JULY 2006

CAN MARYLAND MAKE EMPLOYERS "PAY OR PLAY"?

The short answer is, "no," because the United States District Court for the District of Maryland ruled on July 19, 2006, that the "Fair Share" Act is preempted by the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Judge Frederick Motz explained:

> My finding that the Act is preempted is in accordance with long established Supreme Court law that state laws which impose employee health or welfare mandates on employers are invalid under ERISA. *See, e.g., Greater Washington Board of Trade,* 506 U.S. 125; *Shaw,* 463 U.S. 85.

Slip Op. at p. 19; *Retail Industry Leaders Assn. v. James Fielder, Jr.,* USDC Maryland, Case No.: 1:06-CV-316 (JFM). Jones Day represents the U.S. Chamber of Commerce as amicus curiae in the *Retail Industry Leaders Assn.* case.

What follows are the positions of both the proponents and opponents of Maryland's Fair Share legislation staked out prior to the July 19 ruling.

THE MARYLAND "FAIR SHARE" ACT

On January 12, 2006, Maryland became the first state to enact a law mandating that employers with 10,000 or more employees ("10K employers") spend a minimum percentage of payroll on health-care costs or pay a certain amount into the state Medicaid fund. The Maryland law is titled the "Fair Share Health Care Fund Act" ("Fair Share") and goes into effect on January 1, 2007.

The new Maryland statute establishes a Fair Share Fund and subjects 10K employers to a health-care payroll assessment that supports the operations of the Maryland Medicaid program. The amount assessed for the Fair Share Fund is to be the difference between 8 percent of the 10K employer's payroll costs (6 percent of payroll for nonprofit entities) and the amount spent on health-care insurance costs, if the latter amount is lower. The legislative history to the Fair Share Act shows there are three employers in Maryland with more than 10,000 employees: Giant Food, Wal-Mart, and Johns Hopkins University. Only Wal-Mart has health insurance costs low enough to be subject to the payroll assessment.

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Opponents of Maryland's Fair Share legislation point out that this law directly conflicts with ERISA, which provides for a uniform national employee benefit law. "Fair Share" supporters argue that the law does not place requirements directly on employee benefit plans but instead regulates employer conduct. Employers can either "pay" into the state fund or "play," by providing medical plan benefits to their employees.

Three questions are raised by the Maryland Fair Share Act. (1) Why does it matter to Maryland if a large company does not provide medical plan coverage to all of its employees? (2) What role, if any, does federal law play in regulating employer-provided medical plan coverage? (3) Can a state, like Maryland, require a corporation to provide its employees with medical plan coverage?

FOLLOW THE MONEY

Forty years after its introduction, Medicaid has evolved into a budgetary Frankenstein overburdening both the federal treasury and the budgets of all 50 states. At the National Governors Association meeting held in Washington, D.C., in February 2005, Medicaid was identified as the number-one problem facing state governments.[1] When Medicaid was introduced in 1965, this federal-state policy to provide for the medical needs of the poor was so overshadowed by passage of the sweeping Medicare guarantees for every American over the age of 65 that President Johnson barely mentioned it at the signing ceremony.

State and federal governments together are expected to have spent close to $330 billion on Medicaid in 2005.[2] Medicaid accounts for 22 percent of total state spending and has become the second-largest item in most state budgets, after elementary and secondary education.[3] In 1985, Medicaid accounted for 8 percent of total state spending. Spending on Medicaid is crowding out funding for many other programs that states provide for education, transportation, and public safety. Because Medicaid is the biggest source of federal revenue for the states, a slight decrease in the federal match can have a big impact on a state's budget. For example, during 2006, the federal government will require states to pay an additional $527 million for Medicaid.[4] States like New Mexico, Louisiana, and Alaska will be hardest hit and estimate that this reduction in the matching formula will cost them each more than $70 million. Rising health-care costs play a large part in the increasing cost for Medicaid. Meanwhile, Medicaid enrollment increased by almost one-third between 2000 and 2004, causing higher costs for the states.[5] Medicaid spending jumped by more than 50 percent between 2000 and 2004.[6] Changes in the U.S. workplace have also caused an increase in Medicaid enrollment. Because of spiralling health-care costs, employers are more likely to not offer health-care coverage for their employees, forcing some of the working poor to turn to Medicaid.

Maryland's Fair Share Act (discussed below) is a variation on California's "Pay or Play" legislation that was defeated by referendum in 2003. California's proposed law would have required employers with 50 or more employees to either provide health insurance or pay into a state insurance purchasing pool. At least 15 other state legislatures considered similar "Pay or Play" laws during 2005. Arizona, California, Connecticut, New Hampshire, and Tennessee rejected "Pay or Play" legislation. In Vermont, the governor vetoed a "Pay or Play" bill, while in Maryland, the governor's veto was overridden by the legislature. "Pay or Play" legislation remains active in at least nine states: California, Kentucky, Massachusetts, Minnesota, New York, Oregon, Pennsylvania, Washington, and West Virginia. One reason why so many states are looking into the "Pay or Play" legislation is that health-care costs for the poor (Medicaid) seem uncontrollable. Requiring employers to cover workers with health insurance without tapping into the state budget has become an attractive way to balance the state's budget.

A BRIEF HISTORY OF ERISA PREEMPTION

Prior to the passage of ERISA, states were free to regulate the terms of employer-provided medical plans. At the time ERISA was enacted, however, most states had not done so. Indeed, when Congress passed ERISA in 1974, skyrocketing medical plan costs were not yet on the radar. Instead, Congress was responding to a public outcry that arose during the 1960s and 1970s that many pension plan sponsors were either crooks, charlatans, or worse.[7] Determined to protect employees' retirement benefits, Congress devised "rules concerning reporting, disclosure and fiduciary responsibility" to keep plan sponsors on the up and up.[8]

The ERISA statute divides employee benefit plans into two worlds: (1) pension benefit plans; and (2) welfare benefit plans. Under ERISA, pension plans were defined to include retirement plans or other plans that defer the receipt of income to the termination of employment or beyond.[9] Welfare plans included everything else, such as medical, dental, vision, life insurance, disability, and virtually any other employee benefit that is not related to "retirement."[10]

Congress established a uniform set of rules for "conduct" to be used in connection with all employee benefit plans.[11] While the "content" of welfare benefit plans was left largely unregulated, pension benefits are subject to cradle-to-grave regulation, including vesting requirements, funding mandates, nondiscrimination tests, and special rules governing benefit accruals.[12] This means that most welfare benefit plans, such as insured and self-funded medical, dental, disability, or vision plans, are subject to almost no content requirements under ERISA. While all employee benefit plans, including medical plans, are subject to reporting, disclosure, and fiduciary responsibility provisions, insured and self-funded medical plans are subject to few substantive content requirements.

One of ERISA's fundamental purposes is to encourage the formation of employee benefit plans.[13] Congress further explained that ERISA is meant to govern the "operation and administration" of employee benefit plans.[14] To this end, ERISA is designed to provide a single, uniform federal scheme so as to avoid a multiplicity of regulation and to prevent conflicts between federal and state regulatory systems.[15] ERISA thus served to replace a patchwork scheme of state regulation of employee benefit plans with a uniform set of federal regulations.[16] To protect ERISA's primary goal of providing minimum standards and uniform federal regulation of employee benefit plans, Congress enacted a broad preemption clause.[17] When Congress enacted ERISA in 1974, it expressly preempted "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" and broadly defined "State law" to include "all laws, decisions, rules, regulations, or other State action having the effect of law ...."[18] "State" is defined by ERISA as "a State, any political subdivision thereof, or any agency or instrumentality of either which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by ERISA."[19] The primary advantage of the supremacy clause found in the ERISA statute (also referred to as the "preemption provision") is that it has allowed plan sponsors to create uniform employee benefit plans covering different employees in different states.[20]

How did the ERISA statute come to dominate the operation and administration of employee benefit plans? The short answer is "supremacy." Our system of government divides power between state and federal governments. Questions about how power is divided are resolved, for the most part, by the United States Constitution's Supremacy Clause. It states: "This Constitution, and the laws of the United States ..., shall be the supreme law of the land ...."[21] Federal law generally supersedes state law where the two laws conflict or where Congress has otherwise indicated its desire to oust state regulation.[22]

Without uniform federal interpretation, employee benefit plans could be required to keep records in some states but not in others, to provide different benefits in different states, to decide benefit claims in different ways, and to comply with different standards of conduct in administering employee benefit programs. Obviously, the inefficiency caused by a "patchwork" of state-by-state regulation might lead large, national employers with employee benefit plans to provide the lowest common denominator of benefits, or might even discourage those employers from offering any employee benefit program at all.[23]

The Supreme Court has criticized ERISA's preemption provision for not being "a model of legislative drafting."[24] Notwithstanding this criticism, the Supreme Court has consistently described ERISA's preemption provision as "conspicuous for its breadth."[25] The boundaries of ERISA's preemptive reach have been the subject of a series of differing Supreme Court interpretations. Given the difficulty in applying the expansive preemption language found in ERISA to real-world problems, the Supreme Court has issued no less than 24 important ERISA preemption decisions over the course of the last 25 years. These Supreme Court ERISA preemption decisions (written by different judges during different decades) show the Court's evolving views on this issue.

1. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 101 S. Ct. 1895 (1981) (New Jersey law prohibiting the offset of workers' compensation benefits by ERISA plans—preempted).

2. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890 (1983) (New York discrimination in law requiring health-care plans to provide pregnancy coverage—preempted).
3. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S. Ct. 2380 (1985) (Massachusetts insurance law mandating minimum health-care benefits—not preempted).
4. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 107 S. Ct. 1542 (1987) (Mississippi bad-faith insurance law claim concerning improper processing of a benefit claim provides federal jurisdiction under the complete preemption doctrine).
5. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549 (1987) (Mississippi state law causes of action for disability plan benefits—preempted).
6. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 107 S. Ct. 2211 (1987) (Maine statute requiring one-time payment to employees upon closure of facility—not preempted).
7. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 108 S. Ct. 2182 (1988) (Georgia garnishment statute preempted as it purported to exempt from garnishment the assets from ERISA welfare plans).
8. *Massachusetts v. Morash*, 490 U.S. 107, 109 S. Ct. 1668 (1989) (Massachusetts statute regulating unfunded vacation pay plans—not preempted).
9. *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S. Ct. 403 (1990) (Pennsylvania law precluding subrogation or reimbursement of benefits in any action arising out of the use of motor vehicles preempted through application of the "deemer clause").
10. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S. Ct. 478 (1990) (Texas wrongful discharge tort and contract claims concerning pension benefits—preempted).
11. *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 113 S. Ct. 580 (1992) (District of Columbia law requiring employers to provide health-care coverage to employees on workers' compensation leaves—preempted).
12. *John Hancock Mut. Life Ins. Co. v. Harris Trust and Sav. Bank*, 510 U.S. 86, 114 S. Ct. 517 (1993) (New York state law regulating general account funds of insurance company—preempted).
13. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S. Ct. 1671 (1995) (New York law requiring hospitals to collect surcharges from patients from all health-care plans except for Blue Cross/Blue Shield—not preempted).
14. *Boggs v. Boggs*, 520 U.S. 833 (1997) (Louisiana community property law that would change pension plan beneficiaries—preempted).
15. *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 117 S. Ct. 832 (1997) (California law governing prevailing wages for public works projects involving apprenticeship programs—not preempted).
16. *DeBuono v. NYSA-ILA Med. & Clinical Serv. Fund*, 520 U.S. 806 (1997) (New York gross receipts tax on medical centers operated by ERISA plans—not preempted).
17. *Unum Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (California rule that would make the employer an agent of the insurance company—preempted).
18. *Pegram v. Herdrich*, 530 U.S. 211, 120 S. Ct. 2143 (2000) (Mixed eligibility decisions by HMOs are not fiduciary decisions under ERISA and thus not subject to ERISA preemption).
19. *Egelhoff v. Egelhoff ex. rel. Breiner*, 532 U.S. 141, 121 S. Ct. 1322 (2001) (Washington statute overriding pension plan beneficiary designations—preempted).
20. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S. Ct. 2151 (2002) (Illinois HMO act requiring independent review of disputed claims was found to be a law regulating insurance—not preempted).
21. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 123 S. Ct. 1965 (2003) (California "treating physician rule" applied to LTD claims—preempted).
22. *Delta Family-Care Disability and Survivorship Plan v. Regula*, 539 U.S. 901, 123 S. Ct. 2267 (2003) (California following Nord, "treating physician rule" applied to LTD claims—preempted).
23. *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 123 S. Ct. 1471 (2003) (Kentucky "any willing provider" statute precluding HMOs from limiting network providers was found to be a law regulating insurance—not preempted).
24. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 124 S. Ct. 2488 (2004) (Texas law mandating standard of care for HMO benefit coverage decisions—preempted).

Most of the Supreme Court's ERISA preemption cases have revolved around what the "relates to" standard means. Justice Scalia summed up his frustration with this ERISA preemption standard as follows: "But applying 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."[26] Further complicating the issue of ERISA preemption is its exemption from state insurance laws.[27] Determining whether a state statute is an insurance law is, itself, an almost metaphysical endeavor.[28]

While not overruling earlier decisions concerning the breadth of the "relates to" standard, more recent Supreme Court decisions have narrowed the scope of ERISA preemption. For example, in its 1995 *Travelers* decision, the Supreme Court ruled that ERISA did not preempt a state's hospital surcharge that self-funded, employer-sponsored medical plans had to pay.[29]

COMPLETE PREEMPTION AND CONFLICT PREEMPTION

ERISA preemption comes in two varieties: "complete preemption" and "conflict preemption." Complete preemption, arising under the ERISA remedy provisions of 29 U.S.C. § 1132(a), concerns the question of whether a dispute about an employee benefit plan is a federal question or a question for state law. The complete preemption doctrine provides that state law disputes "relating to" employee benefit plans are subsumed under ERISA's limited civil enforcement provisions.[30] This means that state law claims for breach of contract, negligent misrepresentation, and promissory estoppel, as well as other state tort or contract clauses of action, can be removed to federal court. In federal court, these state law contract and tort law claims are not permitted in connection with employee benefit plan disputes.[31]

Under the complete preemption doctrine, a state law claim would be entirely displaced by federal law, and the party being sued has the option of "removing" a claim filed in state court to federal court. The test for determining complete preemption under the *Metropolitan Life v. Taylor* decision[32] is whether the state law claim can be pleaded as an ERISA claim to recover benefits.

On the other hand, "conflict preemption," arising under the supremacy clause of ERISA § 514(a), 29 U.S.C. § 1144(a), concerns whether Congress, by enacting ERISA, meant to completely occupy the field and to prohibit the states from regulating the operation or the administration of employee benefit plans. The test for conflict preemption under ERISA § 514(a) is broader than the test for "complete preemption." A state law cause of action is preempted by ERISA § 514(a) if it "relates to" an employee benefit plan.[33] When applied with claims under state law that are said to implicate ERISA, a court must first decide whether the claims are superseded by ERISA. Thus, "ERISA pre-emption [of a state claim], without more, does not convert a state claim into an action arising under federal law."[34] Hence, when ERISA is simply asserted as a defense to a state law cause of action, the state law claim is not converted into an ERISA claim, and there is no federal question giving rise to jurisdiction.

The scope of complete preemption under ERISA is very narrow, while the scope of conflict preemption is quite broad. The narrowness of complete preemption is derived from the fact that it applies only to claims to recover benefits under an ERISA plan; that is, claims that fall under ERISA § 502(a), 29 U.S.C. § 1132(a) (ERISA's civil enforcement provisions). The conflict preemption defense, on the other hand, involves ERISA's supremacy provision, 29 U.S.C. § 1144(a). Again, this provision states that ERISA preempts all state laws that "relate to" an ERISA-covered employee benefit plan.[35] Both complete preemption and conflict preemption are at issue in the challenge to Maryland's Fair Share Act.

THE RETAIL INDUSTRY LEADERS ASSOCIATION'S CHALLENGE TO MARYLAND'S FAIR SHARE LEGISLATION

On February 7, 2006, the Retail Industry Leaders Association ("RILA") filed a complaint for declaratory and injunctive relief in the USDC for the District of Maryland. The Retail Industry Leaders Association complaint alleges three causes for relief: (1) ERISA preemption; (2) a violation of the federal Equal Protection Clause; and (3) a violation of the Maryland Constitution's prohibition on the enactment of special laws that discriminate against a particular individual or business.

The "ERISA preemption" claim in the RILA complaint states, in pertinent part:

> 22. The Maryland Act conflicts with ERISA's carefully-constructed federal framework and is expressly preempted by ERISA § 514(a), 29 U.S.C. § 1144(a), because it "relates to" ERISA-covered plans and has an impermis-

> sible connection with and reference to ERISA-covered employee health plans. Specifically, the Act improperly requires covered employers to make health insurance payments in connection with ERISA-covered plans, and improperly requires covered employers to sponsor health plans that provide for a specific contribution level. The Act purposely and directly operates with respect to payments that covered employers currently make to ERISA plans or that they will be compelled to make to ERISA plans to comply with the Act.
>
> 23. The Act conflicts with and is preempted by ERISA for the additional reason that it impermissibly interferes with the uniform national administration of benefits plans intended by the Act, since it imposes on covered employers different health care obligations toward employees in Maryland than owed to employees elsewhere in the country. Thus, the Act illegally forces and compels covered employers to change the administration of their plans and/or to create a separate and independent plan for Maryland employees and, accordingly, is preempted and null and void.
>
> 24. Further, the Act's broad reporting and enforcement mandate conflicts with the integrated civil enforcement mechanism of ERISA that is intended to provide the exclusive remedy for plan violations, 29 U.S.C. § 1132(a), and for this reason also the Act is preempted under ERISA and by the Supremacy Clause of the United States Constitution.[36]

The Retail Industry Leaders Association's two ERISA preemption challenges to the Fair Share Act find solid footing in ERISA preemption jurisprudence as well as the underlying policy considerations of ERISA.

DOES THE FAIR SHARE ACT CONFLICT WITH ERISA?

In *Shaw v. Delta Air Lines, Inc.*, the Supreme Court explained that a state law relates to an employee benefit plan if it: (1) has a connection with a plan; or (2) refers to a plan.[37] While proponents of the Fair Share Act argue that the assessment levied on employers that do not spend a minimum amount of payroll on "health insurance costs" does not depend on the existence of an ERISA plan, this statement appears to ignore the words of the statute and a substantial body of case law. The Fair Share Act states in pertinent part:

> An employer that is not organized as a nonprofit organization and does not spend up to 8 percent of the total wages paid to employees in the state on health insurance costs shall pay to the Secretary an amount equal to the difference between what the employer spends for health insurance costs and an amount equal to 8 percent of the total wages paid to employees in the state.

Is the payment by an employer of "health insurance costs" regulated by ERISA? In order to have ERISA regulation, there must be an "employee benefit plan."[38] A welfare plan under ERISA is broadly defined to include:

> [A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death ....[39]

In the Fourth Circuit, which includes Maryland within its jurisdiction, an employer may establish an ERISA plan simply by purchasing insurance for its employees.[40] The Fair Share Act effectively requires employers to provide employees with health insurance. Whether these medical benefits are provided directly through a plan established by the employer or through the employer's payment into a state-mandated health insurance "fund" is irrelevant under the broad definition of an ERISA welfare plan. However, the fact remains that Wal-Mart and other 10K employers do sponsor medical plans. In either event, the required "connection with" an ERISA-governed plan has been met.[41]

The Fair Share Act also mandates that employers pay at least 8 percent of payroll as medical benefits for their employees. The Supreme Court has stated that laws requiring employers to provide benefits based upon state-mandated levels are preempted by ERISA.[42] In *Greater Washington*, the Court was presented with the question of whether the District of Columbia could require employers that provide health insurance for their employees to provide the same health insurance coverage for injured employees eligible for workers'

compensation benefits.[43] Finding the D.C. law to be preempted, the Supreme Court ruled:

> We have repeatedly stated that a law "relates to" a covered employee benefit plan for purposes of § 514(a) "if it has a connection with or reference to such a plan." [Citations omitted.] This reading is true to the ordinary meaning of "relate to," see Black's Law Dictionary 1288 (6th ed. 1990), and thus gives effect to the "deliberately expansive" language chosen by Congress. [Citations omitted.] Under § 514(a), ERISA pre-empts any state law that refers to or has a connection with covered benefit plans (and that does not fall within a § 514(b) exception) "even if the law is not specifically designed to affect such plans, or the effect is only indirect," *Ingersoll-Rand*, *supra*, [498 U.S.] at 139, and even if the law is "consistent with ERISA's substantive requirements," *Metropolitan Life, supra*, [471 U.S.] at 739.
>
> Section 2(c)(2) of the District's Equity Amendment Act specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is pre-empted. The health insurance coverage that § 2(c)(2) requires employers to provide for eligible employees is measured by reference to "the existing health insurance coverage" provided by the employer and "shall be at the same benefit level." ...
>
> Such employer-sponsored health insurance programs are subject to ERISA regulation, see § 4(a), 29 U.S.C. § 1003(a), and any state law imposing requirements by reference to such covered programs must yield to ERISA.[44]

While it is true that the Supreme Court took a more cautious approach to ERISA preemption starting with *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*,[45] it in no way abandoned its earlier preemption analysis. In *Travelers*, a New York law requiring hospitals to collect surcharges from patients covered by a commercial insurance company but not from patients insured by a Blue Cross/ Blue Shield plan was found not to be preempted. The Court explained that where federal law bars state action in fields of traditional state regulation, it has operated on "the assumption that the historic police powers of the states are not to be superseded by the federal act unless there is the clear and manifest purpose of Congress."[46] The *Travelers* court emphasized:

> The basic thrust of the [ERISA] preemption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.
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> Accordingly in *Shaw*, for example, we had no trouble finding that New York's "Human Rights Law," which prohibited employers from structuring their employee benefit plans in a manner that discriminated on the basis of pregnancy and New York's Disability Benefits Law, which required employers to pay employees specific benefits, clearly "related to" benefit plans. 463 U.S. at 97.
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> ... [M]andates affecting coverage could have been honored only by varying the subjects of a plan's benefits whenever New York law might have applied, or by requiring every plan to provide all beneficiaries with a benefit demanded by New York law if New York law could have been said to require it for any one beneficiary .... In each of these cases, ERISA pre-empted state laws that mandated employee benefit structures or their administration. Elsewhere, we have held that state laws providing alternative enforcement mechanisms also relate to ERISA plans, triggering pre-emption. *See Ingersoll-Rand, supra*.[47]

In passing ERISA's preemption provision, we know that Congress intended:

> [T]o ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government ... [and to prevent] the potential for conflict in substantive law ... requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.[48]

The *Travelers* decision makes clear that Congress intended ERISA to preempt at least three categories of state laws that are viewed as having a connection with an ERISA plan:

> First, Congress intended ERISA to preempt state laws that "mandate employee benefit structures or their administration." ... Second, Congress intended to preempt state laws that bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself .... Third, in keeping with

> the purpose of ERISA's preemption clause, Congress intended to preempt "state laws providing alternate enforcement mechanisms" for employees to obtain ERISA plan benefits.[49]

We also know that Congress did not intend to preempt traditional state-based laws of general applicability that do not implicate the relations among the traditional ERISA plan entities, including the principals, the employer, the plan, the plan fiduciaries, and the beneficiaries.[50]

The Maryland Fair Share Act violates at least two of the categories of state laws that can be said to have a connection with an ERISA plan. First, requiring a 10K employer to provide medical plan coverage to employees equal to 8 percent of the 10K employer's payroll costs mandates a particular employee benefit plan structure. Second, the administration of the 10K employer's plan is affected in at least three different ways: (1) It requires the plan to pay a certain level of benefits; (2) it requires a payment to the Fair Share Fund in the event those minimum benefit levels are not met; and (3) it requires ongoing reports to the State of Maryland as to the efforts made in connection with the 8 percent-of-payroll mandate. A failure to make timely report to the State of Maryland results in a $250-per-day penalty. A failure to make timely payments to the Fair Share Fund results in the imposition of a civil penalty of $250,000. The Fair Share Act also commands 10K employers to establish Maryland-centric benefit levels and to abide by Maryland-centric administrative rules precluding their ability to uniformly administer multiple state health-care plans.

In *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*,[51] the U.S. Supreme Court held the law "has a … reference to" a plan where the law "acts immediately and exclusively upon ERISA plans … or where the existence of ERISA plans is essential to the law's operation …." If the law "functions irrespective of … the existence of an ERISA plan," it does not make reference to an ERISA plan so as to be preempted.[52] In *Dillingham*, a California law governing prevailing wages for public works projects involving apprenticeship programs was found not to be preempted. The Maryland Fair Share Act only functions by referencing the 10K employer's expenditures for employer-provided health care. Statutory penalties accrue for failing to satisfy the minimum benefit requirements under the Fair Share Act. The statutory penalties under the Maryland Fair Share Act supplement ERISA's existing enforcement scheme and thus also violate ERISA's complete preemption doctrine.[53]

A number of factors have been used by the courts in determining whether a state law of general application "relates to" an ERISA-regulated plan. In *Fort Halifax Packing Co. v. Coyne*,[54] the Supreme Court explained that if a state law requires an employer to establish a separate employee benefit plan to comply with a state law, it would be preempted.[55] In *Shaw v. Delta Air Lines, supra*, the New York state disability law requiring pregnancy benefits was preempted because it regulated the type of benefits and the terms of an ERISA-regulated plan.[56] In *Fort Halifax Packing Co.*, the Supreme Court also indicated that a state law would be preempted if it impacted the ongoing administration of an ERISA plan. Finally, in *Mackey v. Lanier Collection Agency & Serv., Inc.*,[57] the Supreme Court indicated that a state law would be preempted if it is not consistent with other ERISA provisions.

The Fair Share Act, in effect, mandates employers to pay for employee health plan coverage. By necessity, this statutory mandate changes the relationship between two entities that only ERISA is permitted to regulate.[58] The Fair Share Act dictates the level of health-care plan benefit and thus fundamentally changes the plan sponsor's role in connection with the plan and the plan's participants.[59]

Whether a state can mandate health plan coverage has been previously presented to the Supreme Court. In *Standard Oil Company of California v. Agsalud*,[60] the question presented was whether Hawaii's Comprehensive Prepaid Health Care Act was preempted by ERISA. In finding the Hawaii statute preempted, the Ninth Circuit explained:

> At the time ERISA was enacted, all private plans were voluntary as opposed to mandated by state law and ERISA itself does not require employers to provide plans. We cannot agree, however, with Hawaii's contention that Congress intended to exempt plans mandated by state statute from ERISA's coverage. Congress did distinguish between plans established or maintained by private employers for private employees and plans established or maintained by government entities for government employees. Such government plans are exempt. [Citations omitted.] Private plans are not. The plans which Hawaii would require of private employers are not government plans. There is no express exemption

from ERISA coverage for plans which state law requires private employers to provide their employees. The legislative history convincingly demonstrates a broad congressional preemptive intent. [Citations omitted.][61]

On October 5, 1981, the U.S. Supreme Court issued a Memorandum Opinion affirming the Ninth Circuit's decision.[62]

Maryland's Fair Share Act is precisely the type of state law Congress intended to be preempted. Since the passage of ERISA in 1974, its preemption provision, § 514,[63] has been amended six times. The first amendment to ERISA's preemption provision was given to the State of Hawaii so that it could maintain its Prepaid Health Care Act.[64] It is important to note that Congress did not pass an earlier version of this bill, which would have eliminated ERISA preemption as to any state health-care mandates.[65] In 1999, Congress passed another change to ERISA preemption, permitting the state regulation of multiple-employer welfare plans.[66] State laws governing domestic relations orders were exempted from ERISA preemption in 1984, providing that those orders were "qualified domestic relations orders."[67] Certain child support orders were exempted from ERISA preemption in 1993.[68] In an attempt to help states deal with a growing Medicaid cost problem, in 1986 Congress gave states the power to mandate that employer-sponsored health plans not include a provision requiring employees to exhaust Medicaid benefits prior to claiming benefits under an employer-sponsored plan.[69]

These amendments to ERISA's preemption provision show that Congress has taken an expansive view of ERISA preemption. The consistent message from these minor amendments is that Congress intends federal regulation of employee benefit plans to be exclusive. By establishing employee benefit regulation as reserved to the federal government, Congress sought "to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries."[70] The negative effect of varying state laws mandating employee benefits was described as antithetical to ERISA's purposes in *Shaw v. Delta Air Lines, Inc.*:

> An employer with employees in many States might find that the most efficient way to provide benefits to those employees is through a single employee benefit plan. Obligating the employer to satisfy the varied and perhaps conflicting requirements of particular state fair employment laws, as well as the requirements of [federal law], would make administration of a uniform nationwide plan more difficult. The employer might choose to offer a number of plans, each tailored to the laws of particular States, the inefficiency of such a system presumably would be paid for by lowering benefit levels.... To offset the additional expenses, the employer presumably would reduce wages or eliminate those benefits not required by any State. Another means by which the employer could retain its uniform nationwide plan would be by eliminating classes of benefits that are subject to state requirements with which the employer is unwilling to comply. ERISA's comprehensive pre-emption of state law was meant to minimize this sort of interference with the administration of employee benefit plans.[71]

CONCLUSION

Reduced to its essence, the Fair Share Act is little more than a state mandate to employers to provide medical coverage for their employees. While Maryland's Fair Share Act currently applies only to 10K employers, the ERISA preemption analysis does not depend upon the size of the employer affected by attempted state regulation. If the Fair Share Act withstands challenge, nothing would prevent Maryland (or other states considering similar legislation) from applying the same minimum benefit mandate to all employers. State-by-state regulation of health-care plan benefits would cause the hodgepodge of state regulation ERISA was designed to prevent. In enacting the Fair Share Act, the State of Maryland has overstepped its authority by regulating an area of the law that Congress identified as an exclusive federal concern.

LAWYER CONTACT

For further information, please contact your principal Firm representative or the lawyer listed below. General e-mail messages may be sent using our "Contact Us" form, which can be found at www.jonesday.com.

James P. Baker
1.415.875.5721
jpbaker@jonesday.com

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FOOTNOTES

1 Dan Vock, Kathleen Hunter, Pamela Prah, and Erin Madigan, "Medicaid—Cost and Complexity Tax Reform Efforts," www.stateline.org, March 7, 2005.

2 *Id.*

3 *Id.*

4 *Id.*

5 *Id.*

6 *Id.*

7 1974 U.S. Code Cong. & Admin. News 4670, 4680 (citing the Studebaker shutdown).

8 *Shaw v. Delta Air Lines*, 463 U.S. 85, 91, 103 S. Ct. 2890 (1983).

9 *See* 29 U.S.C. § 1002(1).

10 29 U.S.C. § 1002(2)(a).

11 *See* 29 U.S.C. §§ 1104-05.

12 *See, e.g.*, 29 U.S.C. §§ 1052-54 and 1082.

13 29 U.S.C. § 1001(a).

14 *Id.*

15 *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-57, 115 S. Ct. 1671 (1995).

16 *FMC Corp. v. Holliday*, 498 U.S. 52, 56-60, 111 S. Ct. 403 (1990).

17 29 U.S.C. § 1144(a).

18 ERISA §§ 514(a) and (c), 29 U.S.C. §§ 1144(a) and (c).

19 ERISA § 514(c)(2), 29 U.S.C. § 1144(c)(2).

20 *Shaw v. Delta Air Lines*, 463 U.S. at 105.

21 U.S. Const., article VI, cl. 2.

22 *Malone v. White Motor Corp.*, 435 U.S. 497, 504, 98 S. Ct. 1185 (1978).

23 *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9-11, 107 S. Ct. 2211 (1987).

24 *John Hancock Mut. Life Ins. Co. v. Harris Trust and Sav. Bank*, 510 U.S. 86, 99, 114 S. Ct. 517 (1993).

25 *FMC Corp. v. Holliday*, 498 U.S. at 58.

26 *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.,* 519 U.S. 316, 335, 117 S. Ct. 832 (1997) (Scalia, concurring).

27 ERISA § 514(b); 29 U.S.C. § 1144(b).

28 *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 123 S. Ct. 1471 (2003).

29 *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. at 668.

30 *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66-67, 107 S. Ct. 1542 (1987).

31 *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48, 107 S. Ct. 1549 (1987).

32 *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. at 63.

33 29 U.S.C. § 1144(a).

34 *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. at 63.

35 *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. at 655.

36 On February 7, 2006, a parallel declaratory and injunctive relief action was filed by the Retail Industry Leaders Association against Suffolk County challenging the "Suffolk County Fair Share for Health Care Act," which mandates that large nonunion retail grocery stores in Suffolk County make health-care expenditures on behalf of every employee at a rate of no less than $3.00 per hour worked. *Retail Industry Leaders Association v. James D. Fielder, Jr.,* USDC District of Maryland, Case No. 1:06-cv-00316.

37 *Shaw v. Delta Air Lines*, 463 U.S. at 96-97.

38 *Fort Halifax Packing Co. v. Coyne*, 482 U.S. at 12.

39 29 U.S.C § 1002(1).

40 *Madonia v. Blue Cross & Blue Shield of Virginia*, 11 F.3d 444, 447 (4th Cir. 1993).

41 The law is settled that even in the absence of a written plan document or compliance with ERISA's other requirements, an ERISA-regulated plan may be found to exist. In *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) (*en banc*), the Court held that the test was whether a reasonable person could ascertain from the surrounding circumstances: (1) intended benefits; (2) intended beneficiaries; (3) a source of financing for the benefits; and (4) a procedure for obtaining benefits. The *Dillingham* test has been widely followed. *Wickman v. Northwestern National Life Ins. Co.*, 908 F.2d 1077, 1082 (1st Cir. 1990), *cert. denied*, 498 U.S. 1013, 111 S. Ct. 581 (1990); *Grimo v. Blue Cross/Blue Shield of Vermont*, 34 F.3d 148, 151, 18 EBC 2140 (2d Cir. 1994); *Diebler v. United Food and Commercial Workers' Local Union 23*, 973 F.2d 206, 209 (3d Cir. 1992); *Elmore v. Cone Mills Corp.*, 23 F.3d 855 (4th Cir. 1994) (*en banc*); *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 240-241 (n.4) (5th Cir. 1990); *Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546, 551 (6th Cir. 1989); *Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.*, 805 F.2d 732, 7 EBC 2414 (7th Cir. 1986), *cert. denied*, 482 U.S. 915, 107 S. Ct. 3188 (1987); *Harris v. Arkansas Book Co.*, 794 F.2d 358 (8th Cir. 1986); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 5 EBC 2744 (9th Cir. 1984), *cert. denied,* 474 U.S. 865, 106 S. Ct. 183 (1985); *Scott v. Gulf Oil Corporation*, 754 F.2d 1499 (9th Cir. 1985); *Peckham v. Gem State Mutual of Utah*, 964 F.2d 1043, 1047 (10th Cir. 1992); *Kenney v. Roland Parson Contracting Corp.,* 28 F.3d 1254, 18 EBC 1892 (D.C. Cir. 1994). The Supreme Court has noted that the existence of an ERISA plan also requires "some minimal ongoing 'administrative' scheme or practice." *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 134, n.2, 113 S. Ct. 580 (1992).

42 *Greater Washington Board of Trade*, 506 U.S. at 126-7.

43 *Greater Washington Board of Trade*, 506 U.S. at 126-7.

44 *Id.* at 129-31.

45 *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645.

46 *Id.* at 655.

47 *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. at 657-58.

48 *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 111 S. Ct. 478 (1990).

49 *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1468 (4th Cir. 1996) (quoting *Travelers*, 514 U.S. at 658).

50 *Custer v. Sweeney*, 89 F.3d 1156, 1167 (4th Cir. 1996).

51 *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316.

52 *Id.* at 328.

53 *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. at 66-67.

54 *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1.

55 *Id.* at 12-13.

56 *Shaw v. Delta Air Lines*, 463 U.S. at 96-97.

57 *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 108 S. Ct. 2182 (1988).

58 In order to determine whether a state law's connection to an ERISA plan is sufficient to warrant preemption, several courts have also looked to the effect the law has on the "principal ERISA entities," such as the employer, plan participants, plan fiduciaries, and beneficiaries. *See, e.g., Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters., Inc.,* 793 F.2d 1456, 1467-68 (5th Cir. 1986).

59 *Id.*

60 *Standard Oil Company of California v. Agsalud*, 633 F.2d 760 (9th Cir. 1980).

61 *Id.* at 764.

62 *Agsalud v. Standard Oil Co.*, 454 U.S. 801, 102 S. Ct. 79 (1981).

63 29 U.S.C. 1144.

64 ERISA § 514(b)(5).

65 95th Congress First Session (1977), SF 1383.

66 29 U.S.C. § 1144(b)(6).

67 29 U.S.C. § 1144(b)(7).

68 29 U.S.C. § 1144(b)(7).

69 29 U.S.C. § 1144(b)(8).

70 *Ingersoll-Rand Co. v. McClendon*, 498 U.S. at 142.

71 *Shaw v. Delta Air Lines*, 463 U.S. at 105, n.25.

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