=H1OF STATE LABORATORIES AND LEGISLATIVE ALLOYS: HOW "FAIR SHARE" LAWS CAN BE WRITTEN TO AVOID ERISA PREEMPTION AND INFLUENCE PRIVATE SECTOR HEALTH CARE REFORM IN AMERICA

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=S1Introduction

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

Justice Brandeis's famous dissent in *New State Ice Co. v. Liebmann* remains apt today, particularly when viewed through the prism of America's developing health care crisis. As health care costs rapidly rise,[2] state and federal deficits increase,[3] and

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

2. For a thorough discussion of the increase in health insurance premium prices over the last six years, see Kaiser Family Foundation, Snapshots: Health Care Costs, available at http://www.kff.org/insurance/snapshot/chcm020707oth.cfm (last visited Sept. 3, 2007).

3. *See* ELIZABETH C. MCNICHOL & IRIS J. LAV, CTR. ON BUDGET & POLICY PRIORITIES, STATE BUDGETS: ON THE EDGE? (2006), http://www.cbpp.org/5-4-06sfp.pdf (discussing the often unstable, sometimes dire nature of many state fiscal budgets); CONGRESSIONAL BUDGET OFFICE, PRELIMINARY ANALYSIS OF THE PRESIDENT'S BUDGET REQUEST FOR 2008,

the rolls of the uninsured swell,[4] the importance of finding new avenues for public and private funding of health care assistance becomes increasingly salient.

In keeping with long-standing tenets of federalism, in recent years several states have taken the lead on trying to solve some of health care's impending difficulties.[5] One

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http://www.cbo.gov/ftpdocs/78xx/doc7836/03-02-Prelim_Analysis.pdf (stating that in 2008 the CBO estimates that the federal deficit under the President's budget will total $226 billion, or 1.6% of GDP).

4. *See* CTR. ON BUDGET & POLICY PRIORITIES, THE NUMBER OF UNINSURED AMERICANS CONTINUED TO RISE IN 2004, *available at* http://www.cbpp.org/8-30-05health.htm (last visited Sept. 3, 2007) (noting how U.S. Census Bureau data from 2004 showed that 45.8 million Americans were without health insurance, up from 45 million in 2003 and 39.8 million in 2000).

5. *See, e.g.*, Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 198 (4th Cir. 2007) (Michael, J., dissenting) ("Innovative ideas for solving the [Medicaid] funding crisis are required, and the federal government, as the co-sponsor of Medicaid, has consistently called upon the states to function as *laboratories* for developing workable solutions.") (emphasis added); Edward A. Zelinsky, *Maryland's "Wal-Mart" Act: Policy and Preemption*, 28

prevailing notion has been to use "pay or play" legislation[6] to shift some of the burden for financing health insurance to the private sector through America's competitive, efficient, and highly imaginative capitalist economy.[7]

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CARDOZO L. REV. 847, 874 & n.125 ("It is a truism of contemporary federalism that states should serve as laboratories of experimentation.").

6. For a survey of the landscape of "pay or play" bills entered into state assemblies in 2006, categorized by state, bill number, number of employees/mandated percentage, status, sponsor(s), and date of introduction, see RETAIL INDUSTRY LEADERS ASSOCIATION, PENDING STATE HEALTH CARE MANDATE MATRIX (2006), http://www.retail-leaders.org/new/resources/matrix.pdf.

7. Already four states (Maine, Massachusetts, Vermont, and Hawaii) have attempted to secure near universal health coverage for their citizens. In January 2007, Gov. Arnold Schwarzenegger of California proposed a $12 billion plan to provide health coverage for all of the state's 36 million residents. If approved, the plan would extend Medi-Cal, the state's Medicaid program, to children and to adults who earn as much as 100% above the federal poverty line. In addition to requiring 2% or 4% revenue contributions from doctors and hospitals, respectively, another provision of the plan would require businesses that

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

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choose not to offer health coverage to pay 4% of their total Social Security wages to a state fund that would be created to subsidize the purchase of coverage by the working uninsured. The cost of such coverage would be measured on a sliding scale depending on what an employee earned, and employees would be able to pay for it using pre-tax dollars. *See* Jennifer Steinhauer, *California Plan for Health Care Would Cover All*, N.Y. TIMES, Jan. 9, 2007, at A6. For the official Governor's Health Care Proposal, see http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf.

8. MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to -107 (West 2006).

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

10. § 8.5-104(b).

fund, which would be used to supplement the State's Medicaid program.

Opponents of the FSA, primarily in the retail and commerce communities, dubbed the Act the "Wal-Mart Law" because the three other in-state employers to which the law could apply were exempted, for reasons explained below.[11] The Retail Industry Leaders Association challenged the Fair Share Act in federal court, alleging that the Act was preempted by federal law. A federal district court held[12] that the Maryland Fair Share Act was preempted by the federal Employment Retirement Income Security Act of 1974 ("ERISA"),[13] and the court's decision was upheld on a 2-1 ruling by the Fourth Circuit Court of Appeals in early 2007.[14]

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11. *See infra* Part I.A.

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

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

14. 475 F.3d 180 (4th Cir. 2007). For a discussion of the Fourth Circuit Court of Appeals' decision, see *infra* section III.C.

This Note examines Maryland's preempted statute and the United States District Court case[15] that granted its opponents declaratory relief. After reviewing the Fair Share Act, the federal ERISA statute,[16] and the significant changes in Supreme Court jurisprudence towards ERISA preemption in the past decade, this Note will offer new approaches through which states can modify the analytical framework outlined by the Fair Share Act to achieve improvements in the state-financing of Medicaid through large private employers. The goal of this Note is to analyze ways to fit future "fair share" legislation within the non-preempted confines of ERISA.

The proposed modifications include: (1) rewriting "fair share" laws as unequivocal, non-regulatory Medicaid taxes from which compliant employers may become exempt; (2) dulling the sharp edge of the FSA's punitive texture through decreasing the 100% shortfall tax to 35-50%; (3) expanding the options that employers have as "outlets" for meeting the 8% health expenditure benchmark, such as through an increase in non-medical fringe benefits, thus giving the statute a less coercive feel; (4) a "total package" benefits approach analogous to unpreempted ERISA prevailing wage cases; and (5) a state-initiated higher minimum

15. RILA v. Fielder, 435 F. Supp. 2d 481 (D. Md. 2006).

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

wage for very large employers, with an incentivized exemption provision stating that an employer can revert back to the state or federal government's general minimum wage if the employer spends a certain percentage of payroll wages on employee health insurance.

Part I of this Note will describe the legislative history and passage of the Maryland Fair Share Act, as well as the role played by Wal-Mart in the retail sector nationally and in Maryland. Part II will provide a brief background on the Employment Retirement Income Security Act of 1974. Subsections within Part II will discuss early Supreme Court jurisprudence regarding ERISA, as well as the interpretive changes of the High Court towards ERISA since the landmark *Travelers* decision in 1995. Part III treats *RILA v. Fielder*, giving particular attention to the rationale employed by Judge Frederick Motz with respect to the Tax Injunction Act and ERISA preemption. The Fourth Circuit's 2-1 affirmance will additionally be briefly discussed.

Part IV introduces modifications for future "fair share" legislation, and Part V proposes an approach focused on rewriting the law as a Medicaid tax, rather than a legislative regulatory mandate. Part V stresses the importance of statutory language, a Medicaid financing purpose, a reduction in the shortfall tax, the

means of collection of the tax, and the legislative record of the statute. Part VI offers a second approach: the introduction of employer size-specific minimum wages and "total package" benefit statutes that provide additional means for employers to meet their minimal expenditure requirements.

Part VII discusses a concern voiced by Judge Motz in *RILA v. Fielder*: the perceived strain on employers' reporting requirements and uniform plan administration. This Part argues that large employers such as Wal-Mart, with a massive workforce and a multitude of health insurance plan offerings, have regularly collected and accessible payroll and personnel data, as well as a plan administration that already cannot be described as "uniform." Lastly, Part VIII will conclude the Note by summarizing the approaches described, and stressing the long-term federal interest in allowing states to act as "laboratories" by shifting to the free market some of the burden of grappling with enlarging Medicaid costs.

=S1I. The Maryland Fair Share Act

=S2A. The Law and Its Background

In 2005 the state legislature of Maryland passed Senate Bill 790 and House Bill 1284, the "Fair Share Health Care Fund Act."[17]

17. MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to -107 (West 2006).

Though vetoed by Governor Robert L. Ehrlich Jr., the Maryland General Assembly overrode the veto on January 12, 2006, enacting[18] the law scheduled to take effect on January 1, 2007.[19] The FSA created a fund to assist the operations of Maryland's Medicaid program, the health insurance program jointly funded by the states and the federal government that serves eligible low-income parents, children, seniors, and people with disabilities.[20] Prior to passing the law, the Maryland legislature learned that "between fiscal years 2003 and 2006, annual expenditures on [Maryland's Medicaid and children's health programs] increased from $3.46 billion to $4.7 billion."[21]

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18. Editorial, *Wal-Mart's Agenda*, WASH. POST, Jan. 13, 2006, at A20.

19. § 8.5-103(a)(1). Since the FSA was held preempted in July 2006, the law was never enacted.

20. For an excellent statistical analysis of health insurance, Medicare, and Medicaid expenditures in all fifty states compared to the United States as a whole, see the Kaiser Family Foundation's State Medicaid Fact Sheets, available at http://www.kff.org/mfs/medicaid.jsp?r1=MD&r2=US (last visited Sept. 3, 2007).

21. Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 183 (4th Cir. 2007).

The FSA's fund was to be replenished through a health care "payroll assessment" on large employers who did not spend at least 8% of their total payroll on health insurance costs. Underpaying employers of more than 10,000 in-state employees[22] were required to pay the difference between their payroll costs and the 8% target set by the statute.[23] The FSA also required such employers to report annually to the Secretary of Labor, Licensing and Regulation their total number of in-state employees, the amount spent by the employer on health insurance, and the percentage of payroll spent by the employer on health insurance costs.[24] As defined by the FSA, "health insurance costs" included payments for "medical care, prescription drugs, vision care, medical savings accounts, and any other costs to provide health benefits"[25] as defined under § 213(d) of the Internal Revenue Code.[26]

In Maryland there are four employers of 10,000 or more employees: Johns Hopkins University, Northrop Grumman Corporation, Giant Food Inc., and Wal-Mart. The law did not apply

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22. MD. CODE ANN., LAB. & EMPL. § 8.5-102 (West 2006).

23. § 8.5-104(b).

24. § 8.5-103.

25. § 8.5-101(d).

26. 26 U.S.C. 213(d) (2006).

to Northrop Grumman, because that company successfully lobbied for a provision in the FSA permitting employers to exclude, for purposes of calculating the percentage of payroll spent on healthcare, compensation paid to employees above the median household income in the state.[27] Johns Hopkins is a non-profit organization that met the lower 6% benchmark set by the FSA for non-profits,[28] and Giant Food Inc.'s health care expenditures already exceed 8% of the total wages it pays to its in-state employees.[29]

The remaining institution affected by the Fair Share Act was Bentonville, Arkansas-based Wal-Mart Stores Inc., an employer of 14,301 individuals in Maryland according to the FSA's 2005 General Assembly Fiscal and Policy Note.[30] The Fiscal and Policy Note commented that some states claim that:

[M]any Wal-Mart employees end up on [their] public

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27. *See* RILA v. Fielder, 435 F. Supp. 2d 481, 485 (D. Md. 2006); MD. CODE ANN., LAB. & EMPL. § 8.5-103(b) (West 2006).

28. § 8.5-104(a).

29. RILA v. Fielder, 435 F. Supp. 2d at 485.

30. Md. Dep't of Legis. Servs, Fiscal and Policy Note (Revised), S. 790, at 3 (2005), *available at* http://mlis.state.md.us/2005rs/fnotes/bil_0000/sb0790.pdf (hereinafter "Fiscal and Policy Note" or "FPN").

> health programs such as Medicaid. A survey by Georgia officials found that more than 10,000 children of Wal-Mart employees were enrolled in the state's children's health insurance program (CHIP) at a cost [to the State] of nearly $10 million annually. Similarly, a North Carolina hospital found that 31% of 1,900 patients who said they were Wal-Mart employees were enrolled in Medicaid, and an additional 16% were uninsured.[31]

The FPN reflects the view held by many that as the largest private employer in the United States, providing work for over 1.36 million people in 4,091 stores,[32] Wal-Mart should not set sub par standards in labor practices and wages. Many argue that Wal-Mart has done just that.[33] In Maryland alone, at the end of

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31. *Id.* at 2.

32. *See* Wal-Mart Facts.com, United States Operational Data Sheet-August 2007, *available at* http://www.walmartfacts.com/articles/5231.aspx (last visited Sept. 3, 2007).

33. *See* Anthony Bianco & Wendy Zellner, *Is Wal-Mart Too Powerful?,* BUS. WEEK, Oct. 6, 2003, at 102 (stating that average wages for full-time Wal-Mart associates in fiscal year 2002 were less than $14,000 per year, versus a federal poverty line of

fiscal year 2004 Wal-Mart paid its 14,301 employees $270 million in total wages, while Giant Food paid $536 million to its 18,902 employees.[34] A Harvard Business School study from 2003 estimated that Wal-Mart spent an average of $3,500 per employee per year on health insurance, while the average spending per employee in the wholesale/retail sector was $4,800, and the average for U.S. employers in general was $5,600 per employee.[35] As the FPN also notes, "Wal-Mart officials say the company provides health coverage to about 537,000 people [nationwide], or 45% of its total work force. As a matter of comparison, Costco Wholesale

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$14,630 for a family of three). In Maryland, the average wage for regular, full-time hourly associates is $10.26 per hour. *See* Wal-Mart Facts.com, Maryland Community Impact, *available at* http://www.walmartfacts.com/StateByState/?id=20 (last visited Sept. 3, 2007).

34. Fiscal and Policy Note, *supra* note 30, at 3. As of July 2007, the total number of Wal-Mart associates in Maryland is 17,123. *See* Wal-Mart Facts.com, Maryland Community Impact, *supra* note 33.

35. *See* Panjak Ghemawat, Stephen Bradley & Ken Mark, *Wal-Mart Stores in 2003*, Harvard Business School Case Study 9-704-430, at 13 (revised Jan. 30, 2004); *see also* Bernard Wysocki, Jr. & Ann Zimmerman, *Wal-Mart Cost-Cutting Finds a Big Target in Health Benefits*, WALL ST. J., Sept. 30, 2003, at 1.

provides health insurance to 96% of eligible employees.[36]

Although focused on Wal-Mart as the quintessential "very large" employer, this Note is genuinely not intended to malign that company. Rather, Wal-Mart and its employee health care policies are being cited because that employer is exemplary of the type of company whose behavior "pay or play" legislation like the Fair Share Act is intended to influence. Although Wal-Mart is the only applicable large employer in Maryland who pays less than 8% of payroll wages towards health insurance, other states have similarly large employers.[37] The important point is that in passing legislation such as the FSA, state legislatures have begun to announce that employers whose policies have unfavorable effects on state public health insurance budgets may now be expected to mitigate the resulting situations by either paying

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36. Fiscal and Policy Note, *supra* note 30, at 3.

37. For a listing of the largest for-profit and non-profit employers in each state, see America's Career Info Net, available at http://www.acinet.org/acinet/select_state.asp?id=11,&nodeid=12&soccode=&next=state1 (last visited Sept. 3, 2007). For example, in Colorado, Allstate Insurance Co. employs 17,000 workers, in New York, Merrill Lynch & Co. Inc. employs 15,000 workers, and in Pennsylvania, Motorola, Inc. employs 12,000 workers.

more to their employees' health insurance, or by paying more to the state to offset the cost to the state's Medicaid funds—and by proxy and its taxpayers—of not doing so.

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

=S1II. Employment Retirement Income Security Act of 1974

=S2A. The Law and Its Background

ERISA is a complex federal statute that was designed to "supersede any and all State laws"[38] that "relate to"[39] employee benefit plans ("EBPs"). By virtue of the Supremacy Clause of Article VI of the U.S. Constitution,[40] Congress may by statute expressly preempt state law. An expansive, voluminous piece of legislation, ERISA deals with the administration of "employee pension benefit plans" and "employee welfare benefit plans."[41] The statute itself defines an "employee welfare benefit plan" as:

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38. *See* ERISA § 514(a), 29 U.S.C. § 1144(a) (2006).

39. *Id.*

40. U.S. CONST. art. IV, § 2.

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

> [A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employer organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness....[42]

ERISA was initially enacted to "protect ... the interests of participants in employee benefit plans and their beneficiaries"[43] by setting out substantive regulatory requirements for EBPs and to "provid[e] for appropriate remedies, sanctions, and ready access to the federal courts."[44]

The purpose of ERISA was thus to provide a predictable, uniform regulatory regime over employee benefit plans. To this end, Congress included broad preemption provisions[45] which were intended to ensure that EBP regulation would be "exclusively a

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42. § 3(1), 29 U.S.C. § 1002(1).

43. § 2(1), 29 U.S.C. § 1001(b).

44. *Id.*

45. § 514(a), 29 U.S.C. § 1144(a).

federal concern."[46] ERISA imposes a variety of administrative requirements on employee welfare plans with respect to such matters as reporting,[47] disclosure,[48] participation and vesting requirements,[49] funding standards,[50] and fiduciary responsibility.[51] Although the statute does not regulate the terms of employee benefit plans, it does preempt regulation of them by state or local governments.[52]

=S2B. Early Supreme Court Interpretation of ERISA

=S31. Health Benefit Mandates

In the first two decades after the passage of ERISA, the Supreme Court took a very narrow view of the extent to which state laws could survive ERISA preemption challenges. Throughout the late 1970s and 1980s, the Supreme Court adopted such a broad

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

47. ERISA §§ 101–111, 29 U.S.C. §§ 1021–1031 (2006).

48. *Id.*

49. §§ 201–211, 29 U.S.C. §§ 1051–1061.

50. §§ 301–308, 29 U.S.C. §§ 1081–1086.

51. §§ 404–414, 29 U.S.C. §§ 1101–1114.

52. JOHN H. LANGBEIN & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW 892 (Foundation Press 3d ed. 2000) (1990).

view of ERISA that preemption of state statutes became essentially routine.[53] One discernible "trigger" for preemption came from state laws that mandated health care benefits. In *Shaw v. Delta Air Lines*,[54] the Court held that § 1144(a)[55] preempted state laws that "relate to" employee benefit plans. The Court found that a law "relates to" an EBP if "it has a connection with or reference to such a plan."[56]

Consequently, a New York Human Rights Law forbidding EBPs from discriminating on the basis of pregnancy, and a Disability Benefits Law requiring employers to pay sick-leave benefits to employees unable to work because of pregnancy or other non-occupational disabilities, were found to sufficiently "relate to" employee benefit plans such that they were struck down. The Court did, however, in this important case sow a discrete jurisprudential seed that would later take on an increased significance: "Some state actions may affect employee benefit plans in *too tenuous, remote, or peripheral a manner* to warrant a finding that the law "relates to" the plan .... [This case is not] a borderline question, and we express no views about where

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53. *Id.* at 892.

54. 463 U.S. 85 (1983).

55. ERISA § 514(a).

56. *Shaw*, 463 U.S. at 97.

it would be appropriate to draw the line."[57] Although vague, this aspect of the *Shaw* holding would figure prominently in the Court's reasoning in the later *Travelers* decision.[58]

=S2C. The New Paradigm: The *Travelers*, *Dillingham*, and *De Buono* Trilogy

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

=S31. Travelers

If Supreme Court case law for the first two decades following ERISA's enactment may be described as broad in its preemptive scope, then precedent from the last twelve years must

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57. *Id.* at 100, n.21 (citations omitted) (emphasis added); *see also* Dist. of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 130 n.1 (1992) (holding that ERISA preempts state and local workers' compensation laws that require employers who provide health insurance for their employees to provide equivalent health insurance coverage for injured employees eligible for workers' compensation benefits).

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

be described as treating preemption in a much more nuanced and less reflexive manner. One watershed 1995 case in particular "narrow[ed] [the Court's] interpretation of the scope of ERISA preemption" and "adopted a pragmatic approach"[59] to determining whether a state law "relates to" an employee benefit plan. This case, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.* ("*Travelers*"),[60] established a new framework for preemption analysis because, in the words of Justice Souter, the *Shaw* analysis "d[id] not give [the Court] much help [in] drawing the line"[61] for where the phrase "relates to" ends.

In *Travelers*, the unanimous Court examined a New York statute[62] that required hospitals to collect surcharges on hospital bills from patients covered by commercial insurers, but *not* from patients insured by Medicare or Empire Blue Cross/ Blue Shield ("BC/BS") plans. Many of the commercial insurance patients had insurance purchased by employee health care plans governed by

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59. Coyne & Delany Co. v. Selman, 98 F.3d 1457, 1468 (4th Cir. 1996).

60. 514 U.S. 645 (1995).

61. *Travelers*, 514 U.S. at 655.

62. N.Y. PUB. HEALTH LAW § 2807-c (Gould 2006).

ERISA.[63] The statute also subjected most health maintenance organizations (HMOs) to surcharges that varied with the number of Medicaid recipients that they enrolled.[64] The revenue collected by these 9%–24% surcharges was used to subsidize the state's Medicaid program.[65]

The Court began its analysis by stating clearly that questions of preemption must start with the presumption that Congress does not intend to supplant state law.[66] Because preemption claims turn on Congress's intent, the Court examined ERISA's language and history. Justice Souter remarked:

> The governing text of ERISA is clearly expansive. [O]ne might be excused for wondering, at first blush, whether the words of limitation ("insofar as they ... relate") do much limiting. If "relate to" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for "really, universally, relations stop nowhere." But that, of course, would be to read Congress's words of limitation as mere sham, and to

63. *Travelers*, 514 U.S. at 650.

64. *Travelers*, 514 U.S. at 649.

65. *Travelers*, 514 U.S. at 654.

66. *Id.*

> read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality.[67]

The Court rejected any argument that the New York statute "related to" an employee benefit plan through "reference to"[68] it, since the surcharges were imposed upon patients and HMOs regardless of whether the commercial coverage was secured by an ERISA plan.[69] The Court next took up whether the statute "related to" an EBP through a "connection with"[70] such a plan. Stating that "[f]or the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections,"[71] the Court declared that it had to "go beyond the unhelpful text [of § 1144] and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive."[72]

Noting that a primary goal of ERISA's passage was "to ensure

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67. *Id.* (citations omitted).

68. *See* Shaw v. Delta Air Lines, 463 U.S. 85, 96-97 (1983).

69. *Travelers*, 514 U.S. at 656.

70. *See Shaw*, 463 U.S. at 96-97.

71. *Travelers*, 514 U.S. at 656.

72. *Id.*

that plans and plan sponsors would be subject to a uniform body of benefits law,"[73] and thus "minimize the administrative and financial burden of complying with conflicting directives among States,"[74] the Court differentiated the New York surcharge statute from prior preemption cases. The Court held that that even though the surcharges that BC/BS plan holders were exempt from exerted an "indirect economic effect" on commercial insurance buyers and ERISA plans, by making BC/BS more attractive competitively, the Court significantly held that:

> [a]n indirect economic influence, however, *does not bind plan administrators to any particular choice* and thus function as a regulation of an ERISA plan itself .... *Nor does the indirect influence of the surcharges preclude uniform administrative practice* ... if a plan wishes to provide one. It simply bears on the costs of benefits and the relative costs of competing insurance to provide them. It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can

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73. *Travelers*, 514 U.S. at 656 (citing Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990)).

74. *Id.*

get, surcharges or no surcharges.[75]

As such, although the surcharges had an indirect economic influence on ERISA plans, they were not preempted by ERISA because they neither sufficiently "related to" employee benefit plans, nor adopted "acute"[76] schemes of coverage that effectively restricted an ERISA plan's choice of insurers.

Justice Souter concluded his analysis in *Travelers* by writing that to read § 1144's[77] preemption provision as nullifying all state laws that affect the costs and charges of EBPs, simply because they "indirectly relate"[78] to ERISA plans, "would effectively read the limiting language in § [1144](a) out of the statute, a conclusion that would violate basic principles of statutory interpretation"[79] and go against the previously enunciated principle that "pre-emption does not occur ... if the state law has only a tenuous, remote, or peripheral connection with covered plans."[80] Having examined ERISA, the Court found

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75. *Travelers*, 514 U.S. at 659-660 (emphasis added).

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

77. ERISA § 514.

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

79. *Id.*

80. *Id.* (quoting Shaw v. Delta Air Lines, 463 U.S. 85, 100 n.21 (1983); Dist. of Columbia v. Greater Wash. Bd. of Trade, 506 U.S.

that there was "nothing in the language of the Act or the context of its passage [which] indicate[d] that Congress chose to displace general health care regulation, which historically has been a matter of local concern."[81]

=S32. Dillingham

Building on its decision in *Travelers*, the Supreme Court further refined its ERISA preemption analysis in the case of *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.* ("*Dillingham*").[82] In *Dillingham* the Court dealt with a California prevailing wage statute[83] that required contractors on public works projects to pay their workers the local prevailing wage—typically the local union wage—except that apprentices in state-approved apprenticeship programs could be paid less than the prevailing wage.[84]

An employee benefit plan under ERISA includes apprenticeship programs.[85] Despite this, under the California statute an approved apprenticeship program did not necessarily need to be an

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125, 130 n.1 (1992)).

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

82. 519 U.S. 316 (1997).

83. CAL. LAB. CODE ANN. § 1771 (West 1989).

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

85. *See* ERISA § 3(1), 29 U.S.C. § 1002(1) (2006).

employee benefit plan, because the program's "costs [could] be defrayed out of that employer's general assets."[86] So, because the prevailing wage law was facially and technically "indifferent"[87] to the funding of the apprenticeship program and any ERISA coverage, Justice Thomas, writing for a unanimous Court, found that the statute did not make "reference to" ERISA plans.[88]

Turning next to the question of whether the wage law had a "connection with" ERISA plans, the Court found that "in every relevant respect, California's prevailing wage statute [wa]s indistinguishable from New York's surcharge program."[89] Like New York hospital surcharges in *Travelers*, the Court believed that the wages paid on state public works projects had long been regulated by the States,[90] and that the wages to be paid to apprentices on such projects were quite remote from the reporting, disclosure, and fiduciary duty areas with which ERISA is expressly concerned.[91] Reiterating the view from *Travelers*

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86. *Dillingham*, 519 U.S. at 326.

87. *Dillingham*, 519 U.S. at 328.

88. *Id.*

89. *Dillingham*, 519 U.S. at 330.

90. *Id.*

91. *Id.*

that a reading of ERISA preemption that would supplant "traditionally state-regulated substantive law in those areas where ERISA has nothing to say would be 'unsettling,'"[92] the Court held that the lack of positive indications from Congress that it intended to supersede the historic police powers of the States was sufficient here to sustain the law.

The Court found that the effect of the statute—a wage differential that made state-approved apprentice program members economically more attractive to employers because of their lower labor costs—did "not bind ERISA plans to anything."[93] Justice Thomas noted that the effect of the statute on ERISA apprenticeship programs was "merely to provide some measure of *economic incentive to comport with the State's requirements*, at least to the extent that those programs seek to provide apprentices who can work on public works projects at a lower wage."[94] The Court stated that it had not been demonstrated that the "added inducement created by the wage break"[95] was

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

93. *Dillingham*, 519 U.S. at 332.

94. *Id.* (emphasis added).

95. *Dillingham*, 519 U.S. at 333.

"tantamount to a compulsion upon apprenticeship programs,"[96] and thus it was legal.

=S33. De Buono

The final case in the *Travelers* trilogy is *De Buono v. NYSA-ILA Medical and Clinical Services Fund* ("*De Buono*").[97] *De Buono* dealt with a state statute[98] that imposed a tax on gross receipts for patient services at hospitals, residential health care facilities, and diagnostic treatment centers.[99] The tax applied equally to medical centers that were owned and operated by an ERISA plan. The revenue raised from the tax, called the Health Facility Assessment ("HFA"), would become part of the state's general revenues.[100] According to the Court, the statute came about because in 1990 the New York General Assembly was "faced with the choice of either curtailing its Medicaid program or generating additional revenue to reduce the program deficit,"[101] a choice reminiscent of Maryland today, and it chose the latter.

The respondents in the case were the trustees of a fund that

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96. *Id.*

97. 520 U.S. 806 (1997).

98. N.Y. PUB. HEALTH LAW § 2807-d (Gould 1990).

99. *De Buono*, 520 U.S. at 809-10.

100. *Id.*

101. *De Buono*, 520 U.S. at 809.

administered a self-insured, multiemployer welfare benefit plan, which owned three medical centers that provided health care benefits to individuals.[102] Respondents argued that because they paid HFA assessments totalling $7,066 based on their hospitals' patient income of $1,177,670, the law "related to" the fund within the meaning of § 1144(a)[103] of ERISA, and was therefore preempted as it applied to the practice of hospitals being run by ERISA plans.[104]

The Court was unpersuaded. Again citing the "historic police powers of the State[,] includ[ing] the regulation of matters of health and safety,"[105] Justice Stevens found that the Health Facility Assessment was a revenue raising measure that clearly operated in a field that had been traditionally occupied by the States.[106] The Court did not find that the respondents had met their "considerable burden" of overcoming the "starting presumption that Congress does not intend to supplant state law."[107] The state tax on hospital gross receipts was likened to

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102. *De Buono*, 520 U.S. at 810.

103. ERISA § 514(a).

104. *Id.*

105. *De Buono*, 520 U.S. at 814.

106. *Id.*

107. *Id.* (quoting N.Y. State Conference of Blue Cross & Blue

the state laws of general applicability in *Travelers* and *Dillingham* that "impose[d] some burdens on the administration of ERISA plans but nevertheless d[id] not 'relate to' them within the meaning of the governing statute."[108]

Finding that the HFA was a tax on hospitals, most of which are not owned by ERISA plans or funds, the Court declared that "[a]ny state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute."[109] As such, the state tax that was intended to raise revenue for New York's Medicaid program was held to be valid.

With this discussion of historic and recent Supreme Court

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Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654 (1995)).

108. *De Buono*, 520 U.S. at 815.

109. *De Buono*, 520 U.S. at 816. Note also that the Court found: "As we acknowledged in *Travelers*, there might be a state law whose economic effects, intentionally or otherwise, were so acute 'as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers' and such a state law 'might indeed be pre-empted under § [1144].' That is not the case here." *Id.* (citations omitted).

ERISA jurisprudence in mind, it is now possible to contextualize the Maryland General Assembly's passage of the Fair Share Act over Governor Ehrlich's veto. Likewise, the rationale and legal reasoning employed by Judge Motz in *RILA v. Fielder* are now understandable within the ERISA preemption framework outlined by the High Court.

=S1III. Retail Industry Leaders Association v. Fielder

On July 19, 2006, the United States District Court for the District of Maryland held in the case of *Retail Industry Leaders Association v. Fielder* ("*RILA v. Fielder*")[110] that the Maryland Fair Share Act was preempted by the federal Employment Retirement Income Security Act of 1974. Two major questions posed by the Maryland law were treated in the opinion: the federal Tax Injunction Act and ERISA preemption.[111]

=S2A. Tax Injunction Act

The court's discussion of taxes and regulatory fees is germane to any future prescriptive offering to other states about how to structure "pay or play" legislation. Maryland argued that the FSA's "payroll assessment" was in fact a "payroll tax" on

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110. 435 F. Supp. 2d 481 (D. Md. 2006).

111. Judge Motz's discussion of standing and his dismissal of RILA's equal protection discrimination claim will not be discussed, as they are outside the scope of this Note.

covered employers. It did this, it seems, because of the Tax Injunction Act[112] ("TIA") of the United States Code. In its entirety, the Tax Injunction Act reads: "The district courts shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State."[113] Because Maryland state courts could serve as an adequate forum for a "plain, speedy and efficient remedy" if they had heard the case, the state argued that the Fair Share Act was a payroll tax in order to, in the words of Judge Motz, "strip[] this [federal] court of jurisdiction to hear the case."[114]

While the court ultimately found that the Fair Share Act was not a tax, the reasoning employed by Judge Motz is nonetheless instructive. In ascertaining whether the FSA was a tax (which would trigger the Tax Injunction Act and remove the case to state court), or a regulatory fee (which would not), the court looked to prior case law dealing with attempts to differentiate between taxes and regulatory fees. The court cited an opinion by then-Chief Judge Stephen Breyer stating that:

The classic "tax" is imposed by a legislature upon

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112. 28 U.S.C. § 1341 (2006).

113. *Id.*

114. *RILA*, 435 F. Supp. 2d at 501.

> many, or all, citizens. It raises money, contributed to a general fund, and spent for the benefits of the entire community. The classic "regulatory fee" is imposed by an agency upon those subject to its regulation. It may serve regulatory purposes directly by, for example, deliberately discouraging particular conduct by making it more expensive. Or, it may serve such purposes indirectly by, for example, raising money placed in a special fund to help defray the agency's regulation-related expenses.[115]

Judge Motz additionally opined, "In close cases 'the most important factor becomes the purpose behind the statute, or regulation, which imposes the charge.'"[116]

The District Court found problematic the fact that under the FSA the responsibility for collecting any payments from for-profit employers not meeting the 8% "health insurance costs" benchmark was placed upon the Department of Labor, Licensing and Regulation, instead of the state treasurer (here the Comptroller

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115. *RILA*, 435 F. Supp. 2d at 490 (quoting San Juan Cellular Tel. Co. v. Pub. Serv. Comm'n, 967 F.2d 683, 685 (1st Cir. 1992) (citations omitted)).

116. *RILA*, 435 F. Supp. 2d at 491 (quoting Valero Terrestrial Corp. v. Caffrey, 205 F.3d 130, 134 (4th Cir. 2000)).

of Maryland).[117] In the eyes of Judge Motz, "This [wa]s not merely a formal matter," but rather it "reflect[ed] the underlying reality that the potential assessment imposed by the Act. . .[was] part and parcel of a regulatory process designed to implement a health care mandate."[118]

The court reviewed whether the purpose of the statute was to raise revenue or to punish large employers. Looking to the legislative history behind the Fair Share Act, in which no sponsor of the FSA ever referred to the assessment as a "tax," and in which Wal-Mart seemed to be targeted by certain legislators, the court concluded that "the General Assembly neither intended nor contemplated that the Act would raise any revenue for the State. To the contrary, its purpose was to force Wal-Mart to increase the level of its health care benefits."[119] As such, Judge Motz held that the Fair Share Act fell under the

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117. *RILA*, 435 F. Supp. 2d at 491. The treasurer or comptroller is typically the individual whose primary duty is to collect taxes. *See, e.g.*, Comptroller of Maryland's Homepage, Comptroller of Maryland Duties, http://www.comp.state.md.us/comptroller/duties.asp (last visited Sept. 3, 2007).

118. *RILA*, 435 F. Supp. 2d at 491.

119. *RILA*, 435 F. Supp. 2d at 493.

penumbra of a "regulatory fee," and thus the Tax Injunction Act did not divest the federal court of jurisdiction.

=S2B. ERISA Preemption

The District Court began its preemption analysis by stating that it found that the FSA had a "connection with" an ERISA plan, and was thus preempted on that basis. Judge Motz recalled from *Travelers* that "the main objective of ERISA's preemption clause is to 'avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.'"[120]

The court found that the Fair Share Act created health care spending requirements that were either not applicable for multi-state employers in other jurisdictions, or came into conflict with "fair share" legislation in other states.[121] It held that the

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120. *RILA*, 435 F. Supp. 2d at 494 (quoting N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995)).

121. *RILA*, 435 F. Supp. 2d at 494–95; *see, e.g.,* N.Y.C. ADMIN CODE § 22–506(c)(2) (Gould 2006) & Suffolk County, N.Y., REG. LOCAL LAW § 335-3(A) (Gould 2006) (requiring Wal-Mart to spend an amount annually on health care, as determined by an administrative agency); Oklahoma H.B. 2678, 50th Leg., 2d Sess. (2006) (providing for an almost identical regime as Maryland's Fair Share Act; not yet voted on at the time of this writing);

"intended effect"[122] of the FSA was to "force Wal-Mart to increase its contribution to its health benefit plan, which is an ERISA plan, and the actual effect of the Act will be to coerce Wal-Mart into doing so."[123] Asserting that the State of Maryland "over-read" the *Travelers* trilogy cases on which it relied, Judge Motz said that he found nothing in those cases suggesting that the Supreme Court "would now uphold a state statute or local ordinance mandating that an employer provide a certain type or monetary level of welfare benefits in an ERISA plan."[124]

To specifically refute any analogy to the statutes described in the *Travelers*, *Dillingham*, and *De Buono* cases, the District Court argued that they "lie at the periphery of ERISA analysis, not (as does the Fair Share Act) at its core."[125] After briefly describing the state laws at issue in those cases, Judge Motz

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Minnesota H.F. 3143, 84th Leg., Sess. (2006) (calculating total wages, from which an employer's minimum spending level is determined, with reference to Minnesota's median house income). *See also supra* note 5 for a listing of "fair share" laws circulating in state legislatures during 2006.

122. *RILA*, 435 F. Supp. at 495.

123. *Id.*

124. *Id.*

125. *Id.*

contrasted them with the Fair Share Act. He contended that the FSA was "not merely tangentially related to ERISA plans but [wa]s focused upon them."[126] He drew upon the legislative history of the FSA to say that the law was targeted directly at the ERISA plan of a singular employer, the effect of which was direct because it would require Wal-Mart to increase its in-state health care benefits and administer its plan in a manner that would ensure that the statutory spending required by the FSA was met.[127] This was seen as violating ERISA's purpose of providing for uniform national benefits and administration.

The District Court of Maryland also took issue with the State's argument that the Fair Share Act was not a mandate. While the Secretary maintained that employers could comply with the law without increasing its health care benefits, by either (1) contributing to Health Savings Accounts ("HSAs"), (2) spending 8% of payroll on first aid facilities (as allowed in the FSA's text), or (3) simply paying a sum equaling 8% of payroll wages to the State without increasing health care expenditures, the court was not swayed.[128] Faulting the HSA proposal because those accounts must be initiated by employees, rejecting the first aid

126. *RILA*, 435 F. Supp. 2d at 496.

127. *Id.*

128. *RILA*, 435 F. Supp. 2d at 497-98.

facilities suggestion as unrealistic, and saying that the payment of equal funds to the State rather than employees would be irrational,[129] Judge Motz viewed the Fair Share Act as "imposing a substantive mandate"[130] that had a "connection with" an ERISA plan, and was thus preempted.

=S2C. The Fourth Circuit Court of Appeals' Decision

In many ways, the opinion and dissent in the Fourth Circuit's *Retail Industry Leaders Association v. Fielder*[131] decision were merely a seconding of the respective arguments of Wal-Mart and the state of Maryland. In his affirming opinion for the Circuit, Judge Niemeyer wrote that "a state law that directly regulates the structuring or administration of an ERISA plan is not saved by inclusion of a means for opting out of its requirements."[132] This dispatched with the notion that just because affected employers had the option of not paying higher

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129. *Id.*

130. *RILA*, 435 F. Supp. 2d at 497.

131. 475 F.3d 180 (4th Cir. 2007).

132. 475 F.3d at 192 (citing Egelhoff v. Egelhoff, 532 U.S. 141, 150-51 (2001) (holding that ERISA preempted a Washington State law voiding the designation of a spouse as the beneficiary of a nonprobate asset, such as a life insurance plan, if the plan was governed or related to ERISA)).

amounts to their employees' ERISA-governed plans, by instead paying the difference to the state, that it represented a non-coercive choice that did not implicate ERISA. Further arguing that the Fair Share Act specifically targeted Wal-Mart, the majority found that unlike *Travelers* and *Dillingham*, the Maryland law in question "directly regulates employers' structuring of their employee health benefit plans. This tighter causal link between the regulation and employers' ERISA plans makes the Fair Share Act much more analogous to the regulations at issue in *Shaw* and *Egelhoff*, both of which were found preempted by ERISA."[133]

Judge Michael's dissent, however, found the Act to be an appropriate and legal response by the state to "wrestling with explosive growth in the cost of Medicaid."[134] For the sole dissenter in this 2-1 decision, the fact that the FSA offered covered employers the option of paying an assessment into a state fund to support Medicaid, thus offering a means of compliance that did not impact ERISA (since an ERISA plan technically did not need to exist to comply with the law), was determinative.[135]

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133. 475 F.3d at 195-96.

134. 475 F.3d at 198 (Michael, J., dissenting).

135. 475 F.3d at 201 (Michael, J., dissenting) ("An employer can comply with the Act either by paying assessments into the special fund or by increasing spending on employee health insurance. The

Judge Michael was likewise unpersuaded by the argument that the Act would impede large employers' ability to administer ERISA plans, since the FSA did not dictate a plan's system for processing claims, paying benefits or determining beneficiaries,[136] and the Act's reporting requirements to the secretary were normal calculations of the cost of benefits and the number of payees that employers such as Wal-Mart already regularly recorded.

=S1IV. Modifications for Future "Fair Share" Legislation

Having reviewed ERISA, the Fair Share Act, and the federal district court case that preempted it, it is now possible to turn to the ways in which other states can draft legislation that avoids some of the pratfalls of Maryland's ill-fated statute. As delineated by Judge Motz in *RILA v. Fielder*, sometimes the voids were relatively minor: suspect aspects of the legislative record, or the title of the individual whose job was to oversee the collection of revenues. Other times, the deficiencies were more serious: unrealistic alternate avenues for non-health insurance expenditures and uniform administration of plans. The following sections seek to offer potential remedies to some of the ailments

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Act expresses no preference for one method of Medicaid support or the other. As a result, the Act is not preempted by ERISA.").

136. 475 F.3d 180, 202.

endemic to the Fair Share Act, in hopes of elucidating for other states how to craft workable "fair share" legislation.

=S1V. Approach #1: Re-Write the Law as a Medicaid Tax, Not a Regulatory Mandate

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

=S2A. Statutory Language and Medicaid Financing Purpose

Under this first approach, it is paramount that future laws hoping to influence employer health care spending be unambiguously written as Medicaid taxes falling within an "area[] traditionally subject to local regulation:"[137] the financing of public health programs. In this regard, the language and purpose of the statutes must evolve from the Fair Share Act's current position. They can no longer be written as legislative regulatory mandates, implicitly designed to force employers to increase health care benefits; they must instead be written to genuinely aid in the funding of state Medicaid budgets and low-income health insurance programs. Achieving this fundamental step

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

through a revenue-raising tax, and correctly using the language necessary to do so, will greatly alter the interpretation and feel of these laws.

First, the vagueness of terms like "payroll assessment" must be eliminated, replaced with clear language that removes the specter of the gray area between a tax and a regulatory fee. A "Medicaid tax" is not only semantically more direct, but it is also a better description of the true purpose of the law, in keeping with Judge Motz's view that "the most important factor becomes the purpose behind the statute, or regulation, which imposes the charge."[138]

The Medicaid tax is designed to ease the burden and facilitate the state's traditional police power of providing for the health and safety of its citizens, and as such, its only concern must be raising general revenues for the state's Medicaid funds. Moreover, a Medicaid tax for revenue-generating purposes is also much more likely than a payroll assessment to trigger the Tax Injunction Act if challenged,[139] potentially keeping jurisdiction of the lawsuit in state court.

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138. *RILA*, 435 F. Supp. at 491 (quoting Valero Terrestrial Corp. v. Caffrey, 205 F.3d 130, 134 (4th Cir. 2000)).

139. 28 U.S.C. § 1341 (2006). *See supra* Part III.A. for a discussion of the Tax Injunction Act.

Second, such laws must contain a *tax credit* and a specific *exemption* provision for employers that would prefer to comply with the Medicaid tax indirectly, by investing in employee health care what they would otherwise pay the state. Again, the credit and exemption provisions are merely alternatives to the main thrust of the law, which is to serve as a revenue-raising Medicaid tax. For instance, one iteration of this scheme would be an across-the-board Medicaid tax of 10% of total payroll wages paid by in-state employers with 10,000 or more employees, to be paid directly to the state's Medicaid budget. Every employer must consequently pay 10% of total payroll wages to the state to satisfy the universal Medicaid tax, but a tax credit could be applied for each percentage that the employer spent on individual employees' health insurance instead. It is thus an option, not the transparent requirement that existed in the Fair Share Act.

Under this scenario, an employer who spends 4% of its payroll wages on employee health insurance costs would have an automatic 4% tax credit, leaving it to pay 6% more to the state to meet the Medicaid tax's requirement.[140] Likewise, an employer

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140. *See infra* Part V.C. for the discussion of the shortfall reduction, which would actually decrease the remaining amount owed by the employer under the Medicaid tax, if the employer

who already spends 10% of total payroll wages on health insurance costs would opt out of the Medicaid tax by virtue of its tax credits and thus be exempt. The exemption provision should not, however, be the tacit aim of the statute. It must be secondary, existing only to allow employers to generate good will with their employees if they so choose, rather than directly paying the tax to the state, as the law requires.

=S2B. Legislative Record and Collection of the Tax

In *RILA v. Fielder*, Judge Motz objected to the Wal-Mart references in the Fair Share Act's congressional record, and to statements evincing a purpose other than that of raising revenue.[141] These maladies are easily fixable for future legislation. Firstly, General Assembly members and any accompanying Fiscal and Policy Notes should refer to the bill at all times as what legislators want state and federal courts to consider it: a Medicaid tax. Secondly, the text of the statute and the lawmakers discussing it should never single out an individual employer or a certain type of employer (beyond those of a specified in-state workforce size). The actual class sizes for this kind of legislation should be theoretically unlimited, in keeping with the argument that "[a]n assessment imposed upon a

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chose to spend it directly on employee health insurance costs.

141. 435 F. Supp. 2d 481, 492–493.

broad class of parties is more likely to be a tax than an assessment imposed upon a narrow class."[142] Thirdly, states should consider setting benchmarks for employers of other sizes, so as to dull the feel of singling out only large employers. For example, a 3% Medicaid tax rate could be applied to employers with *fewer* than 10,000 employees in the state.

Another significant modification that may appear at first blush to be merely cosmetic is the path of the legislative bill in committee. Judge Motz expressed his concern that "the House of Delegates referred the bill to the Committee on Health and Government Operations, not to the Ways and Means Committee, which has jurisdiction over 'state and local taxation matters.'"[143] Consequently, lawmakers should ensure that Medicaid tax legislation passes through only those committees that deal with

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142. *RILA*, 435 F. Supp. at 491 (quoting Bidart Bros. v. Cal. Apple Comm'n, 73 F.3d 925, 931 (holding that an assessment was more like a regulatory fee because the impacted class was limited to only California apple produces)). *But see* Antosh v. City of College Park, 341 F. Supp. 2d 565, 568 (D. Md. 2004) (holding that a trash-collection charge was more like a tax because the impacted class consisted of all people who lived in single-family rental homes or apartments).

143. *RILA*, 435 F. Supp. at 493 n.11.

taxes. The Ways and Means Committee, Budget and Taxation Committee, the Finance Committee, and their counterparts in different states, should take the lead on drafting the Medicaid tax and performing markups. Moreover, it is essential that the law be codified in the state tax code, rather than something such as the Labor and Employment Code,[144] to underscore its purpose as a legitimate tax to raise revenue for the benefit of the general public.[145]

Another important feature of the Medicaid tax is the determination of whose eventual responsibility it will be to collect the revenue raised by the tax. In *RILA v. Fielder*, the court noted that "[i]f the responsibility for administering or collecting the assessment lies with the general tax assessor, it is more likely to be a tax; if this responsibility lies with a regulatory agency, it is more likely to be a fee."[146] Pointing out

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144. *Id.*

145. *RILA*, 435 F. Supp. at 492 (stating that "a court ordinarily asks whether ultimately the general public will benefit from the revenue raise or whether the benefits 'are more narrowly circumscribed.'") (quoting Valero v. Caffrey, 205 F.3d 130, 134 (4th Cir. 2000)).

146. *RILA*, 435 F. Supp. at 491 (quoting Collins Holding Corp. v. Jasper County, 123 F.3d 797, 800 (4th Cir. 1997)).

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

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

=S2C. Reduce the Shortfall Tax

Under the Fair Share Act, an employer who did not meet the for-profit 8% threshold was required to pay 100% of the difference between the percentage of its actual total wages paid towards health insurance, and the 8% mark. In effect, as the law was written, if Wal-Mart did not meet the 8% barrier, then it would have to match the shortfall by a one dollar-to-one dollar ratio either to Maryland or to its employees. It is for this reason that the court in *RILA v. Fielder* found the regulatory

mandate to be a "Hobson's choice,"[147] because the law felt coercive and unlike a real choice at all.

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

For instance, as in the scenario described *supra* in Part V.A., for a state with a Medicaid tax having a minimum threshold of 10% of total wages paid, an employer who already spends 4% of its payroll wages towards health insurance costs would be required under the Medicaid tax to pay the state the remaining 6%. However, with a shortfall tax of 50%, rather than the 100% found in the Maryland FSA, the employer would be able to spend

147. *RILA*, 435 F. Supp. 2d at 497 (quoting *Travelers*, 514 U.S. at 664).

only 3% (i.e., 50% of 6%) of payroll wages on employee health insurance and meet its requirement, rather than paying the full 6% to the state. Under this scenario, an economic incentive in the mold of *Dillingham* and the lack of a Hobson's choice would likely change the employer's cost-benefit analysis. After all, although the court in *RILA v. Fielder* suggested that forcing an employer to choose between paying 100% to the state or 100% to its employees was no choice at all, here there is a significant difference between a company paying $1 to the state or $.35 to $.50 to its employees.

States should adopt a tax rate on the shortfall that approximates the highest marginal income tax for that state,[148] which usually falls somewhere between 35%–50%. When the rate is higher than that, and especially when it is 100%, courts are much more likely to view the statute as patently punitive, a reality that played out in Judge Motz's examination. A 50-percent-and-below rate, however, is a figure that not only looks like a normal tax or surcharge, but it is also in line with the "indirect economic influence" language of *Travelers* and *De Buono.*

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148. For a listing of state individual income tax rates for tax year 2007, see http://www.taxadmin.org/fta/rate/ind_inc.html (last visited Sept. 3, 2007).

A reasonable shortfall tax on employer wages, coupled with tax credits for the state's Medicaid financing scheme—a function within traditional state regulation—is less punitive and operates irrespective of whether an employer utilizes ERISA plans.

The result of a legitimate Medicaid tax with (1) a built-in tax credit based on the employers' present health care expenditures, (2) an exemption for employers who prefer to pay the tax funds in full to its employees that it would have paid the state, and (3) a 35%-50% shortfall tax rate, is no longer a coercive legislative mandate. It now becomes a choice and a matter of preference to employers. The Medicaid tax would exert an "indirect economic influence"[149] as it did in *Travelers*, but this non-acute influence would "[neither] bind plan administrators to any particular choice,"[150] nor sufficiently "relate to" employee benefit plans. As in *Dillingham*, the effect of the state statute would be "merely to provide some measure of economic incentive to comport with the State's requirements,"[151] here, in the form of a Medicaid tax.

=S1VI. Approach #2: Minimum Wage and "Total Package" Benefits

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

150. *Id.*

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

=S2A. Employer Size-Specific Minimum Wages

One very important conclusion from the *Dillingham* case[152] was that where a state law functions independently or irrespectively of an ERISA plan, the state law does not necessarily have a sufficient "connection with" or "refer to" an ERISA plan.[153] In *Dillingham*, both ERISA and non-ERISA covered apprenticeship programs could be approved under the California prevailing wage statute, so the Court found that the law was "indifferent" to ERISA, even though the vast majority of state-approved apprenticeship programs were in fact ERISA plans.[154]

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

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152. See supra, Part II.C.2.

153. Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 325-28 (quoting Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 139 (1990).

154. *Dillingham,* 519 U.S. at 327 n.5.

The purpose of such a minimum wage statute would be to have employers put money into the hands of low-income employees who otherwise would be mathematically at risk of needing public health insurance assistance, given sub par employer health coverage. As stated above, the average national wages for full-time Wal-Mart associates in fiscal year 2002 were less than $14,000 per year, versus a federal poverty line of $14,630 for a family of three.[155] Although it would be impossible to ensure that the resources gained from a higher minimum wage would definitely be spent on health care costs, it would at the very least put employees in a position to do so. Furthermore, this approach is not coercive, because it does not in any way require the employer to interact with ERISA plans, while it may have the direct effect of allowing individual employees to better control their own health care needs.

A size-specific minimum wage would borrow from prevailing wage cases, in which a standard is set for employers to pay employees who work on certain projects or have taken part in certain programs. A state-wide prevailing minimum wage for large employers (e.g., over 10,000 employees) is not irrational, given that many employees for such companies are already paid according

155. Bianco & Zellner, *supra* note 33.

to the federal or state minimum wage, and many of these same workers are at a high risk, relative to other workers, of becoming part of the state's Medicaid program. Moreover, it is also quite commonplace for states to enact minimum wages higher than the federal government's, as is the case in Alaska, California, Connecticut, Delaware, Florida, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, New Jersey, New York, Oregon, Rhode Island, Vermont, Washington, and Wisconsin.[156]

In many ways, requiring employers of a certain size to raise their employee wages is not unlike New York's hospital surcharge in *Travelers*, nor the wage differential created in *Dillingham*. In

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156. To see the specific wages in these states, see Department of Labor, Minimum Wage Laws in the States – July 24, 2007, *available at* http://www.dol.gov/esa/minwage/america.htm (last visited Sept. 3, 2007). Note that thirty states have a minimum wage higher than the federal minimum wage. A trend is apparent as well, given the number of minimum wage increases that were approved in 2006 through ballot measures in Arizona (66%), Colorado (53%), Missouri (76%), Montana (73%), Nevada (69%), and Ohio (56%), CNN.com – Elections 2006, http://www.cnn.com/ELECTION/2006/pages/results/ballot.measures/ (last visited Sept. 3, 2007).

both of those cases the state tax or prevailing wage had the effect of providing some measure of indirect economic influence or incentive, but they did not bind ERISA plans or lead to undue administrative burdens. The same would be true in the case of a statute requiring that, for example, in-state employers of more than 10,000 workers must pay $2.00 more than the state's present minimum wage.[157]

There could, of course, be a provision written into the minimum wage statute that would allow employers to be exempt from the higher state minimum wage if a certain percentage of their total wages paid to employees was spent on health insurance costs. So, if the employer met the exemption benchmark set forth in the law, it could revert to the standard minimum wage for that state. The goal of such an exemption would be to provide an incentive to employers who wish to invest in employee health care the money that they would otherwise be paying to their employees in higher wages. Once again, such an exemption provision would

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157. The $2.00 figure is being offered here only for means of conjecture. In reality, an appropriate minimum wage increase for affected employers would result from a calculation of the average expenditure that the state must pay to subsidize the deficiency from the defaulting employer.

neither bind or refer to ERISA plans, nor burden them. It would merely serve as a possible way to meet a prevailing wage statute that is part of "traditionally state-regulated substantive law in those areas where ERISA has nothing to say ...."[158]

=S2B. Additional Options for Employers to Meet Minimal Expenditures

=S21. Clinics and Health Savings Accounts

Under the Maryland Fair Share Act, for-profit employers could meet the requirement of 8% of total wages paid to employees on "health insurance costs" without the existence of an ERISA plan. Judge Motz, however, was not persuaded by the avenues for doing so. As mentioned above, he quibbled with the state's contention that on-site first aid facilities would be adequate.[159] The court said that "[w]hile the Secretary's argument may evidence the active imagination of his lawyers, it is utterly out

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158. *Dillingham*, 519 U.S. at 330-31 (quoting *Travelers*, 514 U.S. at 665).

159. The State's argument here derived from 29 C.F.R. § 2510.3-1(c)(2), excepting from the definition of ERISA plans: "[t]he maintenance of the premises of an employer of facilities for the treatment of minor injuries or illness or rendering first aid in case of accidents occurring during working hours." RILA v. Fielder, 485 F. Supp. 2d 481, 497 (D. Md. 2006).

of line with reality."[160] Although Judge Motz may be correct that making up the difference between a large company's present health insurance expenditure percentage and 8% solely through the creation of new on-site medical facilities is not practical, the building of these facilities is nonetheless not insignificant. Moreover, although the Circuit Court noted that the Department of Labor strictly interprets such facilities not to cover a facility that treats members of employees' families or more than "minor injuries,"[161]Wal-Mart itself has in fact already begun making such expenditures, before the Fair Share Act even took effect. A February 2006 Wal-Mart News Release recounted that the employer intended to open 50 more such clinics in 2006, and that in the Northwest Arkansas region alone, three clinics have already treated 4,300 patients and administered more than 1,800 flu shots in just six months.[162] Nearly half of all the patients treated at

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160. *Id.*

161. Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 196 (4th Cir. 2007) (citing Labor Dep't Op. No. 83-35A, 1983 WL 22520 (1983)).

162. Wal-Mart News Release, *Wal-Mart CEO Calls for a "New Commitment" between Government and Business Leaders*, Feb. 27, 2006, *available at* http://www.prnewswire.com/cgi-bin/stories.pl?ACCT=109&STORY=/www/story/02-26-

the three clinics cited were uninsured.[163]

Maryland also argued that the spending requirement could be met through contributions to employee Health Savings Accounts ("HSAs"), tax-advantaged medical savings accounts that were established as part of Section 1201 of the 2003 Medicare Prescription Drug, Improvement, and Modernization Act.[164] The U.S. Department of Labor's Field Assistance Bulletin 2004-1[165] describes HSAs as "established to receive tax-favored contributions by or on behalf of eligible individuals, and amounts in an HSA may be accumulated over the years or distributed on a tax-free basis to pay or reimburse 'qualified medical expenses.'"[166]

In order to establish an HSA, individuals must be covered under a High Deductible Health Plan (HDHP), and no other more comprehensive health plan. This coverage can be made available by

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2006/0004300659&EDATE= (last viewed on Mar. 16, 2007).

163. *Id.*

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

165. DOL Assistance Bulletin 2004-I, Apr. 7, 2004, *available at* http://www.dol.gov/ebsa/regs/fab_2004-1.html (last viewed on Sept. 3, 2007) ("DOL Assistance Bulletin 2004-I").

166. *Id.*

the employer or purchased by the employee without establishing an ERISA plan.[167] In fact, the same Department of Labor guide states that:

> We would not find that employer contributions to HSAs give rise to an ERISA-covered plan where the establishment of the HSA is completely voluntary on the part of the employees and the employer does not: (i) limit the ability of eligible individuals to move their funds to another HSA...(ii) impose conditions on utilization of HSA funds...(iii) make or influence the investment decisions with respect to funds contributed to an HSA...(iv) represent that the HSAs are an employee welfare benefit plan established or maintained by the employer; or (v) receive any payment or compensation in connection with an HSA.[168]

Wal-Mart itself has said that it offers HSAs to its associates, to "provide yet another option for families to gain access to health insurance and save for future health care needs. Wal-Mart matches associates' contributions to their HSAs dollar-for-dollar...and associates own the accounts. (The match ranges from

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167. 29 C.F.R. § 2510.3-1(j) (1975).

168. DOL Assistance Bulletin 2004-I.

$250 to $1,000, depending on coverage level selected.)"[169]

The District Court objected to this method on the grounds that HSAs fall outside the definition of ERISA plans unless "the establishment of the HSAs is completely voluntary on the part of the employees."[170] Even so, it is clear that for those employees who do wish to establish HSAs, the spending would be useful and applicable under fair share legislation. Again, although by itself such expenditures may not be independently sufficient to meet the minimum "health insurance costs" requirement, they nonetheless must be included in the definition of very significant non-ERISA options.

Still, in order for fair share legislation to be less coercive and more palatable to employers and courts, new laws must include additional options for meeting mandatory spending levels. The key to expanding the expenditure options that employers have is to present them with numerous coherent, valid choices, but to make health insurance expenditures the most

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169. Wal-Mart News Release, *Wal-Mart's Health Care Benefits are Competitive in the Retail Sector*, July 7, 2006, *available at* http://www.walmartfacts.com/articles/1802.aspx (last visited Mar. 16, 2007).

170. RILA v. Fielder, 485 F. Supp. 2d 481, 497 (D. Md. 2006) (quoting DOL Assistance Bulletin 2004-I).

attractive of all the viable avenues. Essentially, the state must present employers with fair options, even if employers are not enamored of the options, that lead under-providing members of the private sector to invest more in either the health care of their employees or in the public health insurance funds of the state.

=S32. "Total Package" Statutes

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

Prevailing wage statutes often contain both a cash component and a benefits component.[171] Under many of these statutes, contracts for public projects must either provide benefits contributions at the level determined in the prevailing wage or a monetary equivalent. As one apposite case noted:

> Appellees suggest this provision creates a preemptible relation to ERISA plans merely by providing the option of complying with part of the minimum [prevailing] wage through benefits contributions. We disagree. The

171. *See, e.g.*, 34 PA. CODE § 9.106 (2000) ("Payment of general prevailing minimum wage rates").

> provision does not require or encourage an employer to provide certain benefits, to alter the manner in which it provides benefits, or even to provide any benefits at all. The benefits component only relates to ERISA plans when an employer decides to satisfy it through contributions to ERISA plans instead of cash payments or contributions to non-ERISA benefits. *Where a legal requirement may be easily satisfied through means unconnected to ERISA plans, and only relates to ERISA plans at the election of an employer, it "affects employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan.*[172]

In one post-*Dillingham* case, a state law allowed employers to meet their prevailing wage liability in any combination of benefit plans or wages. The Second Circuit in *Burgio &*

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

*Campofelice, Inc. v. NYS Dep't of Labor* ("*Burgio*")[173] examined one such "total package" statute that "require[d] employers to match the total cost of all prevailing supplements. Employers [we]re no longer required to match one-for-one the specific prevailing rate for each prevailing supplement, or even to provide each type of prevailing supplement,"[174] rather, they could meet the supplement benchmarks through a combination of features.

With this in mind, states are able to pass "total package" fair share laws which place a greater emphasis on non-ERISA fringe benefits as an option for compliance.[175] Some of these benefits could include: (1) employee discounts[176] on qualified property or services; (2) payment for employees' business

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173. 107 F.3d 1000 (2d Cir. 1997) (holding that the prevailing wage law in question, when used with a "total package" approach, was not preempted because it did not mandate employee benefit structures or their administration).

174. *Id.* at 1004.

175. A "working condition fringe" is any property or service provided to any employee of an employer to the extent that, if the employee paid for the property or service, the amount paid would be allowable as a deduction under 26 U.S.C. §§ 162 or 167. *See* 26 C.F.R. 1.132-5 (2001).

176. 26 U.S.C. § 132(c)(1) (2006).

periodicals;[177] (3) membership in professional associations (if the expense could have been deducted as a business expense had the employee paid the dues herself);[178] (4) outplacement services;[179] (5) ordinary vacation benefits, paid out of an employer's general assets like wages rather than out of a dedicated fund;[180] (6) employer-paid club dues;[181] (7) employer-paid trips with specific bona fide business purposes;[182] (8) local personal phone calls;[183] (9) occasional parties or picnics for employees and their guests;[184] (10) holiday gifts, other than cash, with a low fair market value;[185] (11) tuition

177. 26 C.F.R. § 1.132-5(a)(1)(iii) (2001).

178. *Id.*

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

180. Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 190 (4th Cir. 2007) (describing Massachusetts v. Morash, 490 U.S. 107, 115-16 (1989)).

181. 26 C.F.R. § 1.132.5(s)(1) (2001).

182. *See* Townsend Indus., Inc. v. United States, No. 02-3756 (8th Cir. 2003).

183. 26 C.F.R. § 1.132.6(e)(1) (2001).

184. *Id.*

185. *Id.*

reimbursements;[186] (12) flexible spending accounts,[187] (13) employer-paid educational assistance programs;[188] (14) transportation in connection with travel between the employee's residence and the place of employment;[189] and (15) meals furnished on the business premises of the employer.[190] All of these examples represent possible non-medical fringe benefits that could serve as targets for wage supplements under a "total package" approach. This second approach outlined above would present large employers with other fair, though perhaps not coveted, options for their expenditures under fair share legislation. A fair share "total package" statute could thus be written such that large employers would be required to spend 10% of payroll wages on health insurance. This 10% benchmark could then be met through a

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186. 26 C.F.R. § 1.127-2 (1983).

187. Rev. Rul. 2003-102, 2003-38 A.R. 08. Flexible spending accounts are tax-advantaged accounts set up through employer cafeteria plans that allow employees to set aside portions of their earnings to pay for medical and dependent care expenses. The most common of these plans is similar to a Health Savings Account.

188. 26 C.F.R. § 1.127-2 (1983).

189. 26 U.S.C. § 132(f)(1)(A)-(C) (2006).

190. 26 U.S.C. § 119 (2006).

combination of higher wages, numerous non-ERISA fringe benefits expenditures, the maintenance of on-site medical facilities, and HSAs, as well as by employers who would rather increase their ERISA plan expenditures, or simply pay the difference to the state's Medicaid fund.

=S1VII. Reporting Requirements and Uniform Plan Administration

As stated above, a primary purpose of ERISA is to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."[191] This does not mean, however, that ERISA preempts any state law that would have any effect on an ERISA employee benefit plan. As the Second Circuit noted in *Burgio*, "preemption does not occur where a state law places on ERISA plans administrative requirements so slight that the law 'creates no impediment to an employer's adoption of a uniform benefit administration scheme.'"[192] After all, "ERISA plan expenditures are considered in the calculation of an employer's total level of health insurance spending, but this factor does not create an impermissible connection with an ERISA

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

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

plan."[193]

The vastness of a company like Wal-Mart's health insurance plans aside,[194] any requirements resulting from the "fair share" legislation proposals outlined above would be a product of the relationship between the employer and the state, and they would function regardless of whether the employer even used an ERISA plan in that state. Indeed, multi-state employers assume the risk of being subject to individual state laws when they do business there. Moreover, as one post-*Travelers* case noted: "[I]nformation such as a list of plan participants, payroll lists, the amount of an employer's contributions and the names of people for whom the employer made contributions are appropriate areas of inquiry substantially similar to the record production we approved in *Burgio*."[195]

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193. Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 202 (4th Cir. 2007) (Michael, J., dissenting).

194. According to Wal-Mart's 2004 I.R.S. Form 5500, the Wal-Mart Associates Health and Welfare plan utilized nearly 50 insurance companies in different states to provide benefits. *See* FreeErisa.com, *available at* http://www.freeerisa.com/5500/CompanyDetail.asp?comany=WAL%2DMART+STORES+INC (last visited Mar. 16, 2007).

195. HMI Mech. Sys. v. McGowan, 266 F.3d 142, 151 (2d. Cir. 2001)

Other courts have made clear that very large employers such as Wal-Mart already keep extensive records of payroll and personnel data,[196] and that ERISA does not preempt two-tier state prevailing wage laws just because they require ongoing calculations to determine cash wages and total contributions to employee benefit plans.[197] For this reason, and because of the fact that Judge Motz in *RILA v. Fielder* did not find the FSA reporting requirements objectionable enough to establish a "connection with" employee benefit plans, limited reporting requirements related to employers seeking to meet a Medicaid Tax

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(citing Burgio & Campofelice, Inc. v. NYS Dep't of Labor, 107 F.3d 1000, 1009 (2d Cir. 1997)).

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

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

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

=S1Conclusion

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

One such subtlety that should not get lost in translation is the efficacy of rewriting fair share legislation as state Medicaid taxes falling under the purview of an area traditionally subject to local regulation: public health and safety. An affirmative Medicaid tax on large employers, designed solely for funding the state’s public health assistance programs, provisioned with tax credits and possible exemptions for those employers who wish to invest in employee health care what they would otherwise pay to the state, appears very promising based on relevant Supreme Court case law. Moreover, the reduction to a 35-

50% shortfall tax on the difference between what an employer would be required to pay the state, and what it could instead spend on its employees in health care costs, would give employers reasonable indirect economic incentives to increase their employee health expenditures while not directly "relating to" or having "connection with" ERISA plans.

Likewise, employer size-specific minimum wages have the potential to serve as the connective tissue between indirectly influencing large employer behavior and increasing the financial resources available to low-income employees for their health care expenses. Statutory exemption clauses allowing for a reversion to the standard state minimum wage for those employers who meet a certain percentage of payments towards health insurance costs would also facilitate this process. Similarly, an increase in the viable options that employers have for meeting spending requirements, whether through HSAs, on-site medical facilities, or non-ERISA fringe benefits, would detract from the argument that so few options under the Fair Share Act led to a Hobson's choice. Coupled with a "total package" scheme and a prevailing wage and benefits statute, this approach to fair share legislation could be very formidable.

Medicaid taxes, minimum wage laws, and "total package" arrangements can thus be conceived of as medals, the alloy of

which states as "laboratories"[198] can employ to catalyze the process of lessening their public health burden, while encouraging large employers to contribute a greater proportion to employee health care. As this prominent debate continues in political and policy circles nationwide, it will be interesting to watch in the years ahead as states inevitably devise new fair share proposals to shift some of the burden of health care maintenance from the state and individual taxpayers to the private sector. What will perhaps be even more fascinating, however, is seeing how the innovative free market in America will respond to these proposals, most likely creating workable solutions that preempt, in practice, the very fair share proposals that spawned them.

*Darren Abernethy*

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