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ERISA Federal Preemption Problem with a State-Based Solution: The Need for Regulatory Subdivision in Employee Benefits

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Introduction

Michael Moore is considered a radical who appeals to a very leftist liberal audience. Therefore, critics and politicians were surprised that his latest project, *SiCKO*, struck a chord with so many in the silent middle. In this documentary, Moore suggests that the real American healthcare victims are not the uninsured, but the workers of the middle class – the employees with benefits who have employer-provided medical coverage find themselves being taken advantage of by their more powerful employer and its even more powerful employee benefits plan administrator. Moore points out what many people already know - that plan administrators and healthcare providers operate under a conflict of interest with incentive to deny healthcare, especially when the procedure is expensive and an illness is life threatening. Moore ultimately advocates that the only effective solution is a nationalized healthcare scheme, similar to those in Canada, England, and even Cuba.

However, just because the current system is not working efficiently does not mean we should completely overhaul the system. A much less invasive solution of eliminating ERISA preemption is both more efficient and practical. We can, and should, eliminate the federal laws that prevent state experimentation. By doing so, states will be free to enact comprehensive healthcare legislation through whichever means they choose (e.g., taxing employers that do not offer health benefits). This way, people's reasonable expectations will align with actual benefits received. Moreover, by removing the safety net for employer-provided healthcare sponsor negligence, we can place a check on serious and inherent conflicts of interest, and encourage more diligence from the medical insurance industry.

Currently, all employer-provided plans, including 401(k) and medical insurance plans, are regulated by the Employee Retirement Income Security Act of 1974 ("ERISA")[1]. Though enacted to protect workers and lower transaction costs of interstate healthcare insurance, ERISA lead to the unintended and undesirable consequences by currently interpretation of its ambiguous preemption and remedies provisions. First, it encourages insurers to shirk negligently their responsibilities. Second, ERISA refuses to allow plaintiffs who suffered clear violations of ERISA fiduciary provisions to recover damages. Third, ERISA preempts any state law that attempts to fix either the conflict of interest or inadequate remedies. Finally, ERISA places societal costs of uninsured workers on the state while prohibiting the state from forcing the employer or the administrator to internalize these shifted costs.

Many scholars and courts are calling for either Congress or the Supreme Court to fix ERISA by clarifying the remedies provision to allow more expansive recovery.[2] However, in this essay, I suggest a step in a different direction: changing the nature of ERISA by getting rid of broad preemption in favor of a federalist solution focusing on state law. Part I of this essay will focus on outlining the purpose behind ERISA and the situation in employment that prompted its enactment in the 1970s with the Studebaker Plant closing. Here, I will first show that ERISA was enacted not only for the sake of uniformity, but also to ensure that employers continue to provide promised employee benefit plans in a fiduciary capacity. In Part II, I will explain how ERISA preemptive force is used today to block plaintiffs alleging violations from receiving damages that are not "equitable" in nature, which results in violations and medical negligence within employer-provided healthcare insurance to go unchecked. I will also discuss public choice theory, and address why neither Congress nor the Supreme Court has taken steps to

[1] Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 824 (1974) (codified as amended at 29 U.S.C. § 1001 *et seq*. and I.R.C. § 401-415 (2004)).
[2] *See* Eichorn v. AT&T Corp., 489 F.3d 590, 594 n.4 (3d Cir. 2007) (Ambro, J., Concurring) (collection of cases).

amend ERISA though great dissatisfaction exists. In Part III, I will introduce examples of how states try to regulate healthcare insurance and the ERISA obstacles they face. Specifically, I will focus on the Maryland's Fair Share Health Care Fund Act and the Massachusetts Health Law of 2006, and how such legislation is probably very beneficial for society, even if merely as an experiment, but has either already been overturned or will likely be overturned in the future by ERISA. Finally, in Part IV, I will assert that because preemption (and less-than-careful drafting) is the cause of these inconsistencies, a return to pre-ERISA federalism where common-law and state-law remedies govern employers who violate employee benefit rights is the most efficient solution. First, I will explore other possible solutions, such as forming a "Preemption Committee" or allowing certain exceptions for certain states. I will explain how these solutions would cause more complexity in the law. Finally, I will conclude that by allowing workers to "vote with their feet" for the best employee benefit laws, "regulatory balkanization" will offer employees and employers better-realized expectations of benefit plans, leading to more efficient outcomes.

In his documentary, Michael Moore never mentions the law that protects the healthcare administrators to employer-provided plans. Perhaps, by allowing each state to adopt any scheme of healthcare without disruption from federal laws, we can adequately protect employee-beneficiaries. Any worker can move to the state whose system he prefers, which allows any American to realize the healthcare coverage and legal recourse he expects to receive. Furthermore, by allowing states to experiment with different systems, we can have a single-payer system, as well as a completely capitalist every-payer-for-himself system, and see how each one works out. This basic solution would not only result in more working class individuals receiving

the healthcare they expect and the coverage they demand, but the results would be more efficient than any single solution on a federal level.

Part I - ERISA & Broad Preemption

All employer-provided plans, including employer-provided medical insurance plans, are regulated by ERISA.[3] While the primary objective of ERISA was to "provide a uniform regulatory regime" over these plans, to accomplish this objective, ERISA § 514(a) broadly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" that ERISA covers.[4] The point the preemption clause was to minimize administrative burdens of complying with conflicting directives among states to an employer that provides employee benefits, thereby reducing transaction costs of interstate operations.[5] Although the aim of reducing employer costs of tailoring to each state's specific laws may have been achieved, during the past thirty years certain unintended and undesirable consequences came along with it. Some of these immediate consequences are costs of excessive litigation, unremedied societal costs, and uncompensated victims of healthcare negligence. All this stems from ambiguities likely to arise in such a comprehensive and overarching law. The courts were directed to create their own brand of "federal common law" to govern employee benefit plans because of ambiguities in ERISA provisions, which lead to transaction costs of extensive

[3] Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 824 (1974) (codified as amended at 29 U.S.C. § 1001 *et seq*. and I.R.C. § 401-415 (2004)).
[4] Aetna Health Inc. v. Davila, 542 U.S. 200, 207 (2004) (uniformity is the primary objective); 29 U.S.C. § 1144(a) (ERISA preemption clause).
[5] *See* Ingersoll-Rant Co. v. McClendon, 498 U.S. 133, 142 (1990) (holding that the aim of the preemption provisions is "to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government" and to reduce "the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction").

litigation.[6] Good for lawyers; not so good for businesses, insurers, and clients. Moreover, because of broad preemption, ERISA lead to another indirect and undesirable consequence: prohibition of states to enact comprehensive healthcare laws to insure the uninsured whenever such a state law even remotely relates to or references an ERISA plan in the broadest sense.

A. Studebaker Plant Closing & Good Intentions

Let's start from the beginning. ERISA came from politicians' more noble impulses, after they watched employers close the plants with predominantly older workers. In many cases, these workers spent years laboring at the plant, waiting for retirement, only to be terminated just before their plans vested.[7] ERISA was finally enacted after more than a decade of investigations by Congress, presidential commissions, and the Departments of Labor, Justice, and Treasury into pension funds, employee benefit plans and other promises that would "vest" after a certain time in the future – that is, after the employee fulfilled his obligations and before it comes time for the employer to reciprocate.[8] In the 1960s and 1970s, as today, most states operated under an employment at-will presumption, where employees may be terminated at any time for any reason[9] unless they contract otherwise. Before ERISA (and other erosions to the at-will employment default rule that took place over the past few decades), an employer could legally fire an employee for being close to the date of his pension benefits vesting.

For ERISA, the defining moment was the Studebaker Plant Closing in South Bend, Indiana. When Studebaker-Packard closed this plant, thousands of workers found themselves without pensions – even some who had vested rights in those pension plans. Studebaker-Packard

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[6] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 110-112 (1989) (ERISA requires federal courts to develop federal common law contract and trust to construe employee benefit plans).
[7] Dana M. Muir, "James A. Wooten. The Employee Retirement Income Security Act of 1974", 32 J. Health Politics Policy & Law 737 (2007).
[8] John H. Langbein, *What ERISA Means By "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103 Columbia L. R. 1317, 1321-22 (2003).
[9] With the exception of some federal prohibits, such as Title VII.

held a unionized plant that employed thousands of workers. After negotiating with the union, the plant offered many different pensions and benefits, including hourly-pension plans. However, the employer failed to place enough funds aside to pay off the promised pensions in the future. These pension funds were illusory, and completely under-funded. Finally, as more and more employees were reaching retirement and pension age, Studebaker shut down its plant after it became evident that it would not be able to support its promised pension plans. Most workers, including retired workers, did not receive the pensions they were promised.[10] The union of the closed plant pushed for legislation and after years of study, the Studebaker Plant was the straw that broke the camel's back. ERISA was finally enacted, not to appease special interest groups but to protect the worker's interests in employee benefits promised to him by his employer after the employee performed his obligations.

B. ERISA Provisions – the What and Why

Reacting to abuses, Congress intended the new law to provide broad protections. To protect the employee, ERISA contains fiduciary duties of loyalty and of care, grounded in trust law and the common law of agency. [11] The duty of loyalty requires that a fiduciary must operate the benefits plan "for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan."[12] The duty of care requires an ERISA fiduciary to act in accordance "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and

[10] *See* James A. Wooten, "*The Most Glorious Story of Failure in Business:" The Studebaker-Packard Corporation and the Origins of ERISA*, 49 Buffalo L. Rev. 683, 686 (2003).
[11] Dana M. Muir & Cindy A. Schipani, *Fiduciary Constraints: Correlating Obligation with Liability*, 42 Wake Forest L. Rev. 697, 707 (2007).
[12] 29 U.S.C. § 1104(a)(1)(A).

with like aims."[13] Furthermore, ERISA contains no distinction between officer, director, or employer, so that any person or entity with authority can be held responsible for violations of these duties.[14] Specifically, a defendant can be held to fiduciary standards in two ways: (i) because of his actions; or (ii) because the terms of the benefit plan imply it.[15] In addition to board fiduciary duties, Congress intended to provide comprehensive legislation, and not just focus on plant closing or pension benefits alone. Since Congress's purpose was to regulate and protect against employer abuses in the broad sense, ERISA was drafted to apply "to any employee benefit plan if it is established or maintained . . . by any employer engaged in commerce or in any industry or activity affecting commerce".[16]

This is why ERISA is so pertinent to healthcare law. If the employer provides his employees with healthcare insurance, ERISA and only ERISA regulates it. There are many reasons why medical insurance fits under the umbrella of ERISA. One reason is that ERISA fiduciary duties are almost automatically implicated. Supplying healthcare insurance makes the coverage vulnerable to employer abuse: the employer has incentive to shirk his responsibilities once the benefit of providing the insurance is achieved because healthcare insurance is a cost to the employer.[17] Like pension benefits, health insurance is a form of delayed compensation to the employee and a cost of production to the employer. Another reason why medical insurance fits under ERISA is that such a classification is practical. In certain situations, it is difficult to

[13] 29 U.S.C. § 1104(a)(1)(B).
[14] See H.R. Rep. No. 93-1280, at 323 (1974) (Conf. Rep.), as reprinted in 1974 U.S.C.C.A.N. 5038, 5103 ("Under this definition, fiduciaries include officers and directors of a plan, members of a plan's investment committee and persons who select these individuals.").
[15] Dana M. Muir & Cindy A. Schipani, *Fiduciary Constraints: Correlating Obligation with Liability*, 42 WAKE FOREST L. REV. 697, 701-702 (2007).
[16] S*ee* § 4(a), 29 U.S.C. § 1003(a) (2000).
[17] ERISA does not require an employer to provide healthcare benefits, or even to continue a program, except for those employees who have vested benefits. However, this example assumes that the employer benefits by providing – or promising to provide – fringe benefits. For example, an employee is more likely to take a job with an employer that promises "health and dental" in addition to a salary. The benefit is the employee agrees to work the for the employer, but the employer's obligation – like the obligation to provide a pension plan – is delayed.

separate the employer-provided medical benefits from the pension benefits. For example, many pension plans also include healthcare insurance the employee will receive throughout his retirement.[18] In such a situation, it is simpler to have one law govern both the pension and the insurance.

Fearing a race to the bottom where that states will compete with each other over businesses by lowering employee benefits standards locally, Congress added a broad preemption clause that prohibits any state law from regulating any plan ERISA covers.[19] But what about the state's right to regulate the health care of its citizen? Congress recognized that states, as sovereign entities, possess fully "police power" in areas traditionally left to the states, unless these areas are constitutionally delegated to the federal government.[20] Significantly, states are traditionally known to have great latitude in promoting public health and safety, and may use these police powers to protect of the "lives, limbs, health, comfort, and quiet" of their citizens.[21] Federal law, however, could "supplement[] state law where compatible, and supplant[] it only when it prevents the accomplishment of the purposes of the federal Act".[22]

Consciously intending to limit ERISA so it passes constitutional challenge, Congress provided the Deemer and Savings clauses. The Savings Clause, which states that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance", explicitly exempts from preemption state laws that regulate insurance law.[23] However, the Savings Clause is limited by the Deemer Clause, which states that

[18] *See* Bruce D. Pingree, *Current Issues in Termination and Modification of Welfare Plans*, 14 TAX MANAGE COMP. PLAN J. 311 (1986).
[19] 29 U.S.C. § 1144(a) (2000) (ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan").
[20] Medtronic, Inc. v. Lohr, 518 U.S. 470, 475 (1996).
[21] Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 756 (1985) (holding that a Massachusetts insurance regulation law regarding mental-health care was valid and not preempted by ERISA).
[22] *Id*.
[23] 29 U.S.C. § 1144(b)(2)(A) (2000).

employee benefits plans shall not "be deemed to be an insurance company . . . for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."[24] The point here is that states can regulate the insurance industry – an area traditionally regulated by the state – as long as this regulation would not affect or interfere with ERISA's goals, and avoids employer-provided healthcare plans.

Sounds good so far! But there is always a tradeoff. Your average run-of-the-steel-mill worker generally does not have that much clout on a federal level. Moreover, ERISA does not require employers to provide benefits. Wide-reaching employee protections had to be balanced out with something for the employer. That something is the remedies provision. Section 502(a) of ERISA allows plaintiffs to recover personally only "equitable relief", unless the plaintiff is either tying to enforce a term in the plan or is a member in a class action suit for the benefit of the plan as a whole.[25] Like with most statutory employment laws, easier and more guaranteed recovery is balanced directly against less recovery, both in quantity and quality.[26]

Part II - ERISA Today & Unintended Consequences

The federal courts were left to interpret a very sparse remedial provision coupled with a very broad preemptive clause, both with ambiguous terms.[27] Disaster resulted. Victims of negligent, and even intentional, losses to their employer-provided benefit plans found themselves in court, standing before judges who lamented being helpless to provide any remedy. These judges noted that equitable remedies must be in the form of "injunction, mandamus, and

[24] 29 U.S.C. § 1144(b)(2)(B) (2000)
[25] 29 U.S.C. § 1132(a)2-3.
[26] For less "quality", think National Labor Relations Act, which, unlike under tortious discharge, does not allow a wrongfully discharged employee to recover punitive damages, and usually does not to allow frontpay if the employee can be reinstated. For less "quantity", think Workers Compensation claims, which almost always look only to compensate for injury and wages, but rarely compensate for emotional distress and pain and suffering.
[27] That is, the term "related to" in the Preemption Clause and the term "equitable" in the Remedies Provision. Of course there are many other ambiguous terms in ERSIA, but that's for another paper.

restitution,"[28] and if the real damage suffered by the victim cannot be remedied in anyway other than damages, then it cannot be remedied at all. There is no choice but to grant summary judgment.[29] The judges' hands are tied.

Even more disturbing because of its greater societal effect is when the preemptive clause is the focus instead of the remedial provision. In such cases, a state notices a problem with heavy societal costs, for example, lack of citizens' healthcare insurance. This lack of insurance results in vast financial costs to the state, and therefore the state responds by enacting very comprehensive laws to regulate healthcare provisions, including taxing business, etc. A special interest group responds immediately with a preemptive suit to keep this new law from going into effect.[30] The court notes that a comprehensive suit is likely to "relate to" or "reference" employer provided health insurance, and invalidates the state law. As discussed below, even under the Savings clause, a comprehensive healthcare initiative is likely preempted. "Thus, the federal government has arguably created the worst of all possible worlds - lack of a comprehensive federal approach while hampering the ability of the states to attempt to enact meaningful reform."[31]

A. Broad Interpretation of a Broad Preemption Clause

Technically, the Savings Clause seems to leave the regulation of the healthcare industry to the states – after all, is not healthcare in America all about insurance? However, for the first

[28] Mertens v. Hewitt Assocs., 508 U.S. 248, 256 (1993).
[29] *See* LaRue v. DeWolff, Boberg & Assocs., Inc., 450 F.3d 570 (4th Cir. 2006) *cert. granted* No. 06-856, 127 S. Ct. 2971 (June 18, 2006). Note, the Supreme Court vacated and remanded this case after this paper was written, on February 20th of 2008. LaRue v. DeWolff, Boberg & Assocs., 128 S. Ct. 1020 (2008). However, considering that the decision does not overturn past precedent, and asserts that ERISA "§ 502(a)(2) does not provide a remedy for individual injuries distinct from plan injuries", it is likely that *LaRue* may bring even more ambiguity into litigation, or may be limited to its facts in the future. *Id.* at 1026.
[30] A similar situation is found in this case, except here the plaintiffs and the defendants reached a deal outside of court. Golden Gate Restaurant Ass'n v. City and County of San Francisco, No. 06-06997, 2007 WL 1052820 (April 5, 2007).
[31] Susan J. Stabile, State Law Health Care Initiatives, 19 ST. THOMAS L. REV. 87, 89-90 (2006).

decade of its enactment, the courts interpreted the preemption clause "capaciously, interpreting that provision as preempting virtually any state law touching upon an employee benefit plan."[32] *Shaw v. Delta Air Lines, Inc.,*[33] illustrates the problem. In *Shaw*, the Supreme Court preempted New York's Human Rights Law and the Disability Benefits Law. These statutes prohibited employers from discriminating in the terms of benefits by required that employers who pay disability benefits in general must also pay pregnancy-related disability benefits. The Supreme Court invalidated these statutes because they had a "connection with or a reference to" an ERISA plan, even though they clearly dealt with the health, safety and morals of New York citizens.[34]

Until as late as 1995, ERISA would *implicitly* preempt a state law if that law related to an ERISA plan, even if the law was made to regulate the insurance industry.[35] This judicial practice changed with the Supreme Court decision in *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*.[36] In *Travelers*, the Supreme Court recognized that "the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress".[37] However, a state law was still preempted if it "mandated" the employee benefit plans or their administration, either directly or indirectly though coercive economic incentives.[38]

Today, a state law is evaluated under a three-step analysis.[39] First, the court determines whether the state law "relates to" an ERISA-regulated plan (e.g., a plan that provides healthcare insurance). If it does then, under *Shaw*, such a law is automatically given the presumption of

[32] Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption & Experimentation*, 49 WM. & MARY L. REV. 229, 251 (2007).
[33] 463 U.S. 85 (1983).
[34] *Shaw*, 463 U.S. at 96-97.
[35] Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 52 (1987).
[36] 514 U.S. 645 (1995).
[37] *Travelers*, 514 U.S. at 654-55.
[38] *Id.*, 514 U.S. at 668.
[39] Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption & Experimentation*, 49 Wm. & Mary L. Rev. 229, 252-53 (2007).

preemption. Note that any comprehensive state healthcare reform legislation will not be able to avoid this presumption. Second, the court must determine whether this state law regulates insurance. If it does, then, under the Savings Clause and *Travelers*, the state law is safe. However, this brings us to the third step. Finally, the court must determine whether the state law imposes indirect economic incentives that force employer to alter their ERISA plans. This is where the Deemer Clause comes into play. If the state law provides incentives that indirectly mandate an employer to offer employee benefit plans, or to offer a certain types of benefits, the state law is still invalid under *Travelers*. How all this works will further be discussed in Part III(A) *infra* with the Wal-Mart Act.

B. Preemption Without Remedies & Consequences

Preemption, by itself, did not cause an ever-expanding problem in employee benefits protection. Such a problem is exacerbated by the very limited remedies available under ERISA.[40] Current interpretation of the Remedies Provision holds that "equitable remedies" recovered under ERISA are limited to "those categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)", as Justice Scalia put it.[41] Many critics believe that the term "other equitable remedies" could have meant much more.[42] This makes sense. Had Congress meant to limit remedies in ERISA only to injunction, mandamus, and restitution, Congress would have explicitly written "injunction, mandamus, and restitution". It certainly would not have taken up too much more space than "equitable", and it would have saved the rest of us a lot of headaches.

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[40] Under ERISA § 502(a), plaintiffs may personally recover only "equitable relief", unless the plaintiff is either tying to enforce a term in the plan or is a member in a class action suit for the benefit of the plan as a whole. 29 U.S.C. § 1132(a)2-3.
[41] *Mertens v. Hewitt Associates*., 508 U.S. 248, 256 (1993).
[42] *See, e.g.,* E. Daniel Robinson, *Embracing Equity: A New Remedy for Wrongful Insurance Denial*, 90 Minn. L. Rev. 1447, 1459 (2006).

However, as of today, the current interpretation stands and damages in the form of cash cannot be recovered, unless such money is an equitable lien or equitable restitution (meaning the defendant actually possesses the exact funds in a separately kept account, and that such funds are completely identifiable). The negative effects of such a narrow remedy on plaintiffs in bad-faith insurance claims cases are obvious.

C. Moral Hazard & Bad Faith

ERISA gives insurers incentive to refuse reimbursement on a small scale. However, just because the claims are small does not mean to societal costs in aggregate are equally insignificant. For example, let us say a patient's insurer wrongfully refuses to cover the cost of his prescribed medication – a small claim. The patient rationally purchases a cheaper generic drug, which produces a severe reaction requiring prolonged treatment and hospitalization, as well as an appreciable amount of pain and suffering. Under ERISA § 502(a), plaintiffs may personally recover "equitable relief" only and, therefore, our patient's injuries would not be considered "equitable". The only object the insurer wrongfully withheld that is identifiable and not "legal damages" was the small-scale claim - the originally prescribed medication. So our patient can recovery the cost of the correct medication, if he can prove that he was entitled to it. Nothing else would be "equitable".

However, the insurer's moral hazard is not limited to small-scale claims. The insurer also has incentive to deny claims that require immediate care. For example, let us say a patient goes through surgery, which the insurer pays accordingly. However, the patient experiences some unexpected problems and her doctor recommends that she remain in the hospital. The patient asks the insurer to pre-authorize her extended stay. Unfortunately, the patient's insurer only agrees to pay for one day in the hospital following surgery, even after being provided with the

doctor's recommendation. The patient makes a rational decision to leave the hospital rather than pay the large bill she cannot afford, and suffers severe post-surgery complications she would not have suffered had she stayed in the hospital. The patient cannot recovery under ERISA because compensation for her injuries would be in the form of cash, and therefore not equitable.

Both of these examples are taken from *Aetna Health Inc. v. Davila*.[43] The plaintiffs who suffered the injuries explained above sued under the Texas Health Care Liability Act – a statute that allows plaintiffs to recover legal damages.[44] However, the Supreme Court held that only ERISA remedies where available to the plaintiffs. "Upon the denial of benefits, respondents could have paid for the treatment themselves and then sought reimbursement through a § 502(a)(1)(B) action, or sought a preliminary injunction."[45] Though the Texas statute would have provided plaintiffs with a cause of action for legal damages, the Supreme Court made it clear that this statute was preempted because it sought to give plaintiffs additional relief.

First, let's note that preliminary injunctions are very impractical in medical insurance cases. It is very unlikely that an average worker whose insurer refuses to pay for his prescription for Vioxx would call up his lawyer and move for an injunction. Very likely, the patient will find the costs of bringing litigation, finding a lawyer or even filling out the paperwork to outweigh the benefit of such a tiny claim. Clearly, from the insurer's point of view, denying a small claim makes economically rational sense.

Second, when it comes to cases of immediate care, remedies like preliminary injunction are impossible. Moreover, the insurer understand that because of the time pressure, the patient cannot wait and must make a decision to accept the care or leave. By accepting the care, the

[43] 542 U.S. 200 (2004).
[44] Texas Health Care Liability Act, Tex. Civ. Prac. & Rem.Code Ann. §§ 88.001-88.003 (West 2004 Supp. Pamphlet).
[45] *Davila* 542 U.S. at 211.

insurer might be forced to reimburse the patient, but this results in the insurer paying the same amount it would have had to pay anyway. Since there is a chance that the insurer will not be forced to pay, an economically rational insurer will prefer to take chances, at the expense of the patient.

D. Societal Costs of Moral Hazard

Davila illustrates not only a problem for the insured, but also a problem for the state: the state is forced to pay for societal costs but it is prohibited from forcing the parties involved to internalize the costs. Since the insurer is unwilling to pay for medication or extended hospital stay, this forces the employees to make an economically rational decision to forgo needed care. This leads the further complications, and these complications add to more hospital time, more injury, and less productivity.

Moreover, if neither the insurer nor patient pay the claim, the state may also have to pony-up the money for the procedures and suffer negative societal externalities. This can happen if the plaintiffs do just as the Supreme Court suggested they should – receive the treatment and then seek reimbursement – because it is likely that an employee cannot afford the treatment. For example, had the patient in *Davila* been unable to afford the cost of post-surgery complications and extended hospital stay, either society will pay a cost stemming from this employee's unnecessary medical issues, or Texas will allow her to receive medical treatment and stay in a public hospital. If Texas lets the employee stay and gives her medical assistance, it risks the possibility that the insurer will win the suit, and Texas will never be reimbursed if the employee can never repay the state. Neither the employer nor the insurer is willing to pay for these societal costs that, under the Texas statute, they would have to internalize, but under ERISA, is merely an externality for which no one is responsible except the state as a whole.

In addition to externalities, there is also a problem in the disparate results of damages depending on insurance. In 1993, a widower sued his health insurance after his wife died at just 38 years of age. She struggled with a very aggressive form of cancer that spread to her bone marrow. Her physicians recommended a bone marrow transplant. Her insurer refused to pay for it. After she died, her husband sued in a California state court for bad-faith breach of contract, intentional infliction of emotional damages, and punitive damages.[46] He received a verdict of $89 million, even though the actual bone marrow transplant cost was $212,000. In fact, $77 million of the verdict was purely punitive. *Fox* was a shocking case and one of the largest punitive damages awards received at the time.[47] But what's even more shocking is comparing *Fox* to a more recent case, *Kuthy v. Mansheim*.[48] In *Kuthy*, the plaintiff was also a widower, who also lost his wife to aggressive breast cancer, who was also denied a physician-recommended bone marrow transplant by the plaintiff's insurer. However, in this case, the insurer asserted ERISA preemption. The Fourth Circuit agreed. The plaintiff received nothing.

We know under ERISA why the widower in *Kuthy* was unable to recover: wrongful death claims cannot be equitable. They can only be legal. No amount of money can bring the widower's wife back to life, and even the cost of the bone marrow transplant would not be equitable because the widower has no need for a bone marrow transplant himself. But why such a large recovery – especially punitive – in *Fox*? The answer is bad faith and moral hazard. In *Fox*, the jury found that the insurer acted in bad faith, trying to avoid a very costly procedure. *Kuthy*, which could not even be reviewed by a judge on the merits of a bad faith claim, would never reach a jury.

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[46] *Fox v. Healthnet*, No. 219692 (Cal. Super. Ct. Riverside Cty. December 28, 1993).
[47] Peter D. Jacobson *et al*., *Litigating the Science of Breast Cancer Treatment*, 32 J. Health, Politics, Policy & L. 785, 790-91 (2007).
[48] 124 Fed.Appx. 756; No. 04-1290, 2004 WL 2757437 (December 3, 2004).

As noted above with the discussion of *Davila*, an insurer will want to risk a bad faith denial because, perhaps, the patient will pay for the care or refuse the care because she cannot afford it and then for some reason neglect to sue for reimbursement. Unlike in *Fox*, under ERISA, if the insurer is caught in a bad faith claim, all the insurer must do is give "equitable" remedy to the patient by paying her what the insurer should have from the beginning. This is the moral hazard of small claims and immediate care claims. With expensive and life-threatening claims, the moral hazard is sadly at its worst. The cost to the insurer of an expensive procedure is – well – expensive, much more so than one in a small claim or an immediate care claim. While the incentive to shirk is greater, so is the probability of the patient dying. If the patient dies all ERISA claims dies with her. This is the ultimate example of bad faith in insurance companies, and as seen in *Davila*, ERISA does nothing in the form of judicial enforcement to keep an insurer from exercising it.

E. Pervasiveness of Employer-Provided Healthcare Insurance

Every two out of three Americans receive healthcare insurance through employer-sponsored plans, making such plans the principal form of healthcare insurance in the United States.[49] It is important to mention why employees prefer to have employer-provided health insurance instead of simply "opting out" of ERISA by electing to pay for their own health insurances. There are three primary reasons. First, the Internal Revenue Service allows employers to provide employees with health insurance as an excludable income tax fringe benefit. In other words, both the employee and the employer do not recognize the compensation paid directly to the employee when it goes to qualified health insurance instead of directly to the employee. This insurance would cost the employee more if the employer paid the employee the

[49] See Health Ins. Coverage in Am., 2003 Data Update, (Kaiser Comm'n on Medicaid and the Uninsured, D.C.), Nov. 2004, at 22, available at http:// www.kff.org/uninsured/7153.cfm.

same money directly because the employee's taxable income rate would go up every year. Second, because of its size, the employer has more bargaining power with an insurance company than a single employee. Therefore the employer can get reduced aggregate rates, while if the employees had to purchase insurance independent of each other, they would have to pay a greater price. Third, signing up for employer-provided insurance cuts transaction costs of finding an insurer for one's self.

F. Public Choice Problem: A Silent Congress

Congress, federal courts, and even the Supreme Court are all unhappy about the current state of ERISA protections for the employee. After extensive interpretation by the federal courts of this sparse remedial provision coupled with the broad preemptive provision, employees who suffered a court-recognized ERISA violation and who would have recovered at a state level are left without meaningful remedy time and time again, turning ERISA into "an unjust and increasingly tangled [] regime."[50] "Because the [Supreme] Court has coupled an encompassing interpretation of ERISA's preemptive force with a cramped construction of the 'equitable relief' allowable under § 502(a)(3), a regulatory vacuum exists: virtually all state law remedies are preempted but very few federal substitutes are provided."[51] The chocked remedies provision has led to surprising results when, after a court determines that the administrator violated ERISA, a suit is still dismissed because a plaintiff cannot recover.[52] Something has to be done. But something had to be done for quite some time now. The Supreme Court continually defers to the

[50] DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 453 (3d Cir. 2003) (Becker, J., concurring).
[51] Aetna Health Inc. v. Davila, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring).
[52] *See, e.g.*, Eichorn v. AT&T, 484 F.3d 644 (2007), *reh'g denied*, 489 F.3d 590 (affirming dismissal of suit because while an employer violated ERISA § 510 (29 U.S.C. § 1140) by laying off plant employees to prevent their pension benefits from vesting, any remedies the plaintiffs sought were "damages" in the form of back pay, and therefore not equitable under ERISA); Millsap v. McDonnell Douglas Corp., 368 F.3d 1246, 1266 (10th Cir. 2004) (Lucedo, J., dissenting) ("Here, reinstatement would have been an appropriate equitable remedy had McDonnell Douglas not so delayed proceedings as to make reinstatement impossible. Thus, through no fault of their own, the class plaintiffs find themselves devoid of the undeniably appropriate equitable remedy of reinstatement.").

legislation whenever it gets the chance to change the way it interprets ERISA preemption, and Congress talks a lot about amending the Preemption Clause but has yet to act.[53] Why?

The answer lies in a public choice problem. ERISA was intended to, first, protect the employee through its fiduciary duties clause and, second, to protect the employer from transaction costs of interstate compliance.[54] However, Professor Hills suggests that the Supreme Court interpreted the preemption clause to be even broader then intended, and this lead ERISA to protect third parties – powerful special interest groups, never intended to be protected under ERISA. "Nothing about ERISA's history suggested the slightest hint that it was intended to protect doctors, hospitals, MCOs, or other third parties who administered plan benefits on behalf of employers".[55] However, once the Supreme Court interpreted the ambiguous "related to" in the preemption clause broadly, all these special interest groups saw a new way to protect themselves from liability.

This resulted in the stymied congress. Congress saw five bills to reduce ERISA preemption to state health care between 1992 and 1994. None made it out of committees.[56] Again, there was a lot of activity in Congress between 1997 and 2001, some of these bills passed, but the result was the same: Congress refused to act and preemption remained in full force.[57] Professor Hill argues that these moments of congressional activity were a manipulative response

[53] Note that Congress has amended ERISA, but not Preemption. In 1985 under the Consolidated Omnibus Budget Reconciliation Act, Congress amended ERISA to require employers provide continuation coverage to employees who lose coverage under certain circumstances. The Health Insurance Portability and Accountability Act amended ERISA, adding provisions limiting pre-existing condition exclusions. The Newborn & Mothers' Health Protection Act of 1996 requires maternity coverage. The Mental Health Parity Act requires parity in lifetime benefits of medical and mental health benefits. "All of these are positive actions. However, all federal regulation has been in the context of acceptance of the basic model of employer-provided health care, and each of these statutes represents an ad hoc approach to a problem that requires a more comprehensive solution." Susan J. Stabile, State Law Health Care Initiatives, 19 ST. THOMAS L. REV. 87, 89-90 (2006).
[54] Roderick M. Hills, Jr., Against Preemption: How Federalism Can Improve the National Legislative Process, 83 N.Y.U. L. REV. 1, 41-42 (2007).
[55] *Id.*, at 41 (2007).
[56] *Id.*, at 42-42 (2007).
[57] *Id.*, at 43 (2007).

to Supreme Court decisions. When the Supreme Court seemed ready to narrow its interpretation of preemption, Congress would start circulating all these bills, making it seem like they were ready to amend the legislation. The Supreme Court would defer, waiting for an amendment that would never come.[58] "Because the courts had already delivered the benefits of preemption to them, [Congress] had no need to set forth any more specific – and, therefore, politically risky – preemption proposal."[59]

How public choice theory works here is that small groups with focused interests will have more influence in politics over a larger and more dispersed group.[60] Not only are special interest groups like MCOs concentrated and united in their cause, but also they are very powerful because they are very well funded. While concern for the lowly pension-dependant worker may have started ERISA legislation, getting preemption repealed or even scaled back seems impossible at this point.

Part III - State-based Health Laws and ERISA Preemption

Preempted or not, states have and continue to attempt to sidestep ERISA through state legislation that, in some cases, is sure to fail in court. States, naturally, try to fix the problems outlined above with their own legislations because when citizens go uncompensated because of healthcare negligence, the societal costs are dramatic. This is especially true when the societal costs of uninsured workers falls onto the state directly though public assistance programs of which employers may take advantage, causing a free rider problem. Perhaps such futile legislations are a form of protest, however, all 50 states in the union have attempted to regulate

[58] *Id.*, at 43-46 (2007).
[59] *Id.*, at 50 (2007).
[60] *See* Mancur Olson, *The Logic of Collective Action* (1965).

healthcare for their citizens, with over 900 laws in the past eight years.[61] Over the years, many creative measures were used to try to get around preemption. However, in the past, the real thrust of the states' attempts was to give plaintiffs who clearly suffered a wrong caused by an insurance administrator a more complete remedy.[62] Nonetheless, as Justice Thomas wrote for a unanimous Supreme Court, "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted."[63]

Recently, because of the problems in healthcare in general, some states have enacted legislation that is far more comprehensive than in the past. Some are called "fair share" and others "pay or play", but the idea is to give the employers a choice between paying a tax and or paying substantively what the state considers the right amount on healthcare insurance for its workers.

A. Maryland's Wal-Mart Act

Maryland's Fair Share Health Care Fund Act,[64] unofficially and better known by the more descriptive term as the "Wal-Mart Act," a "pay or play" law, was designed to encourage large employers to provide health insurance for their employees. Maryland started noticing rising societal costs of public health assistance increase by over one billion dollars in the span of one year. After some investigation, it seemed this cost was related directly to an increase in employed but uninsured workers. Maryland responded with this Act, which required any employer of 10,000 or more Maryland employees to spend either 8% or more of the total wages

[61] National Conference of State Legislatures, Managed Care & States, http://www.ncsl.org/programs/health/managed.htm.
[62] *See, e.g.,* Texas Health Care Liability Act, Tex. Civ. Prac. & Rem.Code Ann. §§ 88.001-88.003 (West 2004 Supp. Pamphlet).
[63] Aetna Health Inc. v. Davila, 542 U.S. 200, 209 (2004).
[64] Fair Share Health Care Fund Act, 2005 Md. Laws 3 (codified as amended at Md. Code Ann., Health-Gen. § 15-142 (LexisNexis 2007)).

paid to Maryland employees on healthcare insurance costs, or to pay a tax of that same amount to Maryland. If the employer refuses to either pay or play, the employer faces a $250,000 civil fine. [65]

The Act was nicknamed the Wal-Mart Act because, in practical effect, the Act only applied to Wal-Mart.[66] In fact, Maryland specifically designed the Act to apply only to Wal-Mart.[67] The Retail Industry Leaders Association filed suit on behalf of Wal-Mart to enjoin the Act, claiming it was federally preempted by ERISA.[68] The Fourth Circuit affirmed the Maryland District Court judgment that the Wal-Mart Act was preempted and therefore invalid. The Fourth Circuit reasoned that this law was not a "true tax" but, instead, a coercive punishment. While a state has the right to tax, a tax must be to produce state revenue. The practical effect of this tax was to indirectly force any logical employer to provide a minimum health insurance expenditure. Therefore, the Wal-Mart Act would not raise revenue but, under *Travelers*, mandate and force an employer to adopt substantive changes to an ERISA plan.[69]

It is clear that under *Travelers* the Wal-Mart Act would be preempted. However, a better question is, "should it be?" Maryland clearly believed that employers Wal-Mart's size should offer better healthcare benefits to Maryland workers. Whether one believes that this is a good thing or a bad thing is beside the point. *Maryland* believed it was good, and it was the state that experienced over a one-billion dollar increase in costs due to employers like Wal-Mart.

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[65] Retail Industry Leaders Ass'n v. Fielder, 475 F.3d 180, 183-184 (4th Cir. Jan. 17, 2007).
[66] *Fielder*, 475 F.3d at 185. Maryland had only four employers who had over 10,000 Maryland employees: Johns Hopkins University, Giant Food, Northrop Grumman, and Wal-Mart. However, the Act did not apply to Johns Hopkins because it was a non-profit employer. The Act also did not apply the Northrop Grumman because it was excluded by special amendment. Finally, the Act did not apply to Giant Food, because it was heavily unionized, and already spent a lot more than the 8% floor.
[67] *Id.*
[68] *Id.*, at 180.
[69] *Id.*, at 192-94.

There is a powerful political debate here. Some believe that employers who do not provide their employees with benefits should be made to pay these benefits. Others point out that making an employer pay these benefits raises the employer's costs and will lead to lower wages, layoffs and even closing down stores in Maryland. Therefore, on the one hand, the argument is then that uninsured but employed workers are better than uninsured *and* unemployed workers. But this argument works *ceteris paribus* – it assumes that things will stay in the same condition they are currently.[70]

The other side of the argument, the situation itself can change around the policy. For example, may the unemployed workers may be better off if they are insured by the state – an insurance that is paid through other means. Here, the point is that employers who do not provide health insurance cause more harm in societal costs than they give benefit through employment; therefore, the Wal-Mart should be forced to move out of Maryland if it cannot cover certain benefits.

As I discuss in further detail in Part IV *infra*: it does not matter which side is right. What matters is that the only persons affected by either policy will be the residents of Maryland who have a remedy either through the political process or through "voting with their feet"- leaving to a state with a different policy that is more aligned the workers' expectations and preferences.

B. Massachusetts Health Law

Another, though yet to be challenged, law is the Massachusetts health law ("Massachusetts Act"),[71] which is also an experiment in a "pay or play" arrangement, but happens to be much more comprehensive. The point of this Act is clear: the Massachusetts Act

[70] In Part III(B) *infra*, I explain how Massachusetts Act or a similarly comprehensive statute may change insurance coverage for all residents within the state. This would change the argument since all workers, employed and unemployed would receive insurance through the state.
[71] Mass. Gen. Laws Ann. ch.111M §1 *et seq.* (2006).

requires that all residents have medical insurance by July 2007.[72] To achieve this goal, the Massachusetts Act: it subsidizes insurance, it creates a "Connector", and it lowers the cost of insurance for individuals.

First, the Massachusetts Act subsidizes the cost of insurance by giving taxpayers who earn less than 100% of the federal poverty line a subsidy for premiums, and individuals who earn between 100% and 300% of the federal poverty line subsidies on a sliding scale basis.[73]

Second, the Act establishes a new public office - Commonwealth Health Insurance Connector (the "Connector"). The Connector assists individuals and small businesses by shopping for insurance for them in bulk. This is all done with pre-tax dollars.[74] Tax-wise, assuming the employees will purchase healthcare for themselves, the money used to provide healthcare coverage will not be considered income for the purpose of taxes to the employee, meaning the employee will spend less on health care than she would otherwise.[75]

Finally, the Act lowers the cost of insurance for individuals by several insurance reforms, including merging the non-group (i.e., private individual) and small-group markets, a move expected to reduce premiums for individual consumers by 24%.[76] The theory is that insurance will be cheaper because the Connector is an aggregate buyer, much like a large employer.[77] The Connector lowers the cost of insurance to the uninsured by pooling individuals into a large

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[72] Susan J. Stabile, *State Law Health Care Initiatives*, 19 ST. THOMAS L. REV. 87, 92 (2006).
[73] Health Care Access and Affordability Conf. Comm. Rep., Apr. 3, 2006, *available at* http://www.mass.gov/legis/summary.pdf.
[74] *Id.*
[75] See I.R.C. § 106 (2000) (excluding from employees' gross incomes the value of employer-provided medical coverage); *See* Edward A. Zelinsky, 49 WM. & MARY L. REV. 229, 238 n.42 (2007).
[76] Health Care Access and Affordability Conf. Comm. Rep., Apr. 3, 2006, available at http://www.mass.gov/legis/summary.pdf
[77] Nina Owcharenko & Robert E. Moffit, The Massachusetts Health Plan: Lessons for the States, Backgrounder No. 1953 (Heritage Found., Washington, DC), July 18, 2006, at 6-7, available at http:// www.heritage.org/research/healthcare/bg1953.cfm.

number, resulting in savings and lower premiums realized when all the uninsured become "a single, state-run insurance pool".[78]

This part of the Massachusetts Act is probably kosher with ERISA. The Fair Share Contribution part of the Act is probably not. Under the this portion of the Act, Massachusetts employers who employ 11 Massachusetts residents or more must either provide healthcare insurance to their employees and make "fair and reasonable contributions" towards such coverage (estimated to be around $295 per employee) or, alternatively, these employers may choose instead to pay the annual "fair share" contribution to the Commonwealth Care Trust Fund.[79] This part of the Act should sound a bit familiar, because it essentially follows the prohibited "pay or play" provision of the Wal-Mart Act. Even further, the Act imposes a "free rider surcharge" on employers who do not provide health insurance, but whose employees use the state's free care.[80] Many scholars predict that Massachusetts Act will be preempted by ERISA for this reason.[81] However, this "pay or play" portion of the Act is important to its main purpose. The portion that the employers contribute to the Commonwealth Care Trust Fund actually goes to free care, and in this way, the Act intends to "level the playing field."

There is a lot of controversy over whether the Massachusetts Act is a good law. Some argue that it will be successful. The Massachusetts Act anticipates because insurers will have to compete for the uninsured through the connector, competitive market forces will not be

[78] Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption & Experimentation*, 49 Wm. & Mary L. Rev. 229, 237-38 (2007) (citing Lawrence H. Mirel & Edmund F. Haislmaier, Doing It Right: The District of Columbia Health Insurance Market Reform (April 6, 2006), in Heritage Lectures No. 936 (Heritage Found., Washington, DC), May 15, 2006, at 2-4, available at http:// www.heritage.org/research/healthcare/hl936.cfm).
[79] Mass. Gen. Laws Ann. ch. 149, § 188 (2006).
[80] Mass. Gen. Laws Ann. ch. 118G, § 18B (2006).
[81] *See* Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption & Experimentation*, 49 Wm. & Mary L. Rev. 229, 235-37 (2007)

disrupted.[82] A number of opponents disagree, considering this Act destined to crash and burn if allowed to proceed as planned.[83] However, whether or not this state law will be effective in reducing the cost of health insurance for the uninsured (and more interestingly, whether it can achieve the goal of having every resident insurance), Massachusetts is entitled to respond to the current healthcare crisis in its own state, just as this - the regulation of insurance - was clearly left to the state before ERISA.

Strictly politically speaking, the Massachusetts Act should take effect without any ERISA obstacles because the people it affects support it politically. This healthcare law cuts across partisan and ideological lines, enacted by a Democratic legislature and signed into law by Mitt Romney, a Republican governor and presidential hopeful.[84] On the left Democratic side, the Massachusetts Act provides a subsidy to the poor through a redistribution of wealth by forcing penalties on employers who fail to provide insurance– penalties that finance the Commonwealth Care Trust Fund, which in turn finances the Commonwealth Care Health Insurance Program, which finally goes to subsidize the insurance plan chosen by the connector.[85] On the right Republican side, the Massachusetts Act strengthens market forces by guaranteeing a large entrance of insurance buyers (or one buyer for many insurance seekers) into the market, forcing

[82] Nina Owcharenko & Robert E. Moffit, The Massachusetts Health Plan: Lessons for the States, Backgrounder No. 1953 (Heritage Found., Washington, DC), July 18, 2006, at 2-3, available at http:// www.heritage.org/research/healthcare/bg1953.cfm.
[83] *See, e.g.,* Patricia Barry, Coverage for All, AARP Bulletin, July-Aug. 2006, at 8, 9 (quoting Michael Tanner of the Cato Institute that the Massachusetts law is a step toward socialized medicine).
[84] Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption & Experimentation*, 49 WM. & MARY L. REV. 229, 245 (2007). I mention Mitt Romney's bid for the presidency because it puts his views on healthcare under even greater scrutiny. Since the Republican Party has not yet chosen a presidential candidate, there is an implication that Romney's actions may be more in-tune with the Republican line because he has to woo his party's approval. However it is also important to note that Governor Romney might not have been vying for the presidency at this time, and even more importantly, that he vetoed the portion of the new Massachusetts law establishing the employer mandates, but the legislature overrode his veto.
[85] Mass. Gen. Laws ch. 149, § 188(d) (2007).

insurers to compete by lowering premiums – a system similar to food stamps, where the subsidy underwrites the recipients' participation in the market.[86]

Part IV – Eliminate Preemption & Solve Healthcare

As discussed above, ERISA preemption is a problem to the state and to the individual. The only question left is what is to be done about it. Possible options include amending the Preemption Clause, making an exception for Massachusetts and similar states, or forming a "Preemption Committee". For the purpose of this section, let us assume that there is no public choice problem, and that we can freely amend or repeal ERISA. The most preferable solution is to repeal the Preemption Clause.[87] Any other solution will almost certainly result in the same problems we experience today.

A. Possible Solutions

In responding to the ERISA problems explored above, the first solution that comes to mind is to merely amend the Preemption Clause. This seems easy enough, but amending comes with its own problems. No matter how we amend the Preemption Clause, courts will still encounter problems with interpretation and ambiguities. For this, we need to look no further than how we got here to begin with. ERISA already excludes state insurance regulation from preemption though the Savings Clause, and yet, ERISA swallows comprehensive healthcare legislation. Congress could repeal the Deemer Clause, but even before *Travelers* when states were evaluated under *Shaw*, a simple matter of interpreting "related to" was enough to preempt most state laws.

[86] Edward A. Zelinsky, 49 Wm. & Mary L. Rev. 229, 245 (2007).
[87] Actually, the true "most preferable" solution is to repeal ERISA altogether but that's a topic for another paper.

i. Amend Preemption Clause

How do we eliminate ambiguities from the Preemption Clause? The term "related to" is the original pain in the neck. Is there a way to redraft ERISA Preemption without the term "related to"? Certainly there is. The problem is that any term used to replace "related to" will be equally ambiguous. For example, "referencing" or "affecting". These are terms used to define "related to" in *Shaw* and *Travelers*. Unfortunately, *Shaw* and *Travelers* did not clear up or unify interpretation. There is no word that is any less ambiguous than "related to", and more explanation will lead to more terms for the federal courts to define.

This brings us to the second reason why amending ERISA preemption is not the best solution: interpretation. Eliminating ambiguities is impossible, and leaving semantics behind, the problem becomes one interpretation – a problem of who sits on the bench and where. This is just not a good way to fix the problem because even if the right judge interprets the amended clause correctly, a decade later, we might find ourselves right were we started.

ii. Exceptions for Certain States

Perhaps we should leave ERISA as is, and focus on allowing states that have "good laws" to circumvent ERISA. We can do this through specific exceptions or perhaps through a creation of a Preemption Committee. However, there are numerous flaws to this solution. Any criteria used to form an exception will be arbitrary.

Explicit state exceptions to ERISA preemption do exist. For example, the Hawaii Prepaid Health Care Act has an express exclusion from preemption within then language of ERISA.[88] The story of the Hawaii Act is interesting. It was enacted in 1974, and shortly thereafter

[88] 29 U.S.C. § 1144 (b)(5)(A), (B), (C) (2004). ("Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat. §§ 393-1 through 393-51).")

preempted by ERISA.[89] Eight years later, Congress made this specific exemption, claiming that the preemption of the Hawaii Act was "inadvertent."[90] Perhaps Congress can make another exception for Massachusetts. But what about other states? Must all states legislation wait eight years and lobby in Washington? This brings us to a possibility of a Preemption Committee, specifically designed to handle criteria and review state proposals before state enactments.

The first problem is the criteria itself. As discussed above in Part III, comprehensive state healthcare statutes face a lot of political controversy. Depending on party affiliations and personal preferences, some believe the Massachusetts Act is a terrible attempt at socialized medicine and other believe it is a step in the right direction. Allowing a single committee in Congress to dictate that, for example, the Massachusetts Act should be exempt but the Wal-Mart Act should be preempted, is arbitrary at its core. Allowing a committee to make such decisions is also contrary to the democratic political process in each state

The second problem is that allowing for certain exceptions is not really a solution at all. Creating a committee for exempting certain laws or excluding states individually to avoid preemption will have either the chilling effect currently experienced by some states, or the opposite –no real effect. It is quite possible that states wound ignore the committee when it refuses to grant an exception and continue enacting legislation that will later be held preempt in federal courts. By placing a committee in charge of making exceptions without any real criteria except the Preemption Clause as it stands today, we are merely shifting the responsibilities of interpreting the law from the federal judiciary to the federal legislature. Both possibilities are just as flawed, and both can be just as capricious. So, again, even if one year the committee gets it "right", in a decade or two, we might be exactly where we started.

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[89] Emily V. Griffen, *"Relations Stop Nowhere": ERISA Preemption of San Francisco's Domestic Partner Ordinance*, 89 Cali. L. Rev. 459, 503 (2001).
[90] *Id.*

B. The Right Solution – Repeal Preemption

Enough is enough. It's time to de-claw the cat - repeal the Preemption Clause from ERISA – and allow states to have the ability to pass meaningful legislation regarding the health and welfare of their citizens once again. First, ERISA has failed in many respects: it does not protect employee rights as promised, it causes excessive litigation costs to employers, and it passes unremedied externalities onto the state. Second, preemption serves to frustrate the political process. Third, there is no reason for legislation on a federal level because healthcare does not produce interstate externalities. Finally, experimentation will lead to the right solution for each state, and most efficient outcomes for each individual.

i. Preemption Ineffective

As mentioned in Part I, ERISA was originally enacted to protect employees. Clearly, it has failed. The remedies are not inclusive enough to cover the harms employees suffer. More importantly, preemption makes it impossible for states to step in where ERISA falls flat. In addition to its failure in employee protection, ERISA has also caused a flurry of litigation to the employer. While ERISA was meant to be a cost saver for the employer, it instead bred new specialties for lawyers, actuaries, and accountants. The employer must not only interpret the ambiguous provisions correctly, but must also be aware of the threat that a different court may expand or constrain the interpretation of ERISA at any time.

Second, ERISA serves to frustrate the political process. As noted above, ERISA preemption has been left untouched because of a public choice problem. Much ink has been spilt but not much has been done to fix any of the problems ERISA preemption caused. Too many unintended third parties are powerful special interest groups. Now that these groups are protected, they will fight to insure that this protection is not repealed.

The same has not been true at the state level, where an average worker is an average voter who can more effectively voice his dissatisfaction. Voices of dissatisfaction have spoken. States have been trying to enacting these healthcare reforms. Moreover, these reforms have no externalities on other states; they are affective only within the state's jurisdiction. In the beginning, Congress feared a race-to-the-bottom. Since many states are attempting to increase protection to their citizens, it seems this fear is unfounded.

Third, there is no reason for a federal-system of healthcare insurance protection. Protection on a large scale makes sense when the good subjected to regulation is a public, non-excludable good. The best example is a clean environment. Pollution and most environmental causes require at least a cooperative federalist system where the federal government provides a safety net – a floor for minimal standards – while the states are allowed to raise environmental standards if they so choose. This is because pollution is a negative externality while a clean environment is a positive one. A state that pollutes has no incentive to realize the full cost of pollution because pollution will expand to its neighboring states. This is a harm the polluting state does not experience. Similarly, a state that spends money to preserve a good environment will not be able to realize the full benefit because the neighboring states will also benefit, and free-ride, enjoying the benefits of a clean environment without having to contribute to cost of keeping it clean. While this is true with the environment, this is not true with healthcare insurance. Employer-provided healthcare insurance is indeed a very excludable good, and it produces no externalities when there is little government intervention.

With ERISA, a state experiences societal costs resulting from a lack of health insurance, but if the state was to enact whichever plan it prefers, it is likely to minimize these costs by forcing the parties to such a transaction (the insurer and the client) to internalize them.

ii. Experimentation

Repealing ERISA preemption is the efficient solution. We should avoid the trap of cooperative federalism, with ERISA as a floor, because such measures would hinder people's preferences. Since there are no externalities without preemption, there is no reason to force any state to accept any terms in adopting its healthcare laws. Currently, there is no longer a fear of a race to the bottom. There is simply no justification for keeping states from experimenting with the healthcare system their residents choose. Let us consider that there are many different theories of which healthcare reform is best for America. Some believe the single-payer system might be best. Others prefer more libertarian proposals. This is precisely why states should adopt whichever system best suits their constituents. We can have these systems simultaneously.

"It is precisely because Massachusetts has done something different from the other states that its experiment should be allowed to proceed. Only in this way can we learn what portions, if any, of the experiment are productive and thus potentially exportable to other states."[91] Experimentation is more efficient for two reasons. First, the demographic differences make each state unique to adopting an efficient healthcare system. Second, residents can opt-out of their state's system by moving to another, thereby receiving the healthcare system they desire.

First, experimentation on a state level allows a system to be tailored to demographic difference while preserving the independence of each system. For instance, California was inspired by Massachusetts and is in the process of adopting a similar "pay or play" legislation that will provide healthcare insurance to all residents.[92] What is most interesting about a

[91] Edward A. Zelinsky, 49 Wm. & Mary L. Rev. 229, 282 (2007).
[92] See generally James W. Kim, Governor Schwarzenegger's Proposal for Universal Health Care: A Policy-Based and Legal Analysis, 15 No. 5 Health Law. 39 (2007). "On January 8, 2007, Governor Arnold Schwarzenegger unveiled his comprehensive proposal to provide health insurance to all residents of California. The Governor's Health Care Proposal (the "Proposal") is an ambitious program that is modeled after many of the changes implemented in states such as Massachusetts and Vermont."

Massachusetts Act system being adopted in California is that Massachusetts has a relatively small uninsured population while California has an estimated 6.5 million residents uninsured – over 20% of California's non-elderly population.[93] This makes California sixth in America in proportion of uninsured residents. While the Massachusetts Act, with its goal of providing health insurance to every resident of the state, may succeed in Massachusetts, it may also fail in California. And that is okay. If the "pay or play" system fails in California, it can be reformed easily for something more suitable. All costs will be realized in California, and changes will be quick. Similarly, the "pay or play" system can work in Massachusetts successfully, unaffected by its failure in California. This is the advantage of "regional balkanization" - independence.

Second, residents are not stuck with some arbitrary form of healthcare with which they are dissatisfied. These states can experiment with other systems of healthcare. Moreover, if residents of one state particularly enjoy a certain form of healthcare insurance but cannot seem to influence their resident state enough to adopt the model, as the Tiebout Model tells us, these residents can "vote with their feet" and leave to a state that will. The results are more effective at solving the ERISA problem, and more likely to give individuals and states efficient results.

Conclusion

According to the U.S. Census Bureau, 45.8 million Americans were without health insurance in 2004, climbing from 41 million in 2000.[94] This is a clear problem. Laws similar to the one adopted in Massachusetts propose a hands-on legislative effort to remedy the societal costs of those uninsured and, therefore, should go forward. It is unanticipated that ERISA – a

[93] See generally James W. Kim, Governor Schwarzenegger's Proposal for Universal Health Care: A Policy-Based and Legal Analysis, 15 No. 5 Health L. 39 (2007).
[94] Press Release, U.S. Census Bureau, Housing and Household Economic Statistics, News Conference on 2004 Income, Poverty, and Health Insurance Estimates from the Current Population Survey (Aug. 30, 2005), *available at* http://www.census.gov/hhes/www/income/income04/prs05asc.html.

law designed to regulate, encourage and protect workers' employer-funded benefits – should stand in the way of a state's effort to provide for its uninsured workers. However, as seen with the Wal-Mart Act, ERISA has broad preemptive power, forcing states to pay societal costs shifted away from the employer and insurance companies. The lack of congressional action over the past three decades makes it clear that it is time for state action. By abolishing ERISA's Preemption Clause, states will be able to succeed where ERISA failed.