

2010

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Repository Citation

Booth, Joshua P. and Palmer, Larry I., "ERISA Preemption Doctrine as Health Policy" (2010). *Faculty Publications*. 1585.
<https://scholarship.law.wm.edu/facpubs/1585>

ERISA PREEMPTION DOCTRINE AS HEALTH POLICY

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I. INTRODUCTION

The Employee Retirement Income Security Act (“ERISA”)¹ was passed by a Democratic Congress and signed by a Republican President, Gerald Ford, in 1974. Since that time, it has been a source of confusion and debate among scholars. The primary focus of the Act, as suggested by its title, was to protect employee pension plans. To this end, ERISA provisions regulate a number of aspects of employee pension plans—such as minimum funding requirements² and specific reporting and disclosure requirements.³

However, ERISA’s scope goes far beyond retirement benefits. In addition to pension plans, ERISA also regulates “employee welfare benefit plan[s,]” which include employer-provided health care benefits—defined as plans designed to provide, “through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness,”—as well as a range of other employee benefits as diverse as disability benefits, day care centers, and scholarship funds.⁴

ERISA’s broad scope has been particularly problematic to courts and scholars trying to explain the Act’s preemption provision. Section

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1. Employee Retirement Income Security Act, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. § 1001 et seq. (2006)).

2. *Id.* § 1013 (codified as amended at 26 U.S.C. § 412).

3. *Id.* §§ 101–07 (codified at 29 U.S.C. §§ 1021–27).

4. *Id.* § 3(1) (codified at 29 U.S.C. § 1002(1)).

514⁵ states that ERISA “shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan.”⁶ In an early ERISA case, the U.S. Supreme Court suggested that a statute could relate to ERISA plans in one of two ways, by having either “a connection with or reference to such a plan.”⁷ These terms, however, are as vague as the statutory language itself, and neither courts nor scholars seem to have been able to clearly state the meaning of this provision. As Peter Jacobson notes: “Finding coherence from the myriad of ERISA opinions is quite difficult. At best, ERISA doctrine is neither predictable nor stable; it is, rather, largely muddled and most opinions are impenetrable.”⁸

Part of this difficulty arises from the fact that many of the scholars who have commented on the subject have focused on employment law and pension benefits—not on health care policy. These scholars attempt to take the framework of preemption created in the context of pensions and other benefits and apply it directly to health care benefits. This practice is, perhaps, understandable. After all, ERISA has a single preemption provision that purportedly applies to both types of statutes. A highly textual approach to statutory interpretation, therefore, might reasonably lead an interpreter to apply the same preemption framework to both types of statute.

We propose that courts typically apply a more pragmatic form of statutory interpretation. As described by scholars such as William Eskridge and his collaborators, courts do not typically adopt a single interpretive framework to be applied in all situations.⁹ Rather, courts utilize a number of interpretive techniques. Which techniques will be applied, and how they will be applied, will depend upon the institutional arrangements and policy considerations in a given area of law, as well as the particular court making the decision.

Under this framework, the assumption that courts will mechanically apply the standards of preemption from other contexts to health care ordinances ignores the unique aspects of health policy and the unique institutional arrangements involved. Health care presents a very different institutional structure than pension benefits. Put another way, the relationship between various institutions, including private market institutions, the courts, state governments, and the federal government,

5. Section 514 of the public law can be found at 29 U.S.C. § 1144.

6. 29 U.S.C. § 1144.

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

8. Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J.L. MED. & ETHICS (SUPPLEMENT 2) 88, 91 (2009).

9. See *infra* Part III.A.

will naturally be different in the health care context than in other contexts. This will lead courts to apply different interpretive techniques. Thus, we believe there is a need for a new way of looking at ERISA preemption of state and local health care statutes that takes into account these unique features of health policy.

This need is emphasized by two recent federal circuit court decisions. In 2007, the Fourth Circuit found a Maryland Statute requiring employers with more than 10,000 employees to make certain health care expenditures for their employees to be preempted in *Retail Industry Leaders Ass'n v. Fielder*.¹⁰ Two years later, the Ninth Circuit found that a San Francisco ordinance that required employers to make certain expenditures for their employees was not preempted by ERISA in *Golden Gate Restaurant Ass'n v. San Francisco*.¹¹ The Supreme Court declined to review *Golden Gate* on June 28, 2010.¹²

Although the two cases present a number of unique institutional considerations, the distinct outcomes cannot easily be explained by most common interpretations of ERISA. This Article proposes that the different outcomes are best explained by looking at ERISA's preemption of health care statutes in light of health policy.

Part II describes the two cases and the apparent conflict between them. It goes on to describe how preemption frameworks imported from pension/disability and other contexts cannot adequately explain the distinct results in these cases.

Part III provides a brief overview of the dynamic form of statutory interpretation that we believe courts apply in dealing with health policy matters. We then discuss how this is likely to result in different judicial methodology for determining preemption of pension laws and health care laws. Specifically, in the health care arena, courts are more likely to eschew a textualist approach in favor of a more dynamic approach that looks at the health policy background in which a statute operates.

Part IV examines what it means to look at ERISA preemption through the lens of health policy. We begin by discussing the health policy context at the time that ERISA was enacted. We then give brief examples of how health policy and institutional concerns have affected Supreme Court decisions on ERISA preemption. We then list some specific health policy implications of ERISA preemption.

Finally, in Part V, we return to the Fourth and Ninth Circuit cases and examine these decisions—and the Supreme Court's decision not to

10. 475 F.3d 180, 183 (4th Cir. 2007).

11. 546 F.3d 639, 642 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010).

12. *Golden Gate Rest. Ass'n v. City & Cnty. of S.F.*, 130 S. Ct. 3497 (2010).

grant certiorari in *Golden Gate*—in light of the analytical methods discussed in Parts III and IV.

II. AN APPARENT “CONFLICT” BETWEEN THE FOURTH AND NINTH CIRCUITS

A. *Maryland’s Fair Share Act*

1. The Statute

In 2006 the Maryland General Assembly passed the Fair Share Health Care Fund Act (the “Fair Share Act”).¹³ The Fair Share Act required employers with at least ten thousand Maryland employees to spend at least eight percent of their payroll on health care for their employees—either through an ERISA plan or through other expenditures.¹⁴ If the employer fell short, it was required to pay the difference to the state.¹⁵

The Fair Share Act was targeted exclusively at one employer, Wal-Mart Stores, Inc. (“Wal-Mart”).¹⁶ By its terms, the Fair Share Act applied only to for-profit employers with more than ten thousand employees in Maryland.¹⁷ Only two employers fell under this definition, and one of these was already in compliance with the Fair Share Act and had actually lobbied for it.¹⁸

Shortly after the passage of the Fair Share Act, the Retail Industry Leaders Association (“RILA”), an association of which Wal-Mart is a prominent member, filed suit, arguing that the Fair Share Act was preempted by ERISA.¹⁹ The district court agreed and granted RILA’s motion for summary judgment, and Maryland appealed to the Fourth Circuit.²⁰

2. The Court’s Analysis

Maryland put forth a number of arguments that the Fair Share Act should not be preempted, all of which were rejected by the Fourth Circuit. Maryland’s primary argument was that the Fair Share Act gave

13. *Fielder*, 475 F.3d at 183.

14. *Id.* at 183, 196.

15. *Id.* at 183.

16. *Id.*

17. *Id.*

18. *Id.* at 185.

19. *Id.*

20. *Id.* at 186.

covered employers (i.e. Wal-Mart) alternatives to establishing an ERISA plan.²¹ While the statute may have affected Wal-Mart's choices by providing certain incentives, it did not force any specific action.²² Maryland pointed out that the Supreme Court had upheld a number of state statutes that influenced, without forcing, employer choices.²³

In developing this argument, Maryland pointed to a number of alternative avenues that employers had for complying with the statute.²⁴ For example, Wal-Mart could comply with the spending requirements either by setting up on-site medical clinics for its employees or by contributing to an employee's health savings account—neither of which would be governed by ERISA.²⁵

The court determined that neither of these were “meaningful alternatives by which an employer can increase its healthcare spending to comply with the Fair Share Act.”²⁶ For an on-site medical clinic to escape ERISA's scope, it would have to limit its activities to “the treatment of minor injuries or illness or rendering first aid.”²⁷ Health savings accounts would be an option only in regards to employees who chose to enroll in a high-deductible health plan.²⁸ Given the low likelihood that Wal-Mart would be able to meet its spending requirement through either method, they did not provide a “meaningful avenue” for Wal-Mart to meet its obligations under the Fair Share Act.²⁹

Maryland next pointed out that employers had yet another alternative—paying the required amount directly to the state.³⁰ This, Maryland argued, gave Wal-Mart a viable alternative that did not require any alteration of its ERISA plans.³¹ The court rejected this argument, based on what it perceived to be an employer's inevitable choices.³² Given the choice between increasing its health care benefits and giving

21. *Id.* at 194-95.

22. *Id.* at 195.

23. *Id.* Maryland relied, in particular, on *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.* *Id.*; see *Travelers*, 514 U.S. 645 (1995). In *Travelers*, the Court approved a statute that gave employers a strong incentive to provide health care benefits through Blue Cross and Blue Shield as opposed to other providers. *Travelers*, 514 U.S. at 659. The Court ruled that, despite the law's rather clear tendency to affect ERISA plans, its effect on such plans was indirect, and was therefore not preempted. *Id.* at 662.

24. *Fielder*, 475 F.3d at 196.

25. *Id.*

26. *Id.*

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.* at 197.

31. *Id.*

32. *Id.*

money to the state, any rational employer would choose the former.³³ Providing increased benefits to employees provides an employer with certain advantages, such as improved ability to recruit and retain employees.³⁴ The state-payment option would provide no such benefits, and an employer would simply look at it as money wasted.³⁵

Thus, the court concluded, the Fair Share Act did not simply provide certain incentives or influence employer choices.³⁶ Rather, the Fair Share Act was a direct mandate that a specific employer increase its compensation under ERISA plans.³⁷ Such a direct mandate, unlike the incentives upheld in previous cases, was preempted by ERISA.³⁸

B. San Francisco Health Care Security Ordinance

1. The Ordinance

In July 2006, the San Francisco Board of Supervisors passed a law that was, in many ways, similar to the Maryland law.³⁹ The San Francisco Health Care Security Ordinance ("HCSO") has two major components, the "Health Access Program" and an employer contribution requirement.⁴⁰

The Health Access Plan ("HAP") is a "[c]ity-administered health care program"⁴¹ designed as a way for uninsured San Francisco residents to obtain health care.⁴² It provides enrollees with "medical services with an emphasis on wellness, preventive care[,] and innovative service delivery."⁴³ The HAP is open to any uninsured resident,⁴⁴ and enrollees pay participation fees based on their ability to pay.⁴⁵

33. *Id.* at 193.

34. *Id.*

35. *Id.*

36. *Id.* at 195, 197.

37. *Id.* at 197.

38. *Id.* Note that following the Fourth Circuit's decision in *Felder*, but prior to the Ninth Circuit's decision discussed below, a district court in New York found a county statute very similar to Maryland's Fair Share Act preempted. *Retail Indus. Leaders Ass'n v. Suffolk Cnty.*, 497 F. Supp. 2d 403, 416, 418 (E.D.N.Y. 2007). The court relied heavily on the reasoning in *Felder*. *Id.* at 416-18.

39. *Golden Gate Rest. Ass'n v. City & Cnty. of S.F.*, 546 F.3d 639, 642 (9th Cir. 2008).

40. S.F., CAL., ADMIN. CODE § 14.1-3 (2006); *Golden Gate*, 546 F.3d at 642.

41. *Golden Gate*, 546 F.3d at 642.

42. S.F., CAL., ADMIN. CODE § 14.2(a).

43. *Id.* § 14.2(f).

44. *Id.* § 14.2(c).

45. *Id.* § 14.2(d).

The second part of the HCSO (and the only part challenged in the lawsuit) is the employer contribution requirement.⁴⁶ Covered employers—meaning employers with at least twenty employees performing work in San Francisco—are required to spend at least a certain amount (between \$1.17 and \$1.76, depending on the employer's size) per employee work-hour for health care on behalf of their employees.⁴⁷ Such contributions can take a number of forms, including contributions to a health savings account, reimbursements directly from the employer to the employee, or contributions to an employee health plan.⁴⁸ Finally, an employer may meet the requirement by paying the amount to the HAP (the “city-payment” option).⁴⁹ If the employer elects to pay the city, its employees will be eligible to enroll in the HAP at a reduced cost.⁵⁰

Shortly after the ordinance was passed, the Golden Gate Restaurant Association filed a complaint, arguing that the employer-contribution requirement was preempted by ERISA.⁵¹ The district court agreed and entered judgment for the Association.⁵² The city appealed to the Ninth Circuit, which concluded that the ordinance was not preempted and reversed.⁵³

2. The Court's Analysis

In contrast with the Fourth Circuit's opinion in *Fielder*, which began with a discussion of ERISA case law,⁵⁴ the Ninth Circuit's opinion began by looking at the specific effects that the HCSO was likely to have on employers.⁵⁵ The court described several different categories of employers—including employers that provide no health benefits to their employees, employers that provide adequate health insurance to all their employees, and employers that provide partial coverage or only cover a portion of their employees.⁵⁶ The court then detailed what an employer within each category would have to do to come into compliance with the ordinance.⁵⁷ Significantly, the court

46. *Golden Gate*, 546 F.3d at 643.

47. S.F., CAL., ADMIN. CODE § 14.1(b)(3), (8), (15); *Golden Gate*, 546 F.3d at 644.

48. S.F., CAL., ADMIN. CODE § 14.1(b)(7)(a)–(c); *Golden Gate*, 546 F.3d at 644.

49. S.F., CAL., ADMIN. CODE § 14.1(b)(7)(e); *Golden Gate*, 546 F.3d at 644–45.

50. *Golden Gate*, 546 F.3d at 645.

51. *Id.* 642–43.

52. *Id.* at 643.

53. *Id.*

54. *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 190–93 (4th Cir. 2007).

55. *Golden Gate*, 546 F.3d at 645–46.

56. *Id.*

57. *Id.* at 646.

pointed out that, in any category, an employer “may choose to leave their ERISA plans intact and unaltered.”⁵⁸ Every employer covered by the ordinance had options available that did not require it to add, alter, or increase utilization of ERISA plans.⁵⁹

The Golden Gate Restaurant Association’s primary argument was that the ordinance had an impermissible connection with employers’ ERISA plans.⁶⁰ The court rejected this argument, citing several Supreme Court cases describing what constituted a connection.⁶¹ These cases, at least by the court’s narrative, seem to define a “connection” in terms of the degree to which an employer is able to make its own decisions regarding the type of benefits it will provide its employees.⁶² The Supreme Court had found impermissible connections in statutes that “bind[] ERISA plan administrators to a particular choice of rules[,]”⁶³ or statutes that “prohibit[] employers from structuring their employee benefit plans’ in a particular manner or ‘which require[] employers to pay employees specific benefits.’”⁶⁴

Unlike the laws described in these cases, the San Francisco ordinance “does not require any employer to adopt an ERISA plan or other health plan[,] [n]or does it require any employer to provide specific benefits.”⁶⁵ Rather, employers can “structur[e] their employee benefit plans in a variety of ways and need not pay employees specific benefits.”⁶⁶ Although an employer may be influenced by the ordinance to adopt or change an ERISA plan, “such influence is entirely permissible.”⁶⁷

3. Comparison to Maryland Law

Finally, the court addressed the apparent conflict between its decision and the Fourth Circuit’s decision in *Fielder*. Most important was the Fourth Circuit’s finding that the Fair Share Act created no “meaningful alternatives” for Wal-Mart but to increase its contributions to ERISA plans.⁶⁸ Under the Fourth Circuit’s analysis, the state-payment

58. *Id.*

59. *Id.*

60. *See id.* at 654.

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

62. *Id.*

63. *Id.* at 655 (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001)).

64. *Id.* (alterations in original) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)).

65. *Id.*

66. *Id.* at 656 (alteration in original) (internal quotation marks omitted).

67. *Id.*

68. *See id.* at 660 (quoting *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 196 (4th Cir. 2007)).

option was not a real option, because no rational employer would choose it.⁶⁹ San Francisco's city-payment option, however, interacted with the HAP in a way that made it a more "meaningful alternative" for employers.⁷⁰ When an employer makes contributions to the city, its employees are eligible for discounted enrollment in the HAP, providing a direct benefit to the employer that was lacking in the Maryland statute.⁷¹ The HCSO, unlike the Maryland statute, did not "effectively mandate[]" any given outcome.⁷² The existence of these reasonable alternatives saved the ordinance from preemption.

C. Inability of Common ERISA Interpretations to Distinguish These Cases

Interpretations of ERISA based on pension and disability law cannot adequately explain the distinct outcomes in these two cases. For example, Edward Zelinsky describes a preemption framework based largely on *Shaw v. Delta Air Lines, Inc.*,⁷³ and other non-health care cases.⁷⁴ His broad conclusion is that "ERISA preemption effectively prevents the states from experimenting in the health care arena by blocking state legislation relating to employer-provided health care."⁷⁵ This conclusion is directly contradicted by the Ninth Circuit's subsequent decision and the Supreme Court's decision not to grant certiorari.

We believe that Zelinsky's failure to foresee a situation in which the courts might uphold a statute that directly relates to employer-provided care arises from the fact that he assumes the courts will apply the same preemption standards in health care cases that they do in other contexts. For example, Zelinsky seems to assume that the same "theory" of preemption should explain how courts should deal with statutes regarding beneficiaries following divorce *and* comprehensive health reform, such as that undertaken in Massachusetts.⁷⁶

Zelinsky acknowledges—as any ERISA scholar must—that the term "relate[s] to" cannot be taken in its most literal sense, or virtually

69. See *id.* at 659-60 (citing *Fielder*, 475 F.3d at 193).

70. See *id.* at 660.

71. *Id.*

72. *Id.* at 660-61 (quoting *Fielder*, 475 F.3d at 193).

73. 463 U.S. 85 (1983).

74. See Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption and Experimentation*, 49 WM. & MARY L. REV. 229, 250-53 (2007).

75. *Id.* at 234.

76. *Id.* at 260-61.

any state or local health care regulation could be preempted.⁷⁷ However, because of his reliance on cases such as *Shaw*, his analysis of whether a given statute “relates” to an ERISA regulated plan seems to rest primarily on how “direct” the relationship is.⁷⁸ For example, in comparing the Maryland statute at issue in *Fielder* to Massachusetts’ health care reform statute, he assumes that the Massachusetts law more strongly relates to ERISA plans because the Massachusetts law more “explicitly describes employers’ ERISA regulated medical plans.”⁷⁹ The fact that, in its operation, the Massachusetts law is likely to be much less coercive to employers than the Maryland law, is not relevant to this analysis.⁸⁰

This interpretation of “relate to,” while certainly logical from a textualist perspective, cannot explain ERISA case law in the health care context. It certainly does nothing to explain the different outcomes in *Fielder* and *Golden Gate*. To distinguish the cases, we need a new way of understanding ERISA preemption as it applies to state and local health care laws. This involves a more dynamic form of statutory interpretation.

III. DYNAMIC STATUTORY INTERPRETATION

We believe that courts usually apply a more dynamic approach to interpreting ERISA. This approach assumes there is a certain level of interaction between courts, Congress, and the administrative agencies to arrive at the correct “institutional balance.”

A. *Method of Dynamic Statutory Interpretation*

William Eskridge (often in conjunction with Philip Frickey) is perhaps the foremost advocate of what he refers to as “dynamic statutory interpretation.”⁸¹ He contrasts this method of interpretation with a number of textualist or “foundationalist”⁸² theories which “treat statutes

77. *See id.* at 251-52.

78. *See id.* at 256, 264.

79. *Id.* at 257.

80. Zelinsky’s conclusion can be contrasted with that of Amy Monahan, who concludes that “[u]nlike Maryland’s Act, which has a very strong ‘pay’ provision, Massachusetts’s fair share contribution law has a weak ‘pay’ provision—arguably allowing it to survive an ERISA preemption challenge.” Amy B. Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 U. KAN. L. REV. 1203, 1205 (2007).

81. *See generally* WILLIAM N. ESKRIDGE, JR., DYNAMIC STATUTORY INTERPRETATION (1994); WILLIAM N. ESKRIDGE, JR., *Dynamic Statutory Interpretation*, 135 U. PA. L. REV. 1479 (1987); WILLIAM N. ESKRIDGE, JR. & PHILIP P. FRICKEY, *Statutory Interpretation as Practical Reasoning*, 42 STAN. L. REV. 321 (1990).

82. Eskridge & Frickey, *supra* note 81, at 324-25.

as static texts.”⁸³ Such theories incorrectly assume that “the legislature fixes the meaning of a statute on the date the statute is enacted.”⁸⁴

Eskridge attempts to take a more pragmatic approach to statutory interpretation. This approach recognizes that, “[a]s society changes, adapts to the statute, and generates new variations of the problem which gave rise to the statute, the unanticipated gaps and ambiguities [in the original statute] proliferate.”⁸⁵

In light of this, a statutory interpreter should not look simply at the text and legislative history of the statute. Rather, an interpreter must consider at least “three different perspectives, no one of which will always control.”⁸⁶ These are (1) the “textual perspective[,]” which focuses on the statutory text; (2) the “historical perspective[,]” which focuses on legislative history, compromises reached, and the circumstances surrounding the enactment of the statute; and (3) the “evolutive perspective[,]” which analyzes how the statute has changed and the way in which the relevant societal and legal environment has changed.⁸⁷

Which perspective will control in any given case is dependent on a number of factors. For example, “[w]hen the statutory text clearly answers the interpretive question, . . . it normally will be the most important consideration.”⁸⁸ When strict adherence to the text creates “highly unreasonable consequences[,]” however, then an interpreter should consider the historical perspective.⁸⁹ The evolutive perspective is most important “when the statutory text is not clear and the original legislative expectations have been overtaken by subsequent changes in society.”⁹⁰

Cass R. Sunstein and Adrian Vermeule offer yet another factor that could affect a court’s interpretive method—the court’s perception of its own institutional capacity, compared to that of other political branches, to answer important questions of policy.⁹¹ Where a judge sees the courts as having little capability to decide important issues, the judge is likely to take a more formal approach to interpretation, leaving policy issues to

83. Eskridge, *supra* note 81, at 1479.

84. *Id.* at 1480.

85. *Id.*

86. *Id.* at 1483.

87. *Id.*

88. *Id.*

89. *Id.* at 1483-84.

90. *Id.* at 1484.

91. See Cass R. Sunstein & Adrian Vermeule, *Interpretation and Institutions*, 101 MICH. L. REV. 885, 890 (2003).

the legislature.⁹² If, however, a judge perceives that the legislative and executive branches are either unable or unwilling to actively address policy questions, we might expect that judge to take a more active and inclusive approach to interpretation.⁹³

One of the most important implications of this type of dynamic statutory interpretation is that interpretation is likely to proceed differently in different fields of substantive law.⁹⁴ Most importantly for our purposes, ERISA's preemption provision is likely to be interpreted differently in the health care context than it would be in the pension benefit context.

This type of analysis is generally lacking in the scholarship on ERISA preemption. Courts and scholars tend to lump both types of cases together without considering that the distinct institutional contexts of health care and pensions might lead to distinct interpretive techniques.

B. Contrast of Pension/Disability Benefits and Health Care

This tendency to import preemption standards from other arenas into the health care context is an understandable textual approach to section 514—which certainly does not mention a distinction between different fields of law.⁹⁵ However, the institutional context of pension and disability benefits is very different from that of health care benefits in at least two ways that are likely to affect a court's interpretation. First, the health care field is much more institutionally complex. Second, the importance of defining the proper roles of the government and the private market is a central, and dynamic, issue in health care policy.

1. Health Care Is Much More Complex, Institutionally

Employer-provided health care plans play an important role in a very complex system for providing health care, involving numerous actors whose actions interrelate in complex ways. Employee health care plans frequently interact directly with patients, providers, government agencies, and other aspects of the health care system.

One implication of this added complexity and interconnectedness, for interpretation of section 514, is that it renders the simplistic language of the section much less determinative in the health care context. Section 514(a)'s statement that ERISA preempts all state and local laws that

92. *Id.* at 887-88, 911, 921, 950.

93. *Id.* at 918 ("Where Congress is inattentive and appears to rely on courts for long periods of time, an irreverent judicial approach to statutory text might be defensible. Where Congress will correct judicial errors fairly costlessly, formalism is easier to justify.").

94. *Id.* at 917-18.

95. Employee Retirement Income Security Act § 514 (codified at 29 U.S.C. § 1144 (2006)).

“relate to” ERISA plans is vague and “unhelpful” in any context,⁹⁶ and even strong textualists admit that it is necessary to go beyond the basic text.⁹⁷ However, the “relate to” language may be sufficiently clear and determinative in the pension/disability benefits context to justify a relatively formalistic approach to interpretation—looking at the text and, perhaps, the legislative history.⁹⁸ Thus, we might expect courts interpreting ERISA preemption in this context to spend little time looking at background policy considerations or how these have evolved since the enactment of the statute.

The added complexity of the health care system, however, renders this simplistic language much more problematic. The interconnectedness of the system and its different actors makes drawing a line between statutes that “relate to” ERISA plans and those that do not much more difficult, simply because the web of potential relationships is so complex. Thus, while a formalistic approach to section 514 may be appropriate in other contexts, it is much less practical in the health care context.

2. The Balance Between the State and the Private Market

In addition to being highly complex, health care policy also raises difficult issues of the role of the state relative to the private market. While this tension is certainly not limited to the health care context, it is particularly acute in this field. In an influential 1963 article, Kenneth Arrow carefully analyzed the unique economic aspects of health care.⁹⁹

96. See *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (“We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.”).

97. See, e.g., *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 335 (Scalia, J., concurring) (“[A]pplying the ‘relate to’ provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else.”).

98. We do not here claim that section 514 is in fact sufficiently determinative in the pension benefit context to justify a textual approach. That is a question outside of the scope of this Article. We simply cite this example to illustrate the simple fact that different issues arise in the health care context than do in other contexts.

99. See Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 948-54 (1963). Arrow found that two major factors (and a number of other attributes) make the market for health care unique from other markets. First, in the health care market it is impossible for parties to efficiently transfer risk; that is, the health insurance market will necessarily be inefficient, either by failing to insure risks that ought to be insured or over-insuring. See *id.* at 945, 963-64. “[I]t is impossible to draw up insurance policies which will sufficiently distinguish among risks, particularly since observation of the results will be incapable of distinguishing between avoidable and unavoidable risks, so that incentives to avoid losses are diluted.” *Id.* at 945. Second, the provision of health care involves, to a great extent, the sale of information, for which there can never be a truly efficient market. See *id.* at 946-47, 951-52.

Health care does not fit, Arrow found, into the economic models used to describe other commodities.¹⁰⁰ Private market mechanisms, left to themselves, will fail to provide an efficient amount of health care, and the government naturally intervenes.¹⁰¹

Most scholars have accepted Arrow's basic premise that health care cannot be treated like other commodities, and that some government regulation of the industry is inevitable.¹⁰² But there is little agreement on where the balance between private market mechanisms and government intervention should rest.¹⁰³ In terms of actual policy, the balance has been—and will no doubt continue to be—very dynamic, frequently changing due to actions by the government and private actors such as insurers, employers, and physician groups.¹⁰⁴

When courts are asked to determine whether state and local laws regulating health care are valid, they are placed at the center of this complex debate. Because of the dynamic nature of this area, the one-size-fits-all framework that may work in other areas of ERISA preemption may be undesirable in the health care context. We do not believe that Congress intended to freeze this balance in place when it enacted ERISA. Rather, this is an area where, as Eskridge puts it “original legislative expectations have been [and frequently will be] overtaken by subsequent changes in society.”¹⁰⁵ With this in mind, courts are likely to look closely at how a statute treats that balance and the way in which it allows the government to interact with private parties.

In short, the generally formalistic approach adopted by many ERISA scholars, while it may work well in the pension/disability benefits context, is inadequate to describe ERISA preemption doctrine in the health care context. Faced with the complexity involved in health care policy, courts will apply a more dynamic approach, looking at both the historical context of ERISA's passage and how the statute and health care policy in general have evolved since its passage. Thus,

100. *Id.* at 948-54.

101. *Id.* at 947.

102. See, e.g., David S. Bloch & William Robert Nelson, Jr., *Defining "Health": Three Visions and Their Ramifications*, 1 DEPAUL J. HEALTH CARE L. 723, 744 (1997); John E. Schneider & Robert L. Ohsfeldt, *The Role of Markets and Competition in Health Care Reform Initiatives to Improve Efficiency and Enhance Access to Care*, 37 CUMB. L. REV. 479, 504 (2007).

103. See Schneider & Ohsfeldt, *supra* note 102, at 511 (“The key to improving health care delivery lies in striking a balance that maximizes all of the benefits of markets and consumer choice while using the most appropriate and efficient government instruments to extend access to care to those who want it but cannot afford it.”).

104. See generally PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

105. Eskridge, *supra* note 81, at 1484.

understanding ERISA's preemption doctrine involves understanding ERISA as a health policy statute.

IV. UNDERSTANDING ERISA AS A HEALTH POLICY STATUTE

To understand ERISA as a health policy statute requires consideration of both the historical and evolutive contexts of the statute. First, we suggest that the health benefits provision of ERISA should be understood in the larger context of the health policy agenda at the time of its enactment. Our analysis here focuses on the key ideas about the role of the government and private market mechanisms in the financing and structure of health care delivery prevalent in the 1970s. Second, we propose an analysis of how ERISA preemption doctrine has been implemented by the courts in the health benefit, as opposed to the retirement benefit, context. Third, we examine directly some of the health policy implications of ERISA preemption.

A. *Framing Health Policy in the 1970s*

Scholars often see ERISA's inclusion of health care plans as being a last-minute addition whose implications were not fully thought out. For example, Jacobson complains about "Congress's failure to give much thought to the implications of adding health benefits to what was primarily a pension statute."¹⁰⁶ We do not question the traditional narrative that ERISA was primarily the product of many years of effort to protect employees' rights to obtain pensions promised by employers. Pensions and other benefits—not health care plans—were undeniably the primary focus of the ERISA debate.¹⁰⁷

What our analysis adds to this narrative is the notion that, at the time ERISA was enacted, Congress and its staff had some overall concepts of how the nation's health care "problems" should be dealt with,¹⁰⁸ and ERISA's inclusion of health care benefits within its scope was not inconsistent with those concepts. The idea that ERISA's preemption scope is consistent with Congress' ideas about general health policy is strengthened by the fact that, despite passing a number of amendments to ERISA itself, Congress has not attempted to clarify the basic scope of preemption.¹⁰⁹

Thus, understanding ERISA preemption as it applies to health care statutes involves understanding Congress' ideas about health care at the

106. Jacobson, *supra* note 8, at 91.

107. *See id.* at 89.

108. STARR, *supra* note 104, at 382-83.

109. *See Jacobson, supra* note 8, at 91.

time ERISA was passed. We begin our analysis with an institutional question: What was the health care policy and legal landscape in the early 1970s when Congress enacted ERISA? The health policy agenda at this time was driven by a need to control health care costs.¹¹⁰ It was generally accepted that the rising cost of health care in the United States had reached crisis level.¹¹¹ Public spending on health care was going up drastically.¹¹² Much of this spending, it was generally recognized, was wasteful—a product of the distorted incentives created by Medicare, Medicaid, and private insurance practices.¹¹³

While many Democrats hoped to deal with the problems of rising cost by greater governmental control of medical care, or even a nationalized health insurance system,¹¹⁴ the solution that was finally enacted was a compromise that used both public and private mechanisms to control costs. The federal Health Maintenance Organization Act of 1973 (“HMO Act”),¹¹⁵ a compromise bill passed by a Democratic Congress and signed by Richard Nixon, was designed to encourage the development of HMOs and to encourage employers to offer HMOs to their employees.¹¹⁶ HMOs’ strong incentive to limit costs, it was hoped, would reverse the perverse incentives inherent in the system and thus bring down costs.¹¹⁷ This represents an attempt to control costs through federal incentives to private institutions for restructuring the financing and organization of health care delivery.¹¹⁸ Even though managed care did not become a dominant form of financing and delivery of health care until after the failed Clinton reforms,¹¹⁹ we should not ignore the significance of this incremental HMO legislation. The political process had produced a largely private alternative to the Democratic Party’s goal of universal health care access through public programs.

110. STARR, *supra* note 104, at 383-84.

111. *See id.* at 383.

112. *Id.* at 384 (“[Between 1965 and 1970, the government’s] share of national health expenditures jumped from 26 to 37 percent In that same period, the annual rate of increase in state and federal health expenditures was 20.8 percent. The \$10.8 billion government had spent in 1965 became \$27.8 billion by 1970.”).

113. *Id.* at 384-88.

114. *Id.* at 394.

115. Pub. L. No. 93-222, 87 Stat. 914 (codified at 42 U.S.C. § 300(e) et seq.).

116. ESTHER UYEHARA & MARGARET THOMAS, HEALTH MAINTENANCE ORGANIZATION AND THE HMO ACT OF 1973, at 3 (1975), <http://www.rc.rand.org/pubs/papers/2009/P5554.pdf>; Presidential Statement on Signing the Health Maintenance Organization Act of 1973, 1973 PUB. PAPERS 1029 (Dec. 29, 1973), <http://www.presidency.ucsb.edu/ws/?pid=4092>.

117. *See* Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 402 (2002) (Thomas, J., dissenting) (“[T]he genesis of HMOs[] stemmed from spiraling health costs.”); UYEHARA & THOMAS, *supra* note 116, at 10.

118. *See* JAMES W. HENDERSON, HEALTH ECONOMICS & POLICY 206 (2d ed. 2002).

119. *Id.*

Efforts to use private market mechanisms to increase health care coverage continued after the passage of the HMO Act. In February 1974, President Nixon sent Congress a message outlining a plan for a Comprehensive Health Insurance Plan.¹²⁰ One of the key features of his plan was that “[e]very employer would be required to offer all full-time employees the Comprehensive Health Insurance Plan.”¹²¹ President Nixon further distinguished his approach from other proposals: “My proposed plan differs sharply with several of the other health insurance plans which have been prominently discussed. The primary difference is that my proposal would rely extensively on private insurers.”¹²² Of course, President Nixon’s political disgrace and his subsequent resignation meant there was no specific debate about his proposal.¹²³ But this does not mean that the underlying notion of using federal law to provide incentives for the private market to increase access and control costs did not pervade congressional thinking about what was politically feasible and appropriate health policy.

It seems reasonable to assume that when Congress enacted ERISA, including the language bringing employee health benefit plans within a regulatory structure for employee retirement plans, Congress had in mind the same policy considerations that it had used when enacting the HMO Act the previous year. Put another way, exempting federally regulated employee benefit plans from state regulation is consistent with the ideology of market forces as the drivers of health reform that was a significant part of the policy debate in the early 1970s.¹²⁴

B. The Courts’ Implementation of ERISA Preemption

In addition to the historical context in which ERISA was enacted, insight can be gained by looking at court decisions interpreting ERISA. In doing so, however, it is important to avoid attempting to resolve alleged inconsistencies in various courts’ interpretations without considering the context and health policy background of those decisions.

120. Special Message to the Congress Proposing a Comprehensive Health Insurance Plan, 1974 PUB. PAPERS 132 (Feb. 6, 1974), <http://www.kaiserhealthnews.org/Stories/2009/September/03/nixon-proposal.aspx>.

121. *Id.* at 134.

122. *Id.* at 138.

123. CATHERINE HOFFMAN, THE HENRY J. KAISER FAMILY FOUND., NATIONAL HEALTH INSURANCE—A BRIEF HISTORY OF REFORM EFFORTS IN THE U.S. 6 (2009), *available at* <http://www.kff.org/healthreform/upload/7871.pdf>.

124. At least one Supreme Court decision has referred to the HMO Act in attempting to discern Congress’ intent in enacting ERISA. *See* *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 367-69 (2002).

It is beyond the scope of this Article to do a comprehensive history or evaluation of ERISA case law. Rather, this Article suggests a method for such evaluation. We will examine only two Supreme Court cases, decided three years apart. These cases, *District of Columbia v. Greater Washington Board of Trade*¹²⁵ and *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,¹²⁶ give us certain insights about the importance of looking at institutional background when examining ERISA case law.

1. *Greater Washington Board of Trade*

Greater Washington Board of Trade involves a District of Columbia ordinance that required any employer who provided health insurance coverage to an employee to continue to offer the same level of coverage while that employee received workers' compensation benefits.¹²⁷

The district court hearing the case found that the law was not preempted.¹²⁸ The district court concluded that an employer could, if it so chose, comply with the statute without altering its ERISA plans "by creating a separate administrative unit to administer the required benefits."¹²⁹ The statute did not require employers to alter their ERISA-covered health plans.¹³⁰ Rather, employers only had to alter the way they administered workers compensation plans—which were not covered by ERISA.¹³¹ Therefore, the statute was not preempted.

The Supreme Court, however, followed a different line of reasoning that more fully accounted for general health policy considerations. Although the Court did not disagree with the factual assertion that an employer could comply with the statute without altering its ERISA plans, it pointed out that the amount of coverage an employer is required to give an employee on workers' compensation is "measured by reference" to the amount of health care coverage the employer chooses to provide its employees.¹³² Such a reference was sufficient to bring the ordinance within ERISA's preemptive scope.¹³³

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

126. 514 U.S. 645 (1994).

127. *Greater Washington*, 506 U.S. at 127-28.

128. *Id.* at 128.

129. *Id.*

130. *Id.*

131. *Id.*

132. *Id.* at 130.

133. *Id.* at 130-31.

The decision is best understood, we believe, by looking at how the statute actually affected employers' "choice architecture"¹³⁴ in light of health policy considerations. There has long been a general policy in the United States of encouraging employers to move some compensation from direct payment to health care benefits. Tax laws, for example, do this by exempting that compensation from taxation.¹³⁵ ERISA attempts to do this by limiting remedies and providing a uniform benefit structure.

It seems likely that the Court had this policy in mind when it made its decision. The Court realized that the D.C. statute created incentives that ran directly contrary to this policy. Under the statute, an employer deciding whether and how to provide benefits would have to consider that it would be required to continue paying those benefits if the employee ended up receiving workers' compensation. By imposing an extra burden on those employers who choose to supply health care benefits, the statute might dissuade some employers from offering those benefits or encourage them to offer a lower level of benefits.

Looking at these policy issues also helps to explain why the Court is not persuaded by the reasoning in Justice Stevens' dissent. Justice Stevens pointed out that an injured worker's compensation had traditionally been "measured by [the employee's] entire loss of earnings—including the value of fringe benefits such as health insurance."¹³⁶ By ensuring that employees continued to receive all benefits, including health care benefits, after an injury, the statute merely sought to ensure that this practice continued.¹³⁷ Under this characterization, the statute did not single out employee health care plans for special treatment—which would have subjected it to ERISA preemption.¹³⁸ Rather, the statute sought to ensure that health plans would be treated the same as other compensation.¹³⁹

Such reasoning seems persuasive at first glance. However, when one considers the statute not only on its own terms, but in light of background policy concerns, the majority's reason for rejecting this position becomes clear. As pointed out above, part of the health care policy framework that had been prevalent for decades in the United States was to encourage employers to offer health care plans.¹⁴⁰ Contrary to Justice Stevens' assumption, all forms of compensation are

134. See discussion *infra* Part III.C.1.

135. See I.R.C. § 106(a) (2006).

136. *Greater Washington*, 506 U.S. at 133 (Stevens, J., dissenting).

137. *Id.* at 137.

138. *Id.*

139. *Id.* at 134.

140. See *supra* text accompanying notes 134-35.

not to be treated the same. Health benefits are to be encouraged, and thus receive special treatment.

2. *Travelers*

Travelers dealt with a New York statute that regulated the rate that hospitals charged patients or their insurers.¹⁴¹ The statute required hospitals to use prospective payment, charging not for the actual cost of treatment that an individual receives, but for the average cost of treating someone with the patient's medical problem.¹⁴² In addition to this average cost, hospitals were required to charge a surcharge to all commercial insurers, including self-funded employer plans.¹⁴³

Blue Cross/Blue Shield plans (the "Blues") were exempt from this surcharge, however.¹⁴⁴ These charge differentials were justified because "the Blues pay the hospitals promptly and efficiently and, more importantly, provide coverage for many subscribers whom the commercial insurers would reject as unacceptable risks."¹⁴⁵ The purpose of the differentials, then, seems to have been to subsidize the Blues, who were performing a public service and relieving the public of expenses by insuring those whose health care might otherwise have fallen to the state.¹⁴⁶

The plaintiffs were several commercial insurers and labor groups who claimed that the price differentials affected ERISA plans to such an extent that they were preempted by ERISA.¹⁴⁷ The lower court agreed, stating that although the surcharges' effect on ERISA plans was indirect, there was "little doubt that the [s]urcharges . . . will have a significant effect on the commercial insurers."¹⁴⁸ In particular, the lower court found it significant that the "entire justification for the [s]urcharges" was to encourage employers and individuals to choose the Blues over other insurers.¹⁴⁹

The Supreme Court disagreed, holding that, while the statute would likely influence employers' choices, its influence was too indirect to warrant preemption.¹⁵⁰

141. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 506 U.S. 645, 649 (1995).

142. *Id.*

143. *Id.* at 650.

144. *Id.* at 649.

145. *Id.* at 658.

146. *Id.* at 659 n.5.

147. *Id.* at 651.

148. *Id.* at 652 (alteration in original) (citation omitted) (internal quotation marks omitted).

149. *Id.* (alteration in original) (citation omitted) (internal quotation marks omitted).

150. *Id.* at 662.

At least two policy implications can be derived from the Court's decision. First, it tells us something about how ERISA preemption relates to choice architecture. The Court took pains to point out that the statute "does not bind plan administrators to any particular choice[.]"¹⁵¹ but leaves them free to choose among a number of plans. The fact that the statute incentivized one plan over another did not cause it to be preempted.¹⁵²

Looked at in comparison with *Greater Washington Board of Trade*, this decision is, at first glance, somewhat confusing. *Greater Washington Board of Trade* also dealt with a statute that only indirectly incentivized certain actions. In fact, it could easily be argued that the incentive in *Travelers* was both stronger and more intentional than that in *Greater Washington Board of Trade*. Why then, would one incentive be preempted while another, stronger one, would not?

The answer seems to lie not simply in how "strong" or how "direct" the incentive is, but in how well the incentive comports with general health policy implications. As pointed out above, the incentive in *Greater Washington Board of Trade* conflicted with an important part of the nation's health policy framework—encouraging employers to offer health plans.¹⁵³ The incentive in *Travelers*, on the other hand, comports much more smoothly with general health policy concerns. Specifically, the price differentials are designed to encourage and support the Blues, which in turn, at that particular time when the Blues in New York were a not-for-profit organization, provided an important public service by insuring the uninsured.¹⁵⁴

A second insight to be gained from *Travelers* is that the Court may look more favorably upon regulations that are fully integrated into a more general health policy reform. The disputed provision was part of a more general statute that required hospitals to use prospective payment

151. *Id.* at 659-60.

152. *Id.* at 662.

153. See *supra* text accompanying notes 135-36.

154. See James C. Robinson, *The Curious Conversion of Empire Blue Cross*, 22 HEALTH AFF. 100, 101, available at <http://content.healthaffairs.org/content/22/4/100.full.pdf> (explaining that Empire Blue Cross Blue Shield of New York converted to for-profit status on November 7, 2002); *Coordinated Issue Paper-Blue Cross Blue Shield/Health Insurance; Life Insurance*, IRS.GOV (June 4, 2008), <http://www.irs.gov/businesses/article/0,,id=183646,00.html> ("Prior to June 1994, the Association's membership standards and licensing agreements required that its member licensees be nonprofit organizations" and "[i]n general, the plans were organized . . . under special legislation requiring that the plan operate on a nonprofit basis and declaring it a 'charitable and benevolent institution.'"). Incentives toward one particular for-profit health insurance carrier would likely not be viewed as legitimate health policy. See Robinson, *supra*, at 115 (explaining that after converting to for-profit status, Empire Blue Cross Blue Shield of New York now has the same obligations to New York State as its competitors).

rather than charge for the actual cost of services. The statute seems to have been designed to divorce the amount that hospitals charged from the expenses they actually incurred on a given procedure—thus encouraging hospitals to control costs.¹⁵⁵

Although the Court does not list this as a specific reason that the statute survives preemption, the Court does express concern with extending ERISA preemption so far that it could “displace general health care regulation, which historically has been a matter of local concern.”¹⁵⁶ It seems that part of the Court’s hesitancy to interfere with the charge differentials in the New York statute is that the differentials formed an integral part of a general health care statute.

3. Institutional Capacity and the Failure of Clinton Health Care

It is important to note one final piece of background that may have affected the outcomes in *Greater Washington Board of Trade* and *Travelers*. In 1992, when *Greater Washington Board of Trade* was decided, the prospect for federal health care reform seemed high. President Bill Clinton had recently been elected, having campaigned largely on health care reform. In this situation, where the federal government appeared ready to take a more active role in regulating health care, the Court may have been more likely to look at individual state regulation as interference.

By 1995, however, President Clinton’s health care proposals had failed, and the prospect for federal reforms looked much dimmer. With the federal government assuming a hands-off approach, the Court was likely to be much more tolerant of individual states’ attempts to address their individual health care crises.

We have already seen that courts’ interpretive methods adapt to specific health policy concerns. Here, we see an example of the Court’s interpretive method adapting to changes in the institutional capacity of the other branches. When the Court perceived the political branches as being both capable of and active in dealing with policy question, it was reluctant to step in with a statutory interpretation that might interfere with these institutions’ attempts to resolve problems. When, on the other hand, it seemed clear that the political branches were unable to deal with health care problems, the Court was more willing to step in and attempt to correct problems itself.¹⁵⁷

155. In fact, the rise of “prospective payment” systems has been tied directly to the medical cost crisis that led to the HMO Act. See Rick Mayes, *The Origins, Development, and Passage of Medicare’s Revolutionary Prospective Payment System*, 62 J. HIST. MED. & ALLIED SCI. 31 (2007).

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

157. See *supra* notes 91-93 and accompanying text.

C. Some Policy Implications of ERISA Preemption

Our analysis of both the historical context in which ERISA was passed and the contexts in which it has been implemented by the courts suggests certain policy implications. We do not need to enter the debate about whether the preemption doctrine is, or normatively should be, narrowly or broadly construed by the courts. Rather, we suggest the courts should treat ERISA preemption, in conjunction with the HMO Act and other developments, as part of an institutional experiment¹⁵⁸ in utilizing the private market—particularly employers—to help contain health care costs.

We call this an institutional experiment because the actual effect of legal intervention into the health care market was, and to some degree still is, unknown. For instance, President Nixon and his cohort were just starting to realize the fiscal effects of Medicare and Medicaid on state and federal budgets, not to mention the inflationary aspects of Medicare on the private cost of health care.

Under this experimental metaphor for the ERISA doctrine, whether or not a particular state incentive or disincentive is preempted by ERISA depends upon the institutional context in which an employer is asked to respond to the state incentive. In essence, the relevant question is whether a given statute continues the experiment or interferes with it. The statute in *Greater Washington Board of Trade* interfered with this experiment, while the statute in *Travelers* helped to further it.

An understanding of ERISA preemption, then, involves understanding the specific policy concepts that form this health care “experiment.” We list here two such policy implications that seem to arise from the historical factors and cases we have discussed so far. This is far from an exhaustive list, however, and one could no doubt find a number of policy implications not discussed here.

1. Creating a Choice Architecture

While ERISA does not mandate that employers provide certain benefits, it does provide certain incentives for employers to provide quality health care. For example, it ensures that the liability employers assume in providing health care will be limited by prescribing specific and limited remedies, and it attempts to lower the cost to multistate employers of providing such benefits through increased uniformity.¹⁵⁹

158. See Larry I. Palmer, *Research with Human Subjects as a Paradigm for Teaching*, 16 L. MED. & HEALTH CARE 183, 187-88 (1988) (suggesting the application of “institutional experiments” to teaching and learning).

159. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983).

Thus, an important part of the ERISA experiment is an attempt to influence the direction of, without directly interfering with, the private market.¹⁶⁰

Richard Thaler and Cass R. Sunstein describe the ability of legal institutions to create a “choice architecture”—encouraging, without mandating, certain choices.¹⁶¹ The ideal form of this choice architecture is “libertarian paternalism”—encouraging and incentivizing certain actions while neither prohibiting nor unduly burdening other choices.¹⁶²

We might characterize the complex policy structure of federal, state, and local incentives and disincentives as presenting employers with a specific choice architecture. ERISA preemption plays an important role in this by ensuring that local laws do not unduly interfere with private employers’ choices. This scheme, if not entirely “libertarian” paternalism, at least discourages direct coercion of employers by states. States are allowed to create laws that influence the choices of employers, such as encouraging them to provide benefits. However, state governments are severely limited in their ability to dictate certain results or certain benefits. The employers’ ability to make certain choices is protected by ERISA preemption.

2. Defining the Role of Private Actors and the Government

As discussed above, another important aspect of the ERISA experiment is utilizing the private market to reduce health care costs and increase coverage.¹⁶³ ERISA’s preemption provision can be seen as playing an important role in maintaining the balance between the private market and the states. Specifically, ERISA’s preemption provision gives the courts some ability to oversee state laws that interfere with the private market mechanisms that ERISA seeks to encourage. ERISA thus gives courts an important role in “the essential and difficult tasks of determining the extent of market and government roles.”¹⁶⁴

Thus courts, in examining statutes challenged under ERISA, will be concerned not only with how the statute operates in isolation, but how it

160. Whether and to what extent ERISA has been successful at encouraging employers to offer health care benefits is a question beyond the scope of this Article. Peter Jacobson notes that “[m]any observers and stakeholders credit ERISA preemption with facilitating the growth of managed care and allowing large employers to develop national coverage arrangements for employees.” Jacobson, *supra* note 8, at 89.

161. See generally RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008).

162. *Id.* at 5.

163. See *supra* note 158 and accompanying text.

164. NEAL K. KOMESAR, *LAW’S LIMITS: THE RULE OF LAW AND THE SUPPLY AND DEMAND OF RIGHTS* 167 (2001).

relates to other health care provisions. If the statute merely focuses on a single side of the equation, such as employer contributions, courts are more likely to find that the statute is incompatible with the ERISA experiment. If, on the other hand, the statute creates a scheme involving a role for both private actors and the state, the courts are likely to uphold the statute.

V. THE FOURTH AND NINTH CIRCUIT DECISIONS UNDER THIS FRAMEWORK

By looking at ERISA preemption through the lens of the policy concerns described above, we can make more sense of the different outcomes in *Fielder* and *Golden Gate*. At least three possible explanations for the different outcomes in the two cases arise—one based on choice architecture, one based on the role of the market and the state, and another based on concerns about institutional capacity.

A. Choice Architecture

In evaluating the respective statutes, both courts focused heavily on the choice architecture that the statute presented employers. The *Fielder* Court specifically distinguishes between statutes that “effectively mandate[] some element of the structure or administration of employers’ ERISA plans” and those that “create[] only indirect economic incentives that affect but do not bind the choices of employers.”¹⁶⁵ The court’s decision focuses on whether the Fair Share Act falls into the “incentive” or the “mandate” category.¹⁶⁶

The court found that employers’ choices under the statute were so limited that the Fair Share Act constituted a mandate.¹⁶⁷ The court examined the alternative means for complying with the Fair Share Act—contributions to health savings accounts, on-site clinics, and the state-payment option—and dismissed them all as red herrings.¹⁶⁸ The Fair Share Act created a choice architecture designed to lead employers to one specific choice: increasing health insurance provided to employees.¹⁶⁹

Of course, the court did not address how it would have analyzed the Fair Share Act had it left employers with more choices. The implication,

165. Retail Indus. Leaders Ass’n v. Fielder, 475 F.3d 180, 193 (4th Cir. 2007) (emphasis added).

166. *Id.* at 197.

167. *Id.* at 196-97.

168. *Id.*

169. *Id.* at 193.

however, is that the analysis, and perhaps the conclusion, would have been very different. The court implicitly recognizes that state statutes may validly affect the choice architecture under which employers operate. State statutes may not, however, remove or severely limit an employer's choices.

The dissenting judge, Judge Michael, similarly focuses on choice architecture—although he bases his analysis on a different factual conclusion. Judge Michael does not see the state-payment option as an unrealistic alternative.¹⁷⁰ Rather, he sees it as a “real” choice that Wal-Mart might conceivably choose.¹⁷¹

The *Golden Gate* opinion also focused on choice architecture. In upholding the San Francisco ordinance, the court emphasized that the ordinance gives wide latitude to employers and does not bind them to any specific outcome.¹⁷² In describing the effect the ordinance has on employers, the court conspicuously emphasized that employers have choices.¹⁷³ “A covered employer *may* choose to adopt or to change an ERISA plan An employer *may* be influenced by the Ordinance to do so”¹⁷⁴ However, an employer may also “fully discharge its expenditure obligations by making the required level of . . . expenditures . . . in whole or in part to the City.”¹⁷⁵ And if employers do choose to offer benefits, they “may structur[e] their employee benefit plans in a variety of ways.”¹⁷⁶

Furthermore, in distinguishing *Fielder*, the Ninth Circuit's opinion focused almost exclusively on the difference in choice architecture between the two ordinances.¹⁷⁷ The Maryland ordinance, while it nominally had a “state-payment” option, gave employers no realistic alternative.¹⁷⁸ The Maryland law was “intended to ‘force Wal-Mart to increase its spending on healthcare benefits’” and “[u]nlike the Maryland law, the San Francisco Ordinance provides nearly all employers within the city with a legitimate alternative.”¹⁷⁹

170. *Id.* at 202 (Michael, J., dissenting).

171. *Id.*

172. *Golden Gate Rest. Ass'n v. City & Cnty. of S.F.*, 546 F.3d 639, 655 (9th Cir. 2008) (“The Ordinance does not require any employer to adopt an ERISA plan or other health plan. Nor does it require any employer to provide specific benefits through an existing ERISA plan or other health plan.”).

173. *Id.* at 655-56.

174. *Id.* at 656 (emphasis added).

175. *Id.* at 655-56.

176. *Id.* at 656 (alteration in original) (citations omitted) (internal quotation marks omitted).

177. *Id.* at 659-61.

178. *Id.* at 660.

179. *Id.* (quoting *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 185 (4th Cir. 2007)).

B. The Provision's Function in Defining the Role of Government and Private Actors

San Francisco's employer "mandate," looked at in the broader context of the reforms created by the HCSO, reveals a complex relationship between the government and employers. While the ordinance certainly requires employers to make an increased contribution to health care costs, it does not do so in isolation, but in the context of general health care reform. For example, employers' contributions interact directly with the HAP in providing health care for employees. In this sense, the HCSO is similar to the statute in *Travelers*. These statutes are not focused simply on increasing employer contributions, but on increasing the provision of health care and defining its structure.

Maryland's Fair Share Act, on the other hand, did nothing to define the role of the government and only defined the role of the market for a single employer, Wal-Mart. Whereas the San Francisco employer mandate is integrated into a wider attempt to define the role of the government and employers, the Maryland ordinance seems more isolated and punitive—requiring a single employer to shoulder a greater burden.

Thus, if ERISA is looked at, partially, as an experiment in defining the roles of the government and private employers in providing health care, the HCSO does much more to further that experiment than does the Fair Share Act.

C. Concerns for Institutional Capacity

As discussed above, the courts are also influenced by their perceptions of their own institutional capacity as compared to that of the other branches.¹⁸⁰ This may explain the difference of opinion between the dissent and the majority in *Fielder*. The majority in *Fielder* seem to feel that the institutional capacity of the courts to address health policy concerns is low. While it recognizes Maryland's "noble purpose" in enacting the Fair Share Act,¹⁸¹ it refuses to consider the basic policy behind the Fair Share Act or the problems facing Maryland that led to it.

In his dissent, Judge Michael seems to feel more comfortable with the institutional capacity of the courts to evaluate the policy concerns behind the Fair Share Act. He begins his analysis, not with a discussion of ERISA case law, but with several pages describing the Medicaid

180. See *supra* notes 91-93 and accompanying text.

181. *Fielder*, 475 F.3d at 198.

crisis that led Maryland to enact the Fair Share Act.¹⁸² These different interpretive styles arise from different views of the capacity of the courts to answer policy questions.

Concerns about institutional capacity may also have influenced the Supreme Court's decision not to grant certiorari in *Golden Gate*. On May 26, 2010, the United States filed an amicus brief recommending that the Court deny certiorari.¹⁸³ The brief emphasized that, in the wake of the passage of the Patient Protection and Affordable Care Act ("ACA"), the balance between the private market and the states has yet to be "fleshed out."¹⁸⁴ In particular, "[t]he new legislation contemplates a significant role for the States in promoting the availability of health care coverage."¹⁸⁵ The Solicitor General points out that, prior to the enactment of the ACA, the Department of Labor had been considering promulgating regulation to help clarify the scope of ERISA in relation to state reforms.¹⁸⁶ However, the Department now considered regulatory action to be premature and was waiting for the contours and effects of the new health reform legislation to become clearer.¹⁸⁷ By emphasizing that the executive branch was actively pursuing the issue, the Solicitor General seems to be suggesting that the Court should defer to the political branches and the market.

It seems likely that the Court chose not to review *Golden Gate* for the very reasons the Solicitor General suggests. After the passage of the ACA, the federal and state governments are newly empowered to define the direction of health care policy—while the courts have little information about the actual effects of the new law on private parties. It seems likely that the Court perceived the institutional capacity of the political branches to be relatively high, with the capacity of the courts being relatively low. Under these circumstances, the Court decided to stand back—allowing the political branches to determine the contours of the new health policy before interfering.

VI. CONCLUSION

In the wake of the passage of the ACA, much about the landscape of health care policy has changed dramatically. Underlying policies

182. *Id.* at 198-200 (Michael, J., dissenting).

183. Brief for United States as Amicus Curiae at 1, *Golden Gate Rest. Ass'n v. City & Cnty. of S.F.*, 130 S. Ct. 3497 (2010) (No. 08-1515).

184. *Id.* at 15 ("The full contours and effects of many aspects of the new federal framework therefore remain to be fleshed out.").

185. *Id.*

186. *See id.* at 12.

187. *Id.* at 13-14.

about the role of the state and private actors, the incentives under which employers operate, and the institutional capacity of the courts and political branches, will change.

This fact makes understanding the type of analysis we have employed here particularly important. If, as we have argued, courts' interpretations of ERISA take into account a broad range of factors, including policy issues and the courts' perception of their own institutional capacity, then the ACA is likely to have a major effect on ERISA preemption doctrine.

We do not here analyze the specifics of how the ACA will affect preemption analysis. At this point, such an analysis would necessarily be preliminary and speculative. We suggest, however, that scholars attempting to explain ERISA preemption in the future, and how it is affected by both the passage of the ACA and other developments, need to understand the role of health policy concerns in ERISA preemption analysis.