

1-1-2010

THE SURVIVAL OF UNIVERSAL HEALTH CARE IN MASSACHUSETTS: ERISA PREEMPTION OF AN ACT PROVIDING ACCESS TO AFFORDABLE, QUALITY, ACCOUNTABLE HEALTH CARE

Luke T. Tashjian

Follow this and additional works at: <http://digitalcommons.law.wne.edu/lawreview>

Recommended Citation

Luke T. Tashjian, *THE SURVIVAL OF UNIVERSAL HEALTH CARE IN MASSACHUSETTS: ERISA PREEMPTION OF AN ACT PROVIDING ACCESS TO AFFORDABLE, QUALITY, ACCOUNTABLE HEALTH CARE*, 32 W. New Eng. L. Rev. (2010), <http://digitalcommons.law.wne.edu/lawreview/vol32/iss1/4>

This Article is brought to you for free and open access by the Law Review & Student Publications at Digital Commons @ Western New England University School of Law. It has been accepted for inclusion in Western New England Law Review by an authorized administrator of Digital Commons @ Western New England University School of Law. For more information, please contact pnewcombe@law.wne.edu.

THE SURVIVAL OF UNIVERSAL HEALTH CARE IN MASSACHUSETTS: ERISA PREEMPTION OF AN ACT PROVIDING ACCESS TO AFFORDABLE, QUALITY, ACCOUNTABLE HEALTH CARE

LUKE T. TASHJIAN*

INTRODUCTION

It is widely recognized that the health care system in the United States is in crisis.¹ The hallmarks of this crisis are a decrease in the quality of care, an increase in the cost of care, and a decline in access to care.² A reduction in employer sponsored health care coverage has been a root cause of the decline in access to care.³

* Luke T. Tashjian is an attorney practicing law in Worcester, Massachusetts. He received his J.D. with honors from the University of Connecticut School of Law in 2006. He is admitted to practice law in Massachusetts and Connecticut.

1. Retail Indus. Leaders Ass'n v. Fielder, 435 F. Supp. 2d 481, 496 n.15 (D. Md. 2006), *aff'd*, 475 F.3d 180 (4th Cir. 2007). Despite the United States spending sixteen percent of its gross domestic product on health care while other industrialized nations spend ten percent or less, Brief for AARP as Amici Curiae Supporting Appellant at 6, *Retail Indus. Leaders Ass'n*, 475 F.3d 180 (Nos. 06-1840 & 06-1901), the United States consistently performs more poorly than most industrialized countries on many measures of health care quality. NAT'L COAL. ON HEALTH CARE, HEALTH CARE FACTS: QUALITY OF CARE (2009), http://nchc.org/sites/default/files/resources/Fact_Sheet-Quality.pdf. "The U.S. is 33 percent worse than the best country on mortality from conditions amenable to health care—that is, deaths that could have been prevented with timely and effective care." NAT'L COAL. ON HEALTH CARE, FACTS ON THE QUALITY OF HEALTH CARE 1 (2008) (on file with *Western New England Law Review*) [hereinafter *FACTS ON THE QUALITY OF HEALTHCARE*]. "Medication-related errors for hospitalized patients cost roughly \$2 billion annually." THE INSTITUTE OF MEDICINE, THE CHASM IN QUALITY: SELECT INDICATORS FROM RECENT REPORTS 1 (2008), <http://www.chicagomdjd.com/CM/Articles/The-Chasm-in-Quality-Highlighted.pdf>. "Medical errors kill more people per year than breast cancer, AIDS, or motor vehicle accidents." *Id.* "The infant mortality rate in the U.S. is 7.0 deaths per 1,000 live births, compared with 2.7 in the top three countries." *FACTS ON THE QUALITY OF HEALTHCARE, supra*, at 1.

2. Brief for AARP as Amici Curiae Supporting Appellant, *supra* note 1, at 3.

3. *Id.* at 6; David Pratt, *The Past, Present and Future of Health Care Reform: Can it Happen?*, 40 J. MARSHALL L. REV. 767, 773-74 (2007); see NAT'L COAL. ON HEALTH CARE, HEALTH CARE FACTS: COSTS (2009), <http://nchc.org/sites/default/files/resources/Fact%20Sheet%20-%20Cost.pdf>.

R

The role of this reduction is hard to overstate since most Americans receive their coverage through an employer.⁴

Politicians and citizens alike have realized that action must be taken to stem the decline in employer sponsored health care, but there has been a historic inability at the federal level to employ effective solutions.⁵ This inability has led to efforts by the States to protect, encourage, and in some cases mandate employer sponsored coverage.⁶ These state efforts have consistently come up against and been struck down by a federal statute that, ironically, was intended to promote the provision of employee benefits, the Employee Retirement Income Security Act of 1974⁷ (“ERISA”).

The Commonwealth of Massachusetts undertook one of the most recent and sweeping state efforts to reverse the decline in access to health care. This effort is reflected in a bill passed by the Massachusetts legislature and signed into law by Governor Romney in 2006 (“the Bill”).⁸ The Bill sought to reverse the decline in access to care by mandating that individuals procure minimum creditable coverage and that employers make a fair and reasonable contribution toward this coverage.⁹ Due to these mandates, there has been wide success in reducing the number of uninsured in Massachusetts.¹⁰

Improved access to health care, however, may be short-lived. Similar to earlier state-enacted legislation, the Bill is likely to face an ERISA preemption challenge, and upon hearing this challenge, a court will likely hold that a key provision of the Bill, the employer fair share contribution requirement, is preempted.

Without subjecting the Bill to ERISA preemption, the objective of the employer fair share contribution requirement, namely

4. Elise Gould, *The Erosion of Employer-Sponsored Health Insurance* 1 (The Economic Policy Institute, Briefing Paper No. 223, 2008), available at http://epi.3cdn.net/d1b4356d96c21c91d1_ilm6b5dua.pdf.

5. David Simon, *Fair Share at Health Care: Current ERISA Preemption Jurisprudence Paves the Way for Health Care Reform*, 31 SETON HALL LEGIS. J. 497, 499 (2007).

6. *Id.* at 500.

7. Employee Retirement Income Security Act, 29 U.S.C. §§ 1000-1461 (2006); Simon, *supra* note 5, at 501.

8. An Act Providing Access to Affordable, Quality, Accountable Health Care, ch. 58, 2006 Mass. Acts 77 (codified in scattered sections of MASS. GEN. LAWS (2008)), available at <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>.

9. Steve LeBlanc, *State Broadens Health Insurance Regs for Firms*, WORCESTER TELEGRAM & GAZETTE, Oct. 2, 2008, at A4 (quoting Sarah Iselin, Commissioner of the Massachusetts Division of Health Care Finance and Policy).

10. Glen Johnson, *State Insurance Law Result Remarkable*, WORCESTER TELEGRAM & GAZETTE, Aug. 20, 2008, at A3.

that employers be required to contribute to their employees' coverage,¹¹ can still be accomplished if certain changes are made to the Bill. These changes include repealing the fair share contribution requirement, increasing the state minimum wage while structuring it to resemble a prevailing wage with cash and benefit components, restricting employee access to Commonwealth Care policies to employees who finance their contributions towards these policies with direct deposits from their paychecks, and strengthening the individual mandate by providing that withholdings shall be taken from the paychecks of individuals who fail to procure minimum creditable coverage.

I. ERISA PREEMPTION

A. *ERISA Preemption in General*

In 1974, Congress enacted ERISA to encourage the adoption of employee benefit plans and to protect the interests of plan participants. It was the belief of Congress that replacement of the disparate state laws governing employee benefit plans with the substantive and uniform federal regulatory scheme¹² contained in ERISA would reduce the administrative burden placed on interstate employers, and this reduced burden would, in turn, increase the number of employers offering employee benefit plans.¹³ "To this end, ERISA includes expansive pre-emption provisions, . . . which are intended to ensure that employee benefit plan regulation would be 'exclusively a federal concern.'"¹⁴

One type of employee benefit plan that falls within the reach of ERISA's preemption provision is an employee welfare benefit

11. See State House News Service, Daily Transcript, May 4, 2006 (on file with *Western New England Law Review*) (Senator Lees's response to question regarding overriding Governor Mitt Romney's veto of section 47 of House Bill 4779).

12. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). "Nothing in ERISA requires employers to establish employee benefit plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996).

13. See *Ingersoll-Rand Co.*, 498 U.S. at 142.

14. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)); see also Anthony Ten Haagan, *Surviving Preemption: The Importance of Chapter 58 in the Context of America's Health Care Crisis*, 33 AM. J.L. & MED. 663, 664 (2007); Wendy K. Mariner, *State Regulation of Managed Care and the Employee Retirement Income Security Act*, 335 NEW ENG. J. MED. 1986, 1986 (1996).

plan.¹⁵ An “employee welfare benefit plan” is defined broadly by ERISA to include any

plan, fund, or program which was . . . established or maintained by an employer or by an employee organization . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, [or] disability.¹⁶

Within this definition of an employee welfare benefit plan, a “plan” is “a set of rules that define the rights of a beneficiary and provide for their enforcement.”¹⁷

While established definitions of “employee welfare benefit plan” and “plan” exist, neither ERISA nor its legislative history define the term “medical benefit,”¹⁸ and in the absence of statutory guidance, courts have interpreted the term broadly.¹⁹ This broad judicial interpretation of “medical benefit” results in the vast majority of health care benefits that an employer extends to its employees, including employer sponsored health insurance programs, qualifying as employee welfare benefit plans.²⁰

The actual preemption rule, which is subsection (a) of section 514 of ERISA, provides, “Except as provided in subsection (b) of this section [the Savings Clause], the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan”²¹ The Savings Clause states that, “Except as provided in subparagraph (B) [the Deemer Clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which

15. 29 U.S.C. §§ 1002(3), 1003(a), 1144(a) (2006). The other type of employee benefit plan is an employee pension benefit plan. *Id.* § 1002(3).

16. *Id.* § 1002(1); *Standard Oil Co. of Cal. v. Agsalud*, 633 F.2d 760, 763 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981).

17. *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000). “Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan.” *Id.*

18. *Aloha Airlines, Inc. v. Ahue*, 12 F.3d 1498, 1502 (9th Cir. 1993).

19. *See id.* at 1503 (holding FAA-mandated medical examinations for pilots are considered medical benefits).

20. *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 190 (4th Cir. 2007); *Madonia v. Blue Cross & Blue Shield of Va.*, 11 F.3d 444, 447 (4th Cir. 1993) (holding that a closely held corporation that subsidized health insurance policies for some of its employees had established an ERISA employee welfare benefit plan); Brief for Chamber of Commerce of U.S.A. as Amici Curiae Supporting Appellee at 15, *Retail Indus. Leaders Ass’n*, 475 F.3d 180 (No. 06-1840) (citing to 29 U.S.C. § 1003(a)).

21. 29 U.S.C. § 1144(a).

regulates insurance, banking, or securities.”²² The Deemer Clause restricts the application of the Savings Clause by providing,

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment.²³

To summarize the mechanics of these three provisions, the Preemption Clause preempts state laws that relate to employee welfare benefit plans, but it does not preempt state laws regulating insurance. However, states are prohibited from regulating employee benefit plans through laws purporting to regulate insurance.²⁴

B. *Test for ERISA Preemption*

With respect to ERISA’s preemption clause, the United States Supreme Court has “observed repeatedly that this broadly worded provision is clearly expansive.”²⁵ The degree of expansiveness, however, is dependent upon the meaning given to the innocuous term “relate to” contained in the clause. As the Supreme Court has stated, “the term ‘relate to’ cannot be taken ‘to extend to the furthest stretch of indeterminacy,’ or else ‘for all practical purposes pre-emption would never run its course.’”²⁶

In light of this limitation, the Supreme Court has developed a two-part test to determine if a state law “relates to” an employee benefit plan. Under this test, the Court examines if the challenged law has either a “connection with” or “reference to” an ERISA plan.²⁷ In traditional areas of state regulation, such as health care,²⁸ courts apply this test in conjunction with a presumption that Congress did not intend to preempt the state law.²⁹

22. *Id.* § 1144(b)(2)(A).

23. *Id.* § 1144(b)(2)(B).

24. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987).

25. *Egelhoff v. Egelhoff*, 532 U.S. 141, 146 (2001) (internal quotation marks omitted) (quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995)).

26. *Id.* at 146 (quoting *Travelers*, 514 U.S. at 655).

27. *Id.* at 147; *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97 (1983).

28. *Great Atl. & Pac. Tea Co. v. Cottrell*, 424 U.S. 366, 371 (1976).

29. *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813-14 (1997) (citing *Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715

A statute has “reference to” an ERISA plan when the “State’s law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law’s operation.”³⁰ Under this inquiry, the Court has held preempted state laws that imposed requirements by reference to ERISA-covered programs,³¹ that specifically exempted ERISA plans from otherwise generally applicable garnishment provisions,³² and that established causes of action requiring the existence of ERISA plans.³³

Even if a state law does not contain a prohibited “reference to” an ERISA plan, the state law will still be preempted by section 514(a) if it has a “connection with” a covered plan.³⁴ To determine if a state law has a prohibited “connection with” a covered plan, a court must examine whether it was Congress’s intent for ERISA to preempt the type of challenged law by analyzing the nature of the effect of the challenged state law on the uniform nationwide administration of employee benefit plans.³⁵ State laws with only a “tenuous, remote or peripheral” effect on ERISA plans will be upheld.³⁶ In general, these “are typically ‘laws of general application—often traditional exercises of state power or regulatory authority—whose effect on ERISA plans is incidental.’”³⁷ In contrast, state laws that

(1985)); *Retail Indus. Leaders Ass’n v. Fielder*, 435 F. Supp. 2d 481, 494 (D. Md. 2006) (quoting *Travelers*, 514 U.S. at 657), *aff’d*, 475 F.3d 180 (4th Cir. 2007); *see also Egelhoff*, 532 U.S. at 148; *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987).

30. *Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson*, 201 F.3d 1212, 1216 (9th Cir. 2000) (internal quotation marks omitted) (quoting *Cal. Div. of Labor Standards v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997)).

31. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130-31 (1992).

32. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 828 n.2 (1988).

33. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1996) (preempting state cause of action based on wrongful termination of employee when termination based on vesting of ERISA plan benefits).

34. *Id.*; *see Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 98 (1983).

35. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001); *Dillingham Constr.*, 519 U.S. at 325-26; *Travelers*, 514 U.S. at 659.

36. *Travelers*, 514 U.S. at 661 (quoting *Greater Wash. Bd. of Trade*, 506 U.S. at 130 n.1). The indirect effect of a surcharge on hospital expenses for those whose expenses were not paid by Blue Cross & Blue Shield did not bind plan administrators to any particular choice and was not preempted. *Id.* at 664; *see also Shaw*, 463 U.S. at 100 n.21.

37. *Aloha Airlines, Inc. v. Ahue*, 12 F.3d 1498, 1504 (9th Cir. 1993) (quoting *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146 (2d Cir. 1989)).

mandate some element of the structure or administration of ERISA plans will be preempted.³⁸

In determining whether or not a state law is preempted under the “connection with” test for effectively mandating some element of the structure or administration of a covered plan, a court considers four factors.³⁹ The first factor examines “whether the state law regulates the types of benefits provided by ERISA employee welfare benefit plans.”⁴⁰ The second factor examines “whether the state law requires the establishment of a separate employee benefit plan to comply with the law.”⁴¹ The third factor examines “whether the state law imposes reporting, disclosure, funding, or vesting requirements on ERISA plans.”⁴² The fourth factor examines “whether the state law regulates certain ERISA relationships, including the relationships between an ERISA plan and an employer and, to the extent an employee benefit plan is involved, between an employer and employee.”⁴³

II. THE MASSACHUSETTS HEALTH CARE REFORM BILL

The Massachusetts Health Care Reform Bill⁴⁴ constitutes the second “pay-or-play” statute that was implemented by a state.⁴⁵

38. See *Shaw*, 463 U.S. at 97; see also *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 192-93 (4th Cir. 2007).

39. See *Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson*, 201 F.3d 1212, 1218 (9th Cir. 2000).

40. *Operating Eng’rs Health & Welfare Trust Fund v. JWJ Contracting Co.*, 135 F.3d 671, 678 (9th Cir. 1998) (quoting *Aloha Airlines*, 12 F.3d at 1504); see also *Shaw*, 463 U.S. at 100 (preempting a state law requiring ERISA plans to pay benefits to individuals unable to work due to pregnancy).

41. *JWJ Contracting Co.*, 135 F.3d at 678 (quoting *Aloha Airlines*, 12 F.3d at 1504); see also *Fort Halifax Packing Co. v. Cyne*, 482 U.S. 1, 18-19 (1987) (holding that one-time lump sum severance payment does not relate to an ERISA plan since the law does not require the establishment or maintenance of a plan).

42. *JWJ Contracting Co.*, 135 F.3d at 678 (quoting *Aloha Airlines*, 12 F.3d at 1504); see also *Standard Oil Co. of Cal. v. Aghalud*, 633 F.2d 760, 763 (9th Cir. 1980) (holding a state cannot require an employer to provide certain employee welfare benefits through an ERISA plan), *aff’d mem.*, 454 U.S. 801 (1981).

43. *JWJ Contracting Co.*, 135 F.3d at 678 (quoting *Aloha Airlines*, 12 F.3d at 1504).

44. An Act Providing Access to Affordable, Quality, Accountable Health Care, ch. 58, 2006 Mass. Acts 77, available at <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>.

45. The first pay-or-play law was the Maryland Fair Share Act, MD. CODE ANN., LAB. & EMPL. § 8.5-102 (LexisNexis 2008). This is not including the Hawaii Prepaid Healthcare Act because the Hawaii Act was granted an exemption from preemption. The Maryland Act was preempted by ERISA in *Retail Industry Leaders Ass’n v. Fielder*, 475 F.3d 180 (4th Cir. 2007). See Brief for Chamber of Commerce of U.S.A. as Amici Curiae Supporting Appellee, *supra* note 20, at 3 (defining pay-or-play laws).

While this may make it appear that such statutes requiring employers either to contribute to their employees' coverage or pay a state surcharge are a new concept, the Massachusetts legislature struggled for almost two decades to implement a pay-or-play statute.

The initial effort to compel Massachusetts employers to contribute to their employees' coverage resulted in the passage of an act in 1988 titled, "An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Funding" ("the 1988 Act").⁴⁶ The 1988 Act incorporated a form of a pay-or-play statute by requiring businesses employing six or more employees to pay a medical security contribution of up to twelve percent of their employees' wages into a state fund, but allowing a credit against this contribution equal to the employer's contribution toward its employees' health care coverage.⁴⁷ Although this law would have accomplished the Bill's goal of requiring employers to contribute to their employees' coverage, the 1988 Act was amended to remove the tax and tax credit features it contained before these features were implemented.⁴⁸

Similar to the 1988 Act, the Bill mandates that covered employers make legislatively-determined fair and reasonable contributions toward their employees' coverage, but unlike the tax and tax credit features of the 1988 Act, the Bill requires covered employers to either make the contribution or pay a fixed surcharge. Also, in contrast to the prior legislation, the Bill places a mandate on individuals to obtain minimum creditable coverage.

A. *The Individual Mandate*

The individual mandate contained in the Bill required all residents of the Commonwealth who are over eighteen years of age to obtain minimum creditable coverage by July 1, 2007.⁴⁹ To assist in the procurement of this coverage, the Bill established both a sliding scale under which the cost of premiums for commercial plans is sub-

46. An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing, ch. 23, 1988 Mass. Acts 85, available at <http://archives.lib.state.ma.us/actsResolves/1988/1988Acts0023.pdf>.

47. § 46, 1988 Mass. Acts at 142-43.

48. An Act Providing for Improved Access to Health Care, ch. 203, § 21, 1996 Mass. Acts 913, 928-32, available at <http://archives.lib.state.ma.us/actsResolves/1996/1996acts0203.pdf>; see Jared Stiefel, *ERISA Preemption of Chapter 58: The Future of the "Pay or Play" Model of Health Care Legislation*, 33 AM. J.L. & MED. 683, 691-92 (2007).

49. MASS. GEN. LAWS ch. 111M, §§ 1-2 (2008).

sidized based on an individual's income⁵⁰ and the Commonwealth Health Insurance Connector ("the Commonwealth Connector").⁵¹ The Commonwealth Connector assists individuals in obtaining coverage by enabling them to purchase insurance through a larger risk pool, analyzing the benefits provided by the plans it offers, and negotiating with insurers for competitive rates.⁵²

An individual's coverage can either be deemed per se to constitute minimum creditable coverage⁵³ or it can be determined to constitute minimum creditable coverage by complying with the regulations promulgated by the Commonwealth Connector.⁵⁴ As of January 1, 2009, these regulations require the provision of a broad range of care and a prescription drug benefit, restrict the imposition of deductibles to within established limits, restrict the imposition of in-network deductibles, and prohibit overall maximum benefit and per-illness, annual maximum benefit caps for covered core services.⁵⁵

Unless one of two exceptions apply, a resident's failure to obtain "minimum creditable coverage" will result in the individual's loss of his or her state personal income tax exemption as well as the individual being charged for fifty percent of the cost of the least expensive plan offered through the Commonwealth Connector.⁵⁶ The first exception from the application of these penalties applies to individuals who the Commonwealth Connector has determined there is an absence of affordable coverage for.⁵⁷ The second exception exempts individuals who can establish that they did not obtain minimum creditable coverage because of sincerely held religious beliefs.⁵⁸

B. *Employer Mandates*

The Bill imposes three mandates on covered employers, which are employers that employ eleven or more full-time equivalent employees in the Commonwealth.⁵⁹ The first mandate requires covered employers to make a "fair and reasonable premium

50. *Id.* ch. 118H, §§ 1-5.

51. *Id.* ch. 176Q, § 2(a).

52. *Id.* §§ 1-4.

53. *Id.* ch. 111M, § 1.

54. *Id.*

55. 956 MASS. CODE REGS. 5.03 (2008).

56. 830 MASS. CODE REGS. 111M2.1(5)(c) (2008).

57. MASS. GEN. LAWS ch. 111M, § 2.

58. *Id.* § 3.

59. *Id.* ch. 118G, § 6C; *id.* ch. 149, § 188(b); *id.* ch. 151F, § 2.

contribution” to their employees’ group health insurance.⁶⁰ The second mandate requires covered employers to establish cafeteria plans under § 125 of the Internal Revenue Code that offer at least one premium-only health benefit option.⁶¹ The third mandate requires covered employers to comply with statutory reporting requirements.⁶²

1. The Fair and Reasonable Contribution Requirement

All covered employers must make a “fair and reasonable premium contribution” to their employees’ “group health plan” as defined in § 5000(b)(1) of the Internal Revenue Code.⁶³ A covered employer that employs fifty or fewer full-time equivalent employees in the Commonwealth may make a “fair and reasonable premium contribution” by either offering to pay thirty-three percent of the premium of a group health plan offered by the employer or by having twenty-five percent of its employees enrolled in its group health plan.⁶⁴ Beginning January 1, 2009, an employer who employs more than fifty full-time equivalent employees in the Commonwealth is only deemed to have made a “fair and reasonable premium contribution” when either at least seventy-five percent of its employees are enrolled in its group health plan or both of the prior two tests are met; namely, no less than twenty-five percent of its employees are enrolled in its plan and it offers to pay for thirty-three percent of the plan premium.⁶⁵

Covered employers who fail to make a “fair and reasonable premium contribution” toward a group health plan for their employees are required to pay a surcharge to the Commonwealth Care Trust Fund.⁶⁶ The calculation of this surcharge reflects a portion of the cost the Commonwealth incurs in providing state-funded care. At the present time, the surcharge is at the statutory maximum of

60. *Id.* ch. 149, § 188.

61. *Id.* ch. 151F, § 2; 114.5 MASS. CODE REGS. 17.01 (2007).

62. MASS. GEN. LAWS ch. 118G, § 6C.

63. *Id.* ch. 149, § 188(a). Within the meaning of § 5000(b) of the Internal Revenue Code, a group health plan is “a plan (including a self-insured plan) of, or contributed to by, an employer . . . or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.” 26 U.S.C. § 5000(b)(1) (2006).

64. 114.5 MASS. CODE REGS. 16.03 (2009).

65. *Id.*

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

\$295 per year for each full-time employee,⁶⁷ and the surcharge is not expected to fall below this statutory ceiling.

2. The Cafeteria Plan Mandate

Unless an employer provides health care coverage under either a bona fide collective bargaining agreement or through the Insurance Partnership Program, covered employers are also required to establish cafeteria plans, within the meaning of § 125 of the Internal Revenue Code, that offer at least one premium-only health benefit option.⁶⁸ While employers are free to contribute to these plans, and may be required to contribute to them, under the fair and reasonable contribution requirement, the cafeteria plan requirement simply requires the establishment of a premium-only cafeteria plan with one or more medical care options.⁶⁹

If the cafeteria plan requirement applies to an employer and the employer fails to offer group health insurance to its employees through a cafeteria plan, the employer will be subject to the imposition of a surcharge, called the “free rider surcharge,” when certain triggering events occur.⁷⁰ These triggering events include the employees of an employer who fails to comply with the cafeteria plan requirement or the dependents of these employees incurring an aggregate of \$50,000 in uncovered health care costs in a year and either (A) one employee or a dependent of an employee uses free care more than three times in a year or (B) the aggregate of the

67. *Id.* § 188(c)(10); 114.5 MASS. CODE REGS. 16.04; *see also* Div. of Unemployment Assistance, Executive Office of Labor & Workforce Dev., Important Notice of Statutory and Regulatory Changes to the Fair Share Contribution Program (2009), available at <http://www.mass.gov/Elwd/docs/dua/business/FSC2009Instructions.pdf> (identifying the quarterly payments for 2009 at \$73.75).

68. MASS. GEN. LAWS ch. 151F, § 2; *id.* ch. 118G, § 1; 114.5 MASS. CODE REGS. 17.01 (2007). A cafeteria plan under § 125 of the Internal Revenue Code, which is also referred to as a Section 125 Plan, is a plan established by an employer under which employees can elect to receive certain benefits such as health insurance instead of cash compensation and through such an arrangement the employees are able to purchase the benefits offered through the plan with pre-tax dollars.

69. MASS. GEN. LAWS ch. 151F, § 2; 114.5 MASS. CODE REGS. 17.01. Employers that are required to establish cafeteria plans must file copies of the plan documents with the Commonwealth Connector. Commonwealth Health Ins. Connector Auth., Administrative Information Bulletin 03-07 (2007), available at <http://www.mass.gov/Elwd/docs/dua/business/fscAdmInfoBulletin03.rtf>.

70. MASS. GEN. LAWS ch. 118G, § 18B(a). The free rider surcharge ranges from 10% to 100% of the cost incurred by the Commonwealth in providing care to the employer's employees and their dependents. *Id.* § 18B(b). This surcharge varies based on the number of employees the employer employs and the level of state funded costs. 114.5 MASS. CODE REGS. 17.04.

employer's employees and their dependents use free care more than five times in a year.⁷¹

3. Mandated Employer Reporting

In addition to the fair and reasonable premium contribution requirement and the cafeteria plan requirement, covered employers must also comply with three statutory reporting requirements.

The first reporting requirement obligates all covered employers to complete and sign "employer health insurance responsibility disclosure" forms on an annual basis.⁷² In completing these forms, employers must provide information that the Division of Health Care Finance and Policy will use to implement the free rider surcharge.⁷³

Employers of employees who decline employer sponsored coverage must also complete and cause their employees who decline coverage to complete a second form called an "employee health insurance responsibility disclosure" form.⁷⁴ These forms, which must be completed annually and retained by the employer for at least three years, require the employer to indicate whether it has offered to pay for employee health insurance and whether it has a compliant cafeteria plan.⁷⁵ The employee must then indicate on the same form whether she has elected to receive health care coverage and whether she has an alternative source of coverage.⁷⁶

The third reporting requirement imposed on employers mandates that employers who sponsor minimum creditable coverage provide their employees with the 1099-HC forms that their employees will need to complete their individual state income tax returns.⁷⁷

71. 114.5 MASS. CODE REGS. 17.04.

72. MASS. GEN. LAWS ch. 118G, § 6C(a).

73. *Id.*; see Div. of Health Care Fin. & Policy, Executive Office of Health & Human Servs., Employer Health Insurance Responsibility Disclosure 2008: FSC-Exempt Employers, available at http://www.mass.gov/Eeohhs2/docs/dhcfp/g/hcr/employer_hird_fsc_exempt.pdf. This requires the employer to indicate if they have adopted a compliant cafeteria plan. *Id.* An employer who either fails to file a health insurance responsibility and disclosure form or who provides falsified information on a filed form is subject to a fine of not less than \$1,000 and not more than \$5,000. MASS. GEN. LAWS ch. 118G, § 6C(b).

74. MASS. GEN. LAWS ch. 118G, § 6C(b).

75. *Id.*

76. *Id.*; see Div. of Health Care Fin. & Policy, Executive Office of Health & Human Servs., Employee Health Insurance Responsibility Disclosure Form 2009, available at http://www.mass.gov/Eeohhs2/docs/dhcfp/g/hcr/employee_hird_2009.pdf.

77. 830 MASS. CODE REGS. 111M2.1(8) (2008).

III. ERISA PREEMPTION OF THE MASSACHUSETTS BILL

In light of what is generally perceived as a national health care crisis, it would seem that to the extent ERISA allows, it is strongly in the public interest to permit states to perform their traditional role of serving as laboratories for experiment in controlling the costs and increasing the quality of health care for all citizens.⁷⁸

Nonetheless, like the only pay-or-play law that has been implemented before it, the Bill is likely to face an ERISA preemption challenge.⁷⁹ While a court hearing this challenge is unlikely to hold that the individual mandate, cafeteria plan requirement, and reporting requirements are preempted, a court is likely to hold that the fair share contribution requirement is preempted.⁸⁰

The 1099-HC reporting requirements are imposed upon employers by the Massachusetts Act. However, an employer insured under a contract with a Massachusetts-licensed carrier, Blue Cross, Blue Shield or an HMO, shifts the obligation to furnish the form 1099-HC to the carrier. Self-insured plans and out-of-state employers insuring Massachusetts employees and their dependents under contracts written in other states must either provide the form directly or contract with a third-party administrator or out of state carrier to provide the form.

Peter Marathas, Robert Rachal & Yolanda Montgomery, *Pay-or-Play State Health Insurance Laws and ERISA Preemption*, 14 HR ADVISOR: LEGAL & PRACTICAL GUIDANCE 3, 3-4 (2008), available at 14 No. 3 HR-ADV 3 (Westlaw).

78. Retail Indus. Leaders Ass'n v. Fielder, 435 F. Supp. 2d 481, 496 n.15 (D. Md. 2006), *aff'd*, 475 F.3d 180 (4th Cir. 2007).

79. The Hawaii Prepaid Health Care Act is not being included here because it was granted a waiver from ERISA preemption by Congress after it was held preempted in *Standard Oil Co. of California v. Agsalud*. 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981); see 29 U.S.C. § 1144(b)(5)(A) (2006) (exception for Hawaii Prepaid Health Care Act). Interestingly, Governor Michael Dukakis initially contemplated seeking such a waiver for the Massachusetts Health Security Act, but it was determined that Congress would be unwilling to grant a waiver. Susan A. Goldberger, *The Politics of Universal Access: The Massachusetts Health Security Act of 1988*, 15 J. HEALTH POL. POL'Y & L. 857, 873 (1990).

80. The fair share contribution requirement is contained in a freestanding statute that is distinct from the other statutory provisions established by the Bill. This will help to insulate the remaining provisions from being preempted upon the preemption of the Fair Share Contribution Requirement. In general, ERISA only preempts state laws insofar as they relate to covered plans. Even when a part of a statute is preempted, the remainder of a statute will be upheld so long as the preempted provision is severable from the additional provisions of the statute. *Shaw v. Delta Airlines*, 463 U.S. 85, 98 n.17 (1983); *In re Laxson*, 102 B.R. 85, 89 (Bankr. N.D. Tex. 1989). Whether the provision is severable from the remainder of the statute is a question of state law and the intent of the state legislature. *Id.* A separability or severance clause in a statute is given effect as an aid in determining the legislative intent, but a court can uphold the remainder of an act irrespective of the existence of such a clause. *Carter v. Carter Coal*.

A. *The Individual Mandate Should Not Be Preempted*

It is unlikely that the individual mandate established by the Bill would be found to “relate to” ERISA plans and, thus, be preempted because the individual mandate has neither a “connection with” nor a “reference to” ERISA plans.

The individual mandate requires residents of the Commonwealth, regardless of their employment status, to obtain health care coverage that complies with the requirements established for “minimum creditable coverage.”⁸¹ The requirement that such coverage be obtained is placed on individuals and not on their employers, should they in fact be employed.⁸² As a state law that applies to a wide variety of situations, including a large number of situations that have no appreciable linkage to ERISA plans, the individual mandate constitutes a law of general application⁸³ in an area of traditional state regulation, health care.⁸⁴

Since the individual mandate is a law of general application in an area of traditional state regulation, there is a rebuttable presumption that Congress did not intend for ERISA to preempt it. It is unlikely that a court would find this presumption rebutted and hold that the individual mandate has a prohibited “reference to” or “connection with” ERISA plans.

It is unlikely a court would hold that the individual mandate has a prohibited “reference to” ERISA plans because it neither acts immediately and exclusively on ERISA plans nor is the existence of such plans essential to its operation.⁸⁵ In contrast, the imposition of the individual mandate is dependent solely on age and residency, namely whether or not an individual is both a resident of the Commonwealth and older than eighteen years of age. Since the factors underlying the individual mandate are independent of both the ex-

Co., 298 U.S. 238, 312 (1936); *see, e.g.*, *Corporate Health Ins., Inc. v. Tex. Dep’t of Ins.*, 215 F.3d 526, 540 (5th Cir. 2000).

81. *See supra* section II.A.

82. 830 MASS. CODE REGS. 111M2.1(3) (2008).

83. *Pharm. Care Ass’n v. Rowe*, 429 F.3d 294, 304 (1st Cir. 2005) (providing that “[a] state law that applies to a wide variety of situations, including an appreciable number that have no specific linkage to ERISA plans, constitutes a law of general application” (alteration in original) (quoting *Carpenters Local Union No. 26 v. U.S. Fid. & Guar. Co.*, 215 F.3d 136, 144-45 (1st Cir. 2000))); *see, e.g.*, *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815 (1997); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 838 (1988).

84. *See N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995).

85. *See Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 335 (1997).

istence of ERISA plans and the status of an individual under an ERISA plan, the individual mandate cannot be said to have a “reference to” such plans.⁸⁶

The presumption that the individual mandate is not preempted is also unlikely to be rebutted by a court holding that it has a prohibited “connection with” ERISA plans because the individual mandate neither directly regulates nor effectively mandates some element of the structure or administration of ERISA plans.⁸⁷ At most, the individual mandate creates an indirect economic incentive that may affect, but does not bind, the choices of employers or their plans.⁸⁸

This indirect economic incentive for employers to provide coverage that complies with the individual mandate is created by the greater value attributed to compliant coverage by employees and the desire of employers, in turn, to provide an employee benefit to which their employees attribute the greatest value.⁸⁹ Employees attribute greater value to compliant coverage than noncompliant coverage because employees who receive noncompliant coverage must incur the cost of purchasing additional coverage to satisfy the minimum creditable coverage requirement placed on them by the individual mandate. Importantly, this increased value of compliant coverage, while sufficient to give employers an indirect incentive for its provision, is insufficient to create a Hobson’s Choice for employers, whereby employers are effectively required to provide compliant coverage.⁹⁰

86. See *Travelers*, 514 U.S. at 656.

87. *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 192-93 (4th Cir. 2007).

88. *Travelers*, 514 U.S. at 658; *Retail Indus. Leaders Ass’n*, 475 F.3d at 192-93.

89. Employers have a desire to minimize their total labor costs by providing the cash and benefit combination that their employees attribute the most value to. Sherry Glied & Joshua Graff Zivin, *Modeling Employer Decisions to Offer Health Insurance 12* (2004), available at <http://www.rwjf.org/files/research/no7researchabstract.pdf>. On average, sixty percent of an employee’s compensation is composed of wages or salary and the remaining forty percent is composed of benefits such as health insurance and retirement benefits. MICHAEL B. SNYDER, *BENEFITS GUIDE* § 2.1 (2008).

90. *Retail Indus. Leaders Ass’n*, 475 F.3d at 192-93. The court in *Retail Industry Leaders Ass’n* held that the Maryland Fair Share Act, MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to -107 (LexisNexis 2008), which provided that an employer who employed more than 10,000 employees in Maryland must either contribute eight percent of the total wages it pays to Maryland employees toward employee health care costs or pay the difference between its contribution and eight percent to the state, created a Hobson’s Choice. *Retail Indus. Leaders Ass’n*, 475 F.3d at 193. This Hobson’s Choice effectively required covered employers to pay eight percent of their total payrolls to covered plans because no rational employer would pay money to the state instead of increasing an employee benefit. *Id.*

Like the economic incentives upheld in both *Travelers*⁹¹ and *Dillingham*,⁹² the indirect economic incentive created by the individual mandate lacks a “connection with” or “reference to” covered plans because it fails to bind plan administrators to any particular choice, function as a regulation of an employer, or preclude uniform administrative practice or the provision of a uniform benefit package in different states.⁹³

B. *The Cafeteria Plan Requirement Should Not Be Preempted by ERISA*

Like the individual mandate, a court would likely conclude that ERISA does not preempt the cafeteria plan requirement, which requires covered employers to establish premium-only cafeteria plans.⁹⁴ It is unlikely a court would hold the requirement preempted because an analysis of it shows that it lacks both a “connection with” and a “reference to” covered plans.

The cafeteria plan requirement does not have a prohibited “reference to” covered plans because it neither acts immediately and exclusively on covered plans nor are they essential to its operation. In contrast, the cafeteria plan requirement requires the provi-

91. *Travelers*, 514 U.S. 645. In *Travelers*, the Court examined New York’s Prospective Hospital Reimbursement Methodology, which called for the cost of treatment at a hospital to be based on the average cost of treating a condition rather than the actual cost of treating it. See N.Y. PUB. HEALTH LAW § 2807(c) (McKinney Supp. 2010). The cost of treating the condition was based on its categorization under one of the 794 Diagnostic Related Groups. *Travelers*, 514 U.S. at 649. Each Diagnostic Related Group was then adjusted based on each particular hospital’s operating costs. *Id.* at 649-50. Patients with Blue Cross & Blue Shield were billed at the appropriate rate for the Diagnostic Related Group while other patients were surcharged up to twenty-four percent above this level. *Id.* at 650.

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

In *Dillingham*, the Supreme Court reviewed a California law that regulated wages contractors paid to apprentices on public construction projects. The law at issue allowed contractors to pay apprentices lower wages if they participated in state certified apprentice programs. The Court found that by allowing contractors to pay lower wages, the law created an indirect incentive for ERISA plans to obtain state certification. The Court determined that the incentive to seek certification was not strong enough to eliminate the choice regarding whether to seek certification. The Court found that the law was similar to the New York Statute upheld in *Travelers* and determined that it was not preempted by ERISA.

Retail Indus. Leaders Ass’n v. Suffolk County, 497 F. Supp. 2d 403, 413 (E.D.N.Y. 2007) (citations omitted).

93. See *Dillingham Constr.*, 519 U.S. at 326, 329; *Travelers*, 514 U.S. at 659-60.

94. See *supra* section II.B.

sion of a noncovered benefit, namely a premium-only cafeteria plan that offers a group health insurance option.

A premium-only cafeteria plan that offers a group health insurance option is not a covered plan because neither a cafeteria plan, in and of itself, nor a premium-only group health insurance plan constitutes a covered plan.⁹⁵ A cafeteria plan, in and of itself, is not an ERISA plan⁹⁶ since it is a mere funding mechanism by which employees can utilize pre-tax dollars to obtain certain benefits, and the provision of tax advantaged treatment is not a benefit subject to ERISA.⁹⁷

Despite a cafeteria plan, in and of itself, failing to constitute a covered plan, the mandate that employers establish cafeteria plans under which employees can purchase group health insurance would still be preempted by ERISA if the required benefit under the employer mandated cafeteria plans is an ERISA plan.⁹⁸ The critical analysis, therefore, is whether the benefit required by the cafeteria plan requirement, namely employee access to a premium-only group health insurance plan, constitutes an ERISA plan.

An employer sponsored health insurance plan constitutes a covered plan,⁹⁹ but a health insurance plan that satisfies five conditions will be not be deemed to be employer sponsored and consequently will not be an ERISA-covered plan.¹⁰⁰ These five conditions are (1) the employer must not make any contributions to the plan; (2) employee participation in the plan must be voluntary; (3) the sole function of the employer with respect to the plan must be either permitting the insurer to publicize the program or collecting premiums through payroll deductions; (4) the employer cannot receive any consideration from the insurer other than reasonable compensation for the administrative services the employer actually renders in connection with payroll deductions; and (5) the employer

95. "Congress pre-empted state laws relating to *plans* [as defined in ERISA], rather than simply to *benefits*." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987).

96. Dep't of Labor Op. Ltr. 96-12A (July 17, 1996), *available at* <http://www.dol.gov/ebsa/programs/ori/advisory96/96-12a.htm>.

97. *Id.*

98. *Id.*

99. *See supra* section I.A.

100. 29 C.F.R. § 2510.3-1(j) (2009); *see also* Dep't of Labor Op. Ltr. 96-12A (July 17, 1996), *available at* <http://www.dol.gov/ebsa/programs/ori/advisory96/96-12a.htm>; U.S. D.O.L. Field Assistance Bulletin 2004-1, *available at* http://www.dol.gov/ebsa/regs/fab_2004-1.html (discussing contributions to health care savings accounts) (last visited Apr. 8, 2010).

must not endorse the benefit.¹⁰¹ The cafeteria plan requirement fails to require that an employer sponsor health insurance because an employer can comply with the requirement without violating any of these five conditions.

The fact that the cafeteria plan requirement fails to require the provision of a covered benefit also results in it lacking a prohibited connection with covered plans because employers and plan administrators can satisfy the requirement without altering their covered plans, and it does not otherwise interfere with the uniform nationwide administration of employee benefit plans.¹⁰²

C. *The Reporting Requirements Should Not Be Preempted*

Like the cafeteria plan requirement, the reporting requirements imposed by the Bill on both employers and individuals would not be preempted,¹⁰³ but unlike the cafeteria plan requirement, the reporting requirements have, at least in a technical sense, a “connection with” covered plans. Despite this connection, the reporting requirements are not preempted because they do not interfere with the uniform nationwide administration of employee benefit plans.

The reporting requirements in the Bill requiring employers to report information regarding a covered benefit, group health insurance,¹⁰⁴ lack a “reference to” ERISA plans because they function irrespective of the existence of an ERISA plan,¹⁰⁵ and a state law has a “reference to” an ERISA plan only when it acts immediately and exclusively on covered plans or when the existence of covered plans is essential to its functioning.¹⁰⁶ While an employer spon-

101. 29 C.F.R. § 2510.3-1(j); *see also* Dep’t of Labor Op. Ltr. 96-12A, *supra* note 100. An employer is deemed to have endorsed a benefit when the employer fails to appear neutral to its employees in regard to their election to forgo receiving cash compensation in exchange for their purchase of a benefit available through the plan. An employer is not deemed to have endorsed a plan by merely limiting the providers that it allows to market products available through its cafeteria plan. Dep’t of Labor, *Interpretive Bulletin Relating to Payroll Deduction IRAs*, 29 C.F.R. § 2509.99-1 (2009).

102. *See* *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 12-14 (1987).

103. *See supra* section III.B. A health insurance plan that “involves a fund or program maintained by an employer for the purpose of providing health benefits for [an] employee ‘through the purchase of insurance or otherwise’” is an ERISA-covered plan. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130 (1992) (quoting 29 U.S.C. § 1002(1)).

104. *Golden Gate Rest. Ass’n v. City & County of S.F.*, 535 F. Supp. 2d 968, 974-76 (N.D. Cal. 2007), *rev’d*, 546 F.3d 639 (9th Cir. 1996).

105. *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 328 (1997).

106. *Id.* at 326.

sored health insurance plan is an ERISA-covered plan, the Bill requires all covered employers to report information, irrespective of whether they have an employer sponsored health insurance plan. This statutory indifference towards the existence or inexistence of a covered plan results in the reporting requirement lacking a “reference to” covered plans.¹⁰⁷

Despite lacking a “reference to” covered plans, a statute can be preempted under ERISA if it fails the broader “connection with” test. By requiring employers to report information to the Commonwealth beyond the information that must be reported in other states, the reporting requirements of the Bill place a burden on the uniform nationwide administration of employee benefit plans. Due to this resulting burden, the reporting requirements have, at least technically, a “connection with” ERISA plans.¹⁰⁸

In this technical sense, the Bill’s reporting requirements have a “connection with” covered plans, but since the burden imposed on covered plans is so slight, a court would likely determine that this connection does not result in the reporting requirements being deemed to “relate to” covered plans.¹⁰⁹ Similar to the reporting requirements upheld in *Keystone Chapter, Associated Builders & Contractors, Inc. v. Foley*,¹¹⁰ the reporting requirements established by the Bill require the reporting of only general and readily available payroll information.¹¹¹ The reporting of such information has a “connection with” covered plans, but the slight administrative burden arising from reporting such information does not burden or influence the benefits or structure of employee benefit plans or

107. *Id.* at 328; see *Keystone Chapter, Associated Builders & Contractors, Inc. v. Foley*, 37 F.3d 945, 956-57 (3d Cir. 1994) (holding that a law does not contain a prohibited reference to covered plans if it is neither specifically designed to affect employee benefits, singles out ERISA plans for special treatment, or creates a scheme in which ERISA plans are so central that “the rights and restrictions [the law] creates are predicated on the existence of such a plan”); see also *Golden Gate Rest. Ass’n*, 546 F.3d at 657; *WSB Elec., Inc. v. Curry*, 88 F.3d 788, 792-93 (9th Cir. 1996).

108. See *supra* section I.B.

109. *Burgio & Compofelice, Inc. v. N.Y. State Dep’t of Labor*, 107 F.3d 1000, 1008 (2d Cir. 1997); see also *Keystone*, 37 F.3d at 963; *Felix A. Marino Co. v. Comm’r of Labor & Indus.*, 689 N.E.2d 495, 498 (Mass. 1998).

110. *Keystone*, 37 F.3d at 958 (holding that reporting requirements established under the Pennsylvania prevailing wage statute that allowed employers to use the value of covered benefits to calculate the wages being paid fails to have a “reference to” covered plans).

111. It may be posited that the burden of the Massachusetts statute is greater than that in *Egelhoff* or in *Keystone* because the Bill requires administrators to first determine if their plans meet the requirements of the individual mandate before sending employees 1099-HC forms. See *id.* at 962.

otherwise interfere with the congressional goal of allowing the nationwide administration of uniform employee benefit plans, and, accordingly, the reporting requirement is not preempted.¹¹²

D. *The Fair Share Contribution Requirement Is Preempted*

Whereas the individual mandate, the cafeteria plan requirement, and the reporting requirements are all likely to survive an ERISA preemption challenge, the requirement imposed on employers to make a fair and reasonable contribution to their employees' coverage under an employer-established group health plan, as such plan is defined in § 5000(b)(1) of the Internal Revenue Code, is likely to be held preempted by ERISA under both the "reference to" and "connection with" tests.

The fair share contribution requirement fails both prongs of the "reference to" test.¹¹³ It has both an immediate and exclusive impact on covered plans, and such plans are essential to its operation. An immediate impact on covered plans exists when a state statute requires employers to make contributions to ERISA plans.¹¹⁴ Group health plans, as defined in § 5000(b)(1) of the Internal Revenue Code, to which employers make contributions, are necessarily ERISA plans.¹¹⁵ By mandating that covered employers make a specific contribution to a § 5000(b)(1) group health plan,

112. *See id.*; *see also* *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146-47 (2d Cir. 1989) ("What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit."); *see also* *Egelhoff v. Egelhoff*, 532 U.S. 141, 158 (2001) (Breyer, J., dissenting) (citing *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815 (1997), and *Mackey v. Lanier Collection Agency & Serv., Inc.*, 482 U.S. 825, 831-32 (1988)); *Golden Gate Rest. Ass'n*, 546 F.3d at 657 (holding that the administrative burden created by requiring employers to calculate their health care expenditures for their employees fails to have a prohibited connection with covered plans); *WSB Elec., Inc.*, 88 F.3d at 796.

113. *Mackey*, 486 U.S. at 828; *see* *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997).

114. *Gen. Elec. Co. v. N.Y. Dep't of Labor*, 891 F.2d 25, 30 (2d Cir. 1989); *Local Union 598, Plumbers & Pipefitters Indus. Journeyman & Apprentices Training Fund v. J.A. Jones Constr. Co.*, 846 F.2d 1213, 1219 (9th Cir. 1988).

115. *Madonia v. Blue Cross & Blue Shield of Va.*, 11 F.3d 444, 447 (4th Cir. 1993); Brief for Chamber of Commerce of U.S.A. as Amici Curiae Supporting Appellee, *supra* note 20, at 15. The overlap of the definitions of group health plans under the Internal Revenue Code and employee welfare benefit plans under ERISA is readily apparent. The former defines a group health plan as "a plan (including a self insured plan) of, or contributed to by, an employer . . . or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or

which is necessarily an ERISA plan, the fair share contribution requirement acts immediately and exclusively on covered plans.

The fair share contribution requirement also has a prohibited “reference to” covered plans because covered plans are essential to its operation. The fair share contribution requirement forces employers to establish and contribute to group health plans within the meaning of § 5000(b)(1) of the Internal Revenue Code, which, as indicated above, are necessarily ERISA plans. By requiring the establishment of and contributions to covered plans, covered plans are essential to the operation of the fair share contribution requirement.¹¹⁶

Even if the fair share contribution requirement lacked a prohibited reference to covered plans, it would still be preempted for having a “connection with” such plans because the nature of the effect of the state statute is to interfere with the nationwide uniform administration of employee benefit plans.¹¹⁷ This interference exists because obligating employers to make specific contributions to covered plans or to pay fees to the Commonwealth Care Trust Fund forces plan sponsors to adjust their contributions to comply with the levels of funding established by the fair share contribution requirement.¹¹⁸ This required level of funding impairs the nationwide uniform administration of employee benefit plans by preventing plan administrators and employers from adopting uniform nationwide funding schemes¹¹⁹ and gives rise to a prohibited connection with such plans.¹²⁰

their families.” 26 U.S.C. § 5000(b)(1) (2006). The latter defines “an employee welfare benefit plan” as

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

29 U.S.C. § 1002(1).

116. See *Dillingham*, 519 U.S. at 326; *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990); *Mackey*, 486 U.S. at 829; *Golden Gate Rest. Ass’n v. City & County of S.F.*, 535 F. Supp. 2d 968, 974-76 (N.D. Cal. 2007), *rev’d*, 546 F.3d 639 (9th Cir. 1996).

117. See *supra* section I.B.

118. See *Golden Gate Rest. Ass’n*, 535 F. Supp. 2d at 976.

119. *Retail Indus. Leaders Ass’n*, 475 F.3d at 193-94.

120. “A [state] statute which mandates employer contributions to benefit plans and which effectively dictates the level at which those . . . contributions must be made has a most direct connection with an employee benefit plan.” *Local Union 598, Plumbers & Pipefitters Indus. Journeyman & Apprentices Training Fund v. J.A. Jones Constr. Co.*, 846 F.2d 1213, 1219 (9th Cir. 1988).

It has been posited that the fair share contribution requirement might not be preempted by ERISA because it only relates to ERISA plans at the election of employers.¹²¹ The premise of this position is that covered employers face only a \$295 per employee fee for noncompliance, which it is argued is substantially less than the cost of making a fair share contribution. Based upon this premise, the proponents of this position conclude that the fair share contribution requirement may be found to only constitute an economic incentive that neither binds plan administrators to a particular choice nor mandates the particular funding of a covered plan and is, therefore, not preempted.¹²²

While it is true that indirect economic incentives that merely provide a financial benefit to a plan if the plan makes certain choices lack a prohibited connection with covered plans,¹²³ there are three reasons why the fee imposed by the Bill for noncompliance is not the type of indirect economic incentive that falls within this exception. First, the fee is not intended to constitute a financial incentive but is rather a fee for noncompliance.¹²⁴ Second, unlike the options available in *Golden Gate Restaurant Ass'n*, where an employer could comply with the contribution requirement by either providing a covered benefit or a noncovered employee benefit,¹²⁵ the fair share contribution requirement does not provide employers with a set of alternatives. It mandates a specific action and charges a fee for noncompliance that does not go to the direct benefit of the employees¹²⁶ but, instead, goes to the Commonwealth Care Trust

121. See, e.g., Stiefel, *supra* note 48, at 699-700.

122. See *id.*

123. Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 334 (1997); N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 659-60 (1995); Keystone Chapter, Associated Builders & Contractors, Inc. v. Foley, 37 F.3d 945, 960 (3rd Cir. 1994).

124. MASS. GEN. LAWS ch. 149, § 188(b) (2008); see Retail Indus. Leaders Ass'n v. Fielder, 435 F. Supp. 2d 481, 495 (D. Md. 2006), *aff'd*, 475 F.3d 180 (4th Cir. 2007); see also Egelhoff v. Egelhoff, 532 U.S. 141, 150-51 (2001).

125. Golden Gate Rest. Ass'n v. City & County of S.F., 546 F.3d 639, 660-61 (9th Cir. 2007).

126. *Id.* at 655-56; see also *Travelers*, 514 U.S. at 664; Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 193 (4th Cir. 2007); *J.A. Jones Constr. Co.*, 846 F.2d at 1218 (stating that a law relates to an ERISA plan if it directly or indirectly purports to regulate employee benefit plans by attempting in one way or another to reach the terms or conditions of such plans). In *Retail Industry Leaders Ass'n*, the court determined that the two options provided by the statute resulted in a Hobson's Choice because one option was impractical. See *Retail Indus. Leaders Ass'n*, 475 F.3d at 197. Neither the appellee nor the appellant argued, and the court did not discuss, the possibility that a third option existed: breach the statute and pay a \$250,000 fine. See *id.* at 193-97; see

Fund.¹²⁷ Third, unlike the financial incentives in *Keystone*,¹²⁸ *Travelers*,¹²⁹ and *Dillingham*,¹³⁰ the fee is not contained in a law of general application that imposes an indirect burden on covered plans.¹³¹ It is contained in a law that imposes a direct burden on covered plans.¹³²

E. Conclusion

ERISA preempts state laws insofar as they “relate to” ERISA plans. This prohibited relationship exists if the state law has a “reference to” or “connection with” covered plans. Under this test the individual mandate, cafeteria plan requirement, and reporting requirements of the Bill will be upheld, while its fair share contribution requirement will be preempted.

IV. PROPOSED AMENDMENTS TO THE MASSACHUSETTS BILL

A. Introduction

Irrespective of how you look at it, the Bill is in trouble. Its cost has far exceeded the cost predictions at the time of its passage,¹³³

also MD. CODE ANN., LAB. & EMPL. § 8.5-105(b) (LexisNexis 2008). For employers with over 10,000 employees, Maryland’s \$250,000 fine may be substantially less than the Massachusetts contribution, a \$295 annual per employee surcharge. In Massachusetts no second option exists; an employer either complies with the law by making a fair and reasonable premium contribution or pays the surcharge plus any applicable fines. See MASS. GEN. LAWS ch. 149, § 188.

127. MASS. GEN. LAWS ch. 118G, § 18B(e).

128. See *Keystone*, 37 F.3d at 957-58 (upholding a state prevailing wage statute that allowed contributions to ERISA plans to be taken into account when calculating prevailing wage payments).

129. See *Travelers*, 514 U.S. at 656 (upholding a state statute imposing surcharges on all patients covered by insurers and HMO plans other than Blue Cross and Blue Shield).

130. See *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 328 (1997) (holding that California’s prevailing wage statute that allowed employees who are enrolled in apprenticeship programs to be paid a lower wage did not relate to covered plans despite some apprenticeship programs constituting covered plans).

131. Laws of general application are state laws that apply to both covered plans and situations that do not involve covered plans. These laws have been held to include generally applicable state garnishment statutes, *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 841 (1988), and statutes requiring companies to make lump sum severance payments, *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 23 (1987).

132. *Pharm. Care Ass’n v. Rowe*, 429 F.3d 294, 304 (1st Cir. 2005).

133. When the Bill was passed the legislature predicted that \$725 million would be needed for Commonwealth Care subsidies in the third year, but it appears \$869 million will be required. Trudy Lieberman, *Cautionary Healthcare Tales from California and Massachusetts*, THE NATION, Mar. 25, 2008, <http://www.thenation.com/doc/>

and one of its central requirements, the fair share contribution requirement, is subject to preemption. Preemption of the fair share contribution requirement would, moreover, defeat the purposeful interrelation between the individual mandate and fair share contribution requirement in the Bill.

The interrelation between the individual mandate and the employer fair share contribution requirement effectively divides the cost of mandated coverage between employees and employers. The underlying purpose for this interrelation is the belief that while health care coverage is an individual responsibility and necessity, employers should be at least partially responsible for assisting employees in procuring such coverage.¹³⁴ Preemption of the employer fair share contribution requirement will destroy its interrelation with the individual mandate with the result that individuals will bear the entire cost of the mandated coverage. The Commonwealth of Massachusetts cannot confidently expect to salvage the Bill and its objective of dividing the cost of mandated coverage between employers and employees unless an amendment or amendments implement certain changes to the Bill and the state minimum wage.

There are four changes that are necessary to avoid a successful ERISA preemption challenge while still accomplishing the objective of having employers contribute to their employees' mandated coverage. First, an amendment should remove the employer fair

20080407/lieberman. There are three primary causes for this discrepancy. First, estimates at the time of the Bill's passage placed the number of uninsureds in the Commonwealth at 400,000 when in fact the number was closer to 650,000. *Id.* Second, it was expected that reductions in the number of uninsureds would reduce the costs incurred by the state's free care pool by between \$500 million \$600 million. *Id.* These savings have failed to materialize. Third, the cost of health care in Massachusetts has continued to skyrocket at about ten percent per year. *Id.*; see also Alice Dembner, *Healthcare Cost Increases Dominate Mass. Budget Debate*, BOSTON GLOBE, Mar. 26, 2008, at A12. The actual amount spent on free care was reduced by approximately forty-one percent. Glen Johnson, *State Insurance Law Result 'Remarkable,'* WORCESTER TELEGRAM & GAZETTE, Aug. 20, 2008, at A-3, available at <http://www.telegram.com/apps/pbcs.dll/article?AID=/20080820/NEWS/808200370/1052>. The present shortfall between the funds available for the Commonwealth Care subsidies and the actual cost of subsidizing the policies has been resolved through placing an additional one dollar per pack tax on cigarettes. This tax is expected to generate \$174 million annually. Medical News Today, *Massachusetts Cigarette Tax Increases by \$1 Per Pack to Fund State Health Insurance Law*, July 4, 2008, <http://www.medicalnewstoday.com/articles/113934.php>.

134. See State House News Service, Daily Transcript, May 4, 2006 (on file with *Western New England Law Review*) (Senator Lees's response to question regarding overriding Governor Mitt Romney's veto of section 47 of House Bill 4779).

share contribution requirement because it has generated a meager \$6 million¹³⁵ and, more importantly, is preempted by ERISA.¹³⁶ Second, an amendment to the state minimum wage should both increase and bifurcate the minimum wage into a cash portion and a benefit portion, similar to a prevailing wage. Third, an amendment to the Bill should implement further restrictions on employee access to plans under the Commonwealth Care Program. Fourth, an amendment strengthening the individual mandate should be passed.

B. *Removal of the Fair Share Contribution Requirement and Restructuring of Minimum Wage*

Despite ERISA preempting state efforts to force employers to contribute to their employees' health care coverage, the goal of the fair share contribution requirement, to have employers contribute to their employees' coverage, can still be accomplished through a more indirect means. This indirect means would involve increasing the minimum wage by the amount that it is believed employers should contribute to their employees' coverage and structuring the minimum wage to resemble a prevailing wage by dividing it into cash and benefit portions.¹³⁷ This proposed minimum wage would resemble the existing New York prevailing wage¹³⁸ in that employers could not satisfy the benefit portion by paying its cash equivalent. As a result, all employees, irrespective of their cash compensation, would receive a threshold level of benefits. To survive preemption, employers must be able to satisfy the benefit portion of the wage by providing, at their election, either ERISA-covered benefits, such as employer sponsored health care coverage, or benefits that fall beyond the scope of ERISA.¹³⁹

This option to provide a benefit other than a contribution towards an employee's health care coverage is necessary for the revised minimum wage to survive preemption¹⁴⁰ but could lead to the failure of the statute to accomplish its goal of having employers share in the cost of their employees' health care coverage. To re-

135. Dembner, *supra* note 133.

136. *See supra* section III.D.

137. This could also help to address the discrepancy between the cost of providing care to uninsureds and the maximum employer fee of \$295 per employee for covered employers who fail to make a fair and reasonable premium contribution to their employees' coverage.

138. N.Y. LAB. LAW § 220 (McKinney 2009).

139. *Burgio & Campofelice, Inc. v. N.Y. State Dep't of Labor*, 107 F.3d 1000, 1009 (2d Cir. 1997).

140. *Id.*

duce the risk of failure, employers must be persuaded to satisfy the benefit portion of the wage with contributions towards their employees' health care coverage, instead of providing an alternative noncash benefit. This persuasion could be created by placing incentives on employees to favor a contribution towards their health care coverage over an alternative noncash benefit because if the cost to an employer is the same, a rational employer will elect to provide the benefit to which its employees attribute the greatest value.¹⁴¹

The existing individual mandate creates an incentive for employees to favor a contribution towards coverage over a different noncash benefit because a contribution towards coverage would reduce an employee's premium, leaving more cash in the employee's pocket, and, in general, employees favor additional cash compensation over additional noncash benefits.¹⁴² This preference for increased cash compensation over increased benefits provides a canvas upon which the Commonwealth can design additional incentives for employees to favor premium contributions over alternative noncash benefits.

One such additional incentive could be to limit employee access to Commonwealth Care Plans to employees who fund their premium contributions with payroll deductions. By limiting employee access to these subsidized plans to employees who fund their contributions with payroll deductions, employees who qualify for the plans will elect to pay for their coverage with payroll deductions rather than purchasing nonsubsidized plans. The payroll deductions will then reduce the employee's weekly take-home pay by the amount of the pay period's subsidized premium. In order to alleviate this deduction and increase the employee's take home pay, which in general an employee would prefer over receiving an additional noncash benefit, the employee would pressure his employer to contribute towards his premium instead of providing an alternate noncash benefit.¹⁴³

141. *See supra* note 90.

142. *See Promoting Retirement Plan Coverage Among Small Employers: Hearing on Pension Issues Before the Ways and Means Subcomm. on Oversight*, 105th Cong. (1998) (testimony of Paul J. Yakobowski, Senior Research Associate, Employee Benefit Research Institute), available at <http://www.ebri.org/publications/testimony/index.cfm?fa=t110>.

143. In essence, employees who receive the contribution towards their coverage would receive a contribution by their employer towards coverage and a subsidy from the Commonwealth for this coverage, thereby increasing the cash plus health insurance value of their paycheck.

To prevent an individual from failing to procure coverage and at the same time receiving an additional noncash benefit that the individual deems to be more valuable than minimum creditable coverage, the individual mandate should be amended. This amendment would provide that if an employee fails to procure minimum creditable coverage, a withholding will be taken from the employee's paycheck in the amount of the premium for the least expensive plan offered by the Commonwealth Connector. These amounts would then be turned over to the Commonwealth Connector and would be used to purchase the least expensive unsubsidized policy that is available for the employee. This would result in the employee having to pay the equivalent of an unsubsidized premium when he might otherwise qualify for a subsidized one, and he would not be receiving employer contributions toward this premium, with the resulting effect that his weekly take-home pay would be reduced. Again, to alleviate this reduction in take-home pay, the employee would seek to have his employer contribute to his coverage instead of providing the additional noncash benefit.

C. *Proposed Amendments and ERISA Preemption*

The proposed amendments to the state minimum wage and the individual mandate would not only rectify the current deficiencies of the Bill but would also likely survive an ERISA preemption challenge.

1. *The Proposed Amendments to the Minimum Wage Would Not Be Preempted*

In analyzing the restructured minimum wage, which includes a cash portion and a benefit portion, a court would begin with the presumption that Congress did not intend to preempt the state law because the regulation of wages is a traditional area of state regulation.¹⁴⁴ With this presumption in mind, a court would then apply the "reference to" and "connection with" tests.

The ability of an employer to satisfy the benefit portion of the wage with either covered or noncovered benefits results in the restructured wage lacking a "reference to" covered plans because

144. *Keystone Chapter, Associated Builders & Contractors, Inc. v. Foley*, 37 F.3d 945, 959 (3d Cir. 1994).

they are neither essential to its operation nor does the restructured wage act immediately and exclusively on them.¹⁴⁵

In addition to preventing the restructured minimum wage from containing a prohibited “reference to” covered plans, the election available to employers in satisfying the benefit portion of the wage also prevents the statute from having a prohibited “connection with” covered plans. There is no prohibited “connection with” covered plans because employers and plan administrators have discretion either to leave their plans intact and provide a noncovered benefit or alter their plans and provide a covered benefit. This choice insulates the statute from interfering with the uniform nationwide administration of employee benefit plans.¹⁴⁶ This result is unaffected by the burden created by requiring employers to calculate the per-hour value of the benefit being provided, which may be a covered benefit because the burden the calculation creates is extremely slight.¹⁴⁷

2. The Proposed Amendments to the Individual Mandate Should Not Be Preempted

In analyzing the enhanced individual mandate, a court would likely break its analysis into two parts. The first part would examine the mandates placed on individuals and the second would examine the mandates placed on employers. Both parts of this analysis would begin with the presumption that Congress did not intend to preempt the state statute because the enhanced individual mandate is a generally applicable law in traditional areas of state

145. *Felix A. Marino Co. v. Comm’r of Labor & Indus.*, 689 N.E.2d 495, 498 (Mass. 1998); *see also Burgio & Campofelice, Inc.*, 107 F.3d at 1008-09; *Keystone*, 37 F.3d at 960-62 (citing *Shaw v. Delta Airlines*, 463 U.S. 85, 100 n.21 (1983)); *Gen. Elec. Co. v. N.Y. State Dep’t of Labor*, 891 F.2d 25, 29-30 (2d Cir. 1989); *Local Union 598, Plumbers & Pipefitters Indus. Journeyman & Apprentices Training Fund v. J.A. Jones Constr. Co.*, 846 F.2d 1213, 1218-19 (9th Cir. 1988). The choice created by the enhanced individual mandate would be preempted if it created a Hobson’s Choice, which is no choice at all, but, unlike covered employers in *Retail Industry Leaders Ass’n v. Fielder*, which were required to provide the covered benefit or pay its cash equivalent to the State, employers in Massachusetts would have a real option of providing either a covered benefit or a noncovered benefit. There would just be an employee preference for the benefit to be a covered benefit, a contribution to employer sponsored health insurance. *See Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 202 (4th Cir. 2007).

146. *Burgio & Campofelice, Inc.*, 107 F.3d at 1009.

147. *Id.* at 1007; *Minn. Chapter of Associated Builders & Contractors, Inc. v. Minn. Dep’t of Labor & Indus.*, 47 F.3d 975, 979-80 (8th Cir. 1995); *Keystone*, 37 F.3d at 962; *see also Golden Gate Rest. Ass’n v. City & County of S.F.*, 546 F.3d 639, 645 (9th Cir. 2008).

regulation, healthcare and wages,¹⁴⁸ but after this common starting point, the two parts of the analysis would diverge.

In analyzing the requirements placed on individuals, a court would apply the “reference to” and “connection with” tests and hold that the requirements survive preemption for essentially the same reasons the existing individual mandate would.¹⁴⁹ The new requirements lack a “reference to” covered plans because the obligation is placed on individuals irrespective of their status under ERISA plans,¹⁵⁰ and, consequently, the requirements do not act immediately and exclusively on covered plans nor is the existence of such plans essential to their operation.

The requirements placed on individuals by the enhanced individual mandate also do not have a prohibited connection with covered plans. A prohibited connection with covered plans exists if the state statute mandates an element of the structure or administration of ERISA plans or otherwise interferes with the uniform nationwide administration of such plans.¹⁵¹ At most, the new requirements imposed on individuals have an indirect effect on covered plans by establishing a financial incentive for employers to provide a covered benefit. This indirect economic incentive neither binds plan administrators to a particular choice nor interferes with the uniform nationwide administration of employee benefit plans. Thus, the connection between the mandates imposed on individuals by the enhanced individual mandate and covered plans is insufficient to result in preemption under the “connection with” test.¹⁵²

After finding that the requirements placed on individuals by the enhanced individual mandate survive preemption, a court would analyze the provisions of the enhanced individual mandate requiring employers to take withholdings from the paychecks of employees who fail to procure coverage. The court conducting this inquiry would find the employer mandates also lack a prohibited “reference to” or “connection with” covered plans.

A challenge to the withholding requirement under the “reference to” test would most likely be premised on an argument that

148. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995); Great Atl. & Pac. Tea Co. v. Cottrell, 424 U.S. 366, 371 (1976).

149. See *supra* section III.A.

150. Egelhoff v. Egelhoff, 537 U.S. 141, 147 (2001); Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 325 (1997).

151. See Shaw v. Delta Airlines, Inc., 463 U.S. 85, 97 (1983).

152. See *Travelers*, 514 U.S. at 659-62.

covered plans are essential to the requirement's operation because the requirement forces employers either to establish or contribute to covered plans. The fundamental flaw with this argument is that the employer withholdings, which are turned over to the Commonwealth Connector and used by it to purchase private insurance, fail to give rise to a "plan," as that term is used in ERISA. Consequently, there is no requirement that employers establish or contribute to covered plans.

The withholding requirement fails to give rise to a plan because to create a plan, as defined in ERISA, there must be the creation of either an employee pension benefit plan or an employee welfare benefit plan.¹⁵³ Since the withholding requirement clearly does not create an employee pension benefit plan, a litigant would premise the challenge on the existence of an employee welfare benefit plan. An employee welfare benefit plan exists when there is a "plan, fund, or program . . . established or maintained by an employer . . . through the purchase of insurance or otherwise . . . [that provides] medical, surgical, or hospital [benefits]."¹⁵⁴

The first requirement for an employee welfare benefit plan is not satisfied by the mandated withholdings because there is no plan, fund, or program. A plan, as that term is used in the definition of an employee welfare benefit plan, "comprises a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing the collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan."¹⁵⁵ A plan, fund, or program does not exist when, as with the withholding requirement, an employer pays amounts out of its general assets on a regular basis and the employer's corresponding administrative duties in calculating and paying such amounts are so ministerial that the abuses Congress was concerned with when it passed ERISA are absent.¹⁵⁶

The ministerial nature of the duties created by the withholding requirement is evidenced by the requirement imposing no greater

153. 29 U.S.C. § 1002(3) (2006).

154. *Id.* § 1002(1); *Golden Gate Rest. Ass'n v. City & County of S.F.*, 546 F.3d 639, 653 (9th Cir. 2008); *Aloha Airlines, Inc. v. Ahue*, 12 F.3d 1498, 1501-02 (9th Cir. 1993).

155. *Pegram v. Herdrich*, 530 U.S. 211, 222-23 (2000); *see also Massachusetts v. Morash*, 490 U.S. 107, 115-16 (1989) (holding that vacation benefits package that an employer pays out of its general assets, like wages, rather than out of a separate fund, fails to constitute a plan).

156. *See Golden Gate Rest. Ass'n*, 546 F.3d at 650-53.

burden on employers than the burden imposed by the multitude of other required withholdings in existence, such as state and federal income and employment tax withholdings.

Even if a plan is found to exist, this plan would not be an employee welfare benefit plan. The second requirement for an employee welfare benefit plan is that the plan provide “medical, surgical, or hospital [benefits]” to its participants “through the purchase of insurance or otherwise.”¹⁵⁷ This requirement would not be met because employers are not providing a benefit through the purchase of insurance or otherwise. Instead, they are making mandated contributions to a state entity that the state entity uses to purchase private insurance. The position that employers are not providing the benefit through the purchase of insurance or otherwise is evidenced by the fact that both the Commonwealth Connector and the policies offered by the private insurers through the Connector would exist irrespective of whether employers make payments to the Connector because employees would be required to purchase the coverage.¹⁵⁸

Despite the withholding requirement lacking a “reference to” covered plans, it could still be preempted under the broader “connection with” test, which examines whether or not the challenged statute interferes with the uniform nationwide administration of employee benefit plans. In contrast to statutes that bind plan administrators to particular choices¹⁵⁹ or force covered plans to provide certain benefits,¹⁶⁰ the withholding requirement fails to force employers to alter their existing plans either directly or by creating a Hobson’s Choice, and it thus fails to contain a prohibited “connection with” covered plans.¹⁶¹

CONCLUSION

One of the most serious problems facing the nation is decreasing access to health care. This decreasing access is caused by a multitude of factors including the spiraling cost of care, the increasing cost of insurance, and a reduction in employer sponsored coverage. Historically, political forces have prevented the implementation of

157. 29 U.S.C. § 1002(3).

158. *Golden Gate Rest. Ass’n*, 546 F.3d at 653.

159. See *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001).

160. See *Standard Oil Co. of Cal. v. Aghsalud*, 442 F. Supp. 695, 696 (N.D. Cal. 1977), *aff’d*, 633 F.2d 760 (9th Cir. 1980), *aff’d mem.*, 454 U.S. 801 (1981).

161. See *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659-60 (1995); *Golden Gate Rest. Ass’n*, 546 F.3d at 656.

the fundamental changes at the federal level that must be made, but states have not ignored the cries of their residents and have attempted to enact measures to increase access to care. The Massachusetts Bill is one of these measures, and it attempts to address a problem that has led to a reduction in access to care—the decrease in employer sponsored coverage.

While the Massachusetts Bill has advanced the process towards creating a solution to the health care crisis, like many initial legislative efforts towards socioeconomic reform, it is flawed. Besides costs exceeding expectations, one of its key elements, the fair share contribution requirement, is subject to being preempted by ERISA, a federal statute that was ironically intended to further the provision of employee benefits. “Still . . . the unraveling of [the Bill] will not signal the end to the story of universal health in Massachusetts. The same pressures that created the conditions for passage of the current law will continue to exert their effect until a more durable solution is found.”¹⁶² As the pressures for a more durable solution continue to grow, examination of the strengths and weaknesses of the Bill and of proposed legislative redress are the necessary building blocks towards devising a durable solution.

162. Goldberger, *supra* note 79, at 859 (discussing the Massachusetts Health Security Act of 1988, which was intended to establish universal coverage for residents of the Commonwealth but was repealed under economic circumstances that mirror those the Commonwealth currently faces).