IS ERISA PREEMPTION SUPERFLUOUS IN THE NEW AGE OF HEALTH CARE REFORM?

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I. INTRODUCTION

In June 2010, the Department of Justice (DOJ) submitted a brief to the United States Supreme Court opposing the grant of certiorari in litigation over the legality of San Francisco's recent health reform law.[1] The claim in the case was that ERISA,[2] which had long preempted a variety of state health reform efforts, also preempted the San Francisco reform.[3] The DOJ, however, recommended against Supreme Court review in large part because of the new federal health care reform law, the Affordable Care Act

[1] Brief for the United States as Amicus Curiae Supporting Respondents, Golden Gate Rest. Ass'n v. City and Cnty. of San Francisco, 130 S.Ct. 3497 (2010) (No. 08-1515), 2010 WL 2173776 [hereinafter DOJ Brief].

[2] Employee Retirement Income Security Act of 1974, Pub. L. 93-406, 88 Stat. 829 (codified as amended in sections of 26 U.S.C. and 29 U.S.C.).

[3] Complaint for Declaratory Relief and Injunction at 1, Golden Gate Rest. Ass'n v. City and Cnty. of San Francisco, 535 F. Supp. 2d 968 (N.D. Cal. 2007) (No. 06-6997), 2006 WL 3853281 (alleging that San Francisco's "Ordinance would intrude both directly and indirectly upon the administration of [ERISA] plans" and seeking a declaratory judgment "that all Ordinance language relating to Required Health Care Expenditures is preempted by federal law" as well as "an injunction permanently enjoining the City and County of San Francisco from implementing" the Ordinance).

("ACA"[4]), had recently been enacted, and even the government was unprepared to predict with confidence its effect on previously settled areas of law like the one at issue in San Francisco.[5] Because the federal reform was so new, the DOJ argued, it was premature for the Court to hear the case.[6]

But the ACA is no longer so new, and though Supreme Court review of the question arising from the San Francisco reform may not have been advisable, it is critical to obtain more clarity now about the ACA's interaction with other major laws. In particular, one of the principal sources of uncertainty is the ACA's relationship to ERISA. ERISA preempts any state laws that "relate to" employer-provided health benefits.[7] Although the ACA is a federal law and thus not preempted by ERISA itself, the states must implement much of it.[8] Yet despite ERISA's reputation as a state reform-killer, Congress did not address whether it would have any preemptive effect once the ACA rolled out.[9] Can the states implement reforms mandated with the ACA without running afoul of ERISA? What about ERISA's effects on states' non-ACA reforms going forward? And then there is the middle ground: state reform plans that receive waivers through the ACA.[10] These have recently received much publicity,[11] but will state reforms that get an ACA waiver be able to avoid ERISA preemption?

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[4] Throughout this Note, "ACA" will refer collectively to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (signed March 23, 2010) as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (signed March 30, 2010).

[5] DOJ Brief, *supra* note 1, at 13–17.

[6] *Id.* at 17.

[7] § 514(a), 29 U.S.C. § 1144(a) (2006). *See infra* Part II.B.1.

[8] *See* discussion *infra* Part III.A.

[9] *See* discussion *infra* Part III.A.2.

[10] ACA, Pub. L. No. 111-148, § 1332, 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18052). *See* discussion *infra* Part III.C.

[11] Sheryl Gay Stolberg & Kevin Sack, *Obama Backs Easing State Health Law Mandates*, N.Y. TIMES, Mar. 1, 2011, at A1 (reporting on the President's announcement of his support for the Senate amendment to move the start-date for the waivers' availability to 2014 from 2017); Kate

As the DOJ noted, at this point the answers to these questions are still unclear.[12] For reform to move forward, it is necessary to promptly determine whether reform may be hamstrung by ERISA preemption, or whether reform makes the preemption issue superfluous. The answer to that important question will come not in the high-profile litigation and political maneuvering by states and others seeking to block reform,[13] but through case-by-case interpretations of the laws and their interactions.

Pickert, *Obama to States: If You Can Do Health Reform Better, Go For It*, TIME (Feb. 28, 2011, 11:52 AM), http://swampland.blogs.time.com/2011/02/28/obama-to-states-if-you-can-do-health-reform-better-go-for-it/ (same).

[12] *See* DOJ Brief, *supra* note 1, at 17.

[13] In the days after President Obama signed the ACA, state attorney generals and individuals filed a multitude of lawsuits seeking to enjoin the law's implementation and to invalidate it. Kevin Sack, *Florida Suit Poses a Challenge to Health Care Law*, N.Y. TIMES, May 11, 2010, at A10 ("In the seven weeks since the legislation passed, at least a dozen lawsuits [were] filed in federal courts to challenge it . . . ."); Janet Zink, *More States Join Florida Lawsuit Against Healthcare Law*, MIAMI HERALD, Jan. 18, 2011, *available at* http://www.miamiherald.com/2011/01/18/2022545/more-states-join-florida-lawsuit.html (reporting that six more states joined Florida's ACA challenge, "making it one of the biggest tests of federal authority in [U.S.] history, with 26 states now in line"); Lisa Lambert, Jeremy Pelofsky & Karen Pierog, *Factbox: Lawsuits Challenging U.S. Healthcare Reform*, REUTERS (Jan. 31, 2011, 4:25 PM), http://www.reuters.com/article/2011/01/31/us-usa-healthcare-legal-idINTRE70U7EG20110131 ("More than half of all states have launched lawsuits challenging the constitutionality of the healthcare reforms championed by President Barack Obama.").

In November 2010, after a new majority of Republicans was elected to the House of Representatives, the party moved on efforts to "repeal and replace" (or simply repeal, or defund) the ACA. *See* Laura Litvan & Drew Armstrong, *Republicans to Take On U.S. Health Law's Taxes, Rules*, BLOOMBERG (Nov. 3, 2010, 4:21 PM), http://www.bloomberg.com/news/2010-11-03/republicans-to-take-on-u-s-health-care-overhaul-from-taxes-to-insurance.html (noting that although Republicans had pledged to repeal the ACA, "the strategy will more likely resemble death by a thousand cuts"); Jennifer Steinhauer & Robert Pear, *G.O.P. Newcomers Set Out to Undo Obama Victories*, N.Y. TIMES, Jan. 3, 2011, at A1 (reporting on Republicans' plans to repeal the ACA and other measures enacted in the previous term).

This Note examines the likely interplay between ERISA and the ACA as the ACA is implemented. Many state and federal regulations still must be written to implement the ACA,[14] and many forces at both the state and federal level oppose the ACA's very existence.[15] As a result, the uncertainty that the DOJ noted about ERISA preemption's new role in light of the ACA's enactment will continue for now.[16] However, ERISA was a major force in health care law prior to the ACA and will continue to play a large role; barring total dismantlement of the ACA, the ACA too will shape the field for many years. Indeed, one might argue that the combination of the two laws will make them, and ERISA's preemptive effect, even stronger, by demonstrating the federal government's intention to occupy the field of

[14] Although recent court decisions have called the constitutionality of certain provisions of the ACA into question, the states still need to implement other aspects of it, and in general the reality is that health reform will be carried out over decades and these initial skirmishes do not alter the conclusions of this Note. *See* Abbe R. Gluck, *A Fatal Blow to Obama's Health Care Law?: What States Still Have to Do*, N.Y. TIMES, Dec. 13, 2010, *available at* http://www.nytimes.com/roomfordebate/2010/12/13/a-fatal-blow-to-obamas-health-care-law/what-states-still-have-to-do (pointing out the provisions of the ACA that the states still need to address); Kevin Sack, *Years of Wrangling Lie Ahead For Health Care Law*, N.Y. TIMES, Dec. 14, 2010, at A24 (describing the legal issues facing the ACA); *see also infra* Part III.B (explaining the states' responsibilities for implementing the ACA).

[15] *See, e.g.* Igor Volsky, *Growing Number Of States Refuse To Implement Health Law Following Vinson's Ruling*, THE WONK ROOM (Feb. 3, 2011, 11:00 AM), http://wonkroom.thinkprogress.org/2011/02/03/vinson-ruling-states/ (noting states' recalcitrance in light of court rulings that the ACA is unconstitutional); Richard Cauchi, *State Legislation and Actions Challenging Certain Health Reforms, 2010–11*, NATIONAL CONFERENCE OF STATE LEGISLATURES (Mar. 3, 2011), http://www.ncsl.org/?tabid=18906 (describing state actions to block federal reform).

[16] Ben Adler, *Will The Supreme Court Overturn Health-Care Reform?*, NEWSWEEK (Dec. 15, 2010), *available at* http://www.newsweek.com/2010/12/15/will-the-supreme-court-overturn-health-care-reform.html ("[T]he constitutionality of the individual mandate will ultimately be decided by the Supreme Court . . . . [and] experts generally predict that the Supreme Court won't be ruling on the issue for another two years.").

health care.[17] Accordingly, the interaction of the ACA and ERISA is a crucial piece of the puzzle of what health care law and policy will look like in the future. By examining their text, purpose, and interpretation by courts (or likely interpretation, in the case of the ACA), and discussing ERISA preemption's future, both for the ACA and otherwise, this Note begins to fit that piece into place.

This Note analyzes the issue of ACA and ERISA interaction in terms of two major stages, mirroring the relevant stages of the ACA's implementation, before making general recommendations and predictions. Part II explains the pre-ACA landscape of ERISA preemption, briefly reviewing ERISA's history and interpretation as well as its impact on previous attempts at health reform. Part III examines how this landscape has changed post-ACA enactment, and how it will continue to change as the ACA is implemented. In particular, that Part will examine the ACA provision allowing states to obtain waivers that would allow them to conduct their own health reform programs and how this implicates ERISA preemption.[18] Part IV identifies some problems with ERISA preemption that remain despite the enactment of the ACA and suggests a few possible solutions.

Before continuing, a few caveats are in order. The ACA has obviously been the subject of much ongoing litigation and controversy.[19] Anyone considering how the ACA will

[17] *See infra* Part IV.A (explaining how the ACA's presence could strengthen ERISA).

[18] ACA, Pub. L. No. 111-148, § 1332, 124 Stat. 119, 203-06 (2010) (to be codified at 42 U.S.C. § 18052).

[19] *See, e.g.*, Kevin Sack, *Judge Voids Key Element of Obama Health Care Law*, N.Y. TIMES, Dec. 14, 2010, at A1 (describing Florida district court decision invalidating individual mandate provision of ACA); Carl Hulse, *House Republicans Edge Back to Business as Usual*, N.Y. TIMES, Jan. 14, 2011, at A15 (explaining that Republicans renewed efforts to repeal the ACA after pause due to Tucson shootings); David M. Herszenhorn & Robert Pear, *Basic Questions, Elusive Answers on Health Law*, N.Y. TIMES, Jan. 19, 2011, at A14 (describing partisan debate over ACA's future); Kevin Sack, *Federal Judge Rules That Health Law Violates Constitution*, N.Y. TIMES, Feb. 1, 2011, at A1 (reporting on Virginia district court decision invalidating all of the ACA as unconstitutional); Kevin

work in the future must acknowledge that the Supreme Court may invalidate it, or that Congress may defund or even repeal it.[20] In addition, even if the ACA remains, it is likely to change shape, whether through amendment or through the hundreds of regulations that are necessary for its implementation, or both.[21] Of necessity, this Note analyzes the ACA as it was enacted. Although time and implementation may alter the ACA, absent total repeal, which still seems unlikely,[22] such alterations are unlikely to

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Sack, *Virginia to Ask Supreme Court to Rule on Health Law*, N.Y. TIMES, Feb. 4, 2011, at A16 (noting that Virginia's state attorney general hopes that the Supreme Court will grant expedited review of the ACA's constitutionality).

[20] *See, e.g.*, David Nather, *Eric Cantor: GOP Will Defund Health Care Law*, POLITICO (Feb. 8, 2011, 4:06 PM), http://www.politico.com/news/stories/0211/49104.html (quoting House Majority Leader as saying "I expect to see, one way or the other, the product coming out of the House to speak to that and to preclude any funding to be used for [ACA implementation]"); Lisa Lerer & Drew Armstrong, *Republicans Move to Dismantle Obama's Health-Care Law*, BLOOMBERG (Jan. 19, 2011, 12:15 PM), http://www.bloomberg.com/news/2011-01-19/republicans-health-care-vote-opens-two-year-campaign-to-undermine-law.html (reporting on newly empowered Republicans' efforts to stop the implementation of the ACA). Despite the Republicans' increased numbers in Congress, their efforts at the time of publication had not yet brought them anywhere close to full repeal of the ACA, which would require the President's signature or the votes of two-thirds of both Houses to override the President's veto. *See infra* note 22 (discussing the efforts at repeal in early 2011); WILLIAM N. ESKRIDGE JR., PHILIP P. FRICKEY & ELIZABETH GARRETT, CASES AND MATERIALS ON LEGISLATION: STATUTES AND THE CREATION OF PUBLIC POLICY 37–38 (2007) (explaining the presentment and veto process). Of course, once Barack Obama is no longer President, the task may become much easier.

[21] *See* CURTIS W. COPELAND, CONG. RESEARCH SERV., R41180, REGULATIONS PURSUANT TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (Pub. L. No. 111-148) 1–3 (2010), *available at* http://assets.opencrs.com/rpts/R41180_20100413.pdf (explaining that the ACA is a "particularly noteworthy example of congressional delegation of rulemaking authority" and noting some of the many regulations that will have to be created over the next years and decades to implement the law).

[22] In January 2011, the U.S. House of Representatives passed a bill "[t]o repeal the job-killing health care law and health care-related provisions in the Health Care and Education Reconciliation Act of 2010."

affect its underlying structure. Accordingly, this Note's analysis and recommendations proceed from assumptions made against that background.

II. THE PRE-ACA LANDSCAPE: ERISA AS AN OBSTACLE TO HEALTH REFORM

ERISA regulates most of the non-wage benefits that employers provide to employees, from retirement savings to welfare benefits, such as health insurance.[23] Just over fifty-five percent of Americans have employer-provided health benefits,[24] so ERISA necessarily plays a major role in

Repealing the Job-Killing Health Care Law Act, H.R. 2, 112th Cong. (2011). However, when it moved to the Senate the following month, Republicans did not garner enough support for it to pass, though "a vote to delete a small, revenue-raising provision of the sweeping law did pass, in a bipartisan vote." *On Party-Line Vote, Health Reform Repeal Fails in the Senate*, KAISER HEALTH NEWS (Feb. 2, 2011), http://www.kaiserhealthnews.org/Daily-Reports/2011/February/02/health-reform-repeal-1099-vote.aspx; *see also* Julie Rovner, *The Year In Health Care Policy: A Topsy-Turvy Ride*, NPR (Dec. 27, 2010), http://www.npr.org/2010/12/27/132262508/the-year-in-health-care-policy-a-topsy-turvy-ride (quoting author of recent book about health reform as saying that the health care bill is likely to stick around despite Republican opposition, though that does not mean there will not be "mischief and delay" by Congress and the states).

[23] Pub. L. 93-406, 88 Stat. 829 (codified as amended in sections of 26 U.S.C. and 29 U.S.C.). *See generally* PATRICK PURCELL & JENNIFER STAMAN, CONG. RESEARCH SERV., RL 34443, SUMMARY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) 1–7 (2009), *available at* http://assets.opencrs.com/rpts/RL34443_20080410.pdf (providing ERISA's historical and legislative background and a summary of employee benefit plans it covers).

[24] CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA C. SMITH, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS P60-238, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009 22–24 (2009), *available at* http://www.census.gov/prod/2010pubs/p60-238.pdf (reporting that "[t]he percentage of people covered by employment-based health insurance decreased to 55.8 percent in 2009, from 58.5 percent in 2008" so that in 2009, 169.7 million people were covered by employer-provided insurance); *see also* PAUL FRONSTIN, EMP. BENEFIT RESEARCH INST., SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED: ANALYSIS OF THE MARCH 2009 CURRENT POPULATION SURVEY 1, 4 (2009), *available at* http://www.ebri.

shaping health care law and policy.[25] Most importantly, ERISA preempts state laws purporting to regulate employee benefits.[26] This section briefly introduces ERISA's background and structure, and then discusses the effect the law has had on health care reform.

A. ERISA Generally

The federal government enacted ERISA in 1974 to respond to growing concerns about the risk of employers defaulting on pension plans, which were increasingly widespread[27] but little regulated.[28] With ERISA, Congress aimed to safeguard "participants in employee benefit plans and their beneficiaries, by . . . establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal

org/pdf/briefspdf/EBRI_IB_9-2009_No334_HI-Cvg1.pdf (asserting that "[e]mployment-based health benefits are still the dominant source of health coverage in the United States, providing coverage for more than 161 million people under age 65," or over sixty-one percent of that population).

[25] *See, e.g.*, Phyllis C. Borzi, *There's "Private" and Then There's "Private": ERISA, Its Impact, and Options for Reform*, 36 J.L. MED. & ETHICS 660, 660–62 (2008) (reviewing the significant, and apparently unexpected, impact that ERISA has had on health law); John Bronsteen, Brendan S. Maher & Peter K. Stris, *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 FORDHAM L. REV. 2297, 2300–03 (2008) (noting the dominance of employer-provided insurance and the resulting influence of ERISA).

[26] Employee Retirement Income Security Act of 1974 § 514(a), 29 U.S.C. § 1144(a) (2006). *See infra* Part II.B.

[27] *See* PURCELL & STAMAN, *supra* note 23, at 3.

[28] There had already been an awareness of the risks of pension default when in 1963 the failure of the Studebaker-Packard Corporation and the catastrophic effects on its workers catalyzed action. *See generally* James A. Wooten, *"The Most Glorious Story of Failure in the Business": The Studebaker-Packard Corporation and the Origins of ERISA*, 49 BUFF. L. REV. 683, 683–84 (2001) (describing the origins of ERISA and asserting that "[n]o single event is more closely associated with ERISA than the shutdown of the Studebaker plant in South Bend, Indiana").

courts."[29] ERISA's four titles protect the rights of people who have pensions and welfare benefit plans through their employer, as well as specifying what the plans must include to qualify for favorable tax treatment, establishing the Pension Benefit Guaranty Corporation, and placing the Departments of Labor and Treasury in charge of administering and enforcing ERISA.[30] ERISA's main protections for these plans come in the form of concrete new "requirements relating to reporting and disclosure, participation, vesting, and benefit accrual, as well as plan funding."[31] It also establishes the essential responsibilities that plan fiduciaries have toward plan participants.[32]

Pensions were the most-discussed benefit at the time of ERISA's enactment, but ERISA also addresses "welfare plans," which include employer-provided health care plans.[33] However, the law covers welfare benefits with much less detail and rigor.[34] It does, however, set some of their

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[29] § 2(b), 29 U.S.C. § 1001(b) (2010).

[30] *See* PURCELL & STAMAN, *supra* note 23, at 1–2. As I discuss in further detail in Part IV.B.4, an Executive Order from President Carter in 1978 was necessary to get the two departments to work together smoothly. Exec. Order No. 12,108, 44 Fed. Reg. 1065 (1978), *reprinted in* 29 U.S.C. § 1001 (1974).

[31] PURCELL & STAMAN, *supra* note 23, in opening summary.

[32] *Id.*

[33] § 3(1), 29 U.S.C. § 1002(1) (2006). "Welfare plans" receive a more extensive definition in a Department of Labor regulation. 29 C.F.R. § 2510.3-1 (2010); *see also* Michael I. Richardson, Note, *Employee Benefits Law: Securing Employee Welfare Benefits Through ERISA*, 61 NOTRE DAME L. REV. 551, 553–59 (1986) (reviewing ERISA's requirements for employee welfare benefit plans and the legislative history behind their inclusion).

[34] *See* Peter J. Wiedenbeck, *ERISA's Curious Coverage*, 76 WASH. U. L.Q. 311, 334–38 (1998) (describing the different levels of regulation that ERISA mandates for employer-provided benefits, with health benefits less closely regulated in comparison with the "intense" regulation of pensions); Dana M. Muir, *James A. Wooten, The Employee Retirement Income Security Act of 1974: A Political History*, 32 J. HEALTH POL. POL'Y & L. 737, 738–39 (2007) (book review) (noting the lack of Congressional debate over welfare benefits and its minimal regulation of them in the final bill); Craig C. Martin, Matthew J. Renaud & Douglas A. Sondgeroth, *Baby Ka-Boom! Coming Developments in ERISA Litigation Due to Social, Demographic,*

parameters. These can be usefully organized into five categories: (1) setting federal standards for the scope of health plan disclosure;[35] (2) setting minimal national standards that govern group health benefits and their coverage;[36] (3) requiring certain fiduciary obligations to be fulfilled by health plans;[37] (4) providing participants with the right to appeal a benefits claim denial;[38] and (5) allowing participants to seek judicial enforcement of benefit claims and relief when the plan violates ERISA, its own terms, or any fiduciary duties.[39] Despite these requirements, most commentators agree that ERISA does not regulate employer-provided health benefits nearly as strongly as necessary.[40]

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and Financial Pressures from the Baby Boom Generation, 41 J. MARSHALL L. REV. 1037, 1046–47 (2008) (describing the lower level of coverage that welfare benefits receive and explaining that "ERISA generally does not regulate the substantive content of welfare benefit plans and it specifically excludes welfare benefits such as medical benefits from the minimum participation, vesting and minimum funding requirements applicable to pension benefits").

[35] Sara Rosenbaum, *Health Reform and ERISA*, HEALTH REFORM GPS (Sept. 27, 2010), http://healthreformgps.org/resources/health-reform-and-erisa.

[36] *See id.*; *Employee Retirement Income Security Act—ERISA*, U.S. DEP'T OF LABOR, http://www.dol.gov/dol/topic/health-plans/erisa.htm (last visited Apr. 14, 2011); Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J.L. MED. & ETHICS 88, 89 (2009).

[37] Elaine Gareri Kenney, *For the Sake of Your Health: ERISA's Preemption Provisions, HMO Accountability, and Consumer Access to State Law Remedies*, 38 U.S.F. L. REV. 361, 372–73 (2004).

[38] *See* Rosenbaum, *supra* note 35.

[39] Jacobson, *supra* note 36, at 90.

[40] Dennis K. Schaeffer, Comment, *Insuring the Protection of ERISA Plan Participants: ERISA Preemption and the Federal Government's Duty to Regulate Self-Insured Health Plans*, 47 BUFF. L. REV. 1085, 1086–87 (1999) ("The federal government's combined action and inaction in this regard has caused employee welfare benefits to experience a 'regulatory vacuum.'"); Alan I. Widiss & Larry Gostin, *What's Wrong with the ERISA "Vacuum"?: The Case Against Unrestricted Freedom for Employers to Terminate Employee Health Care Plans and to Decide What Coverage Is to Be Provided When Risk Retention Plans Are Established For Health Care*, 41 DRAKE L. REV. 635, 639 (1992) (pointing out that "states may not

As discussed below,[41] ERISA preempts states from supplementing ERISA with their own regulations of such plans, leaving employees vulnerable to the harm that stronger regulation would prevent.[42]

One final aspect of ERISA that bears emphasis is the provenance of the plans it covers. Critically, ERISA regulates only private employer- or employee-organization-provided benefit plans, not government or church plans, or plans that one might purchase individually.[43] The reason why the law does not cover all pension and benefit plans stems from ERISA's historical concern with instability in plans run by employers that could potentially go out of business and leave plan-holders without any retirement benefits.[44] Another critical aspect of ERISA is its different treatment of "self-insured" plans as opposed to plans in which the insurance is purchased from a third party: self-insured plans are covered *only* by ERISA, whereas purchased insurance plans are subject to state regulation of

regulate employee benefits, provided by risk retention plans even though they may regulate employee group health insurance plans" but that meanwhile, "ERISA imposes virtually no regulations or requirements for risk retention plans that provide health care benefits").

[41] *See infra* Part II.B.1.

[42] This regulatory vacuum has had well-documented ill effects on benefit holders despite ERISA's apparent good intentions. *See* Paul M. Secunda, *Sorry, No Remedy: Intersectionality and the Grand Irony of ERISA*, 61 HASTINGS L.J. 131, 151–58 (2009) (explaining how the "combined impact of ERISA's broad preemption provisions and its limited remedial provisions act together to defeat the primary purpose of ERISA to protect employee benefits" and providing illustrative case examples); Andrew L. Oringer, *A Regulatory Vacuum Leaves Gaping Wounds—Can Common Sense Offer a Better Way to Address the Pain of ERISA Preemption?*, 26 HOFSTRA LAB. & EMP. L.J. 409, 411–13, 428–36 (2009) (elaborating on the ERISA irony problem and describing how courts have attempted to create a federal common law to deal with it).

[43] § 4, 29 U.S.C. § 1003 (2006).

[44] *See* Wooten, *supra* note 28, at 717–19 (describing the origins of ERISA).

insurance as well as ERISA.[45] These distinctions are important to bear in mind for the analysis of how ERISA may interact with the ACA, which builds on, rather than replacing, the U.S. health insurance system's longstanding ties to employer-provided coverage.[46] It is only in ERISA's coverage of the private employer sphere that ERISA preemption concerns will intersect with the ACA.

B. ERISA's Challenges for Health Care Reform

ERISA, and its preemption provision in particular, have long posed a major problem for health reform, prompting calls for amendment or other change. This section examines how this troublesome aspect of ERISA preemption for health care and health reform began and developed by analyzing the provision's text and its interpretation by courts.

1. The Text of § 514

Part of ERISA's success, its supporters believe, is due to the national uniformity that is possible because of its provision preempting state regulation of employer-provided benefits.[47] This provision is contained in Section 514(a),

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[45] HINDA RIPPS CHAIKIND, CONG. RESEARCH SERV., RS 20315, ERISA REGULATION OF HEALTH PLANS: FACT SHEET (2003), *available at* http://www.allhealth.org/briefingmaterials/erisaregulationofhealthplans-114.pdf.

[46] *See* Patricia C. Flynn, *Health-Care Reform and ESI: Reconsidering the Relationship Between Employment and Health Insurance,* 115 BUS. AND SOC. REV. 311, 312–13 (2010) (describing the United States' continued dependence on employer-provided insurance with the ACA and advocating a critical look at the institution); Christine Eibner, Peter S. Hussey & Federico Girosi, *The Effects of the Affordable Care Act on Workers' Health Insurance Coverage*, NEW ENG. J. MED. (Sep. 1, 2010), http://healthpolicyandreform.nejm.org/?p=12339 (explaining that "[t]he ACA builds on the employer-based health insurance system by developing exchanges through which small employers can offer coverage and by penalizing large employers that do not offer coverage," but noting that some think the ACA's changes to the system could end it).

[47] *See, e.g.*, *Health Policy Issue Brief: Successful Employer-Provided Health Plans Depend On Nationally Uniform Standards*, THE ERISA INDUSTRY COMMITTEE (2007), http://www.eric.org/forms/uploadFiles/e5f60000000f.filename.ERIC_Employers_Depend_on_National_Uniformit

which governs ERISA's interaction with other laws.[48] Section 514(a) provides simply that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" not otherwise exempted.[49] Section 514(b)(2) contains ERISA's "savings" and "deemer" clauses. The savings clause keeps the preemption provision from applying to any state laws in the traditional police power areas of "regulat[ing] insurance, banking, or securities."[50] The deemer clause, in turn, prevents states from taking advantage of the savings clause and "deeming" an employee benefit plan to be insurance company or similarly exempt entity to avoid preemption.[51]

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y.pdf.; Landon Wade Magnusson, Note, Golden Gate *and the Ninth Circuit's Threat to ERISA's Uniformity and Jurisprudence*, 2010 B.Y.U. L. REV. 167, 174–75, 181 (2010) (arguing that the Ninth Circuit's decision in *Golden Gate* threatens one of ERISA's central purposes: "its preemption and the nationwide uniformity that preemption is supposed to create for employee benefit plans") (discussing Golden Gate Rest. Ass'n v. City and Cnty. of San Francisco, et al., 546 F.3d 639 (2008)). The preemption provision was also essential to ERISA's successful enactment. Business and union lobbies, among others, insisted that they not have to deal with fifty different state benefits requirements in addition to the new ERISA requirements. James A. Wooten, *A Legislative and Political History of ERISA Preemption, Part I*, 14 J. PENSION BENEFITS 31, 31 (2006) ("The desire for federal preemption was a key factor—perhaps, the key factor—in creating the coalition that pushed ERISA through Congress.").

[48] 29 U.S.C. § 1144(a) (2006).

[49] *Id.* The exemptions are listed in ERISA § 4(b), 29 U.S.C. § 1003(b) (2006). As indicated *supra* Part II.A, plans that are exempted from ERISA include government plans and church-run plans.

[50] ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (2006); *see also* Jana K. Strain & Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 LOY. U. CHI. L.J. 29, 33–34 (1999) (explaining the states' traditional role in health care).

[51] *Id.* § 1144(b)(2)(B). Importantly, the deemer clause also "prevents state insurance regulations from reaching employer health care benefits plans (EHBPs) that are self-insured, as opposed to those that purchase insurance coverage from a third party. Put another way, ERISA obstructs state regulation on two levels: The statute partially shields all EHBPs from state regulation, and self-insured EHBPs enjoy an enhanced level of protection." Russell Korobkin, *The Battle over Self-Insured Health Plans,*

The net effect is that states can regulate the business of insurance, but they cannot directly regulate the benefits that employers offer. Additionally, they cannot regulate plans offered by "self-insured" employers, making ERISA the only set of legal rules governing such plans.[52]

2. Judicial Interpretation of § 514

ERISA preemption jurisprudence builds, naturally, from the general doctrine of preemption.[53] Federalist values are in constant tension with that doctrine.[54] The Supreme Court has explained that in order to deal with these two apparently conflicting mandates when a potential preemption situation arises, courts employ a strong presumption that federal law does not preempt state police powers—including their ability to regulate their citizens' health and welfare—unless Congress clearly states that preemption is its intent.[55] Courts apply this principle even when the law's text explicitly preempts a state law, because even then it is often

or "One Good Loophole Deserves Another", 5 YALE J. HEALTH POL'Y, L. & ETHICS 89, 89 (2005).

[52] *See* Chaikind, *supra* note 45.

[53] The federal doctrine of preemption has been a part of U.S. law from its earliest days, when it was enshrined in the Constitution's Supremacy Clause, which declares that "[t]his Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the *supreme Law of the land*; and the Judges in every State shall be bound thereby, *any Thing in the Constitution or Laws of any State to the Contrary Notwithstanding.*" U.S. CONST. art. VI, cl. 2 (emphasis added). *See also* Caleb Nelson, *Preemption*, 86 VA. L. REV. 225, 231–44 (2000) (identifying the Supremacy Clause as "the reason that valid federal statutes trump state law" and tracing the early development of Supremacy Clause and preemption doctrine).

[54] James E. Hickey, Jr., *Localism, History and the Articles of Confederation: Some Observations About the Beginning of U.S. Federalism*, 9 IUS GENTIUM 5, 7 (2003) ("The constitutional question [of federalism] . . . is as old as the Constitution: It consists of discerning the proper division of authority between the Federal Government and the States.") (quoting New York v. United States, 505 U.S. 144, 149 (1992)).

[55] Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947).

unclear how far the preemption should reach.[56] Indeed, as discussed below, this question about breadth is an ongoing issue in cases involving ERISA preemption: Section 514's apparently clear text does not elaborate about what kind of state laws it is intended to preempt.[57]

In the taxonomy of preemptive schemes,[58] ERISA preemption falls under two headings.[59] First, Section 514(a) is an example of an express textual indication of congressional intent to preempt state laws in the employer benefits area.[60] This helps to make a court's decision to

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[56] *See* ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 397 (3rd ed. 2006).

[57] For all the importance of the preemption clause to ERISA's enactment, *see* Wooten, *supra* note 47, at 31, it seems not to have been drafted entirely carefully. The Supreme Court has noted this on numerous occasions. *See, e.g.*, Metro. Life Ins. Co. v. Mass., 471 U.S. 724, 739 (1985) ("The two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting . . ."); *see also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 46 (1987); John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank, 510 U.S. 86, 99; Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?*, 74 TUL. L. REV. 951, 955–56 (2000) ("Not surprisingly, given ERISA's confusing preemption language . . . , the Supreme Court has had difficulty defining the extent of ERISA's preemption of state laws.").

[58] *See generally* Nelson, *supra* note 53, at 226, 260–64 (identifying three categories that the Supreme Court uses in preemption cases—express preemption, and then field and conflict preemption, which are both implied from the text—and criticizing the present state of its preemption jurisprudence); CHEMERINSKY, *supra* note 56, at 392–96 (describing the courts' development of the types of preemption).

[59] Donald T. Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 SANTA CLARA L. REV. 105, 114–19, 124–29 (2001) (explaining the legislative history of ERISA's express language to preempt state laws relating to employer-provided benefit plans and the early judicial development of implied preemption of state law remedies).

[60] *Id.*; *see also* Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. LEGIS. 35, 44–46 (1996) (describing ERISA's preemption provision as express); Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251, 258 (1997) (same).

preempt somewhat easier,[61] but, as detailed below, it does not address the more complicated question of how far ERISA preemption reaches.[62] In answering this question, courts have found ERISA to fit in a second preemption category: implied preemption.[63] They have read ERISA to imply that Congress intended the federal law to occupy the field of employer-provided benefits.[64] The potent combination of

[61] David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV. 427, 453 (1987) ("ERISA provides an express and detailed preemption clause . . . . Judicial construction has not been forced to operate in a statutory vacuum.").

[62] There is particular disagreement over the issue of whether Congress intended ERISA to preempt state laws on health care. *See* Dahlia Schwartz, Note, *Breathing Lessons for the ERISA Vacuum: Toward A Reconciliation of ERISA's Competing Objectives in the Health Benefits Arena*, 79 B.U. L. REV. 631, 638–39 (1999) ("Cutting through the Gordian knot of congressional intent underlying ERISA, however, might baffle even a modern day Alexander. Attempts have produced firm proclamations both that Congress always intended, and that Congress never intended, for ERISA to preempt state common and statutory law regulating the provision of health care.").

[63] Implied preemption can occur either in the form of "field preemption," when a court finds that the federal law so completely occupies an area that it is plain that the federal government meant to exclude the states from legislating in the area, or in the form of "conflict preemption," which happens when one cannot comply with both the federal and state law, so the federal law takes precedence because of the Supremacy Clause. *See* CHEMERINSKY, *supra* note 56, at 394 (explaining the types of preemption); Samuel C. Salganik, *What the Unconstitutional Conditions Doctrine Can Teach Us About ERISA Preemption: Is It Possible to Consistently Identify "Coercive" Pay-or-Play Schemes?*, 109 COLUM. L. REV. 1482, 1495–97 (2010) (outlining the operation of preemption in ERISA's scheme and noting in particular that implied preemption can still be effective even in the presence of an express preemption clause).

[64] *See, e.g.*, *Pilot Life*, 481 U.S. at 45–48 (1987) (ERISA's comprehensive regulation of welfare benefits occupies the field and preempts state common law in the area); Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523 (1981) (ERISA establishes pension plan regulation as an exclusive federal concern); *see also* Stephen F. Befort & Christopher J. Kopka, *The Sounds of Silence: The Libertarian Ethos of ERISA Preemption*, 52 FLA. L. REV. 1, 24–32 (2000) (asserting that, contrary to the assertions of many critics of ERISA preemption's breadth, the legislative history indicates that Congress fully intended preemption to be sweeping).

implied field preemption and express preemption has made ERISA's preemption provision remarkably effective and broad in application.[65]

As a result, states may not enact a wide swath of laws: that is, any that "may now or hereafter relate to any employee benefit plan" and that are not otherwise exempt.[66] The provision's key phrase, "relate to,"[67] is deceptively simple for its vagueness. Yet the Supreme Court has interpreted it literally from the time of the statute's enactment,[68] despite the obvious difficulties of containing such a literal interpretation of the phrase within limits that leave adequate room for states' necessary regulatory role in health care.[69] The Court turned to the dictionary to create its

[65] *See* Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 65 (1987) (citing "the unique pre-emptive force of ERISA"); *see also* Emily V. Griffen, Comment, *"Relations Stop Nowhere": ERISA Preemption of San Francisco's Domestic Partner Ordinance*, 89 CAL. L. REV. 459, 462 (2001) (noting the preemption provision's "seemingly irrational preemptive scope" and "correspondingly broad understanding of the statute's preemptive reach by courts"); Donald T. Bogan, *ERISA: State Regulation of Insured Plans After* Davila, 38 J. MARSHALL L. REV. 693, 696 (2005) (noting the strong combination of preemption types in ERISA).

[66] ERISA § 514(a), 29 U.S.C. 1144(a) (2006). Also, the Court in *Pilot Life* determined that ERISA not only preempts new state laws enacted to regulate health care and covering employer-provided plans, but also preempts state common law that enters into the area now covered by ERISA. 481 U.S. at 48.

[67] ERISA § 514(a), 29 U.S.C. 1144(a) (2006).

[68] In *Alessi*, the Supreme Court's first ERISA preemption case, the Court held that "[w]hatever the purpose or purposes of the New Jersey statute . . . it 'relate[s] to pension plans' governed by ERISA because it eliminates one method for calculating pension benefits—integration—that is permitted by federal law" but said it did not need to establish the "outer bounds of ERISA's pre-emptive language" in order to reach that holding. 451 U.S. at 524–25. A subsequent case, *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983), established the test in use today. *See* discussion *infra* notes 73–74 and accompanying text.

[69] In Justice Scalia's apt words, "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." Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc., 519 U.S. 316, 335 (1997) (Scalia, J., concurring). In another case, the

classic formulation of the ERISA preemption test, holding that in the ERISA context, "[a] law 'relates to' an employee benefit plan . . . if it has a connection with or reference to such a plan."[70] With few interruptions, that sweeping approach, hardly less vague than the statutory text, has remained the standard for determining whether a state law is ERISA-preempted.[71] Subsequent cases have created

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Court quoted Henry James when expressing a similar sentiment, saying that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere.'" N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995) (quoting HENRY JAMES, RODERICK HUDSON xli (1980)). The Court then acknowledged that this approach "would be to read Congress's words of limitation as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality. That said, we have to recognize that our prior attempt to construe the phrase 'relate to' does not give us much help drawing the line here." *Id.*

[70] *Shaw*, 463 U.S. at 96–97 (1983) (citing BLACK'S LAW DICTIONARY 1158 (5th ed. 1979)).

[71] Most subsequent decisions have followed the broad preemptive approach. *See* PATRICIA A. BUTLER, STATE COVERAGE INITIATIVES, ERISA PREEMPTION MANUAL FOR STATE HEALTH POLICY MAKERS, 19–25 (2000) (describing Supreme Court and lower court ERISA preemption cases). In the 1990s, the so-called "Trilogy," a spate of cases in which the Supreme Court appeared to be edging toward a narrower interpretation of the preemption provision, encouraged many commentators who disfavored the previously broad interpretation and believed this signaled a new beginning for health reform. *See Travelers*, 514 U.S. 645 (1995); *Dillingham Constr.*, 519 U.S. 316; DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806 (1997); *see also* Jacobson, *supra* note 36, at 91–93 (recounting the trends in ERISA preemption cases); Mary Ann Chirba-Martin, *Drawing Lines in Shifting Sands: The U.S. Supreme Court's Mixed Messages on ERISA Preemption Imperil Health Care Reform*, 36 J. LEGIS. 91, 105 (2010) (noting the brief optimism inspired by the *Travelers* trilogy). The Court turned back, however, and its most recent major ERISA preemption case, Aetna Health Inc. v. Davila, 542 U.S. 200, 208–09 (2004), continued the trend of strong preemption of state laws. A decision from the Court's 2010 term involved ERISA but not preemption, but the Court nonetheless re-emphasized the need for courts to avoid creating the kind of "patchwork" liability or court interpretations that businesses might otherwise have to face, if ERISA did not preempt state laws and the

additional tests for when a law has such a "connection with" or a "reference to" ERISA plans, increasing the opportunities for both preemption of laws and confusion and inconsistency in the courts' application of the tests.[72]

3. ERISA Preemption's Interference with Past Health Care Reform Efforts

A number of the seminal cases establishing the Supreme Court's approach to ERISA preemption involved states and localities that were attempting to reform rules or laws on welfare benefits. For example, in one of the first preemption cases, employers challenged two New York statutes that established certain health care-related workers' rights.[73] The Court held that ERISA preempted one of the laws, and that the other, though not preempted, could not be enforced through regulation of ERISA plans.[74] In a subsequent case, the Court encountered a clash of ERISA preemption with state common law actions brought by a man suing the health benefit plan that he had purchased through his employer.[75] Once again, ERISA prevailed.[76] Finally, reviewing a District of Columbia law mandating equal coverage for injured

states were allowed to each have their own laws governing health insurance. *See* Conkright v. Frommert, 130 S.Ct. 1640, 1649 (2010).

[72] The "reference to" test looks at whether a state law "acts immediately and exclusively on" an ERISA plan, or if ERISA plans are essential to the law. Amy B. Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 U. KAN. L. REV. 1203, 1207–08 (2007) (citing Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 829 (1988), and *Dillingham Constr.*, 519 U.S. 316, 325 (1997)). The "connection with" test looks at whether a law "interferes with ERISA's primary objectives." Monahan, *supra*, at 1210 (citing Egelhoff v. Egelhoff, 532 U.S. 141, 147 (2001)).

[73] *Shaw*, 463 U.S. 85, 88. The laws at issue were the state's Human Rights Law, which forbade discrimination in employment, and the state's Disability Benefits Law, which required payment by employers of sick-leave benefits for employees who could not work because of nonoccupational disabilities.

[74] *Id.* at 107–09.

[75] Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 43 (1987).

[76] *Id.* at 57.

employees who were eligible for workers' compensation, the Court held that it, too, was preempted.[77] Many other ERISA preemption cases have not made it to the Supreme Court, but have still resulted in the invalidation of numerous state laws attempting to reform health care.[78] The Court has, of course, also upheld laws as *not* preempted, but these instances have formed an exception rather than the rule.[79]

This partial review of the context of some of the preemption cases highlights the fact that though Congress's aim in enacting ERISA was to protect employees by regulating non-wage benefits,[80] one of the law's results has been to make it more difficult for states to pass any employee-protecting laws of their own that would update or reinforce ERISA's protections.[81] Congress certainly intended this result to some extent, so that employers would not have to face different regulations in each state, but some of the legislators who agreed to the preemption provision may have done so not knowing how strongly the courts would interpret it, or expecting that strong preemption would be a temporary

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[77] District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 130–31 (1992).

[78] Both because the Supreme Court's statements on how to approach ERISA preemption have not always been clear, and because some courts recognize the problematic aspect of such broad preemption, the lower courts have been somewhat inconsistent with their application of the doctrine—but even this inconsistent application results in frequent preemption. *See* Nicole Weisenborn, *ERISA Preemption and Its Effect on State Health Reform*, 5 KAN. J.L. & PUB. POL'Y 147, 149 (1995) (noting that "lower courts have attempted unsuccessfully to set uniform preemption guidelines and have often disagreed on the scope of preemption").

[79] *See supra* note 71 (reviewing ERISA cases).

[80] ERISA § 2, 29 U.S.C. § 1001(b) (2010) (stating Congress' intent to "protect . . . the interests of participants in employee benefit plans and their beneficiaries").

[81] *See* Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255, 299–305 (1990) (lamenting ERISA preemption's impact on U.S. health care); Bogan, *supra* note 59, at 952–53 (noting that "[g]iven the stated purpose of the Act, it is even more surprising that ERISA has failed so miserably to serve as a beneficial consumer protection statute for ERISA welfare plan participants").

arrangement,[82] or believing that perhaps national health care reform would follow soon thereafter.[83] Of course, extensive reform did not happen soon: indeed, significant federal health care reform proved elusive in the thirty-six years following ERISA.[84] With the federal government apparently unable to help, some states periodically attempted reforms of their own.[85] But, as discussed, because

[82] Fisk, *supra* note 60, at 54–55 (noting that a Task Force to study preemption's effects was mandated in ERISA, and that Senator Jacob Javits, who was one of the major forces behind the law, believed that such a study was necessary, but that it never materialized).

[83] Daniel C. Schaffer & Daniel M. Fox, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 AM. J. TAX POL'Y 47, 48–49 (1988) (describing the legislative process behind ERISA's enactment). *But cf.* James A. Wooten, *A Legislative and Political History of ERISA Preemption, Part 3*, 3 J. PENSION BENEFITS 15, 20–21 (2008) (discussing Sen. Javits' active involvement with amending the bill to have broader federal preemption and coordination with President Nixon, who also desired broader preemption).

[84] That is, until the ACA's enactment in 2010. *See* KAISER FAMILY FOUNDATION, NATIONAL HEALTH INSURANCE—A BRIEF HISTORY OF REFORM EFFORTS IN THE U.S., 5–8, (Mar. 2009), http://www.kff.org/healthreform/upload/7871.pdf (tracing attempts at and failures of health reform). The Clinton Administration's attempt in 1994–95 was probably the most serious, as well as famously disastrous, attempt on a national scale. *See* Derek Bok, *The Great Health Care Debate of 1993–94*, Penn Nat'l Comm'n, Fall 1998, http://www.upenn.edu/pnc/ptbok.html (reviewing the history of Clinton's attempt at reform). That reform would have relied on state participation in a somewhat similar way to what the ACA is doing, and the reform's proponents recognized the importance of this state involvement, but made no real efforts to address the ERISA preemption issues that would have arisen had the reform gone further than it did. *See* Mary Ann Chirba-Martin & Troyen A. Brennan, *The Critical Role of ERISA in State Health Reform*, 13 HEALTH AFFAIRS 142, 152–53 (1994).

[85] *See* Edward Zelinsky, *The Bi-Partisan Rhetoric of Health Care Apocalypse is Wrong*, OUPBLOG (Apr. 5, 2010, 8:32 AM), http://blog.oup.com/2010/04/bi-partisan-rhetoric/ [hereinafter Zelinsky, *Bi-Partisan*] (noting that despite all the controversy over the law, it is being implemented incrementally and does not change certain fundamental aspects of the health care system); Schaffer & Fox, *supra* note 83, at 60–63 (noting some of the many aborted efforts at health reform in the 1980s); Peter D. Jacobson & Rebecca L. Braun, *Let 1000 Flowers Wilt: The Futility of State-Level Health Care Reform*, 55 U. KAN. L. REV. 1173, 1174–75,

so many people were insured through employers,[86] the reforms frequently were preempted by ERISA.[87]

Hawaii is the lone success story: it enacted a health reform law just before the federal government enacted ERISA,[88] but the law was quickly challenged and held to be ERISA-preempted.[89] However, after strenuous efforts by the state's politicians in Congress, Hawaii obtained a limited waiver from ERISA for its health program.[90] Since then, it has developed a relatively efficient system that covers most workers.[91] Despite such success, no other state has ever managed to obtain a waiver.[92]

1197–99 (2007) (reviewing recent state initiatives and examining why so many have failed in the past).

[86] *See supra* note 24 and accompanying text.

[87] *See supra* note 46 (discussing the employer-provided insurance model); *supra* note 71 (noting the trajectory of preemption of state health reform laws by ERISA).

[88] Haw. Rev. Stat. §§ 393-1–51 (1993).

[89] Standard Oil Co. of Cal. v. Agsalud, 633 F.2d 760, 763 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981) (mem.).

[90] Michael G. Pfefferkorn, Note, *Federal Preemption of State Mandated Health Insurance Programs Under ERISA—The Hawaii Prepaid Health Care Act in Perspective*, 8 ST. LOUIS U. PUB. L. REV. 339, 348–53, 358–62 (1989) (recounting the history of Hawaii's law and its legislators' efforts to obtain a waiver).

[91] All employees who work more than twenty hours are covered. *See* Gardiner Harris, *In Hawaii's Health System, Lessons for Lawmakers*, N.Y. TIMES, Oct. 17, 2009, at A1 (describing Hawaii's health care successes). *But cf.* Michael Tanner, *Laboratory Failure: States Are No Model for Health Care Reform*, CATO INSTITUTE (Sept. 23, 1993), http://www.cato.org/pubs/pas/pa197.html (identifying problems in the Hawaii system).

[92] This is not to say that they have not tried to do so. For instance, in 1993, "[a] House subcommittee . . . reported out a bill that would grant ERISA waivers to four states" but none passed "in large part because of the vigorous opposition of the recently formed Coalition for the Preservation of ERISA Preemption . . . ." Chirba-Martin & Brennan, *supra* note 84, at 152. However, "New York managed to obtain some relief from ERISA preemption of its rate-setting scheme" when Senator Moynihan wrangled a change to the federal tax code. *Id.*

4. Preempting "Pay or Play:" ERISA and Recent Attempts at Reform

In the first decade of the new millennium, a new wave of state reform efforts tried to combat the rising health care costs and plan limitations that had led to ever-increasing numbers of uninsured.[93] Many of these efforts have followed the "pay or play" model in which employers must either comply with new strictures on plans and their contributions to them, or else pay a tax.[94] The model's most notable success was in Massachusetts, which in 2006 enacted a bill aiming to achieve universal coverage.[95] The new law's main

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[93] *See generally* Rebecca A. D. O'Reilly, *Is ERISA Ready For A New Generation of State Health Care Reform? Preemption, Innovation, and Expanding Access to Health Care Coverage*, 8 U. PA. J. LAB. & EMP. L. 387, 387–89 (2006) (explaining the recent spate of state health reform is due in part to growing numbers of uninsured); Mark E. Douglas, Note, *Finally Moving Beyond the Fiction: An Overview of the Recent State Rally for Health Care Reform*, 5 IND. HEALTH L. REV. 277, 280, 290–91 (2008) (providing overview of state efforts to reform their health care systems and their roots in growth of health care cost and numbers of uninsured).

[94] *See* Mary Ann Chirba-Martin, *ERISA Preemption of State "Play or Pay" Mandates: How PPACA Clouds an Already Confusing Picture*, 13 J. HEALTH CARE L. & POL'Y 393, 404–06 (2010) ("With federal reform efforts perennially stalled . . . , states looked for their own solutions, and focused increasingly on the 40% of (mostly small) private sector employers that do not pay their 'fair share' for their employees' uncompensated care"); Monahan, *supra* note 72, at 1203–05 (discussing the surge in pay-or-play laws); Christen Linke Young, *Pay or Play Programs and ERISA Section 514: Proposals for Amending the Statutory Scheme*, 10 YALE J. HEALTH POL'Y, L. & ETHICS 197, 201–04 (2010) (explaining how pay-or-play laws work and noting recent efforts to enact them).

[95] An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts 77–158. *See generally* Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption and Experimentation*, 49 WM. & MARY L. REV. 229, 250–60 (2007) [hereinafter Zelinsky, *Massachusetts*] (focusing on ERISA preemption issues); Elizabeth A. Weeks, *Failure to Connect: The Massachusetts Plan For Individual Health Insurance*, 55 U. KAN. L. REV. 1283, 1303–10 (2007) (identifying various problems with the insurance exchange); Mary Ann Chirba-Martin & Andres Torres, *Universal Health Care in Massachusetts: Setting the Standard for National Reform*, 35 FORDHAM URB. L.J. 409, 445–46 (2008) (praising the

features were an individual mandate that all state citizens have health insurance,[96] an employer mandate requiring covered employers to sponsor "cafeteria" plans for their employees[97] and to make "fair and reasonable" contributions to them or else pay a fine,[98] and the establishment of insurance exchanges through which individuals and businesses could purchase different levels of coverage.[99] Surprisingly, the Massachusetts law has not been challenged thus far, although a fair argument can be made that it is preempted by ERISA.[100]

Maryland also enacted a health reform law in 2006,[101] but it was less comprehensive and much less successful than Massachusetts's law.[102] The law would have affected only employers of more than 10,000 people—hence its nickname, the "Wal-Mart Act," for in practical terms the law would only have impacted Wal-Mart, a fact suggestive to some that

Massachusetts law's achievement and suggesting that it should be used as a model for national efforts).

[96] 2006 MASS. ACTS 92–95.

[97] *Id.* at 117–18.

[98] *Id.* at 115–16.

[99] *Id.* at 135–45.

[100] *See* Zelinsky, *Massachusetts, supra* note 95, at 276 (predicting that Massachusetts new law would be ERISA preempted because it requires residents to "maintain minimum creditable coverage for medical care"); *see also* Joan Indiana Rigdon, *Universal Health Care?*, WASH. LAWYER (Aug. 2008), *available at* http://www.dcbar.org/for_lawyers/resources/publications/washington_lawyer/august_2008/universal_health.cfm (discussing reasons why the law might not have been challenged).

[101] Fair Share Health Care Fund Act, 2006 MD. LAWS 1–6 (codified as amended at MD. CODE ANN., HEALTH-GEN. § 15-142 (West 2006); MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to 107 (West 2006)).

[102] *See generally* Edward A. Zelinsky, *Maryland's "Wal-Mart" Act: Policy And Preemption*, 28 CARDOZO L. REV. 847, 847–48 (2006) [hereinafter Zelinsky, *Maryland*] (agreeing with a district court that the Maryland law is preempted by ERISA and arguing that although the law is "as a matter of policy . . . ill-conceived," states should be able to experiment with medical care without preemption); Catherine L. Fisk & Michael M. Oswalt, *Preemption and Civic Democracy in the Battle Over Wal-Mart*, 92 MINN. L. REV. 1502, 1508–13 (2008) (stressing that Wal-Mart benefits from an "inadequate regulatory framework," but the state's solution to that issue was thwarted by ERISA).

legislators had the retailer in mind when writing the law.[103] Still, the central mechanism that was to apply, even if only to Wal-Mart, was a pay-or-play provision that would have required employers to spend more on their employees' health care.[104] The Retail Industry Leaders Association challenged the law soon after its enactment, arguing that it was clearly an impermissible state regulation of employer-provided health benefits.[105] In 2007, the Fourth Circuit affirmed the district court's decision that ERISA preempted the law,[106] and held that because the law would effectively have forced large employers "to restructure their employee health insurance plans, it conflict[ed] with ERISA's goal of permitting uniform nationwide administration of these plans."[107] Heading off the usual criticism of ERISA preemption's infringement on states' regulatory abilities, the court noted that "[s]tates continue to enjoy wide latitude to regulate healthcare *providers*," but emphasized that the

[103] *See* Zelinsky, *Maryland*, *supra* note 102, at 849; John Wagner & Michael Barbaro, *Md. Passes Rules on Wal-Mart Insurance; Bill Obligates Firms On Health Spending*, WASH. POST, Apr. 6, 2005, at A1 (noting that lawmakers claimed they had not intended to target Wal-Mart, despite the fact that Wal-Mart was the only company affected by the bill).

[104] 2006 MD. LAWS 4. To be precise, the law required that a covered employer would have to spend an amount equal to at least "8% of the total wages paid" on health insurance for Maryland employees, or else pay the difference to the state's Secretary of Labor, Licensing, and Regulation to fund state health care initiatives. *Id.*

[105] Complaint, Retail Indus. Leaders Ass'n v. Fielder, 435 F. Supp. 2d. 481 (D. Md. 2006) (No. 06-cv-00316-JFM) 2005 WL 3782144. *See also* Associated Press, *Retail Industry Challenges Wal-Mart Law; Group Sends Message to Other States About Healthcare Payments*, MSNBC (Feb. 8, 2006, 8:34 AM), http://www.msnbc.msn.com/id/11233737/ns/business-us_business/ (reporting on the lawsuit and various reactions to it from business and political figures).

[106] The district court largely agreed with the industry association's arguments that "the Fair Share Act ha[d] a 'connection with' an ERISA plan and [wa]s preempted on that ground." Retail Indus. Leaders Ass'n v. Fielder, 435 F. Supp. 2d 481, 494 (D. Md. 2006), *aff'd*, 475 F.3d 180 (4th Cir. 2007) [hereinafter "Fielder"].

[107] *Fielder*, 475 F.3d at 183; Michael Barbaro, *Court Rules for Wal-Mart in Maryland Suit*, N.Y. TIMES, Jan. 17, 2007, *available at* http://www.nytimes.com/2007/01/17/business/17cnd-walmart.html.

point of preemption is to save employers from having to create separate plans for each state.[108] Although Maryland's law may not have been the best conceived health reform plan,[109] the decision was yet another blow to state-initiated reform efforts in the face of federal inaction despite the worsening health coverage situation.[110] In 2005, a strikingly similar pay-or-play law was enacted in Suffolk County, N.Y.,[111] but it also collapsed in the face of a challenge by the retail association.[112] The decision was issued in 2007, close on the heels of the Fourth Circuit's decision in Maryland firmly striking down the Wal-Mart law.

In 2009, however, unexpected good news for fans of state experimentation in health care reform came out of the Ninth Circuit, which upheld a pay-or-play law that was challenged on preemption grounds.[113] This law, which applies only to San Francisco, bears less resemblance to the Maryland law than the Suffolk County law did because it applies to more employers and has a more comprehensive social scheme at

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[108] *Fielder*, 475 F.3d at 191.

[109] *See* Zelinsky, *Maryland*, *supra* note 102, at 890–91.

[110] Darren Abernethy, *Of State Laboratories and Legislative Alloys: How "Fair Share" Laws Can Be Written to Avoid ERISA Preemption and Influence Private Sector Health Care Reform in America*, 49 WM. & MARY L. REV. 1859, 1865–68, 1878–83 (2008) (discussing the Maryland law and *Fielder*).

[111] Suffolk County, N.Y., Laws pt. IV, ch. 325, art. I (2008).

[112] Retail Indus. Leaders Ass'n v. Suffolk Cnty., 497 F. Supp. 2d 403, 418 (E.D.N.Y. 2007); *see also* Arlene Akiwumi-Assani, *Four Problems Facing Meaningful State Health Care Reform and Coverage in the United States*, 72 ALB. L. REV. 1077, 1087–95 (2009) (comparing the Suffolk County, Maryland, and San Francisco situations).

[113] Golden Gate Rest. Ass'n v. City and Cnty. of San Francisco, et al., 546 F.3d 639 (9th Cir. 2008) (reversing the district court's decision that the San Francisco law was preempted by ERISA); *see also* Mazda K. Antia, Kathlynn Butler Polvino, Heather C. Meservy & Payal Patel Cramer, *Overcoming ERISA As An Obstacle: The Ninth Circuit's Approval of San Francisco's Fair Share Legislation*, 2 J. HEALTH & LIFE SCI. L. 115, 133–34 (2009) (putting the Ninth Circuit decision in the context of the laws in Massachusetts and Maryland).

its heart.[114] Still, the actual mechanism by which the law aims to achieve its goal—the employer mandate—is similar.[115] However, in holding that ERISA did not preempt the law, the Ninth Circuit emphasized the differences between the San Francisco and Maryland laws.[116] The split with the Fourth Circuit's reasoning in *Fielder* was nonetheless clear, and the law's opponents petitioned the Supreme Court for certiorari.[117] After initial briefing from the parties and amici, the Court requested input from the Department of Justice.[118] As noted in the introduction, the DOJ brief urged the Court not to hear the case, arguing that it would be premature and wasteful for the Court to rule on

[114] *See* Salganik, *supra* note 63, at 1504–06 (explaining San Francisco law's provisions); Edward A. Zelinsky, *Golden Gate Restaurant Association: Employer Mandates and ERISA Preemption in the Ninth Circuit* 6–13 (Benjamin N. Cardozo Sch. of Law, Jacob Burns Inst. for Advanced Legal Studies Working Paper No. 219, 2008), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1090122 [hereinafter Zelinsky, *Golden Gate*] (describing the San Francisco law in detail and comparing it with Maryland's and Massachusetts' laws); Mitchell H. Katz, *Golden Gate to Health Care for All? San Francisco's New Universal-Access Program*, 358 NEW ENG. J. MED. 327 (Jan. 2008), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp0706590 (explaining and appraising the San Francisco law).

[115] Edward A. Zelinsky, *Employer Mandates and ERISA Preemption: A Critique of* Golden Gate Restaurant Association v. San Francisco 4, Jacob Burns Inst. for Advanced Legal Studies Working Paper No. 246, 2008), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1299128 (noting essential similarities between Maryland and San Francisco laws). *But cf.* Zelinsky, *Golden Gate*, *supra* note 114, at 25 (arguing that although employer plans are involved, the San Francisco law is even more violative of ERISA than Maryland's law because of the way in which employers must pay into the plans or pay fines). The relevant provisions of the ordinance are at S.F. ADMIN. CODE, §§ 14.1(b)(3), 14.1(b)(4), and 14.1(b)(15).

[116] *Golden Gate Rest. Ass'n*, 546 F.3d at 659–60.

[117] Petition for Writ of Certiorari, Golden Gate Rest. Ass'n v. City and Cnty. of San Francisco, 130 S.Ct. 357 (2010) (No. 08-1515).

[118] Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco, 130 S. Ct. 357 (2009) (No. 08-1515) (mem.) (invitation from the Court for the Solicitor General to submit a brief "expressing the views of the United States").

the issue because federal reform made it more unlikely that other states and localities would attempt the same sort of reform and because it was unclear how many of the ACA's provisions would be interpreted in court.[119] The Court seems to have found the DOJ's arguments persuasive, for it soon denied certiorari, [120] leaving the Ninth Circuit's judgment in place and a clear road for implementation of San Francisco's reform.[121]

III. POST-ACA: ERISA PREEMPTION'S RELATIONSHIP WITH FEDERAL HEALTH CARE REFORM

The previous section highlighted ERISA preemption and its role in stymieing state health care reform efforts. This was a problem since it seemed that the federal government, whose laws would be unaffected by ERISA preemption, would not even attempt to achieve sweeping reform.[122] Now, health reform has actually happened on a national level—but instead of making it a completely federal proposition, Congress structured the ACA so that the states will be

[119] DOJ Brief, *supra* note 1, at 13.

[120] Golden Gate Rest. Ass'n v. City and Cnty. of San Francisco, 130 S.Ct. 357 (2010) (No. 08-1515).

[121] By the time of the ACA's enactment, San Francisco's program was already up and running. HEALTHY SAN FRANCISCO, http://www.healthysanfrancisco.org/ (last visited Apr. 14, 2011). *See also* Carrie Hoverman Colla, William H. Dow & Arindrajit Dube, *How Do Employers React to a Pay-or-Play Mandate? Early Evidence from San Francisco* 6–10, 19–23, (Nat'l Bureau of Econ. Research, Working Paper No. 16179, 2010) (describing the San Francisco plan as implemented and the results of a study of its impact on employers), *available at* http://www.nber.org/papers/w16179; Mitchell H. Katz & Tangerine M. Brigham, *Transforming A Traditional Safety Net Into A Coordinated Care System: Lessons From Healthy San Francisco*, 30 HEALTH AFFAIRS 237, 242–44 (2011) (evaluating success of San Francisco's program).

[122] *See* Tammy Murray, Note, *State Innovation in Health Care: Congress' Broad Spending Power Under a National Health Care System Will Stifle State Laboratories of Democracy*, 3 IND. HEALTH L. REV. 263, 278–80, 290–91 (2006) (noting political difficulties of national health reform and the advantages of letting the states attempt their own health care reform).

involved extensively in its implementation.[123] In addition, the ACA does not preclude the states from instituting their own programs alongside the ACA reforms.[124] This means that ERISA preemption could still have a role affecting health care even in the new ACA landscape, but it is unclear what that role will be, and whether it will be more or less formidable than it was in the past.

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[123] In particular, as the following sections make clear, the insurance exchanges will be created by the states, as proposed by the Senate, rather than having a national exchange, which the House bill would have created. *See* Timothy S. Jost, *Implementation and Enforcement of Health Care Reform—Federal Versus State Government*, NEW ENG. J. MED, Dec. 2009, at e2(1), http://www.nejm.org/doi/full/10.1056/NEJMp0911636 (explaining the two approaches to state involvement in reform); *Side-by-Side Comparison of Major Health Care Reform Proposals*, KAISER FAMILY FOUNDATION (Apr. 21, 2010), http://www.kff.org/healthreform/upload/housesenatebill_final.pdf (charting the differences between the bills and the provisions of the final bill adopting the Senate's state-based approach). The House had to drop its approach after Republican Senator Scott Brown took the late Senator Edward Kennedy's seat, which ended the Democrats' supermajority in the Senate; Brown's opposition meant the Senate would not reach a new bill or compromise, so the House adopted the Senate bill. *See* Timothy Jost, *Jost: Pass the Bill Now*, THE NEW REPUBLIC (Jan. 20, 2010, 10:22 AM), http://www.tnr.com/blog/the-treatment/jost-pass-the-bill-now (explaining the need for the House to adopt the Senate bill due to changed political circumstances).

[124] Two provisions in the ACA make this clear. Section 1321(d), in Title I, says that "Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title." ACA, Pub. L. No. 111-148, § 1321(d), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18041(d)). In other words, the ACA will not pose an obstacle to state laws as long as those laws do not interfere with the ACA. Of course, other laws, like ERISA, may still preempt those same state laws; this provision of the ACA has no bearing on ERISA preemption. Second, ACA § 1332 creates a "waiver for state innovation" that will allow states to have their own programs starting in 2017. ACA, Pub. L. No. 111-148, § 1332, 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18052); *see* discussion *infra* Part III.C.

A. Overview of the ACA[125]

The ACA's overarching goals are "to substantially reduce" the population of uninsured and underinsured Americans—meaning approximately 46.3 million and over 25 million people, respectively—as well as "to improve service delivery and reduce health care costs."[126] The ACA is designed to achieve these aims in several ways. Most notably, it imposes a mandate on individuals to purchase and employers to provide health care plans, "reform[s] the health care delivery system to improve quality and value," and aims over the long term to "eliminate disparities in health care, strengthen public health and health care access, invest in the expansion and improvement of the health care workforce, and encourage consumer and patient wellness in both the community and the workplace."[127]

The ACA is undeniably sprawling, and it is difficult to neatly categorize in terms of its approach or its intended

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[125] This overview was generally informed by several excellent resources: Professor Timothy Jost's helpful distillation of the two laws and how they fit together; the Kaiser Family Foundation's extremely comprehensive overview of the laws; the Health Reform GPS resource hosted by the George Washington University's Hirsh Health Law and Policy Program and the Robert Wood Johnson Foundation; and a LexisNexis Emerging Issues analysis of the law by leading ERISA practitioners. *See* Timothy S. Jost, *Introduction to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010*, 2010 Emerging Issues 5106 (LEXISNEXIS) (June 2010) [hereinafter Jost, *ACA Intro*]; *Summary of New Health Reform Law*, KAISER FAMILY FOUNDATION (Mar. 26, 2010), http://www.kff.org/healthreform/upload/8061.pdf; HEALTH REFORM GPS, http://healthreformgps.org (last visited Apr. 14, 2011); Brian Kopp, Eric Paley, David L. Bacon & David S. Foster, *New Federal Health Care Reform Legislation—Its Impact on Employers and Employee Benefits Plans*, 2010 Emerging Issues 4954, 13–14 (LEXISNEXIS) (2010).

[126] *See* Abbe R. Gluck, *State Implementation as Federal Statutory Interpretation: A Federalism Agenda for the Age of Statutes (and Health Reform)* 121 YALE L.J. (forthcoming Oct. 2011) (manuscript at 20) (on file with the *Columbia Business Law Review*).

[127] *Reform Overview: Summary of the Health Reform Legislation*, HEALTH REFORM GPS, http://healthreformgps.org/summary-of-the-legislation/ (last visited Apr. 14, 2011).

impacts.[128] Some of its reform initiatives appear as concrete measures that are likely to take on practical relevance in people's daily lives very soon;[129] others target more nebulous problems of overall efficiency and efficacy in the health care system.[130] Accordingly, the ACA is comprised of both immediate and long-term reforms.[131]

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[128] Due to the extensive political haggling over the structure and content of the ACA that was necessary for it to garner enough support, the law, like an increasing portion of modern legislation, is not only extremely lengthy but also has a clearly patched-together feel. *See* ESKRIDGE, FRICKEY & GARRETT, *supra* note 20, at 25–26, 35–37 (describing legislative process and modern changes to it). As Jost notes, commenting on the complexity of the ACA due to the length of the original bill and the subsequent amendments incorporated into it, "[o]ne must, therefore, read the text of the legislation with the manager's amendment in hand, as many of the provisions that still appear in the bill were eliminated or substantially changed by the manager's amendment. The provisions of the PPACA were also, of course, further amended by the reconciliation act." Jost, *ACA Intro*, *supra* note 125, at 1.

[129] For instance, the prohibition on lifetime limits of coverage in private insurance went into effect in September, 2010, as did the extension of parental coverage to children up to the age of 26. ACA, Pub. L. No. 111-148, §§ 2711, 2714, 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. §§ 300gg-11, 300gg-14).

[130] For example, subtitle D of Title VI of the ACA creates, funds, and directs a Patient-Centered Outcomes Research Institute. ACA, Pub. L. No. 111-148, § 6301(b), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 1320e(b)). The Institute's purpose is "to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis . . . ." ACA, Pub. L. No. 111-148, § 6301(c), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 1320e(c)). Another provision in Title III creates one of the ACA's many "demonstration programs," this one to "integrate quality improvement and patient safety training into clinical education of health professionals." ACA, Pub. L. No. 111-148, § 3508, 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 294j). Such programs have worthy goals, but even if they are met, their effects are unlikely to be felt for some years.

[131] *See, e.g.*, *NCSL Health Reform Fact Sheet: Key Provisions That Take Effect Immediately*, NATIONAL CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/documents/health/FactSheet_KeyProv.pdf (last visited

1. Major Elements of the ACA

Great and growing concern over the large uninsured population in the United States was a driving force behind the ACA's enactment.[132] Not surprisingly, then, some of its most prominent features aim to address that issue. These include the individual mandate, which takes effect in 2014, and will require all U.S. citizens and legal residents either to have "minimum essential coverage"[133] or pay a fine.[134] An

Apr. 14, 2011) (highlighting the main insurance reforms and tax credits that took immediate effect upon the ACA's enactment); *Implementation Timeline*, KAISER FAMILY FOUNDATION, http://healthreform.kff.org/timeline.aspx (last visited Apr. 14, 2011) (providing a glance at ACA implementation for 2010 through 2018); HEALTH REFORM GPS, *supra* note 130 (discussing the planned pace of the reform's implementation).

[132] *See, e.g.*, Sheryl Gay Stolberg & Robert Pear, *Obama Takes His Health Care Case to the Public*, N.Y. TIMES, June 12, 2009, at A16 (describing President Obama's pitch to Americans about the benefits of health reform, including extending "health care to the nation's 45 million uninsured"); Robert Pear & David M. Herszenhorn, *Senate Says Health Plan Will Cover Another 31 Million*, N.Y. TIMES, Nov. 19, 2009, at A1 (noting development of proposed law and efforts to cover more people); Igor Volsky, *Fred Barnes: 'Does Anybody Who Can Tie His Shoes Believe' Universal Health Care Reform Will Save Money?*, THE WONK ROOM (Dec. 12, 2008, 12:01 PM), http://wonkroom.thinkprogress.org/2008/12/12/barnes-health/ (commenting on issue of large uninsured population and asserting that more people can be covered without excessive expense); Bowen Garrett, John Holahan, Lan Doan & Irene Headen, *The Cost of Failure to Enact Health Reform: Implications for States* 6, URBAN INST. (Oct. 1, 2009) (reporting expected increase in uninsured population if the ACA, then being debated, were not enacted); Jeffrey M. Jones, *Healthcare Bill Supporters Cite Uninsured; Foes, Big Gov't*, GALLUP (Sept. 16, 2009), http://www.gallup.com/poll/122957/healthcare-bill-supporters-cite-uninsured-foes-big-govt.aspx (results of survey taken during debates over ACA indicated that "[s]upport for healthcare legislation seems primarily motivated by a desire to insure those who currently lack health insurance . . . .").

[133] ACA, Pub. L. No. 111-148, § 1501(a), 124 Stat. 119, 155 (2010) (to be codified at 26 U.S.C. § 5001A(a)) (requiring all people to be covered by health insurance that provides at least "minimum essential coverage," though not defining that term).

[134] *Id.* § 1501(b) (imposing "[s]hared responsibility payment" on anyone who does not comply with the insurance coverage requirement). The individual mandate is indisputably the greatest source of arguments

employer mandate will also take effect in 2014.[135] Any organization that employs more than fifty people must offer minimum qualifying health coverage;[136] organizations that employ more than 200 people must automatically enroll their employees in the health care that the company offers, though employees may choose to opt out.[137] An employer will be required to pay a tax if it does not offer the necessary coverage and any of its employees receives a premium tax credit to be used in one of the insurance exchanges.[138] This is, plainly, a play-or-pay type scheme.[139] The ACA's other major approach to increasing coverage is by expanding and changing Medicare and State Children's Health Insurance

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regarding the ACA's constitutionality. *See, e.g.*, Sam Leineweber, *Life, Liberty and the Pursuit of Healthiness*, THE LEGALITY (Feb. 23, 2011), http://www.thelegality.com/wp-content/lifelibertyandthepursuitofhealthiness.pdf ("The individual mandate portion of the PPACA has created . . . the most controversy and debate"); Amanda Gardner, *Few Support 'Individual Mandate' in Health Care Reform Law, Poll Finds*, BUSINESSWEEK (Mar. 1, 2011, 9:00 AM), http://www.businessweek.com/lifestyle/content/healthday/650359.html (citing a poll that found strong disapproval of the individual mandate but noting that people nonetheless support some aspects of it). There has been vigorous disagreement about whether this payment is a "tax" or a "penalty," though in recent days proponents of the ACA have reverted to calling it a "tax" because Congress has broad taxing power. Jacob Sullum, *The 'Tax' That Was Not a Tax Is Now a 'Penalty' That Is a Tax*, REASON (Dec. 14, 2010), http://reason.com/blog/2010/12/14/the-tax-that-was-not-a-tax-is (noting the switching rationales); John Carney, *Obamacare: Why Calling The Individual Mandate A Tax Won't Save It,* CNBC (Feb. 3, 2011, 7:40 AM), http://www.cnbc.com/id/41393656/Obamacare_Why_Calling_The_Individual_Mandate_A_Tax_Won_t_Save_It (noting reasons behind switch).

[135] ACA, Pub. L. No. 111-148, §§ 1511–1513, 124 Stat. 119, 155 (2010) (to be codified at 29 U.S.C. §§ 218a–b, 4980H). Section 1513(d) provides that the amendments made by that section shall apply to months beginning after Dec. 31, 2013; *see also* KAISER FAMILY FOUNDATION, *supra* note 125 (distilling the provisions of the law and their enactment dates).

[136] ACA, Pub. L. No. 111-148, § 1513, 124 Stat. 119, 155 (2010) (to be codified at 29 U.S.C. § 4980H).

[137] *Id.* § 1511.

[138] *Id.* This tax is non-deductible. *Id.* §1513(c)(7).

[139] *See* Kopp et al., *supra* note 125, at 3–4 (describing the employer mandates).

Program (SCHIP) requirements to reach people who were previously excluded by particular rules and to make the programs work with the state health exchanges.[140]

The ACA also has a multi-prong strategy for reducing health care costs. The "centerpiece" of these[141] is the insurance exchange mechanism.[142] By 2014, each state must establish an "American Health Benefit Exchange" for individuals and a "Small Business Health Options Program" for businesses with up to 100 employees.[143] The federal government is currently providing funding and guidance for these exchanges.[144] If any state does not create an exchange, the federal government, through the Department of Health and Human Services (HHS), will step in to create and run an exchange itself.[145] The exchanges are expected to help reduce health care costs by, among other things, preventing excessive adverse selection (in other words, too many sick

[140] ACA, Pub. L. No. 111-148, §§ 2001(a)(4), 2101, 2201, 124 Stat. 119, 155 (2010). § 2001(a)(4) adds a large swath of text to the Social Security Act in order to provide additional coverage to low-income populations. *See also* Jost, *ACA Intro*, *supra* note 125, at 47–50 (explaining ACA Title II's expansions of Medicaid and SCHIP).

[141] Timothy S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, THE COMMONWEALTH FUND vi–viii, 1, 9–10 (July 2010), http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf (noting the importance of the exchanges to the ACA and suggesting ways in which they can be improved—for example, the states could help by passing laws that discourage people from going outside the exchanges, to reduce adverse selection).

[142] ACA, Pub. L. No. 111-148, § 1311(a), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18031(a)).

[143] *Id.* § 1311(b). Small businesses can participate in the Small Business Health Options Program exchanges starting in 2014; in 2017, larger businesses may participate. KAISER FAMILY FOUNDATION, *supra* note 125, at 4 (explaining the timing structure of the exchanges' availability to employers).

[144] *Id.* § 1311(a)(1); *see also HHS Announces State Insurance Exchange Development Grants*, HEALTH REFORM GPS (Oct. 1, 2010), http://www.healthreformgps.org/resources/hhs-announces-state-insurance-exchange-development-grants/ (reporting that forty-eight states had received money to start building the exchanges for 2014).

[145] *Id.* § 1321(c) (to be codified at 42 U.S.C. § 18041(c)).

people buying health insurance and too few healthy people buying it, thereby skewing costs[146]) and enabling comparative shopping.[147] Other components of the cost-containment strategy include provisions aimed at stamping out systemic waste and fraud,[148] simplifying program registration administration,[149] and increasing the use and utility of comparative effectiveness research.[150] The ACA also requires that insurers begin certain practices, such as allowing children to stay on their parents' health plans until age twenty-six,[151] as well as cease other practices, such as

[146] *See* Paolo Belli, *How Adverse Selection Affects the Health Insurance Market* 1–2 (World Bank, Pol'y Research Working Paper No. 2574 (2001), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=632643.

[147] *See* Jost, *supra* note 141, at 21, 24.

[148] *See, e.g.*, ACA, Pub. L. No. 111-148, § 3310, 124 Stat. 119, 155 (2010) (regarding wasteful dispensing of prescription drugs in long-term care facilities); *id.* § 6406 (requiring doctors to provide documentation on referrals to programs that are at high risk of waste and abuse); *id.* § 1101(f)(1) (authorizing Secretary of HHS to create procedures to protect against waste, fraud, and abuse in high-risk pool context). Similar provisions mandating care to be taken in guarding against waste and fraud appear throughout the ACA.

[149] *Id.* § 1413 (to be codified at 42 U.S.C. § 18083).

[150] As the ACA describes comparative effectiveness research ("CER"), it means "research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items [including health care interventions, protocols for treatment, care management, medical devices, and integrative health practices]." *Id.* § 6301(a) (to be codified at 42 U.S.C. § 18041). Proponents hope that greater use of CER will increase health outcomes as well as efficiency while lowering costs. *See* Harold C. Sox, *Comparative Effectiveness Research: A Progress Report*, 153 ANNALS INTERNAL MED. 469, 469 (Oct. 5, 2010).

[151] ACA, Pub. L. No. 111-148, § 2714, 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 300gg-14). This was already a requirement in various states. *See Covering Young Adults Through Their Parents' or Guardians' Health Policy*, NAT'L CONFERENCE OF STATE LEGISLATURES (Sept. 23, 2010), http://www.ncsl.org/default.aspx?tabid=14497.

"placing lifetime caps on the dollar value of coverage"[152] and rescinding insurance.[153]

Finally, in 2017, states may apply to HHS for a waiver from any or all of the ACA's requirements if they have enacted their own qualifying health reform law.[154] To grant such a "waiver for state innovation," the Secretary of HHS must ensure that the state law provides plans that ensure coverage comparable to the ACA's essential health benefits package,[155] that it has "coverage and cost sharing protections" that are at least as affordable as the ACA's,[156] that it will provide coverage to at least as many state residents as the ACA would,[157] and that it "will not increase the Federal deficit."[158] The waivers last only five years, though states can apply for an extension.[159] Pursuant to the ACA's requirement of detailed regulation of the waivers,[160] in March 2011, HHS published a proposed rule for implementing the waivers.[161]

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[152] KAISER FAMILY FOUNDATION, *supra* note 125, at 6.

[153] ACA, Pub. L. No. 111-148, § 2712, 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 300gg-12).

[154] *Id.* § 18052(b)(1)).

[155] *Id.* § 18052(b)(1)(A).

[156] *Id.* § 18052(b)(1)(B).

[157] *Id.* § 18052(b)(1)(C).

[158] ACA, Pub. L. No. 111-148, § 1332(b)(1), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18052(b)(1)(D)).

[159] *Id.* § 18052(e).

[160] *Id.* § 18052(a)(4)(B). The regulations are to ensure that there will be full disclosure of the state's plans and public comment, and to ensure that the law's progress and success will be monitored by HHS.

[161] Application, Review, and Reporting Process for Waivers for State Innovation, 76 Fed. Reg. 13553 (proposed Mar. 14, 2011) (to be codified at 31 C.F.R. pt. 33 and 45 C.F.R. pt. 155). As its title indicates, the proposed rule primarily addresses the mechanics of the waiver-obtaining process rather than the effects the waiver may have on the ACA's interaction with other laws. Section 33.102 of the proposed rule briefly lays out plans for coordinating the Social Security waivers or waivers "under any other Federal law relating to the provision of health care items or services, provided that such application is consistent with the procedures described in this part, the procedures for section 1115 demonstrations, if applicable, and the procedures under any other applicable Federal law under which

2. The ERISA Preemption Connection

Much of the ACA will not implicate ERISA preemption at all. This is because many of its provisions do not involve the states or require them to enact implementing laws, putting those provisions beyond preemption's reach;[162] others do not relate to employer-provided benefits and so are outside the scope of ERISA;[163] and others still will amend ERISA, but not its preemption clause.[164] However, some of the law does touch upon ERISA's domain, and since preemption seemed to be such a daunting obstacle to health reform previously, it is vital to examine these areas closely to see what the interaction may be in the present era of health reform.

The ACA's text does not address ERISA preemption. One provision actually saves *state* laws from preemption by the *ACA*'s provisions, as long as they do not interfere with the ACA's operation.[165] The absence of any reference to ERISA preemption may not be so surprising: after all, the ACA is federal law, and even its state-implementing components do not all "relate to" employer-provided health benefits in even the minimal manner required to invoke ERISA preemption.[166] Similarly, the mandate that employers provide insurance or pay a tax, which is so similar to the

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the State seeks a waiver." As I discuss further in Part III.C.2, it is not clear whether this language could apply to ERISA preemption waivers, the topic of this Note.

[162] The individual mandate, for example, will be administered solely by the federal government. ACA, Pub. L. No. 111-148, § 1501(a), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18091).

[163] The ACA puts in place numerous changes to Medicare and Medicaid, but these are not employment-based programs, so they do not implicate ERISA.

[164] For example, subtitle G of title I of ACA adds a section 715 to ERISA. *See* Jost, *ACA Intro*, *supra* note 125, at 45.

[165] ACA, Pub. L. No. 111-148, § 1321, 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18041).

[166] ERISA § 514(a), 29 U.S.C. § 1144(a) (2006). Though court interpretations of this provision have been very broad, as discussed, they are not so broad as to encompass many provisions of the ACA such as the expansions of Medicaid and programs to fight fraud, waste, and abuse, which the states are directed to implement.

pay-or-play schemes that ERISA has preempted at the state level, will be imposed and enforced by the federal government, not the states; this will also be the case with the individual mandate.[167]

Not only is the ACA's text void of explicit references to ERISA preemption, but concerns about ERISA preemption were apparently little discussed in Congress, at least once the ACA moved closer to final form.[168] Since ERISA preemption was widely considered such an important issue in health reform prior to the ACA, this silence would be unusual except for the fact that the ACA is technically a federal reform and was being debated by federal legislators.[169] However, as discussed, the implementation design of the ACA means that the states will be enacting laws, potentially bringing ERISA back into the picture.[170] ERISA preemption was discussed later in the debates in connection with the state innovation waiver, when Representative Dennis Kucinich offered an amendment to provide states with waivers from ERISA preemption for this state innovation program.[171] This amendment passed one committee, but did not move forward after that, and the conversation about ERISA preemption also seems to have

[167] ACA, Pub. L. No. 111-148, §§ 1511–1513, 124 Stat. 119, 155 (2010) (to be codified at 29 U.S.C.A. § 218a–b); § 1513 (to be codified at 26 USC § 4980h).

[168] When the ACA was still in an early stage in the House of Representatives, and the bill included a provision for state single-payer systems, it also included a waiver from ERISA preemption. *See* H.R. REP. NO. 111–299, pt. 3, at 40 (2009). When the single-payer option dropped out, so did discussion of ERISA preemption, for the most part.

[169] *See, e.g.*, Elenora E. Connors & Timothy M. Westmoreland, *Project Overview and Emerging Themes*, 37 J.L. MED. & ETHICS 7, 9 (Supp. 2009) (identifying ERISA preemption as one of the top eight things to be concerned about with health reform); Timothy S. Jost, *Health Care Reform Requires Law Reform*, 28 HEALTH AFFAIRS w761, w764–65 (July 16, 2009).

[170] *See supra* note 128 (explaining Congress' adoption of the Senate bill's plan for a state-federal partnership in carrying out health reform).

[171] Amendment to H.R. 3590, Offered by Mr. Kucinich of Ohio, July 15, 2009, *available at* http://democrats.edworkforce.house.gov/documents/111/pdf/markup/FC/HR3200-AmericasAffordableHealthChoicesActof2009/KucinichERISA.pdf.

stopped.[172] However, there are portions of the ACA's two main stages of implementation that have the potential to meet ERISA preemption, as this Note discusses next.

B. Preemption at the ACA's Implementation Stage

One of the main reasons why some had long considered health care reform on a national scale to be preferable to state-by-state reform was that in a federal reform program, ERISA's preemptive effect would not be an issue as it is with states.[173] But because of how Congress designed the ACA, in order for large parts of it to take effect the states will have to enact their own laws, and state agencies will have to create regulations.[174] The question is whether they can do so without risk of being preempted by ERISA in the way such laws used to be preempted. In other words, the question is whether the fact that the states will enact the implementing laws under the umbrella of the federal ACA will save the laws from preemption.

1. The Text of the ACA

Federal and state governments and agencies have already begun to implement some of the ACA's provisions by drafting

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[172] Although it is somewhat hard to prove a negative, my searches of relevant legislative history records in Westlaw and Thomas, as well as media reports of the negotiations over the final ACA, show very little discussion of ERISA preemption, except as further noted in this section with regard to Representative Kucinich's proposed amendment.

[173] § 514(a), 29 U.S.C. § 1144(a) (2006). *See* discussion *supra* Part II.B.

[174] *See* Robert Pear, *Health Care Overhaul Depends on States' Insurance Exchanges*, N.Y. TIMES, Oct. 24, 2010, at A23 (explaining the states' crucial role in building the exchanges, a central aspect of the reform); *see also* Kathleen Sebelius, *How the Affordable Care Act Empowers States*, WASH. POST, Feb. 11, 2011, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2011/02/10/AR2011021006847.html (describing how the ACA "puts states in the driver's seat because they often understand their health needs better than anyone else"); *Laying the Foundation for Health Reform*, STATE COVERAGE INITIATIVES (Feb. 2011), *available at* http://www.statecoverage.org/files/u34/State%20of%20the%20States2011.pdf.

new laws and regulations, and implementation will continue for some years.[175] The ACA components for which the states are primarily responsible include the insurance exchanges, the expansions to Medicaid and SCHIP, and new programs to stem waste in, and abuse of, the healthcare system, expand workforce training, reform insurance, and develop better long-term care resources.[176] There may be academic questions about whether some of these changes "relate to" employer-provided benefits enough that they would run afoul of ERISA preemption if they were not under the ACA's aegis. In particular, the ACA does not dictate the text of the laws the states will have to enact to implement elements of the ACA such as the exchanges, so a state could conceivably shape additional reforms through such laws.[177] The questions will just be speculative, though: although states might challenge the ACA's requirement that they implement parts of the reform (as some already have[178]), it seems

[175] *See State Reports and Research: Federal Health Reform Implementation*, NAT'L CONFERENCE OF STATE LEGISLATURES (last updated Feb. 15, 2011), *available at* http://www.ncsl.org/?TabId=21448 (providing links to information about the steps each state has taken toward implementing the ACA).

[176] *See* Alan Weil & Raymond Scheppach, *New Roles for States in Health Reform Implementation*, 29 HEALTH AFFAIRS 1178, 1178–79 (2010) (describing what states have to do to implement the ACA); Christopher C. Jennings & Katherine J. Hayes, *Health Insurance Reform and the Tensions of Federalism*, NEW ENG. J. MED (May 12, 2010), *available at* http://healthpolicyandreform.nejm.org/?p=3436 (discussing states' important roles in the ACA and the resistance of some to implementing the federal government's law); *see also State Legislator's Check List for Health Reform Implementation FY 2010*, NAT'L CONFERENCE OF STATE LEGISLATURES, (Jul. 15, 2010), http://www.ncsl.org/documents/health/2010CLHlthRef.pdf (providing checklists and information on how and what states must do to implement health reform).

[177] The National Association of Insurance Commissioners has, however, adopted model legislation for the exchanges. *See* AMERICAN HEALTH BENEFIT EXCHANGES MODEL ACT, NAT'L ASS'N OF INS. COMM'RS (Nov. 22, 2010), *available at* http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf.

[178] In one case, the plaintiffs invoke the Tenth Amendment and its federalist principles in arguing that the ACA is unconstitutional. Complaint at ¶¶ 55–57, Thomas More Law Center v. Obama, 720 F. Supp.

unthinkable that they or any business or individual will seriously bring an ERISA preemption challenge to these aspects of the ACA.

Other difficult questions arise in the context of some of the state reforms that were in place before the ACA. The ACA provides Massachusetts's Connector exchange (and any other exchange that had been created before January 1, 2010), with a presumption of validity as an ACA exchange.[179] Existing exchanges will also receive funds from HHS in order to come into compliance with what the ACA requires.[180] The ACA also explicitly maintains Hawaii's ERISA preemption waiver.[181] But other laws' fates are not clear

2d 882 (E.D. Mich. 2010) (No. 10-CV-11156); *see also Principle Legal Challenges to Affordable Care Act*, BUS. ROUNDTABLE (Feb. 9, 2011), http://businessroundtable.org/uploads/studies-reports/downloads/20110209_Summary_of_Legal_Challenges_to_ACA.pdf (summarizing the claims in that case and others). The district court denied the request for an injunction, *Thomas More Law Center* at 896, and the case is currently on an expedited schedule in the Sixth Circuit Court of Appeals. Steve Delchin, *Sixth Circuit Expedites Oral Argument in Case Challenging Health Care Statute*, SIXTH CIRCUIT APPELLATE BLOG (Feb. 9, 2011), http://www.sixthcircuitappellateblog.com/constitutional-law/sixth-circuit-expedites-oral-argument-in-case-challenging-health-care-statute. Attorneys general of numerous states have also made the argument, in particular with respect to the conditions placed on the states for the expansion of Medicaid in the ACA, but these efforts seem unlikely to succeed. Brietta Clark, *Legal Challenges to Medicaid Expansion Likely to Fail*, HEALTH CARE JUSTICE BLOG (Apr. 2, 2010, 7:24 AM), http://healthcarejusticeblog.org/2010/04/legal_challenge.html.

[179] ACA, Pub. L. No. 111-148, § 1321(e)(1), 124 Stat. 119, 155 (2010), (to be codified at 42 U.S.C. § 18041(e)(1)).

[180] *Id.* § 1321(e)(2).

[181] ACA, Pub. L. No. 111-148, § 1560(b), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18118(b)). *See also Senator Akaka Statement on Senate Passage of Health Care Bill Today*, HAWAII POLITICAL INFO (Dec. 24, 2009, 9:41 PM), http://www.hawaiipoliticalinfo.org/?q=node/2218 (comments by Hawaii Senator about his efforts to keep the Hawaii exception and gain other benefits for the state's health care system). *But cf.* Laura Brown, *Exemption from National Health-Care Law No Boon to Hawaii Business*, STATE HOUSE NEWS ONLINE (Oct. 1, 2010), http://statehousenewsonline.com/2010/10/01/exemption-from-national-health-care-law-no-boon-to-hawaii-business (noting that Hawaii's current law has made health-care costs for employers very high, forcing them to hire fewer

from the ACA's text. For instance, San Francisco's reform law got a reprieve thanks to the Supreme Court's denial of certiorari,[182] but how the city's health reform program will interact with the ACA is uncertain. California is now starting to implement the ACA,[183] so San Francisco's reform efforts may be affected if state and local funds have to be directed toward ACA reforms instead. Soon after President Obama signed the ACA into law, Vermont's legislature enacted a bill to study health reform options, including single-payer plans.[184] The state's new governor strongly supports reform and recently proposed a single-payer bill, indicating that a strong push in that direction could be forthcoming.[185] These are just two examples of ongoing non-federal efforts to reform health care, but the ACA makes no affirmative provision for what relation, if any, it will have with such laws, at least before the introduction of the state innovation waivers in 2017.[186]

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workers, and acknowledging that Hawaii's exemption from the national health-care law will only continue these issues).

[182] Golden Gate Rest. Ass'n v. City and Cnty. of San Francisco, 130 S.Ct. 357 (2010) (No. 08-1515).

[183] Cathy Bussewitz, *Calif. Begins Steps to Enact Health Care Reforms*, BUSINESSWEEK (June 1, 2010), *available at* http://www.businessweek.com/ap/financialnews/D9G2I0V80.htm (explaining different proposals the California Legislature is considering in order to comply with the national health care act).

[184] *See Synopsis of Act 128*, VERMONT WORKERS' CTR, http://www.workerscenter.org/act128 (last visited Apr. 14, 2011).

[185] Aimee Miles, *Vermont Gov. Proposes Single-Payer Health Plan*, KAISER HEALTH NEWS (Feb. 8, 2011), http://www.kaiserhealthnews.org/Stories/2011/February/08/vermont-governor-shumlin-single-payer.aspx (describing the governor's proposed plan and noting that it would require federal waivers to go into effect).

[186] As noted *supra* note 171 and accompanying text, ACA § 1321 provides that the new law will not preempt state laws that do not interfere with the ACA's operation, but this does not lay a basis for understanding how the federal and local laws may interact if they coexist. ACA, Pub. L. No. 111-148, § 1321, 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18041).

2. How Courts May Interpret the ACA and Preexisting or New State Laws' Interaction with ERISA

Although, as discussed above, there are questions about state-implemented ACA reforms' vulnerability to ERISA preemption, it seems unlikely that the provisions will be challenged on that basis. Unless states' budgets worsen to such a degree that they actively begin to resist the costs of building the exchanges—the main component of the ACA that could be vulnerable—they are unlikely to be the target of much litigious anti-reform ire, unlike the individual mandate.[187] And even if the exchanges were challenged, courts could still easily find that they are not preempted. The potential, impermissible "relation to" ERISA plans is more tenuous than it was in state reforms like the pay-or-play laws.

By contrast, any future state reform effort that does not happen explicitly under the ACA's aegis will still likely be susceptible to ERISA preemption. The reality that ERISA preemption is not dead for states' non-ACA laws was demonstrated in a recent suit over a District of Columbia law covering pharmacies in which the D.C. Circuit invalidated the law in July 2010 as ERISA-preempted.[188] The same will surely be true of any state laws implementing parts of the ACA but also adding more of their own reforms, should any states attempt that. In these cases, a court's major task would be one of statutory interpretation, as is always the case with ERISA preemption.[189] First, a court would look at

[187] There is a strong possibility that many states' budget problems could worsen. *In Search of an Answer*, ECONOMIST (Jan. 20, 2011), *available at* http://www.economist.com/node/17965497?story_id=17965497. However, the ACA does provide funds to assist states in building the exchanges.

[188] Pharm. Care Mgmt. Ass'n v. District of Columbia, 613 F.3d 179, 190 (D.C. Cir. 2010).

[189] *See* Fisk, *supra* note 60; Edward A. Zelinsky, Travelers, *Reasoned Textualism, and the New Jurisprudence of ERISA Preemption*, 21 CARDOZO L. REV. 807, 809 (1999) [hereinafter Zelinsky, *Reasoned Textualism*].

past preemption decisions for guidance; as discussed above, these have been very broad in the ERISA context and can lead to the preemption of laws that seem only tangentially related to ERISA plans.[190] Second, general preemption principles remain relevant. As with ERISA in the employer benefits field, a court could easily find that with the ACA, the federal government has demonstrated an intent to "occupy the field" of health reform and, on that basis, reinforce its invalidation of any further state reform.

C. Post-2017 Issues: Waiver Possibility?

Starting in 2017, states may at last be able to implement their own reforms; only then will they enjoy the backing of the ACA's waiver for state innovation (if, of course, they meet the requirements for a waiver).[191] The critical question about the waivers is how they will work with ERISA: will the state reforms, which can receive federal approval through the ACA's waiver program but otherwise would likely be forbidden by ERISA, still be preempted as they were before, or will the ACA provide protection?

1. The Text of the ACA

By 2017, at least some of the issues raised by the ACA's general implementation period will have been largely settled, either judicially or legislatively. The state innovation waivers planned to be available that year present different issues. These waivers will allow states to switch from the ACA model to their own health reform programs as long as the change is cost-neutral to the federal government and will continue to cover at least as many people as the ACA. The waivers will raise new and different concerns,

[190] *See supra* note 71 (discussing cases interpreting ERISA's preemption provision).

[191] ACA, Pub. L. No. 111-148, § 1332, 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18052). As discussed *infra*, Part III.C.1, if the bill pending in the Senate to amend this provision passes, the start-date for the waivers could be moved up to 2014.

particularly in the context of ERISA preemption.[192] The waiver provision is relatively detailed in describing what the states must do and must demonstrate to HHS in order to obtain a waiver,[193] as well as what HHS must do to approve a waiver.[194] HHS's proposed regulation provides even more clarity on the process.[195] However, neither the provision nor the regulation address whether states' reform laws will be protected from ERISA preemption. The text of the provision appears to indicate that they will not be, because the provision explicitly instructs that the Secretary of HHS cannot waive any law that is not in HHS's jurisdiction, which ERISA is not.[196] On the other hand, nothing in the text indicates that ERISA preemption will necessarily apply to these laws, and the proposed rule's language on the matter of waivers is quite rather broad, so the issue is, for now, open to debate.

Representative Dennis Kucinich's proposed amendment to the ACA, if it had been included in the final law, would have given a state an automatic waiver of ERISA preemption if it received an ACA state innovation waiver.[197] Although that solution was cut off, there has been recent legislative action with regard to the waivers. In November 2010, Senators Ron Wyden and Scott Brown introduced a bill to amend the ACA by moving the waivers' start date to 2014, from 2017.[198] After the bill gained prominence when

[192] ACA, Pub. L. No. 111-148, § 1332(a), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18052(a)).

[193] *Id.* § 18052(b).

[194] *Id.* § 18052(d).

[195] Application, Review, and Reporting Process for Waivers for State Innovation, 76 Fed. Reg. 13553 (proposed Mar. 14, 2011) (to be codified at 31 C.F.R. pt. 33 and 45 C.F.R. pt. 155); *see also supra* note 161.

[196] ACA, Pub. L. No. 111-148, § 1332(c)(2), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18052(c)(2)). As noted above, ERISA is jointly administered by the Departments of Labor and Treasury.

[197] *See supra* note 171 and accompanying text.

[198] The Empowering States to Innovate Act, S.248, 111th Cong. (2010). Sen. Wyden was the waiver provision's original author. Press Release, Sen. Ron Wyden, Wyden, Brown Introduce Bill to Move Up Date for Health Care Law's State Waiver Provision (Nov. 18, 2010), http://wyden.

President Obama expressed his support for it, Representative Peter Welch introduced a corresponding bill in the House.[199] Despite the bill's appealingly federalist undertones—it enables the states to become Brandeisian "laboratories of innovation"[200] sooner and start experimenting with their own reforms[201]—support for it has not been overwhelming.[202] This has particularly been the

senate.gov/newsroom/press/release/?id=c85d61c7-9fe4-4542-83be-4006c7570a9f (noting that Sen. Wyden originally included the waiver provision in his previous attempt at a health reform law, and subsequently attached it as an amendment to the ACA).

[199] The Empowering States to Innovate Act, H.R. 844, 112th Cong. (2011). *See also* Jason Millman, *Liberals See Open Door for Public Option, Single-Payer Healthcare*, HEALTHWATCH (Feb. 28, 2011, 4:46 PM), http://thehill.com/blogs/healthwatch/health-reform-implementation/146523-liberals-see-open-door-for-public-option-single-payer (reporting on the two bills and Welch's and Vermont's support for the waivers in particular).

[200] New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting); *see also* Ezra Klein, *Have Scott Brown and Ron Wyden Figured Out the Way Forward On Health Care?*, WASH. POST (Nov. 18, 2010, 12:11 PM), http://voices.washingtonpost.com/ezra-klein/2010/11/have_scott_brown_and_ron_wyden.html (noting the amendment should have broad appeal because it would allow the states to implement their own health care reforms rather "wasting time and money setting up a federal structure they don't plan to use").

[201] *See* Ezra Klein, *The Case for Wyden/Brown Gets Stronger*, WASH. POST (Feb. 3, 2011, 9:00 AM), http://voices.washingtonpost.com/ezra-klein/2011/02/the_case_for_wydenbrown_gets_s.html (arguing that the waivers should appeal to states' federalist impulses). *But see* Stuart Butler, *The Wyden-Brown Bill—Short on Flexibility*, NEW ENG. J. MED. (Jan. 19, 2011), http://healthpolicyandreform.nejm.org/?p=13626 (noting various problems with the amendment).

[202] *See, e.g.*, Reihan Salam, *The Limits of the Wyden-Brown Approach to State Innovation*, NAT'L REV. ONLINE (Nov. 18, 2010, 3:19 PM), http://www.nationalreview.com/agenda/253549/limits-wyden-brown-approach-state-innovation-reihan-salam (criticizing the amendment because the waivers that "states offer their citizens insurance [are] as comprehensive as PPACA requires" and innovation will allow states to do more); Brian Bolduc, *Conservatives Send Brown Back to the Drawing Board*, NAT'L REV. ONLINE (Nov. 22, 2010, 11:28 PM), http://www.nationalreview.com/corner/253777/conservatives-send-brown-back-drawing-board-brian-bolduc (noting conservatives' skepticism about the waivers); Ken Terry, *Healthcare Reform: Wyden-Brown Bill is a Trojan Horse*, BNET (Nov. 22, 2010), http://www.bnet.com/blog/healthcare-business/healthcare-reform-

case since President Obama's announcement of support, which removed some of the amendment's potential appeal to Republicans.[203] Nonetheless, it appears that the initial reason for the late start date may have been a concern in the Congressional Budget Office that the cost would be too great, rather than something more political in-fighting, which could be more difficult to reconcile.[204] But if any cost issues can be addressed and the waiver amendment sponsors can garner enough votes for the amendment to pass, the waivers may bring numerous benefits in the form of state experimentation with different approaches to reform.[205] Allowing states to seek the waivers earlier would allow them to begin realizing

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wyden-brown-bill-is-a-trojan-horse/2129 (asserting that the waivers would "open a hole in the ACA large enough for the Republicans to drive a tank through"); Benjamin Domenech, *Health Policy Innovation Is About More than Just Timing*, OREGONLIVE (Dec. 1, 2010, 4:10 PM), http://www.oregonlive.com/opinion/index.ssf/2010/12/health_policy_innovation_is_ab.html (asserting that "[w]e should reject such token innovation as anti-consumer and anti-taxpayer" because "[s]tates deserve more than a one-size-fits-all mandate").

[203] Ezra Klein, *White House Comes Out For Wyden-Brown State Waiver Program*, WASH. POST (Feb. 28, 2011, 12:24 PM), http://voices.washingtonpost.com/ezra-klein/2011/02/white_house_comes_out_for_wyde.html ("[N]ow that Obama has admitted it's not a threat to the Affordable Care Act, a lot of the appeal for Republicans dissipates.").

[204] *See* Ezra Klein, *Sen. Bernie Sanders: 'Vermont Stands a Chance to be the First State in the Nation to Pass Single-Payer,'* WASH. POST (Nov. 18, 2010, 2:54 PM), http://voices.washingtonpost.com/ezra-klein/2010/11/sen_bernie_sanders_vermont_sta.html (interview with Vermont's Senator Bernie Sanders, who was one of the other legislators pushing for state innovation and who still thinks that it could be used to get a single payer system). *But cf.* Butler, *supra* note 201 (expressing the belief that it was a design of the waivers to start late so the states would already be ensconced in the ACA and would not want to leave after having spent the money to implement the federal law). The truth may be a combination of these reasons: a concern about the waiver program's cost as well as "a desire to get the reform elements up and coverage greatly expanded before allowing states to start changing the law." Editorial, *Mr. Obama's Health Care Challenge*, N.Y. TIMES, Mar. 2, 2011, at A24 (opining that neither reason is very compelling).

[205] Kathleen Sebelius, *Empowering States to Innovate*, THE WHITE HOUSE BLOG (Feb. 28, 2011, 11:56 AM), http://www.whitehouse.gov/blog/2011/02/28/empowering-states-innovate (listing benefits to states).

some of those benefits, as well as facilitate a quicker challenge to them under ERISA preemption and thus a sooner answer to the question of how they will fare.

2. How Courts May Interpret the Waiver Provision and New State Laws

Whenever the waivers become available, it seems likely that at least a few states will take advantage of them to leave the ACA and start their own reform.[206] If Congress does nothing in the meantime to answer the ERISA preemption question, it would then only be a matter of time before ACA-approved state reforms are challenged as ERISA-preempted. A court would first look to the ACA's text. The most relevant part of the waiver provision is the subsection that prevents the Secretary of HHS from waiving any law outside of HHS's jurisdiction.[207] It is difficult to see a way around this textual prohibition, which, given the context, seems clearly aimed at precluding the Secretary from granting ERISA waivers for the new state laws.[208]

On the other hand, the waiver provision is part of the ACA, and courts may resist reading the provision in such a way that it could have no effect because of ERISA preemption. They could do this by applying the common-sense presumption that Congress does not enact meaningless law, which the waiver provision would be if ERISA would immediately preempt any laws allowed by the ACA waiver.

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[206] It is certainly possible that fewer states would implement their own reforms in 2017, as noted above, because the ACA will be more entrenched and the states will already have expended funds implementing ACA and will be reluctant to switch to their own systems requiring additional implementation funds. *See* Butler, *supra* note 201.

[207] ACA, Pub. L. No. 111-148, § 1332(c)(2), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18052(c)(2)).

[208] *See, e.g.*, Anne Galloway, *Truth Squad: Is Shumlin's Health Care Plan "Unrealistic"?*, VTDIGGER.ORG (Oct. 15, 2010), http://vtdigger.org/2010/10/15/truth-squad-is-shumlin%E2%80%99s-health-care-plan-%E2%80%9Cunrealistic%E2%80%9D. Although the waiver provision has received a fair amount of attention on blogs and on the internet, it has not yet been analyzed in depth by scholarly commentators.

Additionally, HHS's proposed rule for the waivers contains language acknowledging the need for coordination with other waiver processes.[209] The proposed rule's vague wording, which reaches waivers of "any other Federal law relating to the provision of health care items or services . . . and the procedures under any other applicable Federal law under which the State seeks a waiver"[210] could, under a bold reading, potentially reach ERISA waivers and allow them, if HHS, DOL, or even the President decided to attempt to grant them along with the ACA waivers, though whether that will happen remains to be seen.[211]

At least two other interpretive tactics are important. First, the "dog that didn't bark" canon, which is the "presumption that [a] prior legal rule should be retained if no one in legislative deliberations even mentioned the rule or discussed any changes in the rule."[212] In the waivers' case, given ERISA preemption's importance to the business lobby, someone in Congress would certainly have said something more if the waiver provision was intended to allow states to avoid ERISA preemption.[213] Second, there is the argument from legislative history, using the rejected proposal rule,[214] that Congress did not adopt Representative Kucinich's proposed amendment to the original waiver provision in the

[209] Application, Review, and Reporting Process for Waivers for State Innovation, 76 Fed. Reg. 13553 (proposed Mar. 14, 2011) (to be codified at 31 C.F.R. pt. 33 and 45 C.F.R. pt. 155).

[210] *See id.* § 33.102.

[211] *See* further discussion of these possibilities *infra* Part IV.B.4.

[212] ESKRIDGE, FRICKEY & GARRETT, *supra* note 20, app. at 28.

[213] And indeed, supporters of ERISA preemption have been very explicit that they do not think that the ACA has weakened the preemption possibilities at all. *See, e.g.*, *President Obama Signs Senate Health Reform Bill Into Law*, ERISA INDUS. COMM. (Mar. 23, 2010), http://www.eric.org/forms/documents/DocumentFormPublic/view?id=1FAFB00000001.

[214] As the name indicates, this canon holds that Congress approves the existing interpretation of a law when it considered and rejected a proposal for some legislation that would do the opposite. WILLIAM N. ESKRIDGE, JR., DYNAMIC STATUTORY INTERPRETATION 245–46 (1994).

ACA, to allow for ERISA waivers.[215] This offers a weak indication, which can be anchored by other indicators of Congressional support for ERISA preemption, that removal of its block to state laws did not have adequate political support.[216] In any case, particularly in light of the text prohibiting the Secretary of HHS from waiving laws outside the agency's jurisdiction, it would take a significant leap for a court to say that a law enacted under the waiver provision could avoid ERISA without anything else being done to make this possible.

What result will come of the use of any of these canons will certainly depend on the court in which the new state law is challenged, as well as, to some extent, future politics and the direction the agencies are taking. A judge who is not a strict textualist and who is sympathetic to the ACA's purpose may be willing to overlook the waiver provision's textual indication about the limit on the powers of the Secretary of HHS to grant waivers, in favor of giving effect to its apparent intent: to allow states to enact their own reforms.[217] Failing that, we will have a clearer answer, sooner, about whether the waivers are going to work if Congress adopts the Wyden-Brown amendment to the ACA. However, the provision itself will not address the ERISA

[215] See discussion above of Kucinich amendment legislative history, *supra* note 171 and accompanying text.

[216] Of course, there are myriad reasons why the amendment didn't go through, and not all of them may mean that Congress as a whole was completely against the waivers. In any case, the 112th Congress has brought a group of representatives who are far more supportive of states' rights, so using this information to judge whether the current group of representatives would not want things to be interpreted this way is probably not an effective approach.

[217] The classic aim of purposive interpretation is to address the "mischief" that the legislators were apparently trying to tackle. In this case, it was high cost and many people not having insurance, so a judge could use that knowledge if he or she felt that interpreting the waiver provision differently would achieve the effect of undoing that "mischief," or would at least help to do so. *See* ESKRIDGE, FRICKEY & GARRETT, *supra* note 20, at 693–94 (discussing the "mischief rule" of Heydon's Case).

problem—unless, of course, they decide to add language that would do so, and such an addition is not stripped out.

IV. WHITHER ERISA?

Though many U.S. policymakers and commentators long despaired of health reform ever happening on either a national scale (because of the lack of sufficient political will) or a state-by-state scale (because of the ERISA preemption block), the ACA has brought about both. As federal legislation, it has had a sweeping impact that resembles, to some degree, what resulted from the push for new social legislation decades ago.[218] But the ACA is also being implemented through the states, which have to pass their own laws and create exchanges for the reform to work, or else allow the federal government to do so for them. This kind of arrangement raises the question, in light of the ERISA preemption issues that came up so frequently prior to the ACA: what will ERISA preemption's role be going forward?

A. Is ERISA Preemption Strengthened or Weakened in the Health Care Area?

In the ACA's federal-state partnership, the states will enact certain laws and regulations that will likely have some effect on employer-provided health benefits, as part of the ACA's initial implementation; then they will be able to enact their own laws and waive out of the ACA, though there are a couple of major problems with the waiver scheme, as discussed above. The question of what ERISA preemption's

[218] *See* Sheryl Gay Stolberg & Robert Pear, *A Stroke of a Pen, Make that 20, and It's Official*, N.Y. TIMES, Mar. 24, 2010, at A19 (describing the bill as the most significant piece of social legislation to be signed in decades, comparing it to Great Society and other laws from the twentieth century); Theda Skocpol, *The Political Challenges That May Undermine Health Reform*, 29 HEALTH AFFAIRS 1288, 1288 (2010) (describing the redistributive aspects of the ACA and their similarity to those that were incorporated in social legislation of the twentieth century).

new role will be in relation to health care results in different answers for those two periods.

In the implementation period, ERISA preemption will no longer have the same relevance for health law that it once did. First, many of the ACA's reforms will happen at a federal level, as with the individual and employer mandates.[219] ERISA will not preempt those reforms in the way it would have if a state initiated them, because preemption does not apply to federal laws.[220] Furthermore, the state laws and regulations implementing other parts of the ACA will either not be doing anything that would have invoked ERISA preemption anyway, as with the Medicaid and SCHIP changes, or will not likely be challenged even if there is possibly a question about their relation to employer-provided benefits, as with the insurance exchanges. Also, states may be less inclined to enact their own health reform laws now that the ACA is in place.[221] Even if the states are not happy with the federal reform, they are required to implement the law, and that implementation will inevitably sap resources that they might otherwise have used to implement their own non-ACA programs. Thus, fewer states are likely to proceed on their own with reforms, so there will be fewer state laws for ERISA to preempt.[222]

There is, furthermore, an argument that ERISA preemption's effects will grow stronger rather than become diminished due to the ACA's implementation. Previously one of the strongest cases against ERISA preemption,

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[219] *See supra* Part III.A.

[220] § 514(a), 29 U.S.C. § 1144(a) (2010).

[221] *See* DOJ Brief, *supra* note 1, at 16 (citing this as one reason why the Supreme Court should not grant the writ of certiorari in the San Francisco reform case).

[222] Some commentators are starting to make this argument. *See Local Employer Pay-or-Play Laws: ERISA Preemption a Moot Issue?*, DELOITTE WASH. BULL. (Aug. 9, 2010), http://benefitslink.com/articles/guests/washbull100809c.html. *But cf.* Chirba-Martin & Torres, *supra* note 95, at 421 (noting that "PPACA may have drastically increased the federal government's role in overseeing health care, but even 2000 page bills leave more than enough for the states to do," thus the issue of ERISA preemption needs to be addressed more clearly than it was with the ACA).

particularly in situations where it preempted state tort laws, was that ERISA itself provides no substantial remedy. Thus when state law was preempted, plaintiffs could only recover the value of the health care service they received, and not any punitive or emotional damages.[223] The ACA does not provide any private remedy for people, and it does not change the fact of the absence of a remedy in ERISA. It is possible that courts will decide that the ACA reforms mean that it is no longer necessary to let state laws stand if it appears that ERISA should preempt them, where in the past courts might have tried to find a way around ERISA preemption. This is especially true with non-ACA-shielded state laws that are either less than obviously preempted by ERISA or where a particular case's facts are fairly egregious.

Finally, even if courts do not begin to consider the fact that the ACA is expanding relief to people who would previously have been denied relief due to ERISA preemption of many state causes of action, ERISA's preemption of laws enacted outside the ACA's aegis is undiminished.[224] Although, as noted above, it is possible that fewer states will be inclined to embark on their own reform programs, some still may,[225] and federal courts may even be more likely to preempt state or local laws now, because the ACA is a federal effort at reform. Courts may see the ACA as "occupying the field" of health care reform because of its

[223] Andrew Stumpff, *Darkness At Noon: Judicial Interpretations May Have Made Things Worse for Benefit Plan Participants Under ERISA Than Had the Statute Never Been Enacted*, 23 ST. THOMAS L. REV. (forthcoming spring 2011) (describing ERISA's effects on benefit plan participants' available remedies).

[224] As noted above, in a recent D.C. Circuit case, the court held a local law to be preempted by ERISA. Pharm. Care Mgmt. Ass'n v. District of Columbia, 2010 U.S. App. LEXIS 13991 (D.C. Cir. July 9, 2010); *see also* Stephanie Kanwit, PMCA v. D.C.: *ERISA Is Alive and Well After Health Care Reform*, WASH. LEGAL FOUND. (Oct. 29, 2010), http://www.wlf.org/Upload/10-29-10Kanwit_LegalBackgrounder2.pdf (describing the case and asserting that it demonstrates ERISA preemption's health despite the passage of the ACA).

[225] As noted, Vermont has already forged ahead. *See supra* notes 184–85.

comprehensiveness and all the rhetoric about how sweeping a law it is. The ACA does provide that it will not preempt any state law that does not prevent its operation,[226] but courts may be inclined to allow ERISA's preemptive effect to be enhanced for state healthcare laws that conflict with it, now that the ACA has been enacted, because the ACA creates a broad federal presence in health law.

On the other hand, as discussed in the previous Part, ERISA preemption may come back into relevance once states begin to waive out of the ACA to do their own reforms. Some of the issues just noted for the general implementation period will continue to apply, such as the idea that the ACA is occupying the field in this area and thus the states will be limited in what they can do on their own in the way of meaningful reform. Yet the waivers are undeniably allowed as part of the ACA, demonstrating apparent intent on the part of Congress that states should be able to attempt their own reforms under the right circumstances, which goes contrary to the general impulse of courts interpreting ERISA preemption situations, which is to assume that national uniformity is the prime goal.[227] Overall, the effect of the ACA on ERISA preemption in the waiver stage, as it stands with the ACA's present text, is likely to be that it will neither strengthen nor weaken it. That is just the problem: ERISA preemption will still pose a threat to state innovation in the health reform area, just as it consistently did before, unless politicians or courts take affirmative steps to see that this disruption does not happen.

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[226] ACA, Pub. L. No. 111-148, § 1321(d), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18041(d)).

[227] Magnusson, *supra* note 47 (articulating the reasons why ERISA preemption and the resulting national uniformity are so important). But as other commentators have noted, uniformity is not ERISA's only goal, and the fact that it is also supposed to be employee-protective is another strong element of the law to which courts must attend. *See* Dahlia Schwartz, Note, *Breathing Lessons for the ERISA Vacuum: Toward a Reconciliation of ERISA's Competing Objectives in the Health Benefits Arena*, 79 B.U. L. REV. 631, 638 (1999) (remarking on "the inherent tension between the goal of national uniformity of benefit regulation and the need to protect beneficiaries").

B. Addressing ERISA Preemption Issues to Support Health Care Reform

Few would deny that the ACA has flaws as a health reform bill, but it could be better—and possibly more appealing to state legislators who want to be able to experiment with their own reforms—if there are not nagging concerns about ERISA preemption that must be dealt with and could be litigated. The following subsection discusses some of the possibilities for improving the ACA and/or ERISA to increase the odds of health care reform success.

1. Repeal or Amend ERISA's Preemption Provision

The most obvious way to fix the problem of ERISA preemption would be to repeal the provision altogether, at least with respect to health benefit plans. Commentators have argued for variants of this outcome almost since the ERISA preemption provision was first interpreted broadly by the Supreme Court.[228] But total repeal of the provision seems highly unlikely because of the support that ERISA preemption enjoys from the business lobby and the legislators it supports.[229]

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[228] *See, e.g.*, Bobinski, *supra* note 81, at 344–45 (1990) (advocating limited repeal of ERISA preemption provision); Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1367 (2007) (proposing that ERISA preemption be repealed as it applies to self-insured health plans); Christen Linke Young, Note, *Pay or Play Programs and ERISA Section 514: Proposals for Amending the Statutory Scheme*, 10 YALE J. HEALTH POL'Y L. & ETHICS 197 (2010) (suggesting that ERISA's preemption provision be repealed, or at the very least amended); Zelinsky, *Reasoned Textualism*, *supra* note 189 (arguing for repeal of ERISA preemption but acknowledging that it is unlikely to happen).

[229] *See, e.g.*, Daniel M. Fox & Daniel C. Shaffer, *Health Policy and ERISA: Interest Groups and Semipreemption*, 14 J. HEALTH POL. POL'Y & L. 239, 244–47, 251–53 (describing industry lobbying against weakening of ERISA preemption); *Health Care Policy Priorities for 2011*, U.S. CHAMBER OF COMMERCE, http://www.uschamber.com/issues/priorities/health-care (last visited Apr. 14, 2011) (listing opposition to "state and local efforts to

However, scholars have proffered various suggestions for amending the preemption provision to clarify its breadth (in all cases, to narrow it).[230] The most plausible of these ideas is an amendment to allow states to obtain waivers from ERISA preemption in general.[231] With the ACA, an even more appealing amendment to ERISA's preemption scheme is possible: one limited only to ACA state innovation waivers (i.e., not applying to state reforms outside the ACA's aegis). Such an amendment would thus probably closely resemble the one proposed by Representative Kucinich, which did not pass[232]—but if enough legislators supported the waiver idea and knew of the need to deal with the ERISA preemption issue, perhaps an amendment would gain more backing. Such a relatively limited amendment is the most likely of any to gain traction. Nevertheless, the enduringly strong

circumvent ERISA preemption and interfere with self-insured plans" as a top concern); *About ERISA*, NAT'L COAL. ON BENEFITS, http://www.coalitiononbenefits.org/ERISA/ (last visited Apr. 14, 2011) (explaining the importance of ERISA and its preemption provision to leading business representative group).

[230] *See, e.g.*, Christopher J. Frankenfield, *The Relationship Between ERISA, State and Local Health Care Experimentation, and the Passage of National Health Care Reform*, 13 J. HEALTH CARE L. & POL'Y 423, 455–57 (2010) (arguing that unless courts change their interpretation of ERISA preemption, the only way out is for the preemption provision to be amended); MK Gaedeke Roland, Comment, *Looking for a Prince Among the Frogs: Solutions to ERISA's Preemptive Effect on Improving Health Care*, 47 BUFF. L. REV. 1487, 1530–32 (1999) (concluding that "[u]ltimately, amending ERISA provides the best solution" to health care woes); Edward Zelinsky, *National Health Care Shouldn't Be National: Amending ERISA to Encourage States' Experimentation*, OUPBLOG (Dec. 10, 2007, 1:32 PM), http://blog.oup.com/2007/12/ownership_society/ (commenting that "the first order of business for federal health care reformers should be the modification of ERISA to permit state-by-state innovation").

[231] *See, e.g.*, Devon P. Groves, Note, *ERISA Waivers and State Health Care Reform*, 28 COLUM. J.L. & SOC. PROBS. 609, 651–52 (1995) (emphasizing need for states to get ERISA waiver and suggesting options for drafting one); Scott D. Litman, Note, *Health Care Reform for the Twenty-First Century: The Need for a Federal and State Partnership*, 7 CORNELL J.L. & PUB. POL'Y 871, 913–16 (1998) (similarly arguing for a broad-based ERISA exemption for state health care laws).

[232] *See supra* note 172 and accompanying text.

industry and related congressional support for ERISA preemption means that any amendment, no matter how limited, is unlikely to pass anytime soon.[233]

2. Strengthen the Waiver Provision

The waivers for state innovation have a great deal of potential, but they are also rather problematic because of their late implementation date and, principally, because of the lack of an ERISA preemption waiver.[234] The Wyden-Brown bill, which is currently in the Senate Finance Committee, and the corresponding House bill, may address the first issue.[235] The second issue does not seem to have been addressed at all, either in Congress or in the press, but it is by far the more difficult issue. This is because if ERISA preemption applies to state laws that are enacted pursuant to the waiver section, then unless there is an amendment to ERISA or a workaround through the ACA to address the problem, the waivers will be essentially worthless. But, as with obtaining amendments to or waivers of ERISA preemption itself, changing the ACA's state innovation program to make it less susceptible to preemption is likely to encounter significant opposition from ERISA supporters. So far, they seem largely content because the ACA does not, at least in its language, affect ERISA preemption—even if the ACA's presence makes ERISA preemption less important, as

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[233] *See, e.g.*, Zelinsky, *Reasoned Textualism*, *supra* note 189, at 856 (commenting about the lack of political will to amend ERISA).

[234] The current text of the ACA does not allow the states to obtain waivers until 2017. ACA, Pub. L. No. 111-148, § 1332(a)(1), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18052(a)(1)). As discussed above, although an early version of the ACA in the House had a waiver from ERISA § 514(a) preemption, that did not survive into the final bill.

[235] The Empowering States to Innovate Act, S. 248, 111th Cong. (2010), was unanimously sent by the Senate Committee on Health, Education, Pensions, and Labor to the Finance Committee on Feb. 7, 2011; it also picked up several new co-sponsors in Senators Mary Landrieu of Louisiana, Patrick Leahy of Vermont, Joe Manchin III of West Virginia, and Benjamin Nelson of Nebraska. The House Bill, H.R. 844, which has the same title, was referred to the House Subcommittee on Health on March 8, 2011.

discussed above.[236] If preemption supporters saw a real threat to the provision, which they undoubtedly would with such a measure going forward, they would surely bring to bear all their significant resources and lobbying skills to try to defeat it.[237]

Nonetheless, if enough members of Congress can be convinced to disregard such an onslaught and bolster the state innovation waiver by adding in an ERISA preemption waiver or giving the Secretary of HHS the power to waive ERISA preemption in conjunction with the state innovation waivers, it would save the state innovation section from futility. Congress has already given the states a large role in implementing the ACA; some of the states have resisted that

[236] *See, e.g., President Obama Signs Senate Health Reform Bill into Law,* ERISA INDUS. COMM., (Mar. 23, 2010), http://www.eric.org/forms/documents/DocumentFormPublic/view?id=1FAFB00000001 (commentary by ERISA group explaining the absence of any weakening of ERISA preemption in the final law); *Employee Retirement Income Security Act (ERISA)*, NAT'L BUS. GROUP ON HEALTH, http://www.businessgrouphealth.org/benefitstopics/topics/0023.cfm?topic=0023&desc=Employee%20Retirement%20Income%20Security%20Act%20%28ERISA%29 (last updated Dec. 28, 2010) (claiming that "[t]he Affordable Care Act recognized the importance of ERISA [preemption] and did not touch it").

[237] For instance, soon after the ACA was enacted, the Department of Labor drafted a proposed regulation that would finally provide definitions of "employee welfare benefit plan" and "welfare plan," but in such a way as possibly "to exempt from ERISA preemption State and local government health plans that included non-governmental employees." The ERISA Industry Committee lobbied hard against this change, which did not take effect. *See ERIC Urges Withdrawal of Draft Proposed Regulation That Would Curtail ERISA Preemption,* ERISA INDUS. COMM. (Apr. 29, 2010), http://www.eric.org/forms/documents/DocumentFormPublic/view?id=209300000003D (describing the change and letters of opposition sent to the Office of Management and Budget); *DOL Withdraws Proposed Rule on Definition of Welfare Benefit Plan,* AON HEWITT (Aug. 9, 2010), http://www.hewittassociates.com/Intl/NA/en-US/KnowledgeCenter/LegislativeUpdates/WashingtonReportDetail.aspx?cid=8805&WT.ac=popart_L07_082310. This is only one instance of what is by all accounts a very vigorous support of ERISA preemption that generally happens without being very visible.

role,[238] but some would perhaps be more enthusiastic if they knew they would be able enact their own reforms in due course.[239] However, for that to happen, the ERISA preemption issue that lurks inside the waivers must be addressed.

3. Purposive Judicial Alternative

The text of the ACA waiver provision explicitly directs that the Secretary of HHS cannot waive any law not in his or her jurisdiction.[240] This includes ERISA. However, it is possible that a strongly purposive court could interpret past this, since state innovation seems impossible without an

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[238] *See, e.g.*, Kevin Sack, *Suit on Health Care Bill Appears Likely to Advance*, N.Y. TIMES, Sep. 15, 2010, at A20 (pointing out that "[t]he states also argue that the new law, by vastly expanding the shared state and federal Medicaid program, amounts to a coercive commandeering of state resources"); Letter from Dean Cannon, Speaker-Designate, Fla. House of Representatives, to Charlie Crist, Governor of Florida (Oct. 19, 2010), *available at* http://www.postonpolitics.com/wp-content/uploads/2010/10/Patient-Protection-and-Affordable-Care-Act-Implementation.pdf (announcing that "[c]ommandeering of state insurance regulatory resources generates the greatest concern" with regard to the state's moving ahead with implementation of any of the ACA).

[239] Again, allowing states to obtain waivers earlier should help here, since that would mean that the states would not have to invest much in reforms that are only relevant for the ACA. Ezra Klein, *Have Scott Brown and Ron Wyden Figured Out the Way Forward on Health Care?*, WASH. POST (Nov. 18, 2010, 12:11 PM), http://voices.washingtonpost.com/ezra-klein/2010/11/have_scott_brown_and_ron_wyden.html (commenting on the potential of the amendment and the appeal it should have for states); Kate Pickert, *A Health Care Fix Bernie Sanders and Tim Pawlenty Can Both Love?*, TIME (Nov. 19, 2010, 5:00 AM), http://swampland.blogs.time.com/2010/11/19/health-care-fix-bernie-sanders-and-tim-pawlenty-can-both-love (noting the appeal that the waivers should have for Republicans and others who favor states' rights). *But cf.* Conn Carroll, *Daniels vs Obamacare: Why Wyden-Brown Will Not Work*, THE HERITAGE FOUND. (Jan. 21, 2011, 1:00 PM), http://blog.heritage.org/2011/01/21/daniels-vs-obamacare-why-wyden-brown-will-not-work (arguing that the ACA is already "completely antithetical to the First Principles of this nation" and thus the waivers will not make anything better).

[240] ACA, Pub. L. No. 111-148, § 1332(c)(2), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 18052(c)(2)).

ERISA waiver. In other words, applying the text strictly would have an absurd result, which courts try to avoid.[241] All else equal, courts intending to give the ACA its full effect could use this canon against absurd results as a reason to resist allowing ERISA preemption in such situations. However, the legislative history and context discussed above mean that all is not equal. Apparently, apart from Representative Kucinich, few members of Congress wanted to change the extant ERISA preemption situation, and courts are sure to take note of that lack of support and be less willing to apply the canon.[242] On the other hand, those who voted for the ACA may have thought that the waivers for state innovation would work as written, not realizing that ERISA would be an obstacle. Again, a court aiming to give the ACA its full effect might allow states that receive ACA waivers to circumvent ERISA preemption even without a formal ERISA waiver or amendment.

4. HHS and State Implementation Options

As noted, the ACA will require myriad federal regulations and state-implemented laws to be written for all of its provisions to take effect.[243] If the new regulations and legislation are crafted carefully, with the danger of ERISA preemption in mind, they could perhaps enable states to sidestep some of the issues that stopped many of their

[241] The so-called canon against absurd results is longstanding and has been employed primarily by textualists, to ameliorate the results that might come of plain-meaning interpretations of statutes in certain situations. *See* ESKRIDGE, FRICKEY & GARRETT, *supra* note 20, at app. B, 19. *But see* Jonathan R. Siegel, *The Inexorable Radicalization of Textualism*, 158 U. PA. L. REV. 117, 145–46, 148–50 (2009) (explaining the absurdity exception and why some textualists have begun to reject its use as an "escape valve").

[242] *See supra* note 171 and accompanying text (discussing Rep. Kucinich's amendment proposal).

[243] *See* COPELAND, *supra* note 21, at 2–6 (describing mandatory regulations and substantive rulemaking requirements under the ACA).

previous attempts at reform.[244] They could do so by explicitly building on the ACA and its goals; as a federal law, ACA reforms will not be preempted by ERISA—something that the states on their own could rarely achieve previously.[245] The ACA is still, in many ways, just a skeleton, and it is possible that as states and their agencies engage in fleshing it out, they can create regulations to improve the effectiveness of the overall reform while strengthening the states' involvement even more, using the ACA as a shield from ERISA.[246]

Another interesting possibility would address the problem of the subsection in the waiver provision that prevents the Secretary of HHS from waiving any law not in HHS's jurisdiction.[247] The solution might be an executive order along the lines of one that President Carter issued in 1978, as ERISA was first being implemented.[248] As noted, jurisdiction over ERISA is shared by the Departments of

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[244] *Cf.* Abernethy, *supra* note 110, at 1883–94 (2008) (suggesting ways in which pay-or-play laws can be written to avoid preemption); Patricia A. Butler, *Revisiting Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints*, NAT'L ACAD. FOR STATE HEALTH POLICY, 6–7 (May 2002), http://www.nashp.org/sites/default/files/ERISA_Pay_Or_Play.pdf (offering concrete guidelines on how states can write laws to avoid ERISA preemption).

[245] *See supra* Part II.B.3–4 (discussing preemption by ERISA of state laws addressing health care needs).

[246] Note, in this regard, that with the exchanges, for example, the ACA says explicitly that it is a floor as far as requirements that a state might want to impose, and this kind of language could afford a state opportunities for tinkering with reform to some extent. Although "[a]n Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary" of HHS, ACA, Pub. L. No. 111-148, § 1311(k), 124 Stat. 119 (2010) (to be codified at 42 U.S.C. § 18031(k)), the requirements of the Exchanges are somewhat loose and are certainly the "minimum" which leaves a fair amount of room for adjustment. *Id.* § 18031(c)(1).

[247] *Id.* § 18052(c)(2)).

[248] Exec. Order No. 12,108, 44 Fed. Reg. 1065 (1978), *reprinted in* 29 U.S.C. § 1001. This executive order implemented Reorganization Plan No. 4 of 1978, 43 F.R. 47713, 92 Stat. 3790, as amended Pub. L. 99-514, Sec. 2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 109-280, title I, Sec. 107(c), Aug. 17, 2006, 120 Stat. 820.

Labor (DOL) and Treasury,[249] but coordination during the law's initial implementation phase did not go smoothly.[250] The executive order laid out a plan for how responsibility for administering the law would be shared.[251] A similar order by President Obama could allow for HHS and DOL[252] to work jointly in administering the waiver provision of the ACA, such that a state getting a waiver under the ACA would also get a limited waiver from ERISA for the law that was approved under the ACA waiver provision only.

The President has expressed his support for the Wyden-Brown amendment to allow states to obtain waivers in 2014 rather than 2017 because of the "flexibility" this provides states, which are integral partners in the ACA's implementation.[253] Furthermore, the wording of HHS's proposed rule implementing the waiver section may be expansive enough to allow for ERISA waivers in some form,

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[249] Brian A. Benko, *The Regulatory Systems for Employee Benefits*, 63 TAX LAW. 239, 257 (2010) (explaining the overlapping jurisdictions of DOL and Treasury).

[250] *See* Colleen E. Medill, *The Individual Responsibility Model of Retirement Plans Today: Conforming ERISA Policy to Reality*, 49 EMORY L.J. 1, 40 n.238 (2000).

[251] *Id.*

[252] Although DOL and the Department of Treasury have joint jurisdiction over ERISA, the latter oversees the tax administration part of the law, while DOL oversees the fiduciary aspects of the law. *See* PURCELL & STAMAN, *supra* note 23, at 1 (noting the joint jurisdiction over ERISA's titles).

[253] *See* Remarks by the President and the Vice President to the National Governors Association, Feb. 28, 2011, http://www.whitehouse.gov/the-press-office/2011/02/28/remarks-president-and-vice-president-national-governors-association; *see also* Sebelius, *supra* note 205 ("By maintaining these important basic protections for all Americans–no matter which state is their home–we will combine the benefits of a national movement to improve health and health care with the local innovations that have always made our nation great"); Stolberg & Sack, *supra* note 11 (reporting on Wyden-Brown bill, the President's remarks, and critical Republican reactions).

though only time will tell how the rule develops and is interpreted.[254]

This is an intriguing possibility, but it would not come without problems. Among them is the fact that ERISA does not give the DOL the ability to grant waivers from ERISA preemption. Hawaii's waiver came through an extremely restrictive amendment of ERISA itself.[255] Executive orders have also grown increasingly unpopular over the years, as they make it seem that the President is imposing his will without adequate process.[256] Since the ACA has already been thoroughly divisive, one can only imagine the uproar that would ensue if a President attempted such a thing.[257]

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[254] Application, Review, and Reporting Process for Waivers for State Innovation, 76 Fed. Reg. 13553 (proposed Mar. 14, 2011) (to be codified at 31 C.F.R. pt. 33 and 45 C.F.R. pt. 155); *see also supra* note 160 (discussing the proposed rule).

[255] *See supra* Part II.B.3. Hawaii's waiver was limited to the law it had enacted in 1974; any amendments, and the waiver would not apply. 29 U.S.C. § 1144(b)(5)(B)(ii) (2011). Furthermore, notes accompanying the amendment indicated that it was not to be used as a precedent for any further waivers for other states. Groves, *supra* note 231, at 633–34.

[256] *See generally* Tara L. Branum, *President or King? The Use and Abuse of Executive Orders in Modern-Day America*, 28 J. LEGIS. 1, 2–4, 21–23, 81–83 (2002) (describing the historical evolution of executive orders and criticizing their overuse in the modern era); Leanna M. Anderson, Note, *Executive Orders, "The Very Definition of Tyranny," and the Congressional Solution, the Separation of Powers Restoration Act*, 29 HASTINGS CONST. L.Q. 589, 589–91, 596–97 (2002) (describing the controversy that tends to surround executive orders and the difficulty of reining them in through legislative action).

[257] *See* Zelinsky, *Bi-Partisan*, *supra* note 85 (noting that despite all the heated rhetoric and controversy over the law, it is quite incremental in most respects). Of course, if the waivers are not allowed until 2017, President Obama will be out of office regardless of what happens in the 2012 election, and then all bets will be off as to the future of the ACA. But if the waiver amendment passes, making the waivers available sooner, then President Obama could have involvement in this hypothetical executive order process, especially since he has expressed support for state flexibility. Already, however, other kinds of waivers from the ACA, which HHS has handled but which, as agency actions, bear some resemblance to executive orders, allowing companies to avoid the ACA's requirements, have aroused wrath. *See, e.g.*, Philip Hamburger, *Are Health-Care Waivers Unconstitutional?*, NAT'L REV. ONLINE (Feb. 8, 2011, 4:00 AM),

Finally, despite the President's support for the state innovation waivers, these waivers would not be an unmitigated good, at least from the perspective of someone who wants the ACA to succeed. Waivers arguably have the potential to weaken the ACA as a whole by taking away state participation.[258] Nonetheless, it is a possibility to consider for anyone who wants to bolster the waivers' potential as an alternative mode of reform.

V. CONCLUSION

The ACA's reliance on extensive state implementation was the result of Congress' collective choice not to pursue health reform through an entirely federal scheme.[259] If Congress had instead decided to do everything on a national scale, there would be no hint of the ERISA preemption questions that this Note has discussed, except with regard to any states that continued with their own reforms. But since Congress put this cooperative federalist structure into place, the ERISA preemption questions that do arise, with regard both to the law's general implementation and to the state innovation waivers, whenever they come into effect, will be

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http://www.nationalreview.com/articles/259101/are-health-care-waivers-unconstitutional-philip-hamburger (criticizing the waivers granted to businesses); Jason Millman, *HHS Grants 500 New Healthcare Waivers*, HEALTHWATCH (Jan. 26, 2011, 4:50 PM), http://thehill.com/blogs/healthwatch/health-reform-implementation/140533-hhs-grants-new-reform-waivers-amid-heightened-scrutiny (explaining the waivers and increasing criticism of them).

[258] *See* Bob Doherty, *Is "Compete and Succeed" Better Than "Repeal and Replace"?*, AM. COLL. OF PHYSICIANS ADVOCATE BLOG (Nov. 19, 2010, 2:35 PM), http://advocacyblog.acponline.org/2010/11/is-compete-and-succeed-better-than.html (noting that supporters of federal reform might see the waivers as a "Trojan horse" that would sap reform of participants); Naomi Freundlich, *Letting States Opt Out of Health Reform Is a "Dangerous Idea,"* HEALTH BEAT (Nov. 23, 2010), http://www.healthbeatblog.com/2010/11/letting-states-opt-out-of-health-reform-is-a-dangerous-idea.html (worrying that Republicans "will use the waiver program as a ruse to develop state-based health care systems without an individual mandate, without a minimum level of benefits and without significant subsidies").

[259] *See* Gluck, *supra* note 126, at manuscript pages 21–23.

just as vital to answer as if no federal health reform had happened and the states were entirely on their own.

Most employers and individuals, as well as states, are still playing a waiting game with respect to finding out what the ACA is going to mean in the end because of the uncertainty that continues to swirl about the state and federal politics of its implementation.[260] Although it is unlikely that the state exchanges will be challenged, the state innovation waivers appear vulnerable. The waivers are among the ACA's most promising aspects, as they would allow states to go ahead with their own reforms in such a way that the United States would experience the effects of myriad kinds of health reform rather than one.[261] But despite being a part of the ACA, the waivers still have a potential ERISA preemption problem since no provision has been made for the states to obtain ERISA waivers in addition to the ACA waivers.

Because of this, it is unclear how the states will be able to go about passing meaningful laws that will not be preempted, even if they are allowed under the ACA. If an

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[260] *See, e.g.*, Reed Abelson, *Awaiting Health Law's Prognosis*, N.Y. TIMES, Feb. 2, 2011, at B1 (describing the conundrum faced by many people with illnesses and are in need of stronger insurance protections as they wait to find out whether the ACA will be upheld); Sarah Kliff & Jennifer Haberkorn, *Florida. to Obama: Keep the Health Cash*, POLITICO (Feb. 2, 2011, 3:05 PM), http://www.politico.com/news/stories/0211/48704.html (noting uncertainties about ACA's future because of court decisions and states' reactions).

[261] *See* Jonathan M. Kucskar, *Laboratories of Democracy: Why State Health Care Experimentation Offers the Best Chance to Enact Effective Federal Health Care Reform*, 11 J. HEALTH CARE L. & POL'Y 377, 398–402 (2008) (advocating adoption of a federal approach that would enable states to enact their own health care reforms, from which the federal government could then "cherry pick" the best, but noting that this would require a change in ERISA preemption, or a waiver from it for the states); Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 CONN. L. REV. 115, 117, 125–26 (1995) (advocating "federalist" health reform because "[t]here is unlikely to be any single system that either is or appears 'best' for the whole of these United States" but warning of the fierce business opposition that would inevitably face any proposal to weaken ERISA preemption).

ERISA waiver could be added to the amendment that Senators Wyden and Brown are circulating, or if President Obama enables the Secretary of HHS to work with the Department of Labor to grant ERISA waivers, then the true potential of the waivers can be fulfilled. Without this, the Senators' effort, and the entire state innovation waiver section of the ACA, appears essentially futile. Either way, the coming years will continue to be exciting ones in health reform, as many changes are afoot, but they will be even more exciting and meaningful if Congress provides for a stronger possibility that ERISA preemption's negative impact on health reform efforts will finally disappear.