly. By including self-funded plans within the ambit of that direct and explicit regulation, the Massachusetts statute triggers ERISA preemption under section 514(a) without the protection of section 514(b) for state laws limited to insurance.

A similar conclusion flows from the last of the *Shaw*-based cases. In *Washington Board of Trade*, a District of Columbia statute required any employer providing medical insurance to its employees to provide "equivalent" insurance to any injured employee who "receives or is eligible to receive workers' compensation benefits."¹⁵⁶ Invoking *Shaw* and its "connection with or reference to" standard,¹⁵⁷ the Court held that the D.C. law "specifically refers to welfare benefit plans regulated by ERISA," that is, employers' arrangements for employee health care.¹⁵⁸ "[O]n that basis alone," the Court reasoned, the D.C. workers' compensation statute is ERISA preempted under Section 514(a) as relating to employers' ERISA regulated medical plans.¹⁵⁹

In *Washington Board of Trade*, the D.C. statute did not purport to regulate an employer's ERISA governed medical plan but merely used such plan as a yardstick, the standard for determining mandatory medical coverage for injured employees receiving or eligible to receive workers' compensation.¹⁶⁰ That statutory reference to employers' ERISA regulated medical plans was enough to

154. See MASS. GEN. LAWS ch. 149, § 188(a) (2007).

155. See ERISA § 514(b), 29 U.S.C. § 1144(b) (2000).

156. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 128 (1992) (quoting D.C. CODE ANN. § 36-307(a-1)(1) (Supp. 1992)).

157. See *id.* at 130 n.1.

158. *Id.* at 130.

159. *Id.*

160. See *Greater Wash. Bd. of Trade*, 506 U.S. at 130-31.

trigger the *Shaw* standard for ERISA preemption.¹⁶¹ In contrast, the new Massachusetts health law does not merely refer to employers' medical plans for their employees but goes further, regulating the substance of such plans. Specifically, the new Massachusetts health law mandates that employer-sponsored medical plans must be offered and must receive from the sponsoring employer fair and reasonable premium contributions.¹⁶² If the mere reference to employers' medical plans in the D.C. statute was enough to preempt that statute, a fortiori ERISA section 514(a) also preempts the new Massachusetts statute which both refers to and regulates the substance of such plans.¹⁶³

In the context of the Maryland Wal-Mart statute, Maryland's Attorney General argues, inter alia, that that statute pertains to employers' contributions, not to employers' plans.¹⁶⁴ Consequently, his argument continues, the Maryland statute survives ERISA preemption because section 514 only invalidates state laws as they relate to plans, not as such state laws relate to employers' contributions.¹⁶⁵

In important respects, the Massachusetts law is different from the Maryland Wal-Mart Act. The Massachusetts statute specifies that a covered employer, one with eleven or more full-time employees,¹⁶⁶ must offer a group health plan¹⁶⁷ as well as make required contributions to that plan.¹⁶⁸ The Bay State's statute, like the D.C. workers' compensation law, thus explicitly describes employers' ERISA regulated medical plans in a way the Maryland Act does not.

Even if the new Massachusetts law did not explicitly mention employers' medical plans this way, for the same reasons the Maryland Attorney General's argument is unavailing as to the Wal-Mart law, the argument is also unavailing as to the Massachusetts health statute: Employers' ongoing contributions for their employ-

161. See *supra* note 117 and accompanying text.

162. See MASS. GEN. LAWS ch. 149, § 188(a) (2007).

163. A similar analysis applies to Maryland's "Wal-Mart" law. See Zelinsky, *Wal-Mart*, *supra* note 6, at 853-54.

164. See *id.* at 854.

165. See *id.* at 854 n.34 and accompanying text.

166. MASS. GEN. LAWS ch. 149, § 188(b) (2007).

167. *Id.* § 188(a).

168. *Id.*

ees' health care necessarily entail the kind of permanent commitment that constitutes an ERISA regulated welfare plan, namely, a "plan, fund or program"¹⁶⁹ to provide medical coverage.¹⁷⁰ Consequently, a state's statutory reference to ongoing employer outlays for health care refers to and connects with employer financed health care plans regulated by ERISA.

Moreover, if section 514(a) can be avoided by the semantic expedient of regulating the employers' contributions to plans rather than the plans themselves, much of the Court's ERISA preemption case law becomes a sterile exercise in verbiage.¹⁷¹ For example, *Shaw*, under the Attorney General's parsing of ERISA, is easily avoided by a state legislature that gets the nomenclature right, that is, frames its statutory mandate in terms of employer contributions to plans rather than in terms of the plans themselves.¹⁷²

In short, even if the new Massachusetts health statute were amended to delete its explicit reference to the group health plans covered employers must offer, the statutory requirement of fair and reasonable premium contributions¹⁷³ for employee medical care necessarily relates to such plans since, by definition, employer contributions for medical coverage entail an employer-sponsored plan, fund, or program¹⁷⁴ to receive the required premiums for such coverage. The upshot under the *Shaw* approach to section 514(a) is ERISA preemption of the Massachusetts employer mandate as relating to employers' ERISA regulated medical plans.

The same conclusion emerges under *Travelers*: ERISA section 514(a) preempts the employer contribution mandate of the new Massachusetts health law as unacceptably relating to employers' medical plans for their employees. Even for those who see a sharp break between *Shaw* and *Travelers*,¹⁷⁵ ERISA section 514 after

169. ERISA § 3(1), 29 U.S.C. § 1002(1) (2000).

170. See Zelinsky, *Wal-Mart*, *supra* note 6, at 855 nn.35-48 and accompanying text.

171. *Id.* at 854-55.

172. *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983).

173. MASS. GEN. LAWS ch. 149, § 188(a) (2007).

174. ERISA § 3(1), 29 U.S.C. § 1002(1) (2000).

175. I am not alone in seeing a significant break between *Shaw* and *Travelers*. See, e.g., FROLIK & MOORE, *supra* note 112, at 215 ("In 1995, the Supreme Court appeared to signal a significant retrenchment from the *Shaw* interpretation of the extent of ERISA preemption."); LANGBEIN, STABILE & WOLK, *supra* note 112, at 781 ("Under *Travelers*, the *Shaw* analysis, which resulted in nearly automatic preemption of state law, was

Travelers retains great preemptive force in particular cases. Specifically, *Travelers* indicates that section 514 and its “relate to” terminology preempt state statutes that “mandate[] employee benefit structures or their administration.”¹⁷⁶ This is precisely what the new Massachusetts law does—mandate benefit levels by explicitly and directly requiring employers with eleven or more full time employees¹⁷⁷ to offer group health plans¹⁷⁸ to which such employers must make fair and reasonable premium contributions.¹⁷⁹

Instructive in this context, as in the context of the Maryland Wal-Mart Act,¹⁸⁰ is the Court’s post-*Travelers* decision in *Egelhoff v. Egelhoff*.¹⁸¹ *Egelhoff* addressed the status under section 514 of a Washington state statute which provides that divorce revokes all beneficiary designations of a former spouse.¹⁸² The *Egelhoff* Court held this state statute ERISA preempted insofar as it instructs ERISA regulated fringe benefit plans to disregard a pre-divorce beneficiary designation of a now former spouse.¹⁸³ In such cases, the Court held, the Washington state law “governs” plan administration by negating existing beneficiary designations on file with the ERISA regulated plan.¹⁸⁴

The new Massachusetts health law similarly governs ERISA regulated health plans. The new law requires both that covered employers establish health plans for employees and that covered employers make fair and reasonable payments to these plans.¹⁸⁵ Just as Washington State cannot regulate the administration of ERISA regulated plans, Massachusetts cannot require employers to sponsor plans or to contribute to them. In both cases, state law would mandate employee benefit structures or their administration

abandoned.”).

176. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 658 (1995).

177. MASS. GEN. LAWS ch. 149, § 188(b) (2007).

178. *Id.* § 188(a).

179. *Id.*

180. See Zelinsky, *Wal-Mart*, *supra* note 6, at 860-63.

181. 532 U.S. 141 (2001).

182. *Id.*

183. *Id.* at 146-50.

184. *Id.* at 148.

185. MASS. GEN. LAWS ch. 149, § 188(a) (2007).

in violation of *Travelers*' understanding of ERISA section 514(a) and its "relate to" standard for preemption.¹⁸⁶

Here too there are potential rebuttals available, although these ultimately prove unpersuasive. *Travelers* indicates that "general health care regulation" survives ERISA preemption.¹⁸⁷ Why cannot the Massachusetts law's employer mandate be characterized as such general regulation and thereby be immunized from ERISA's preemptive effect?

The answer is that this argument, if accepted, makes the category of general state regulation so broad as to render section 514(a) a nullity. The *Travelers* Court cites two examples of general health care regulations that survive ERISA preemption: hospital "[q]uality control and workplace regulation."¹⁸⁸ Both examples are compelling: If a hospital patient's care is paid for by an employer sponsored plan, the same quality protections should extend to that patient as to his roommate who pays for his own stay.

In contrast, Massachusetts's new law focuses upon covered employers and orders them to offer¹⁸⁹ ERISA regulated plans to their employees and to make fair and reasonable contributions to such plans.¹⁹⁰ If this statutory mandate—specifically and directly targeted at covered employers and their medical plans—constitutes general regulation of health care spared ERISA preemption, it is hard to envision a law that is preempted under section 514(a) as unacceptably relating to employer plans.

Egelhoff is instructive in this context. The Washington state statute revoking pre-divorce beneficiary designations applied across the board to all nonprobate designations, for example, as to individually purchased insurance policies and to beneficiary designations under non-ERISA plans.¹⁹¹ The Court declined, however, to spare the Washington statute as a "generally applicable

186. See *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995).

187. See *id.* at 661.

188. See *id.*

189. MASS. GEN. LAWS ch. 149, § 188(a) (2007).

190. *Id.*

191. WASH. REV. CODE § 11.07.010(1) (1998). The most common employee welfare plans outside the scope of ERISA are governmental and church plans. See ERISA §§ 4(b)(1)-(2), 29 U.S.C. §§ 1003(b)(1)-(2) (2000).

law[]”¹⁹² because the statute purported to govern “plan administration.”¹⁹³ If the Washington statute does not surmount ERISA preemption as a general law, neither does the Massachusetts law, which governs substantive plan terms by requiring that medical coverage be offered and be financed by fair and reasonable¹⁹⁴ employer contributions.

A second possible rebuttal would focus upon the relatively small penalty—an annual maximum of \$295 per employee—that an employer faces under the new Massachusetts law if the employer does not offer its employees a group health plan or if the employer contributes to the plan less than a fair and reasonable amount.¹⁹⁵ For some covered employers, paying the penalty will be cheaper than maintaining the plan. Hence, the argument concludes, the new law does not mandate benefits within the meaning of *Travelers* and thus survives ERISA preemption.

Again, *Egelhoff* is instructive. The Washington state statute permits employers to elect out of the statute’s coverage and thereby nullify the revocatory effect of participants’ divorces.¹⁹⁶ For the *Egelhoff* Court, this option did not save the Washington statute from ERISA preemption: “The statute is not any less of a regulation of the terms of ERISA plans simply because there are two ways of complying with it,”¹⁹⁷ that is, to treat divorce as revoking prior beneficiary designations of the now former spouse or to give notice that the employer elected against the statutory rule.

The employer contribution mandate of the new Massachusetts law is closely analogous: A covered employer can comply with the Massachusetts mandate by sponsoring a health plan and making required contributions to it or can instead pay yearly up to \$295 per employee to the Commonwealth Care Trust Fund.¹⁹⁸ If the alternative means of complying with the Washington State law does not save that law from ERISA preemption, neither does the alternative of paying to the Massachusetts trust fund.

192. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001).

193. *Id.* at 148.

194. MASS. GEN. LAWS ch. 149, § 188(a) (2000).

195. *See id.* § 188(c)(10).

196. *See* WASH. REV. CODE § 11.07.010(1)(b) (1998).

197. *Egelhoff*, 532 U.S. at 150.

198. *See* MASS. GEN. LAWS ch. 149, § 188(b)-(d) (2006).

Yet a third counterargument to my reading of *Egelhoff* would focus upon the Supreme Court's earlier post-*Travelers* decision in *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*¹⁹⁹ California law requires contractors to pay prevailing wages on public projects, but permits contractors working on such projects to pay lower wages to apprentices enrolled in state-approved apprenticeship programs.²⁰⁰ Dillingham Construction was a contractor on a public project.²⁰¹ Its subcontractor paid lower wages to apprentices in a program that was not state approved.²⁰² When sued by the state, Dillingham Construction argued that California's law, limiting lower wages to apprentices in state-certified programs, was ERISA preempted because apprenticeship programs are ERISA regulated plans.²⁰³

In *Dillingham*, the Court upheld the California law requiring that prevailing wages be paid to apprentices working on public projects unless such apprentices participate in state-approved apprenticeship programs.²⁰⁴ Writing for the Court, Justice Thomas, later the author of *Egelhoff*, stated that California's "prevailing wage statute alters the incentives, but does not dictate the choices, facing ERISA plans."²⁰⁵ That is to say, apprenticeship plans in California can elect to comply with state standards, and thus make their apprentices eligible for hire on public projects at reduced wages, or can eschew those standards, and thus require contractors on public projects to pay their apprentices at prevailing wage rates.

Similarly, the argument would run, Massachusetts employers can elect to offer medical coverage to their employees and make fair and reasonable²⁰⁶ contributions towards such coverage or, alternatively, can choose instead to pay the annual "fair share" contribution to the Commonwealth Care Trust Fund.²⁰⁷ If ERISA section

199. 519 U.S. 316 (1997).

200. *Id.*

201. *Id.* at 321.

202. *Id.* at 321-22.

203. *Id.* at 322; *see also* ERISA § 3(1), 29 U.S.C. § 1002(1) (2000) (declaring that "apprenticeship [and] other training programs" are welfare plans under ERISA).

204. *Dillingham*, 519 U.S. at 334.

205. *Id.*

206. MASS. GEN. LAWS ch. 149, § 188(a) (2007).

207. *Id.* § 188(c)-(d).

514(a) does not preempt the California prevailing wage statute for framing the incentives faced by apprenticeship programs, the argument would conclude, ERISA should similarly not preempt the Massachusetts employer mandate for framing the incentives confronted by employers and their medical plans.

This argument is not without force and highlights possible tension between *Dillingham* and the Court's later decision in *Egelhoff*. Ultimately, however, the distinction Justice Thomas drew between *Egelhoff* and *Dillingham*²⁰⁸ suggests that *Egelhoff*, finding ERISA preemption, controls as to the Massachusetts health law.

The California prevailing wage statute is a "generally applicable law[] regulating 'areas where ERISA has nothing to say'"²⁰⁹ and which has only "incidental effect on ERISA plans."²¹⁰ In contrast, the Washington state statute at issue in *Egelhoff* "governs the payment of benefits, a central matter of plan administration."²¹¹ Unlike the California statute upheld in *Dillingham*, the Washington law "dictate[s] the choices facing ERISA plans' with respect to matters of plan administration."²¹²

From this vantage, the Massachusetts law, because it intrudes upon the design of plan benefits, looks more like the Washington statute, which intrudes upon plan administration and is accordingly preempted by ERISA and section 514(a). In contrast, the California prevailing wage statute does not regulate the terms of apprenticeship plans but merely specifies the wages contractors must pay on public projects, depending upon the nature of their apprentices' training. The impact of the prevailing wage statute upon ERISA regulated apprenticeship plans is thus plausibly characterized as indirect or, to use Justice Thomas's term, "incidental."²¹³

On the other hand, the Massachusetts statute, like the Washington law, "governs the payment of benefits"²¹⁴ as the Massachusetts act specifies that covered employers must offer

208. See *supra* notes 204-05 and accompanying text.

209. See *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001).

210. *Id.*

211. See *id.*

212. See *id.* at 150 (quoting *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 334 (1997)).

213. *Id.* at 148.

214. *Id.* at 147-48.

medical coverage to their employees and must make fair and reasonable contributions for such coverage.²¹⁵ The Massachusetts law prescribes the choices confronting medical plans relative to plan benefits and thus intrudes deeply and directly into the structure and operation of such plans. By comparison, the California prevailing wage statute does not stipulate the terms of state-approved apprenticeship programs, but merely defines the wages that can be paid to apprentices on public projects.

In the final analysis, both Justice Thomas and his colleagues who joined his *Dillingham* and *Egelhoff* opinions concluded that the California prevailing wage law and the Washington beneficiary revocation statute are different for ERISA preemption purposes.²¹⁶ The Massachusetts health law resembles the latter more than the former because that law impacts directly and intrusively upon covered employers' medical plans by mandating the benefits such plans must provide.

To summarize: whether one views the Court's case law construing ERISA section 514(a) as a unified body of decisions or, as some scholars think,²¹⁷ as falling into two distinct strains following either *Shaw* or *Travelers*, section 514(a) and its "relate to" terminology preempt the new Massachusetts health law's employer contribution mandate. Both on the face of the law and implicitly, the Massachusetts health law refers to and has a connection with employers' medical plans for their employees. Moreover, the new Massachusetts statute mandates plan benefits by requiring covered employers to offer medical plans for their employees and to contribute fair and reasonable amounts to such plans.²¹⁸ ERISA section 514(a) preempts these features of the new law as relating to employers' medical plans for their employees.

C. The Employer Cafeteria Plan Mandate

On the other hand, ERISA does not preempt the new law's requirement that employers maintain cafeteria plans qualifying

215. See MASS. GEN. LAWS ch. 149, § 188(a) (2007).

216. See *supra* notes 209-12 and accompanying text.

217. See *supra* note 175.

218. See MASS. GEN. LAWS ch. 149, § 188(a) (2007).

under Code section 125.²¹⁹ Such cafeteria plans are not ERISA regulated welfare plans. Accordingly, Massachusetts's statutory requirement that covered employers maintain cafeteria plans does not run afoul of section 514(a); that statutory requirement does not relate to ERISA regulated plans because cafeteria plans are not such plans.

Recall in this context ERISA's definition of an employee welfare plan: "any plan, fund, or program which ... [is] established or is maintained for the purpose of providing ..., through the purchase of insurance or otherwise," enumerated fringe benefits including "medical, surgical, or hospital care or benefits."²²⁰ Although this definition is expansive, it is not limitless. A welfare plan regulated by ERISA is an arrangement for the purpose of providing particular benefits enumerated in the statute.

In contrast, a cafeteria plan is a compensation device which permits an employee to elect between current salary or an equivalent payment for an income tax-free fringe benefit. A cafeteria plan does not itself provide any benefits; rather, the cafeteria plan allows the participating employee to divert a portion of his current, otherwise taxable compensation to a plan that does provide such benefits. Because it is not an actual provider of statutorily enumerated benefits, a cafeteria plan is not an ERISA governed welfare plan.

The relevant regulations of the Department of Labor (DOL) confirm this reading of ERISA and the consequent distinction between a cafeteria plan and an ERISA regulated welfare plan. As an example, the DOL regulations specify that "a system of payroll deductions by an employer for deposit in savings accounts owned by its employees" is not an ERISA governed welfare plan because this system does not itself "provide benefits."²²¹ The same analysis applies to a cafeteria plan under which the employee elects current salary or, in the alternative, a deduction from salary to pay for a tax-free fringe benefit such as employer-provided medical care. The cafeteria arrangement itself does not provide benefits, but merely

219. For a review of Massachusetts's mandatory cafeteria plan, see *supra* notes 62-68 and accompanying text.

220. ERISA § 3(1), 29 U.S.C. § 1002(1) (2000).

221. 29 C.F.R. § 2510.3-1(a)(2) (2006).

diverts employee salary on a tax-favored basis to plans which do provide such benefits. Because cafeteria plans do not provide benefits, they are not ERISA regulated “welfare benefit plans.” Consequently, state legislation regulating cafeteria plans does not relate to ERISA governed plans.

In its only relevant administrative ruling, Opinion 96-12A, the DOL agreed that a cafeteria plan designed to qualify under Code section 125 is not an ERISA governed welfare plan.²²² Under such a cafeteria plan, the DOL wrote, “employees may receive tax-favored treatment of [their] contributions” to their employers’ medical plans.²²³ The cafeteria arrangement, however, is not an ERISA regulated plan because that arrangement “itself provides [no] enumerated benefit” listed by ERISA.²²⁴

Because, under the statute, regulations, and relevant administrative rulings, cafeteria plans are not ERISA regulated welfare benefit plans, the portion of the new Massachusetts law that requires covered employers to maintain such cafeteria plans does not relate to ERISA governed welfare plans for section 514(a) purposes. Hence, the cafeteria plan requirement of the Massachusetts statute is not ERISA preempted.

The potential rebuttal to this argument would focus upon the relationship under the new Massachusetts law between the cafeteria plans the new law requires and the health care plans that the law also requires. The Massachusetts law specifies that employers’ cafeteria plans must be filed with the connector and must satisfy “rules and regulations promulgated by the connector.”²²⁵ The connector’s rules and regulations require that employees have the ability, through their employers’ respective cafeteria plans, to pay medical premiums on a pre-tax basis under Code section 125.²²⁶ Thus, the argument would run, each employer’s statutorily compelled cafeteria plan will be an integral part of the employer provided medical benefit structure imposed by the Massachusetts law. The statutory requirement to maintain a cafeteria plan that

222. U.S. Dep’t of Labor Advisory Opinion 96-12A (July 17, 1996).

223. *Id.*

224. *Id.*

225. MASS. GEN. LAWS ch. 151F, § 2 (2007).

226. 956 MASS. CODE REGS. 4.06(3)(a) (2007).

meets the connector's standards is preempted by ERISA section 514(a) as that requirement is part of the statutorily mandated structure of medical benefits, itself ERISA preempted.

This rebuttal is not without plausibility. Ultimately, however, employers' cafeteria plans are better understood as free-standing arrangements separate from the employers' plans actually providing medical care, even if such cafeteria plans are required by state law and are legally obligated to permit pre-tax contributions to employers' medical plans to defray premiums. As a matter of federal law, a cafeteria plan is a distinct type of entity, governed by its own Code provision, section 125.²²⁷

The same is true under the Massachusetts statute. If an employer elects against medical coverage and instead pays the Commonwealth Care Trust Fund, the new law still obligates the employer to maintain a cafeteria plan for its employees, even though that employer maintains no plan for such employees' medical care.²²⁸ Because in such cases cafeteria plans will stand alone, cafeteria plans maintained by employers that also sponsor medical plans should be recognized as distinct from such medical plans.

In the final analysis, the Massachusetts statute, insofar as it requires covered employers to maintain cafeteria plans for their employees, does not relate to ERISA governed welfare arrangements because cafeteria plans are not ERISA governed welfare plans. Rather than actually providing medical benefits, cafeteria plans merely divert employees' compensation on a pre-tax basis to plans that do furnish such medical coverage. Accordingly, the Massachusetts mandate requiring covered employers to sponsor cafeteria plans is not preempted by section 514(a).

227. I.R.C. § 125 (2000).

228. See MASS. GEN. LAWS ch. 151F, § 2 (2007). Presumably, in such cases, cafeteria plans must permit employees to make pre-tax contributions to individual health care policies such employees obtain from the connector.

D. The Individual Mandate and the Concept of “Minimum Creditable Coverage”

Consider finally the new Massachusetts mandate for individuals.²²⁹ Under *Shaw*, the new statutory mandate on individuals, via the concept of “minimum creditable coverage,” refers to and connects with employers’ medical plans for their employees. Under *Travelers*, the Massachusetts statute’s standard of minimum creditable coverage is an indirect but acute regulation of the substance of employer-provided medical care because Massachusetts employers offering medical coverage to their employees must in practice meet the Massachusetts standard to satisfy employees’ respective obligations under the individual mandate. Consequently, under either interpretation of ERISA section 514(a) and its “relate to” test for preemption, ERISA preempts the concept of minimum creditable coverage, which implements the new law’s individual mandate.

Recall the basic structure of the new individual mandate: Massachusetts residents with certain specified kinds of coverage, such as Medicaid and Medicare, per se satisfy the statutory mandate to maintain individual medical coverage.²³⁰ Massachusetts residents with sincere religious convictions against medical insurance are excused from compliance with the statutory mandate to maintain individual coverage.²³¹ Massachusetts residents certified by the connector as trying but failing to acquire affordable insurance are deemed to have complied with the statutory mandate to obtain medical coverage.²³² All other Massachusetts residents must have minimum creditable coverage as the connector defines such coverage.²³³ This minimum coverage can be obtained under either an “individual” or a “group health plan.”²³⁴

Most Massachusetts residents satisfying the individual mandate by means of group health plan coverage will receive such group

229. See *supra* Part I.B.

230. See MASS. GEN. LAWS ch. 111M, §§ 1, 2(a) (2007).

231. *Id.* §§ 2(b)(ii), 3.

232. See *id.* § 2(b)(iii).

233. *Id.* §§ 1, 2(a).

234. See *id.* § 1.

coverage from their employers.²³⁵ Hence, under *Shaw*, the connector's definition of minimum creditable coverage refers to and connects with employer-provided medical plans by determining whether such plans satisfy the statutory minimum and thereby discharge employees' legal obligations under the individual mandate. In practice, few, if any, Massachusetts employers will maintain group medical plans that fail the standards for minimum creditable coverage because, in such cases, employees must purchase largely duplicative medical coverage on their own to satisfy the new statute's individual mandate.

Employers must therefore treat the connector's definition of minimum creditable coverage as an obligatory floor that their respective health plans must satisfy. Coverage falling below this floor is of no practical value to the employee who must still pay for individual coverage to satisfy the individual mandate. Consequently, under *Shaw*, the concept of minimum creditable coverage refers to, and has a connection with, employer-provided medical coverage regulated by ERISA because, in practice, that concept establishes a minimum standard that employers must satisfy to discharge employees' obligations under the individual mandate.

Instructive for this discussion is the connector's proposed regulation that employers' health plans, to constitute minimum creditable coverage, must provide "a broad range of medical benefits," and must comply with a variety of limits on deductibles and co-payments.²³⁶ These regulations effectively create a floor that employers' medical arrangements must satisfy to acquit employees of their legal responsibilities under the individual mandate. Under *Shaw*, these regulations relate to employer-sponsored medical plans because these regulations refer to and have a connection with such plans.

235. As noted *supra*, the design of the connector encourages nonemployer groups to obtain insurance for their members through the connector. See *supra* Part I.A. The tax benefits associated with employer-paid medical premiums—excludable from employees' gross incomes—will, however, lead most individuals to use employer based medical coverage when it is available to them. See *supra* note 95 and accompanying text.

236. See 956 MASS. CODE REGS. 5.03 (2007).

Consider again in this context *Metropolitan Life*²³⁷ and the Massachusetts state law that requires insurance policies sold within the state to include specified mental health benefits.²³⁸ Under *Shaw*, that mandated benefit law relates to Massachusetts employers' medical plans because such plans, if they desire to purchase insurance, must buy insurance providing these required mental health benefits. In the same way, a Bay State employer that maintains a medical plan and seeks thereby to discharge its employees' legal obligations under the individual mandate must satisfy the connector's standards for minimum creditable coverage.

At the second stage of analysis, the Massachusetts mandated mental health benefit law survives ERISA preemption as an insurance regulation. In contrast, the connector's standards for minimum creditable coverage apply to all group health plans including self-funded plans that eschew insurance. As we have seen, this impact upon employers' self-funded plans precludes for the new Massachusetts health law the insurance exemption from ERISA preemption.²³⁹

In sum, the *Shaw* approach to ERISA section 514(a), "connection with or reference to,"²⁴⁰ indicates that a key concept of the new statute's individual mandate—minimum creditable coverage—unacceptably relates to employers' ERISA regulated medical plans and is consequently preempted. Minimum creditable coverage is, in effect, a mandatory floor that Massachusetts employers offering medical coverage to their employees must satisfy to discharge such employees' obligations under the new individual mandate. Only by satisfying that standard can an employer enable his employees to discharge their legal obligations under the individual mandate.

A similar conclusion emerges under *Travelers*, which, although retreating from the capacious approach to ERISA preemption embraced in *Shaw*, nevertheless indicates that section 514(a) retains great preemptive effect in specific cases.²⁴¹ In particular,

237. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); see also *supra* notes 144-47 and accompanying text.

238. MASS. GEN. LAWS ch. 175, § 47B (2007).

239. See *supra* Part III.A.

240. See *Shaw v. Delta Air Lines*, 463 U.S. 85, 97 (1983).

241. See *supra* notes 120-23 and accompanying text.

Travelers declares that “a state law might indeed be preempted under [section] 514” if that state law “produce[s] such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage.”²⁴² That is the case under the new Massachusetts individual mandate, which, via the concept of minimum creditable coverage, effectively forces covered employers to satisfy the statutory minimum for employee health care benefits to enable employees to discharge the new law’s individual mandate.

Noteworthy in this context is the decision of the U.S. Court of Appeals for the Fourth Circuit holding that ERISA section 514(a) preempts Maryland’s Wal-Mart law.²⁴³ In that decision, the appellate court persuasively concluded that Maryland’s Wal-Mart Act is ERISA preempted because, inter alia, the Act leaves Wal-Mart with no practical alternative but to increase its outlays for medical coverage to the Maryland Act’s minimum standard, 8 percent of payroll: “In effect, the only rational choice employers have under the Fair Share Act is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold.”²⁴⁴

The same is true of employers covered by the Massachusetts law: They have no practical alternative but to comply with the connector’s interpretation of minimum creditable coverage to enable their employees to satisfy the new Massachusetts mandate for individuals. Massachusetts residents derive little or no utility from employer-provided coverage that flunks those standards and thus fails to discharge the residents’ statutory obligation to carry medical coverage.

In this context, let us revisit the choices presented by the New York law at issue in *Travelers*. That law imposed a surcharge for hospital stays except for those stays paid for by Blue Cross/Blue Shield coverage.²⁴⁵ By increasing the costs of hospitalizations paid for by commercial insurance or by employers’ self-funded plans, the

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

243. Retail Indus. Leaders Ass’n v. Fielder, 475 F.3d 180 (4th Cir. 2007), *aff’g* 435 F. Supp. 2d 481 (D. Md. 2006).

244. *Id.* at 193-94.

245. See N.Y. PUB. HEALTH LAW § 2807-C (McKinney 1993); see also *Travelers*, 514 U.S. at 649.

New York law financially incented employers' medical plans to purchase Blue Cross/Blue Shield insurance rather than obtain competing commercial insurance or self finance employees' medical coverage. Under the New York law, however, these alternatives remained realistic, albeit higher priced, choices. A New York employer rationally could have decided that the financial savings from using Blue Cross/Blue Shield coverage—lower rates for hospital stays—were counterbalanced by compensating benefits obtainable through competing carriers or self funding, such as better coverage, faster claims processing, and more flexibility in determining the contours of coverage.

In contrast, the Massachusetts statute (like Maryland's Wal-Mart Act) gives the employer maintaining medical coverage for its employees no realistic alternative to the minimum creditable coverage standard, as explicated by the connector. If an employer's medical plan fails that standard, the failing employer's employees will be required to acquire on their own individual coverage that meets that standard. Under this statutory scheme, the employer derives no practical benefit by sponsoring medical coverage that flunks the test of minimum creditable coverage and thus fails to discharge the employees' obligations under the new individual mandate. Employees receiving employer coverage below the minimum standard established by the connector will be forced by the individual mandate to purchase their own, largely duplicative medical coverage.

Hence, the new law's individual mandate "produce[s] ... acute, albeit indirect, economic effects ... [that] force an ERISA plan to adopt a certain scheme of substantive coverage,"²⁴⁶ specifically, the requirements for minimum creditable coverage as expounded by the connector. The practical effect of the individual mandate is thus distinguishable from the impact of the New York law at issue in *Travelers* because the New York law left employers' plans with the realistic, albeit higher priced, alternatives of commercial insurance and self funding. In contrast, the new Massachusetts health care statute leaves an employer sponsoring medical care no realistic alternative but to comply with the statute's standard of "minimum

246. *Travelers*, 514 U.S. at 668.

creditable coverage” to discharge employees’ obligations under the individual mandate.

I foresee two possible lines of rebuttal to this analysis. First, it can plausibly be asserted that the impact of the Massachusetts law is not as acute as the impact of Maryland’s Wal-Mart Act. If Wal-Mart fails the Act’s minimum outlays for medical coverage, 8 percent of payroll, Wal-Mart is required to remit the resulting deficiency, dollar-for-dollar, to Maryland’s Fair Share Health Care Fund.²⁴⁷ This imposes a marginal tax of 100 percent for every dollar Wal-Mart falls short of the statutory minimum for health care outlays.²⁴⁸ Confronted with this statutory scheme, District Judge Motz convincingly observed that when “employers are faced with the choice of paying a sum of money to the State or offering an equal sum of money to their employees in the form of health care, no rational employer would choose to pay the State.”²⁴⁹ Accordingly, the Maryland Act effectively mandates Wal-Mart’s level of health benefits in violation of ERISA section 514(a).

In contrast, a covered employer can choose under the Massachusetts law to eschew employer-provided medical plans and instead pay a “fair share employer contribution”²⁵⁰ to the Commonwealth Care Trust Fund.²⁵¹ It is thus plausible to characterize the Massachusetts law as less coercive than the Maryland Act because, in some cases, it will be economically rational for Massachusetts employers to terminate their medical plans and, in lieu of such plans, pay to the Commonwealth Care Trust Fund the penalty for noncoverage.

Notwithstanding this possibility, the Massachusetts health law is still acute in its substantive impact upon employers and their medical plans. Once a Massachusetts employer decides that, for competitive reasons or otherwise, the employer must offer medical coverage to its employees, it makes no economic sense for the employer to provide less than minimum creditable coverage. This

247. Maryland Fair Share Health Care Fund Act, MD. CODE ANN., LAB. & EMPL. § 8.5-104 (LexisNexis 2007).

248. Zelinsky, *Wal-Mart*, *supra* note 6, at 865.

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

250. MASS. GEN. LAWS ch. 149, § 188(b) (2007).

251. *See id.* § 188(d).

minimum is effectively a mandated floor for Massachusetts employers sponsoring medical arrangements for their employees because, under the individual mandate, employees derive no utility from employer-provided medical coverage that does not satisfy that mandate. In the face of employer-financed medical coverage failing the criteria for minimum creditable coverage, employees must, on their own, obtain and pay for largely duplicative medical coverage constituting such minimum creditable coverage.

Moreover, as the *Egelhoff* Court noted,²⁵² the availability of a statutorily created alternative—in this case, the employer's fair share contribution to the Commonwealth Care Trust Fund—does not save a state statute from ERISA preemption when the statute dictates the choices. That is precisely what the Massachusetts statute does: It requires covered employees to either maintain a medical plan constituting minimum creditable coverage or make the fair share contribution to the Commonwealth Care Trust Fund.

A second retort would characterize the individual mandate as the kind of general health law that *Travelers* spares from ERISA preemption. At first blush, this characterization possesses a certain plausibility: Individual and group plan participation constituting minimum creditable coverage are among several forms of health care that discharge the Massachusetts mandate for individuals. Medicaid and Medicare coverage, for example, also satisfy the individual mandate for Massachusetts residents.²⁵³

Consequently, the argument runs, the requirement that individual and group health plans must constitute minimum creditable coverage to satisfy the individual mandate is part of a general scheme under which other, specified forms of health care also satisfy the new statutory mandate imposed upon Massachusetts residents.

Upon closer examination, however, the new law's approach to individual and group health plans is not part of a generalized statutory scheme. Rather, the new law's regulation of individual and group health plans is both *sui generis* and highly intrusive, unlike the law's approach to other forms of creditable coverage

252. See *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001).

253. See MASS. GEN. LAWS ch. 111M, § 1 (2007).

discharging the new individual mandate. Once the connector explicates the statutory standards for minimum creditable coverage, the new law will effectively impose a substantive floor on individual and group health plans in the Bay State. In contrast, the new law makes no effort to prescribe the substantive standards that other forms of medical coverage must satisfy to constitute creditable coverage.

For example, the new law makes no effort to define the content that Medicare must satisfy to constitute creditable coverage. Medicare is *per se* deemed adequate coverage for purposes of the individual mandate.²⁵⁴ The same is true of the other forms of medical care that the new law automatically recognizes as creditable coverage, for example, Medicaid²⁵⁵ and “a medical care program of the Indian Health Service or of a tribal organization.”²⁵⁶ Under the new law, these alternatives are all *per se* deemed creditable coverage satisfying the individual mandate without the Commonwealth or the connector assessing or prescribing their substantive terms.²⁵⁷

In contrast, individual and group health plans constitute minimum creditable coverage only if they comply with the substantive standards promulgated by the connector. The concept of minimum creditable coverage is unique to such plans because only as to them does the connector assess substantive adequacy for compliance with the individual mandate.

Moreover, the statute’s substantive regulation of individual and group plans is highly intrusive. A Massachusetts employer offering medical coverage to its employees has no realistic alternative but to comply with the standards promulgated for minimum creditable coverage to discharge employees’ obligations under the individual mandate. In contrast, the Massachusetts statute makes no other effort to influence the substantive standards of coverage used by Massachusetts residents to discharge the individual mandate.

254. *Id.*

255. *See id.*

256. *See id.*

257. *See id.*

In sum, the concept of minimum creditable coverage is the kind of mandated benefit structure that remains ERISA preempted under *Travelers*.

E. Summary

Under *Shaw*, ERISA section 514 preempts the Massachusetts employer mandate, which requires covered employers to offer medical plans for their employees and to make fair and reasonable contributions to such plans. Also under *Shaw*, section 514 preempts the Massachusetts individual mandate insofar as that mandate requires Massachusetts residents to maintain minimum creditable coverage for medical care. Both the employer and the individual mandates refer to and connect with Massachusetts employers' ERISA regulated welfare plans for medical care.

Similar conclusions emerge under *Travelers*. The employer mandate is a direct and explicit regulation of the benefits that Massachusetts employers must offer their employees through ERISA governed medical plans. The individual mandate's concept of minimum creditable coverage is an indirect, but acute, regulation of such plan benefits: A Massachusetts employer's medical plan for its employees must constitute minimum creditable coverage to discharge its employees' obligations under the individual mandate. Accordingly, under *Travelers*, ERISA section 514(a) preempts both statutory mandates as unacceptably relating to employers' ERISA governed plans.

IV. THE CASE FOR EXPERIMENTATION

The new Massachusetts health law, like the Maryland Wal-Mart Act, was adopted in the context of our ongoing national debate about the provision and financing of health care. Virtually no one defends the health care status quo in the United States, although there is no agreement as to what the problem is. The most frequently quoted statistics, showing that health care outlays in the United States have grown and continue to grow at a rapid rate,²⁵⁸

258. See, e.g., John Abramson, Editorial, *Healthcare Code Blue*, L.A. TIMES, Nov. 3, 2006,

by themselves prove nothing. Americans today spend billions on personal computers that they did not forty years ago, before such computers existed. No one, however, suggests that the rapid growth in personal computer expenditures represents a national crisis. Indeed, most would consider such expenditures a sign of productive investment.

The pronounced growth of health care outlays is perceived as a problem only because of the widespread belief that much of the money is being spent poorly. But there is no consensus as to why that may be so. Insurers' administrative costs, denounced by some as unnecessary outlays for unwanted bureaucracy,²⁵⁹ are justified by others as funds usefully spent on medical cost control.²⁶⁰ Monies devoted to new and experimental treatments can be viewed as sensible outlays to extend health and life spans or as wasteful expenditures on unproven, but typically expensive, methodologies. Many discretionary medical outlays can be cast as unwarranted frivolity or as manifestations of an affluent society satisfying its needs. In the same fashion, much late-in-life medical spending can be characterized as resources devoted by a compassionate society to its elderly or instead as marginally useful expenditures by a society that does not have the discipline to say "no."²⁶¹

at A29 ("The spiraling cost of healthcare is well known: \$7,100 per person this year, projected to increase to \$12,000 in 2015 and compounding at more than double the rate of inflation. Already, medical care gobbles up one-sixth of the GDP."); David R. Francis, *Healthcare Crisis Countdown*, CHRISTIAN SCI. MONITOR, Nov. 6, 2006, at 16 ("The US spends 15 percent of its gross national product on healthcare, of which 31 percent goes for administrative costs."); Kaiser Family Foundation, *Health Care Spending in the United States and OECD Countries* (2007), <http://www.kff.org/insurance/snapshot/chcm010307oth.cfm> ("It is reasonably well known that for some time the United States has spent more per capita on health care than other countries. What may be less well known is that the United States has had one of the highest growth rates in per capita health care spending since 1980 among higher income countries.").

259. Hochman & Woolhandler, *supra* note 108 ("[I]nsurance companies spend several times as much on administrative costs as public programs do."); Leonard Rodberg, *The Unraveling of Private Insurance*, http://www.pnhp.org/news/2006/october/the_unraveling_of_pr.php (Oct. 24, 2006) ("Wasteful. More than 20 percent of our spending on health care in this country is simply for administering our multipayer, for-profit insurance system.").

260. See, e.g., JACOB S. HACKER, *THE GREAT RISK SHIFT* 150 (2006) (discussing those economists who conclude "that health insurers need to exercise more vigilant oversight of patients and medical providers").

261. See, e.g., Eric Cohen & Yuval Levin, *Health Care in Three Acts*, COMMENTARY, Feb. 2007, at 46-47 (discussing "the dilemmas of end-of-life care in a rapidly aging society" and

For some critics of American health care, the problem is fundamentally one of equity. For these critics, although more is being spent on medical costs, too many Americans lack access to medical services. But here also there is no consensus. Whereas some emphasize the medical vulnerability of the uninsured,²⁶² others see rational consumers reasonably assessing the costs and benefits of medical insurance and electing against it.²⁶³

For yet others, the problem is that we place medical costs on the wrong institutions of our society. From this vantage, American businesses, forced to absorb growing expenses for health care, find themselves at a competitive disadvantage compared to firms abroad that do not incur such expenses.²⁶⁴

Underlying this cacophony are three contrasting visions of medical care. For some, medical care is simply a consumer good similar to others.²⁶⁵ From this consumer-based perspective, the principal problem of the status quo is market failure caused by government intervention that has distorted markets for medical

“the painful decisions that come at the limits of medicine and the end of life”).

262. Rodberg, *supra* note 259 (observing that “the employer-based system [is] leaving increasing numbers of Americans without health coverage”).

263. See, e.g., COUNCIL FOR AFFORDABLE HEALTH INSURANCE, STATE HEALTH INSURANCE INDEX 2006: A 50-STATE COMPARISON OF THE NATION’S HEALTH INSURANCE MARKET (2006) (“Surveys of the uninsured consistently show that the cost of health insurance is the primary reason for their being uninsured. Thus, the most efficient way to reduce the number of uninsured Americans is to ensure that people have access to a wide range of affordable health insurance policies.”); see also Cohen & Levin, *supra* note 261, at 47 (noting that, of the medically uninsured, a “fifth (many of them young adults, under thirty-five) earn more than \$50,000 a year but choose not to buy coverage”); David Gratzner, *First, Do No Harm*, FORBES, Feb. 12, 2007, at 32 (“Many people have done the math and have decided not to get coverage.”).

264. See, e.g., Ron French, *Stranglehold: How General Motors and the Nation Are Losing an Epic Battle to Tame the Health Care Beast*, DETROIT NEWS, Sept. 26, 2006, at 1A (“The profits of U.S. businesses are being eaten away by rising health care costs—a financial burden not borne by their competitors based in other countries.”); Joe Nocera, *Resolving to Reimagine Health Costs*, N.Y. TIMES, Nov. 18, 2006, at C1 (“As global competition heats up, and as health care costs continue to rise, it seems to me that more and more companies are going to feel the same way the auto companies feel right now: placed at a serious disadvantage as they compete with companies abroad that do not have to offer health care to their workers, because that’s something their government does.”); Mark Gottlieb, *Great White North*, Jan. 2, 2007, http://www.pnhp.org/news/2007/january/great_white_north.php (“The average real cost of health care to employers in Canada works out to about one-eighth that incurred in the United States.”).

265. See, e.g., COUNCIL FOR AFFORDABLE HEALTH INSURANCE, *supra* note 263.

insurance.²⁶⁶ The current task of public policy is to enable efficient consumer decision making for medical services.²⁶⁷ This vision today finds its most tangible manifestations in HRAs, HSAs, and other forms of consumer-driven health care, as well as the campaign to free medical insurance products from what is characterized as excessive state regulation.²⁶⁸

In contrast is the vision of medical care as an entitlement of citizenship. From this vantage, medical care is a right rather than a service to be purchased. This vision underpins support for single payer medical systems under which the government finances coverage for all its citizens. In the United States today, the most visible embodiment of medicine as a right of citizenship is Medicaid, which provides publicly subsidized medical coverage to qualifying low-income persons and families.

A third perspective is medical insurance as an employment-related fringe benefit. In practical terms, most Americans of working age today receive their medical coverage through their employers. At one level, the employment-based nature of medical coverage in the United States is an accident of tax policy: Because employer-provided medical coverage is excluded from covered employees' gross incomes, the Internal Revenue Code has, over time, caused the financing of medical coverage to shift to employers. Yet others view employers as having a moral obligation to provide health care coverage to their employees. This assumption underlies much of the rhetoric supporting Maryland's Wal-Mart Act and

266. See Grace-Marie Turner, *Massachusetts Health Plan Is No Model for Other States*, GALEN INST., Oct. 26, 2006, <http://www.galen.org/statehealth.asp?docID=932> (“[E]xpensive coverage mandates and regulations ... have made insurance in the private marketplace so expensive in the first place.”).

267. Bill Thomas, Letter to the Editor, *Lather Early, and Often*, FORBES, Nov. 13, 2006, at 34 (“[P]ut consumers in charge of their health services.”).

268. See, e.g., Mark V. Pauly, *Is Massachusetts a Model at Last?*, AEI ONLINE, Jan. 4, 2007, http://www.aei.org/publications/pubID.25372,filter.all/pub_detail.asp (“The best strategy would cease trying to discover the unknown, and instead place as few restrictions or obligations as possible on the coverage a person must have.”). One proposal reflecting this perspective is that federal law permit the creation of national “Association Health Plans” which would transcend particular states’ insurance mandates. See, e.g., H.R. 241, 110th Cong. (1st Sess. 2007).

similar proposals to force Wal-Mart to spend more for its employees' health coverage.²⁶⁹

This lack of consensus might be taken to suggest that the states should do nothing about the perceived problem of medical coverage: If we cannot agree on a diagnosis, we should not agree on a solution. This passive approach, however, is neither politically realistic (there is too much public concern about health care for elected officials to do nothing) nor correct as a matter of policy. The most feasible and productive responses to the perceived problems of health care in the United States will likely be varied, often untidy, combinations of these three different underlying visions. Even in the absence of consensus, states can and should proceed with experiments that combine these competing visions in different ways, as has Massachusetts.

Although the new Massachusetts health law can be derided as something for everybody (perhaps not such a bad thing in a democratic society) it is better characterized as the new law's proponents view it, as a broad and promising compromise forged from elements of different perspectives. Elements of this compromise are being considered in other states.²⁷⁰ Although Massachusetts, like every other state, has its own idiosyncrasies, the implementation of the new Massachusetts law will generate useful information for the entire nation. Maybe a state sponsored connector/exchange will work in Massachusetts or maybe it will not. It will be good to know either way. The same is true of the other features of the new Massachusetts law.

It is here that the ethos of experimental federalism collides with the legal reality of ERISA preemption. State experimentation with

269. See, e.g., AFL-CIO, *THE WAL-MART TAX: SHIFTING HEALTH CARE COSTS TO TAXPAYERS* 1 (2006), available at http://www.aflcio.org/corporatewatch/walmart/upload/walmartreport_031406.pdf ("Wal-Mart is directly contributing to the nation's Medicaid crisis.").

270. See, e.g., Judith Graham, *A New Plan To Insure All: Proposal Would Require Illinoisans to Get Health Coverage*, CHI. TRIB., Dec. 8, 2006, at C1; Richard G. Jones, *Health Insurance for All Is Considered in New Jersey*, N.Y. TIMES, Dec. 12, 2006, at B5; Aurelio Rojas, *Open to New Health Plans: Aides Say Governor May Ask Employers To Shoulder Worker Coverage, But Is Seeking Other Ideas*, SACRAMENTO BEE, Dec. 3, 2006, at A4; M. William Salganik, *Plan Would Require Health Insurance: State Panel Drafts Proposal To Insure All Workers*, BALT. SUN, Nov. 17, 2006, at 1E; Halvorson et al., *supra* note 54, at W80-81.

health care permits each state's regulation to adapt to local conditions and preferences. For example, in some states, like Massachusetts, the uninsured population is relatively small, both in absolute numbers and as a percentage of the total population.²⁷¹ In other states, such as California, the uninsured constitute, both in absolute and relative terms, much larger populations.²⁷² In some states, there may be a willingness to experiment with single payer systems, whereas in others, a more libertarian, consumer driven approach to medical care may predominate. Allowing each state to experiment with its own approach to health care permits adaptation to these (and other) local conditions and preferences, at the same time generating information and alternatives that can be emulated, adapted, or rejected by other states.

Under ERISA section 514(a) and the controlling case law, however, key features of the Massachusetts law are ERISA preempted. Unless Congress acts, it is only a matter of time before the courts, applying section 514(a), *Shaw, Travelers*, and their respective progeny, strike the new law's employer contribution mandates and the new law's concept of "minimum creditable coverage." Regrettably, this will dismantle key features of the Massachusetts experiment and will leave other states' potential experiments stillborn.

The alleged virtue of ERISA preemption is the national uniformity in the provision of employee welfare benefits protected by such preemption. In the context of the Maryland Wal-Mart statute, I argued that this virtue, upon analysis, proves elusive.²⁷³ The same is true of the new Massachusetts health law. It is precisely because Massachusetts has done something different from the other states that its experiment should be allowed to proceed. Only in this way can we learn what portions, if any, of the experiment are productive and thus potentially exportable to other states.

271. Pauly, *supra* note 268 ("[A] relatively small share of Massachusetts' population is uninsured when compared with other states.").

272. Jeffrey Krasner, *Calif.'s Healthcare Plan Looks Familiar but Revamp Faces Taller Hurdles than in Mass. Because the Problem Is Much Bigger There*, BOSTON GLOBE, Jan. 11, 2007, at D1 ("[A] staggering 7.2 million Californians lack healthcare coverage—one in five residents.").

273. See Zelinsky, *Wal-Mart*, *supra* note 6, at 874-77.

Because of the bipartisan provenance of the new Massachusetts health law, Massachusetts is particularly well positioned to request that Congress amend section 514 to immunize the Massachusetts law from ERISA preemption. A model for such an amendment is ERISA section 514(b)(5), which exempts from ERISA preemption the Hawaii Prepaid Health Care Act. Congress can and should adopt a similar exemption for the new Massachusetts health law.

More fundamentally, Congress should add to section 514(b)'s existing exemptions from ERISA preemption another exemption for state health care legislation. Until then, ERISA preemption is a cloud hanging over state experimentation relative to health care. This is so even for those who might read section 514(a) and the ERISA preemption case law as imposing fewer restrictions on the states than I do. Even if section 514 cuts a narrower swath than I have suggested, it still inhibits in significant ways states from legislating as to the provision and financing of health care.

Most comprehensively, Congress should abolish section 514 altogether and thereby avoid the definitional and borderline problems inherent in a more limited exemption from ERISA preemption for state health care laws. Such definitional and borderline problems—for example, when does a state law pertain to health care?—would be a reasonable price to pay if there were a compelling case for keeping section 514(a) and thus ERISA preemption as the residual default rule. But there is no such case.²⁷⁴

True, ERISA preemption does not preclude states from experimenting with insurance regulation or with health care outside the employment context. However, employer-provided health coverage is central to the status quo; as long as states cannot experiment as to employer based medical coverage, states cannot experiment meaningfully. And ERISA section 514(a), under either the *Shaw* or

274. *Id.*

Travelers rubric,²⁷⁵ stops the states from adopting legislation that relates to employer-provided medical care.

Consider, for example, a state that enacts a Massachusetts-style individual mandate *sans* the other features of the new Massachusetts health law. In this state, residents would be required to carry creditable coverage but there would be no connector or subsidized coverage like the Commonwealth Care Health Insurance Program, nor would there be any employer mandates.²⁷⁶ Presumably, individuals would satisfy this statutory mandate, *inter alia*, through either individual or employer-provided coverage meeting specified standards. In this case, the individual mandate would be ERISA preempted for the same reasons the individual mandate of the Massachusetts law is preempted. Under *Shaw*, the mandate, by defining satisfactory coverage, would refer to and connect with employers' ERISA governed medical plans. Under *Travelers*, the mandate would effectively force employers' plans to meet those specified benefit standards in order to discharge employees' obligations under the individual mandate. Consequently, this experiment of a stand-alone individual mandate would be stillborn by virtue of ERISA section 514(a).

275. A third approach suggested by some members of the Supreme Court is to read section 514(a) as embodying nothing more than the Court's normal preemption jurisprudence, jurisprudence that starts with a presumption against preemption. In many cases, that approach produces attractive results because, starting with the Court's standard presumption against preemption, state laws like the Maryland Wal-Mart Act and the new Massachusetts health care law survive legal challenge.

Ultimately, however, this interpretation of ERISA section 514(a) is, for several reasons, unpersuasive. Most importantly, the exemptions of section 514(b) are rendered anomalous if section 514(a) constitutes nothing more than the Court's normal preemption doctrine. From what, then, are the state laws exempted by section 514(b) exempted?

Another alternative to *Shaw* and *Travelers* would be to read section 514(a) as reversing the traditional presumption against preemption and as creating a zone of employer autonomy as to employee welfare plans. I find this the most persuasive of the possible readings of section 514, although under this reasoned textualist approach, the Maryland Wal-Mart Act and the new Massachusetts health law would still be preempted as intruding upon the zone of employee benefit autonomy that ERISA reserves for employers. This leads me to favor the amendment or repeal of section 514. See Zelinsky, *Reasoned Textualism*, *supra* note 112, at 832-34, 836-37, 839-49; Zelinsky, *Wal-Mart*, *supra* note 6, at 867-70.

276. Massachusetts Governor Mitt Romney vetoed the portion of the new Massachusetts law establishing the employer mandates, but the legislature overrode his veto.

Suppose that another state wants to try a single payer system for its residents' medical costs.²⁷⁷ If the state's single payer legislation affirmatively forbids employer-sponsored medical plans, ERISA again preempts that legislation. A state single payer statute explicitly forbidding employers from maintaining ERISA governed welfare plans would relate to such plans for purposes of section 514(a). Even if state legislation establishing a single payer system is silent on the subject of employer plans, that legislation would be ERISA preempted because of its economic effects upon employers' plans. Payments to the state sponsored system would have the indirect but acute (and intended) effect of quashing most, if not all, employer-based medical insurance. Indeed, the advocates of a single payer system view the termination of employment based medical coverage as a major advantage of such a system.²⁷⁸ That state caused termination would itself relate to the employer based plans being terminated.

Prior to *Travelers*, it was common to speak of an ERISA created regulatory gap. ERISA section 514, it was contended, preempted state laws relative to employee welfare plans, in particular, medical plans, without ERISA itself providing any substantive supervision to replace the state laws ERISA preempted. Much of the impetus for a federal Patients' Bill of Rights stemmed from this ERISA created regulatory gap and the inference many drew that federal law needed to fill this gap.²⁷⁹

Travelers and its progeny have, in important measure, closed this regulatory gap. It is, for example, now established that, notwithstanding section 514, standard medical malpractice claims are subject to state tort law, even when negligent medical services are provided through employer financed medical care.²⁸⁰ It is also

277. I am personally skeptical of single payer systems but conclude that, in the interests of experimentation, it would be useful if one or more states tried such a system.

278. See, e.g., Rodberg, *supra* note 259.

279. Edward A. Zelinsky, *Against a Federal Patients' Bill of Rights*, 21 YALE L. & POL'Y REV. 443 (2003), reprinted in NYU REVIEW OF EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION (Alvin D. Lurie ed., 2003); Edward A. Zelinsky, *Against a Federal Patients' Bill of Rights—The Sequel*, in NYU REV. OF EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION § 1.01, at 1-1 to 1-2 (Alvin D. Lurie ed., 2005) [hereinafter Zelinsky, *Sequel*].

280. See *Pegram v. Herdrich*, 530 U.S. 211, 236 (2000) ("The mischief of Herdrich's position would, indeed, go further than mere replication of state malpractice actions with HMO defendants."); see also Edward A. Zelinsky, *Pegram and Preemption: Patients' Rights*

now established that states, via their authority to regulate insurance, can supervise HMOs because HMOs pool risk and thereby function as insurers.²⁸¹ These conclusions have closed much²⁸² of the prior regulatory gap and thereby removed the momentum for federal legislation because the states can, consistent with ERISA, provide tort remedies for medical malpractice and can legislate relative to HMOs.

Although *Travelers* and its offspring have largely closed the ERISA generated regulatory gap, that gap has not been closed in its entirety. The new Massachusetts health law and its status under section 514 evidence the residual regulatory fissure still created by ERISA preemption. Massachusetts can regulate the insurance products purchased by employer plans and, to that extent, can influence those plans indirectly. However, ERISA preempts state law regulating directly the substance of employers' medical plans. In particular, section 514 precludes state regulation of those employers that self fund employee medical care and thereby eschew insurance products subject to state supervision.

Hence, although the scope of ERISA preemption has receded significantly from the expansive vision initially expounded in *Shaw*, section 514 still blocks much useful experimentation by the states, such as the new Massachusetts health law, experimentation that intrudes upon employers' medical arrangements and is thus ERISA preempted. This suggests that section 514(b) should be amended to exempt from ERISA preemption state laws relative to health care or, even better, that section 514 should be abolished altogether.

Because employers that self fund employee medical care are among the principal beneficiaries today of section 514—section 514 protects such employers from state regulations like the new Massachusetts health law and the Maryland Wal-Mart Act—such employers can be expected to resist any effort to repeal or

and the Case for Doing Nothing, 88 TAX NOTES 1053 (2000).

281. See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 386-87 (2002) (upholding Section 4-10 of the Illinois Health Maintenance Organization Act against an ERISA preemption challenge).

282. Not all of the gap has been closed. See *Zelinsky, Sequel, supra* note 279, § 1.01, at 1-1 to 1-3 (discussing the ERISA created limitations on remedies under *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004), and *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002)).

modify section 514. Most such employers are probably unconcerned with statutes like the Maryland and Massachusetts laws, which propound substantive standards most self-funding employers, particularly large employers, satisfy anyway. Rather, motivating self-funding employers' defense of section 514 is the specter of broader, more stringent, and ultimately more expensive state-by-state regulation down the road.

The lesson of the Massachusetts health law is that a system of experimental federalism must give the states ample room to explore different regulatory schemes as they affect employer-provided health care. With ERISA section 514 amended or repealed, some states will choose not to regulate. Others will choose regulation of employer-provided medical care that is quite extensive and stringent. The premise of experimental federalism is the desirability of a plethora of contrasting approaches.

This leads me to oppose proposals to abate ERISA's preemptive effect by establishing a federal commission to which states can submit their respective health care statutes for permission to proceed.²⁸³ Although well intentioned, such proposals are not well advised. States should be free to proceed on their own with the health care experiments they choose. A federal commission with authority to waive ERISA preemption would instead enmesh the states in yet another layer of federal regulation.

In sum, it is hard to envision significant state experimentation with medical coverage that does not run afoul of section 514(a) and ERISA preemption, given the centrality today of employer-provided medical coverage to health care in the United States. ERISA preemption prevents the states from enacting legislation that relates to such employer-provided coverage. ERISA section 514 consequently prevents the states from experimenting with novel approaches to health care, like the new Massachusetts health law. Such experimentation will permit states to adapt to local considerations and preferences, while at the same time providing useful experience and information for the nation as a whole. Congress, accordingly, should alter or abolish ERISA preemption, at least as to health care, to allow Massachusetts and other states to enact

283. See, e.g., The Health Partnership Act, S. 2772, 109th Cong. (2nd Sess. 2006).

their respective experiments with the provision and financing of health care.

CONCLUSION

The principal features of the new Massachusetts health law—the Massachusetts insurance “connector,” the mandates the new law imposes on individuals and employers, and the new Commonwealth Care Health Insurance Program—reflect a bipartisan and eclectic set of compromises. Regrettably, ERISA section 514 preempts key provisions of the new law: the statutory mandate that covered employers offer medical coverage to their employees and make fair and reasonable contributions for such coverage, and the statutory mandate that certain Massachusetts residents must have individual or group medical coverage that constitutes minimum creditable coverage. Under ERISA section 514(a), these statutory mandates unacceptably relate to employer-sponsored medical plans.

Congress should amend section 514 to permit the Massachusetts experiment to go forward. Ideally, and more comprehensively, Congress should amend or repeal ERISA section 514 so that other states may enact their respective experiments in the health care arena.