COMMENTS

FOUR PROBLEMS FACING MEANINGFUL STATE HEALTH CARE REFORM AND COVERAGE IN THE UNITED STATES

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I. INTRODUCTION

According to the United States Census Bureau, the percentage and number of uninsured Americans has increased since 2000 to over 15.8%, or forty-seven million people.[1] Health care premiums are spinning out of control, so fewer employers are offering insurance to their employees or are passing along costs to those employees that are insured.[2] These statistics confirm the escalating health insurance crisis in America and the need for a comprehensive and feasible solution to provide affordable insurance in the midst of rising health care costs.

Specifically in the United States, most insured people are covered through private employers, while some receive public health care insurance via government health plans, or with Medicaid or Medicare.[3] When the government does provide health insurance

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[1] CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, 60-233, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006, 18 (2007), http://www.census.gov/prod/2007pubs/p60-233.pdf.

[2] *See id.* at 18 (stating "[t]he percentage of people covered by employment-based health insurance decreased to 59.7% in 2006, from 60.2% in 2005"); *see also* Julie Appleby, *Employer-Provided Insurance Continues to Decline*, USA TODAY, Nov. 12, 2007, *available at* http://www.usatoday.com/money/industries/insurance/2007-11-12-social-net_N.htm?POE=click-refer (chronicling examples where employers have paid decreasing percentages of insurance premiums for their employees, while increasing the direct costs to insured employees).

[3] *See* DENAVAS-WALT ET AL., *supra* note 1, at 20 (noting that in 2006, 59.7% of Americans have employer-based insurance and 27% are covered by a government plan, specifically 13.6% Medicare and 12.9% Medicaid insured).

and benefits not tied to employment, it is generally based on income level along with other factors, and may include public assistance payments as well as health coverage.[4] Although Medicaid, a health benefit for low income individuals, covers several million Americans who would otherwise be uninsured, several inherent issues arise through astronomical spending, and covered patients may face second-class treatment by essential providers refusing to treat Medicaid patients. Many uninsured individuals are not eligible for Medicaid, however, due to the income and other eligibility requirements, but cannot afford private pay insurance premiums if not offered by their employer.[5] Although Congress attempted to change health care in America, no meaningful reform has yet passed, thus leaving reform to the states to create programs that will help those employed, without health care coverage, and who are above the poverty line.[6]

Looming in the background, however, is the Employee Retirement Income Security Act of 1974 (hereinafter ERISA), which broadly preempts any state program "relat[ing] to any employee benefit plan."[7] Specifically, many state-level health care reforms include mandatory employer-provided insurance, or a "pay-or-play" scheme, which requires employers to contribute a specific amount of payroll towards employee health insurance or pay the difference to the state for publicly-provided health programs.[8] However, ERISA

[4] *See* Centers for Medicare & Medicaid Services, Medicaid Eligibility, http://www.cms.hhs.gov/MedicaidEligibility (last visited June 2, 2009) (explaining that "Medicaid is available only to people with limited income") [hereinafter Medicaid Eligibility].

[5] *See generally* DENAVAS-WALT ET AL., *supra* note 1, at 20 (stating approximately 9.1% of Americans directly pay for insurance); Medicaid Eligibility, *supra* note 4 (stating that "Medicaid does not provide medical assistance for all people with limited incomes and resources").

[6] In 2007, the poverty line was $10,210 per year for single family households in the forty-eight contiguous states and DC, or approximately $850 a month. United States Department of Health & Human Services, The 2007 HHS Poverty Guidelines, http://aspe.hhs.gov/poverty/07poverty.shtml (last visited June 2, 2009). Specifically, in New York State, a single person with no children must earn less than $700 per month to meet income eligibility requirements for Medicaid, but other state funded health care is available even for those living above this income threshold. New York State Department of Health, Medicaid In New York State: How How Do I Know If My Income and Resources Qualify Me For Medicaid?, http://www.nyhealth.gov/health_care/medicaid/index.htm#definition (last visited June 2, 2009); New York State, Healthy NY, Eligibility Criteria for Individuals, http://www.ins.state.ny.us/website2/hny/english/hnyeci.htm (last visited June 2, 2009) (listing criteria for individuals to enroll in New York State's Healthy NY program; specifically, an individual without employer-provided health care is eligible to purchase the publicly funded health insurance if earning less than $2,167 per month).

[7] Employee Retirement Income Security Act of 1974 § 514(a), 29 U.S.C § 1144(a) (2000).

[8] *See* 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.

preempts almost every type of "pay-or-play" plan; if allowed, these plans would help bridge the gap for uninsured Americans.[9] Therefore, without an express mandate from Congress or an exception to allow states to regulate employee benefits only for health insurance, employers may either limit health care benefits offered to employees or choose to stop providing health benefits altogether, forcing uninsured workers to seek health insurance in another arena. Although states may provide indirect incentives for employers to provide health insurance to their employees, such as tax credits, these methods are less effective without an actual mandate for employers.[10] As a result, the current federal government's policy of administrative uniformity in providing employee benefits across the nation apparently supersedes the need for greater health care coverage for all.[11]

Since the federal government has failed to cover forty-seven million Americans, states may still attempt health care reform, but several significant obstacles exist. Specifically, the four main problems presented by the current state models of health care in America are: ERISA preemption of state health care employer mandates; compliance with state individual mandates or tax incentives for employers to obtain health insurance; continuity of coverage regardless of life situation; and fraud and abuse issues in single payer systems such as Medicaid in New York State, including quality of care issues concerning the type and number of health care providers a particular insured patient can utilize. Based on these problems inherent in different models of state health care programs, a comprehensive plan must be adopted to provide meaningful health care coverage for all Americans and high quality care. Therefore, I propose a comprehensive nationally administered health care plan providing equal and continuous coverage to all Americans in the United States, which works in conjunction with an administrative body to enforce health care quality and compliance standards, with premiums so low that people will never decide to forego health care for other life necessities.

LAB & EMP. L. 387, 389 (2006).

[9] *See id.* at 388–89.

[10] *See* David Pratt, *The Past, Present and Future of Health Care Reform: Can it Happen?*, 40 J. MARSHALL L. REV. 767, 788 (2007).

[11] *See* Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990) (explaining the policy of ERISA's broad preemption is "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government").

The pressing issue of health care reform led 2008 Presidential candidates, now President Barack Obama and Secretary of State Hillary Clinton, to propose models of near universal health care coverage for all Americans.[12] These plans call for meaningful health insurance using both individual and employer mandates, but problems may still arise concerning compliance, affordability, and quality of health care.[13] As problematic as these issues may be, the significant obstacles facing state attempts at meaningful health care reform require the federal government to nationally implement such health care mandates or other programs to cover the forty-seven million uninsured Americans.

To further explore the range of options to provide greater and higher quality health care insurance and benefits to more Americans, one must understand the current situation of health care in the United States, state reform attempts, federal programs, and other proposed actions. The purpose of this Comment is to demonstrate the best approach to providing comprehensive health care coverage to more Americans is on a federal level due to the obstacles facing state health care reform. Therefore, this Comment is divided into five parts: Part II summarizes the current state of employer-provided health care in the United States; Part III examines ERISA, its policy, and preemption doctrine; Part IV explores the various state health care reforms and their interaction with ERISA in Maryland, New York, and California; Part V reviews state alternatives to pure employer mandates in Massachusetts and New York; and Part VI explores a national approach to providing health care coverage by evaluating the different strategies the former 2008 presidential candidates advanced in their campaigns, specifically comparing the universal-mandate plan against the child-mandate plan. Finally, this Comment concludes by acknowledging the best approach to providing more Americans health care coverage is by implementing a nationally administered plan.

[12] *See* Asiaing.com, The American Health Choices Plan, Hillary Clinton, http://www.asiaing.com/the-american-health-choices-plan-hillary-clinton.html (last visited June 2, 2009); Plan for a Healthy America, Barack Obama & Joe Biden's Plan, http://origin.barackobama.com/issues/healthcare (last visited June 2, 2009).

[13] *See* American Health, *supra* note 12; Healthy America, *supra* note 12.

II. CURRENT STATE OF EMPLOYER-PROVIDED HEALTH CARE IN THE UNITED STATES

In the United States of America, health insurance is generally accessed through employer-provided benefits.[14] Unfortunately, having a job does not automatically translate into having health insurance, since 82% of Americans without health insurance are in families with at least one part time worker.[15] This problem mostly occurs because many employers either cannot afford to pay rising health care costs and premiums for their employees, or refuse to do so.[16] Specifically, "[s]ince 2001, premiums for family coverage have increased 78%, while wages have gone up 19%," resulting in fewer employers offering health insurance or fewer employees enrolling in health insurance.[17] This is especially true for low-income workers, whose employers are less likely to provide health benefits, so health care premiums are unaffordable either provided through the employer's group plan or individually purchased.[18] Furthermore, even if an employer offers health care benefits, insurance may not cover the employee's family, or may do so at an even higher cost.[19] In 2007, employees paid average premiums of $2,831, or 28% of the cost for family coverage, versus $759 or 16% of premiums for individual coverage.[20] Fortunately, the State Children's Health Insurance Program and Medicaid have less stringent income requirements for families with children, so more poor children are insured that way.[21]

Although many low-income workers do not have health insurance through their employer, they may not be wholly without opportunity for some health care coverage. Requirements vary by state, but generally people below the federal poverty line may be eligible for Medicaid.[22] However, most of the people without health insurance

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[14] *See* DENAVAS-WALT ET AL., *supra* note 1, at 20 (noting that in 2006, 59.7% of Americans had employer-based insurance and 27% were covered by a government plan, specifically 13.6% Medicare and 12.9% Medicaid insured).

[15] KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE UNINSURED AND THEIR ACCESS TO HEALTH CARE 1 (2007), http://www.nbc-2.com/news/documents/swps_uninsuredaccess.pdf.

[16] *See id.* at 2.

[17] *See id.*

[18] *See id.*

[19] *See id.*

[20] THE HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, SURVEY OF EMPLOYER HEALTH BENEFITS 2007 4–5 (2007), http://www.kff.org/insurance/7672/upload/7693.pdf.

[21] *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, supra note 15, at 2.

[22] Centers for Medicare & Medicaid Services, Overview Medicaid Eligibility, http://www.cms.hhs.gov/MedicaidEligibility (last visited June 2, 2009) (explaining "Medicaid

are not below the federal poverty line, but cannot afford to pay health insurance premiums privately when employers fail to provide adequate coverage.[23] Therefore, some measure of reform is required to bridge the gap for health insurance between low-income people on Medicaid and those with comprehensive health insurance through their employer. The most obvious way to change this is to mandate that all employers provide comprehensive health insurance to every employee, but with the Employee Retirement Income Security Act of 1974's broad preemption of all state laws relating to an employee benefit plan, the most obvious route to reform is not the easiest.[24]

III. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

A. Purpose and Background of ERISA

In 1974, Congress enacted the Employee Retirement Income Security Act[25] ("ERISA") as a way to regulate the growing size and complexity of private pension plans offered by employers to their employees.[26] Since employee benefit plans had become more common to offer to employees in lieu of higher salaries due to favorable tax treatment, Congress intervened to regulate these benefits.[27] The driving force behind ERISA was financial inadequacy or faulty plan provisions failing to properly vest employees with accrued benefits, thus leaving retirees with little to no employer provided benefits, defeating their employment expectations.[28] Also, inconsistency in employee benefit administration often led to termination of benefits that employees relied upon for retirement.[29] To combat this inconsistency, ERISA set minimum standards for employee benefit plans and disclosure requirements to "assur[e] the equitable character of such plans and

is available only to people with limited income").

[23] *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 15 (explaining "[l]ow-income Americans have family incomes below 200% of the poverty level and run the highest risk of being uninsured").

[24] *See* Employee Retirement Income Security Act of 1974 § 1, 29 U.S.C. § 1001 (2000); *See also* Pamela A. MacLean, *ERISA, Health Care Clash in States: ERISA Pre-Empts Local Attempts to Mandate Coverage, Businesses Say*, NAT'L L.J., Aug. 27, 2007, at 7 (explaining ERISA's preemptive effect on state-level health care mandates for employers).

[25] Employee Retirement Income Security Act of 1974, 29 U.S.C §§ 1001–1461 (2000).

[26] *See* 29 U.S.C. § 1001.

[27] *See id.*

[28] *See* § 1001(a).

[29] *See id.*

their financial soundness,"[30] as well as to "establish[] standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and . . . provid[e] . . . appropriate remedies, sanctions, and ready access to the federal courts."[31] Based on its policy statement, the main purpose of ERISA is to protect retirees' pension benefits, most commonly income.[32]

B. ERISA's Relevance to Health Care Benefits

Although ERISA's policy and legislative findings focus on vesting retirement benefits, the statute's scope extends benefits employees currently use as well. Specifically, ERISA covers:

> [t]he terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . *medical, surgical, or hospital care or benefits*, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services.[33]

Based on this broad clause, health insurance, if provided as an employee benefit, is covered by ERISA.

ERISA has significant relevance to the health care crisis in America and attempts to combat the number of uninsured working Americans. Mainly, 59.7% of insured Americans have health care benefits through their employers, and the amount of employers providing health care is on the decline.[34] As a result, those employers that do offer health insurance to employees are subject to ERISA, but without a national minimum level of health care

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[30] *Id.*

[31] § 1001(b).

[32] *See id.*

[33] § 1002 (1) (emphasis added).

[34] DENAVAS-WALT ET AL., *supra* note 1, at 18 (stating "[t]he percentage of people covered by employment-based health insurance decreased to 59.7 percent in 2006, from 60.2 percent in 2005"); Julie Appleby, *Traditional Pensions Are Almost Gone. Is Employer Provided Health Insurance Next?*, USA TODAY, Nov. 13, 2007, at A1 (chronicling examples where employers have paid decreasing percentages of insurance premiums for their employees, while increasing the direct costs to insured employees).

benefits to provide, millions of Americans will remain uninsured. Since there is negligible health care reform on a federal level,[35] the problem lies with Congress's exclusive power over regulating employer-provided benefits via ERISA's broad preemption clause.[36] Specifically, ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."[37] On its face, the language seems restricted only to state or local government laws associated with employee benefits. However, the U.S. Supreme Court has broadly interpreted this clause to extend ERISA's preemption over virtually every state or local law that has any effect on an employee benefit.[38]

C. ERISA Preemption Doctrine

Although ERISA's preemption provision appears relatively simple on its face, a plethora of Supreme Court cases have grappled with which state laws actually "relate to" an ERISA plan and are therefore preempted.[39] In an early ERISA preemption case, *Shaw v. Delta Airlines, Inc.*,[40] the Court found "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."[41] Although this construction appears very broad, not every state law with some connection to an ERISA plan automatically triggers preemption.[42] Expanding on this broad reading in a later decision,[43] the Court explained "a state law may 'relate to' a benefit plan, and thereby be

[35] Most notably, health care reform under the Clinton administration's Health Care Security Plan failed to pass, which would have mandated universal health coverage for all Americans, including a provision for employees to maintain health insurance regardless if they switch jobs. "The vast majority of Americans continue to receive their health coverage at work, as they do today. All workers have a choice of health plans, each of which must be certified as meeting quality standards. Unlike today, however, all employers contribute to the purchase of health coverage for their employees, both full and part-time." The Health Security Plan, http://www.ibiblio.org/nhs/health.html (last visited June 2, 2009).

[36] *See* 29 U.S.C. § 1144(a).

[37] *Id.*

[38] *See* Dist. of Columbia v. Greater Washington Bd. of Trade, 506 U.S. 125, 130–31 (1992); Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 144–45 (1990); Shaw v. Delta Airlines, Inc., 463 U.S. 85, 108 (1983).

[39] 29 U.S.C § 1144(a). For a discussion of Supreme Court cases determining the scope of ERISA's preemption clause, see *generally Greater Washington Bd. of Trade*, 506 U.S. at 125; *Ingersoll-Rand Co.*, 498 U.S. at 133; *Shaw*, 463 U.S. at 85.

[40] *Shaw*, 463 U.S. at 85.

[41] *Id.* at 96–97.

[42] *See id.* at 100 n.21 (noting "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan").

[43] *Ingersoll-Rand*, 498 U.S. at 133.

pre-empted, even if the law is not specifically designed to affect such plans, or the effect is only indirect."[44] Based on this language, virtually any state law will be preempted if it has any effect on an ERISA plan. The analysis, however, did not stop there: confusion persists in what "a connection" or "reference to" actually means.[45] In subsequent decisions, the Court actually recognized the difficulty in determining which state laws would be preempted based on this ambiguous construction.[46]

Since ERISA's preemption clause literally applied to state laws "related to" an ERISA plan proves relatively unworkable, another step in ERISA's preemption analysis was highlighted in 1995 with the Court's focus on congressional intent.[47] The Court further clarified "relate to" in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*[48] by relying on ERISA's objectives, mainly:

> to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.[49]

Although ERISA's purpose stated in this way is commendable, the preemption provision extends beyond multi-state employers and conflicting state laws, including all employers and all employee benefit plans.[50] As a result, even a state health insurance law that applied only to single state employers and did not conflict with any

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[44] *Id.* at 139.

[45] *Shaw*, 463 U.S. at 96–97 (footnote omitted).

[46] *See* N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995) (admitting that the Court "simply must go beyond the unhelpful text and the frustrating difficulty of defining ['relate to']" to properly determine whether a state law is in fact preempted by ERISA).

[47] The Court noted under Supremacy Clause analysis the presumption "that Congress does not intend to supplant state law" applies to ERISA preemption so only with unambiguous congressional intent will state police powers be overridden by a federal statute. *Travelers*, 514 U.S. at 654–55; *see also* U.S. CONST. art. VI, cl. 2.

[48] *Travelers*, 514 U.S. at 645.

[49] *Travelers*, 514 U.S. at 656–57 (quoting Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990)).

[50] *See* 29 U.S.C § 1002(1) (defining "employee welfare benefit plan" as any plan created by an employer); § 1003 (listing exceptions for employee benefit plans not covered by ERISA, none including any plan applying in only one state); § 1002(5) (2000) (defining "employer" to encompass both multi-state and single-state employers).

ERISA provision theoretically would still be preempted. Furthermore, the Court summarized that ERISA "pre-empted state laws that mandated employee benefit structures or their administration [as well as] . . . state laws providing alternative enforcement mechanisms."[51] Under this analysis, state laws having an "indirect[] economic effect[]" most likely would not conflict with ERISA's objectives; however, the Court cautioned in its holding that "a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage . . . and that such a state law might indeed be pre-empted under [ERISA]."[52] This point was further elaborated upon in *Egelhoff v. Egelhoff*,[53] where the Court explained that "[a] statute is not any less of a regulation of the terms of ERISA plans simply because there are two ways of complying with it."[54] Based on these decisions, ERISA preemption is a case-by-case analysis, so without litigation, it remains unclear whether a state health law related to employer-provided health benefits will be upheld. This ambiguity is precisely the problem ERISA presents for meaningful state or local government health care reform; until enacted and challenged, states are clueless whether their reform attempts will prove fruitful.

IV. STATE HEALTH CARE REFORM AND INTERACTION WITH ERISA

Since Congress has failed to enact meaningful health care reform on a national level,[55] more states and local governments have proposed legislation to encourage or mandate health insurance for state residents. A variety of plans enacted in several states, including Maryland,[56] Massachusetts,[57] New York,[58] and California,[59] provide broad health care reform by requiring employers to contribute to employees' health insurance costs. In some areas, employers fail to provide an adequate level of health insurance coverage to their employees, so those employees must use

[51] *Travelers*, 514 U.S. at 658.

[52] *Id.* at 668.

[53] 532 U.S. 141 (2001). The case involved an ERISA challenge to a state law mandating a divorced spouse could not inherit an ex-spouse's nonprobate assets, including pension plans, although an opt-out provision existed for employers. *Id.* at 144.

[54] *Id.* at 150.

[55] *See supra* note 35 and accompanying text.

[56] *See* discussion *infra* Part IV.A.1.

[57] *See* discussion *infra* Part V.B.1.

[58] *See* discussion *infra* Part IV.B.

[59] *See* discussion *infra* Part IV.C.1.

state public health assistance, usually Medicaid, to supplement their health care needs.[60] To combat this problem, a commonly proposed state measure has been the "pay-or-play" model, which requires employers to contribute to their employees' health care coverage by a specified amount or percentage, or pay a penalty to the state, often to fund publicly provided health care programs.[61] Under such a regime, employers already offering substantial and comprehensive health care coverage to their employees are unaffected, but other employers are encouraged to provide better coverage for their employees to avoid the fee.[62] Additionally, such laws would halt the decline of employer-provided insurance in that state and decrease the millions of Americans without health insurance at all. However, these laws also fall under ERISA's preemption clause, and thus quality health care reform becomes even more difficult to achieve without federal involvement.[63]

A. Maryland: Fair Share for Health Care

In 2004, despite Wal-Mart being the largest corporation in the United States, the company only provided 48% of employees with health care benefits—versus other large employers averaging 68%—and spent less per employee than the average company.[64] Additionally, the legislative history of Maryland's Fair Share for Health Care Act showed Wal-Mart was the largest employer in Maryland and "provided its employees with a substandard level of healthcare benefits, forcing many Wal-Mart employees to depend on state-subsidized healthcare programs."[65] Wal-Mart's health insurance plan was undesirable due to the employees' high share of premiums, so most employees declined coverage,[66] thus shifting

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[60] *See, e.g.*, Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 183 (4th Cir. 2007).

[61] *See* O'Reilly, *supra* note 8, at 389. For additional proposals and enactments of pay-or-play legislation, see generally National Conference of State Legislatures, 2006-2007 Fair Share Health Care Fund or "Pay-or-play" Bills: Can States Mandate Employer Health Insurance Benefits?, http://www.ncsl.org/programs/health/payorplay2006.htm (last visited Jan. 16, 2009).

[62] *See* O'Reilly, *supra* note 8, at 405.

[63] *See Fielder*, 475 F.3d at 183.

[64] Wal-Mart Watch, *Wal-Mart vs. Maryland: On Background*, http://walmartwatch.com/pages/wal_mart_vs_maryland_background_to_the_fight_ahead (last visited June 2, 2009).

[65] *Fielder*, 475 F.3d at 183.

[66] Specifically "[i]n January 2005, 73% of all associates were eligible for health care benefit plans and only 43% chose to enroll." Julia Contreras & Orly Lobel, *Wal-Martization and the Fair Share Health Care Acts*, 19 ST. THOMAS L. REV. 105, 113 (2006).

health care costs to the state via Medicaid.[67] Even if an employee desired Wal-Mart's health plan, extensive waiting periods for dependent coverage and increasing hour requirements delayed eligibility for up to two years.[68] Based on this information, it was clear Maryland's state legislature had to intervene to protect its employees from Wal-Mart's abominable benefits plans.

1. The Statute

In January 2006, Maryland's General Assembly took revolutionary steps towards health care reform. Specifically, the Fair Share Health Care Fund Act was passed, requiring employers with 10,000 or more Maryland employees to "spend at least 8% of their total payrolls on employees' health insurance costs or pay the amount their spending falls short to the State of Maryland."[69] If employers failed to meet the requirements, the penalties were sent to the Fair Share Health Care Fund "to support the Maryland Medical Assistance Program, which consists of Maryland's Medicaid and children's health programs."[70] The statute appears to have general applicability on its face, but only Wal-Mart was subject to the requirement.[71] Other employers meeting the statute's criteria already spent over 8% on their employees' health care costs (specifically Giant Food), and thus had no alterations to make to their employee benefits.[72] The driving force behind this legislation was to ensure Wal-Mart would provide the required health care spending rather than paying the penalty, thus removing many Wal-Mart employees and their families from Maryland's Medicaid expense.[73] As expected, Wal-Mart did not want to comply with this

[67] *See id.* at 114–15 (suggesting "Wal-Mart has the highest percentage of employees on state funded healthcare").

[68] *See* United Food and Commercial Workers Int'l Union, Wal-Martization of Health Care, http://www.ufcw.org/take_action/walmart_workers_campaign_info/facts_and_figures/walmartonbenefits.cfm (last visited June 2, 2009) (explaining that Wal-Mart required full-time employees to work 6 months and part-time employees to work two years until single coverage eligibility, and increased hours requirements from 28 to 34 hours for full-time status).

[69] *Fielder*, 475 F.3d at 183.

[70] *Id.* at 185.

[71] The Act was written in a way to exclude non-profit employers from the 8% requirement, and other employers had contributed that amount for employee health care costs prior to the law and so were not subject to a penalty. *Id.*

[72] *Id.* Fortunately, Wal-Mart has since altered its employee health insurance by "shorten[ing] wait times to enroll in health coverage and . . . offering family plans to part-time workers." Lauren Coleman Lochner, *Wal-Mart to Expand Health Coverage for Employees*, N.Y. SUN, Sept. 19, 2007, *available at* http://www.nysun.com/business/wal-mart-to-expand-health-care-coverage/629821.

[73] *Fielder*, 475 F.3d at 185.

new mandate and the Retail Industry Leaders Association, of which Wal-Mart was a member, challenged the Act claiming, among other things, it was preempted by ERISA.[74]

2. The ERISA Challenge

In its 2007 opinion, the Fourth Circuit Court of Appeals affirmed the district court's determination that the Fair Share Health Care Fund Act was preempted by ERISA.[75] After reviewing current ERISA preemption precedence, the court determined "[i]n effect, the only rational choice employers have under the Fair Share Act is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold," because the employer has no benefit in paying a penalty to the state that could be avoided by compensating its employees.[76] Even the State agreed this was the goal of the law, and thus the court treated the State's monetary gain from noncompliance as a specific penalty rather than a general tax.[77] Since this functioned as an employer mandate, the court found the Act impermissibly "*directly* regulate[d] employers' structuring of their employee health benefit plans,"[78] as distinguished from an indirect economic incentive,[79] and thus was preempted by ERISA as having an impermissible "'connection with' covered employers' ERISA plans."[80]

Although Maryland's attempt to correct the inequitable imbalance Wal-Mart's inadequate and under-funded health care coverage created in the State, ERISA's broad preemption prevented its efforts from going into effect. Based on this precedent, States must craft health care reform legislation in a way that does not force employers to contribute to their employees' healthcare costs, but leaves employers with a reasonable alternative in order to avoid ERISA preemption as impermissibly connected to an ERISA plan. Other states may have enacted statutes that accomplish the same goal as Maryland but escape preemption, but only through litigation will an entity know the success of their health care reform efforts.

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[74] *Id.*
[75] *Id.* at 198.
[76] *Id.* at 193.
[77] *Id.* at 194.
[78] *Id.* at 195.
[79] *See supra* note 52 and accompanying text.
[80] *Fielder*, 475 F.3d at 197.

B. New York: Suffolk County Fair Share for Health Care Act[81]

In Suffolk County, the county legislature acted to combat the rising Medicaid spending for low-wage retail employees.[82] Similar to Maryland's Fair Share for Health Care Act,[83] Suffolk County responded to the growing population of Wal-Mart and other large retail employees without health insurance by mandating retailers contribute a specific amount to health care costs for each employee.[84] Specifically in Suffolk County, most grocery stores and other retailers provided health care benefits for their employees, but with large retailers like Wal-Mart establishing stores in the area without quality health care benefits for employees, the smaller shops withdrew these benefits to stay in business. Since grocery stores and retailers paid employees less than other jobs, an increasing number of people were on Medicaid for health coverage, so the County's Medicaid spending spun out of control.[85]

1. The Ordinance

The Suffolk County Fair Share for Health Care Act applied only to retail stores "where groceries or other foods are sold for off-site consumption" and used 25,000 or more square feet for selling groceries, the annual revenues exceeded $1 billion and 20% was from groceries, or at least 3% of a 100,000 square foot store was used for selling groceries.[86] Covered employers were required to spend an amount close to the "cost to the public health care system of providing health care to one uninsured employee" multiplied by the annual total employee hours worked.[87] In effect, this Law mandated employers provide Medicaid-level health care spending equal to the amount the County would spend on Medicaid coverage

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[81] SUFFOLK COUNTY, N.Y., LAWS pt. IV, ch. 325, art. I (2008).

[82] *See id.* § 325-1, *available at* http://gcp.esub.net/cgi-bin/om_isapi.dll?&infobase=suffolk.nfo&softpage=Browse_Frame-Pg42 (expand "Chapter 325, Health Care Benefits"; then expand "Article I, Expenditures by Retail Employers [Adopted 9-27-2005 by L.L. No. 30-2005]"; then follow "§ 325-1. Legislative Intent" hyperlink).

[83] *See* discussion *supra* Part IV.A.1.

[84] *See* SUFFOLK COUNTY, N.Y., LAWS pt. IV, ch. 325, art. I, § 325-1(F) (2008), *available at* http://gcp.esub.net/cgi-bin/om_isapi.dll?&infobase=suffolk.nfo&softpage=Browse_Frame_Pg42 (expand "Chapter 325, Health Care Benefits"; then expand "Article I, Expenditures by Retail Employers [Adopted 9-27-2005 by L.L. No. 30-2005]"; then follow "§ 325-1. Legislative Intent" hyperlink).

[85] *See id.* § 325-1(B)–(D).

[86] *See id.* § 325-2, Covered Employer (A)–(C).

[87] *Id.* § 325-3(A).

for each employee, without reducing wages to meet the payment.[88] The law was not restricted, however, to full-time employees; "part-time" or "seasonal" employees were also included, but management and supervisors were not.[89] If the employer failed to meet its requisite amount on health care expenditures, the difference between the required amount and the "actual health care expenditure" became the "civil penalty" paid to Suffolk County.[90]

2. The ERISA Challenge

Since the Maryland Fair Share statute was already challenged and found preempted by ERISA in 2006,[91] the Retail Industry Leaders Association, which Wal-Mart is a member, also challenged the Suffolk County act on the same grounds: ERISA preemption.[92] Basing its decision on *Fielder*, the district court similarly concluded the Act was preempted by ERISA.[93] The main thrust of the decision was that "the only rational choice employers have under [the Act] is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold."[94] The Act had a sufficient connection to an ERISA plan, since health care would be offered as an employee benefit, but the court rejected the idea that paying the civil penalty to Suffolk County was a reasonable alternative to using an ERISA plan.[95] The court also acknowledged that "Suffolk County enacted [the law] in order to mandate that covered employers and, specifically, Wal-Mart, increase spending on healthcare coverage for Suffolk County employees," clearly showing the alternative of paying the money to the County was not the statute's objective so thus was not a reasonable option for covered employers.[96] Furthermore, relying on *Egelhoff*, this type of law is still preempted by ERISA "if taking that option would be disruptive

[88] *Id.* § 325-3(B).

[89] *Id.* § 325-2(C).

[90] *Id.* § 325-4(A).

[91] Retail Indus. Leaders Ass'n v. Fielder, 435 F. Supp. 2d 481, 484 (D. Md. 2006).

[92] Specifically, the Plaintiff alleged the Statute "interferes with the uniform national administration of benefit plans." Retail Indus. Leaders Ass'n v. Suffolk County, 497 F. Supp. 2d 403, 405, 408 (E.D.N.Y. 2007); *see also* Employee Retirement Income Security Act of 1974 § 514, 29 U.S.C. § 1144(a) (2000) (explaining that "the provisions of this subchapter . . . shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan").

[93] *Suffolk County*, 497 F. Supp. 2d at 413–14, 417; *see also Fielder*, 475 F.3d at 183 (holding that Maryland's Fair Share Health Care Fund Act was preempted by ERISA).

[94] *Suffolk County*, 497 F. Supp. 2d at 417 (quoting *Fielder*, 475 F.3d. at 193).

[95] *Id.* at 406, 417.

[96] *Id.* at 417.

to the uniform plan administration."[97] The Suffolk County law, in effect, required employers like Wal-Mart to alter a nationally administered employee benefit for Suffolk County employees only, interfering with its uniformity, and thus was preempted by ERISA.[98] After this decision, it is clear that a mandatory "pay-or-play" scheme advanced in both Maryland and Suffolk County faces the inevitable ERISA preemption, and thus state and local governments must establish an ERISA-neutral scheme to encourage more employers to provide health insurance for their employees.

C. California: San Francisco Health Care Security Ordinance

In California, health care reform efforts may prove successful.[99] Of course, with 6.7 million uninsured residents, both Governor Schwarzenegger and local governments, specifically San Francisco, have proposed and enacted measures to increase residents' access to health care coverage.[100] Depending on the nature of the plan's effect, either proposal could withstand ERISA preemption in a legal challenge.

1. The Ordinance

In 2006, the San Francisco Health Care Security Ordinance was passed, to go into effect on July 1, 2007 and January 1, 2008 respectively.[101] The ordinance jointly established a Health Access Program for uninsured residents regardless of employment, and mandated employer contributions for employees' health care costs.[102] The Health Access Program is not an insurance plan, but rather is a network of participating hospitals and both private and nonprofit health care providers administered by the San Francisco Department of Public Health.[103] It provides various medical services, including treatment and preventative care, and allows

[97] *Id.* at 417–18 (citing *Egelhoff*, 532 U.S. at 151).

[98] *Id.* at 418.

[99] *See* MacLean, *supra* note 24.

[100] *See id.*

[101] *See* Golden Gate Rest. Ass'n v. City and County of San Francisco, 535 F. Supp. 2d 968, 970 (N.D. Cal. 2007), *rev'd*, 546 F.3d 639 (9th Cir. 2008); S.F., CAL., MUN. CODE ADMIN. CODE ch. 14, § 14.8 (2007), *available at* http://www.municode.com (follow "Online Library"; then follow "California" hyperlink; then follow "San Francisco" hyperlink; then follow "San Francisco Administrative Code" hyperlink.).

[102] *See* S.F. CAL., MUN. CODE ADMIN. CODE ch. 14, § 14.2(a), (c), (d) § 14.3 (2007).

[103] *See* § 14.2(a), (b), (e), (f).

each participant to have a primary physician.[104] The Health Access Program ensures each resident of San Francisco has access to some health care, funded in part by employers, individual contributions, and the City.[105]

As for employer contributions, the law mandates covered employers make quarterly health care expenditures for each employee, calculated by the number of hours worked multiplied by the applicable health care expenditure rate.[106] For large businesses averaging over 100 employees, the rate began at $1.60 per hour per employee, while medium sized businesses with twenty to ninety-nine employees paid an hourly rate of $1.06.[107] If a covered employer failed to make the required health care expenditures, a penalty would be assessed at "up to one-and-one-half times the total expenditures that a covered employer failed to make plus simple annual interest of up to ten percent from the date payment should have been made,"[108] and these penalties would be paid into the City's general fund to pay for the Health Access Program.[109]

Unlike traditional "pay-or-play" statutes, like in Maryland[110] and Suffolk County, New York,[111] the San Francisco ordinance mandates that covered employers make health care expenditures for employees, but is not limited only to employer-provided health insurance.[112] Specifically, health care expenditures may consist of:

> contributions by such employer on behalf of its covered employees to a health savings account . . . ; reimbursement by such covered employer to its covered employees for expenses incurred in the purchase of health care services; payments by a covered employer to a third party for the purpose of providing health care services for covered employees; costs incurred by a covered employer in the direct delivery of health care services to its covered employees; and payments by a covered employer to the City to be used on behalf of covered employees."[113]

This broad categorization gives employers a choice in how to meet

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104 *See* § 14.2(e), (f), (h).
105 *See* § 14.2(c), (d).
106 See § 14.3(a).
107 *See* § 14.1(b)(8)(a), (b)(11–12).
108 § 14.4(e)(1).
109 *See* § 14.2(h).
110 *See supra* Part IV.A.
111 *See supra* Part IV.B.
112 *See* S.F. CAL., MUN. CODE ADMIN. CODE ch. 14, §§ 14.1(b)(7), 14.3(a) (2007).
113 S.F. CAL., MUN. CODE ADMIN. CODE ch. 14, § 14.1(b)(7) (2007).

the statute's requirements, unlike the Maryland and Suffolk County laws that practically mandated the employer pay for employees' health insurance or pay a penalty.[114] This distinction may be enough to withstand an ERISA preemption challenge as an indirect incentive for employers, rather than a direct regulation of ERISA plans.[115]

2. The ERISA Challenge

Before the ordinance's employer mandate became effective on January 1, 2008, the Golden Gate Restaurant Association challenged the San Francisco Health Care Security Ordinance in federal district court claiming it was preempted by ERISA.[116] In the district court's analysis, it determined the ordinance both had an impermissible reference to and connection with ERISA plans, and thus was preempted.[117] The decision relied in part on *Fielder*, mainly that:

> [t]he expenditure requirements [of the ordinance] affect the structure of private employers' already existing plans by requiring that, in order to comply with the City's additional requirements, employers either modify the administration of their existing ERISA plans or structure their additional payments with reference to the amounts paid under the existing plans.[118]

However, he district judge failed to recognize the distinction between the statute at issue in *Fielder*, and San Francisco's ordinance. The judge continued, "[t]he requirements [of the ordinance] directly and indirectly affect the relationship between private employers and the provision of health care coverage, a relationship that has traditionally been governed by ERISA," but no existing precedent was cited to support this proposition.[119] Although health care coverage in America is primarily provided by private employers, they are not the only provider of health care coverage, despite ERISA's regulation of it as an employee benefit.[120]

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[114] *See supra* Part IV.A– B.

[115] *See* discussion *supra* Part III.

[116] Golden Gate Rest. Ass'n v. City and County of San Francisco, 535 F. Supp. 2d 968, 971 (N.D. Cal. 2007).

[117] *Id.* at 975.

[118] *Id.* at 976.

[119] *Id.* at 977.

[120] *See* DENAVAS-WALT ET AL., *supra* note 1, at 20 (noting that in 2006, 59.7% of Americans had employer-based insurance and 27% were covered by any government plan, specifically

Furthermore, ERISA only regulates health care coverage if it is provided as an employer provided benefit, and not if it is paid to a general city fund in lieu of privately provided insurance as this ordinance so provides.[121]

Despite the district court's ruling, the 9th Circuit Court of Appeals granted a stay pending appeal, finding the City has "a strong likelihood[] of success in their argument that the Ordinance is not preempted by ERISA,"[122] mostly because:

> [t]he Ordinance does not require employers to establish ERISA plans or to make any changes to any existing ERISA plans. Covered employers may fully satisfy the Ordinance by means other than establishing or changing ERISA plans, including by making payments to the City. The Ordinance requires that covered employers make certain levels of health care payments to an ERISA plan or to some other entity, including the City. It does not require that employers provide certain health care benefits to their employees, through an ERISA plan or otherwise.[123]

Although this order is not a full analysis of the ordinance, "[the] decision may provide a road map for state leaders as they try to craft a related pay-or-play health care program to withstand an ERISA challenge."[124] If this proves true, then state level health care reform and employer mandates are not only a possibility, but a reality; while preserving ERISA's uniform administration of employee benefit plans. However, uncertainty still surrounds the "pay-or-play" scheme, so state and local governments must explore alternatives to employer mandates to enact meaningful health care reform to avoid ERISA preemption.

13.6% Medicare and 12.9% Medicaid).

[121] *See* Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144 (2000); *see infra* note 123 and accompanying text.

[122] Golden Gate Rest. Ass'n v. City and County of San Francisco, 512 F.3d 1112, 1127 (9th Cir. 2008).

[123] *Id.* at 1119 (emphasis omitted).

[124] Cheryl Miller, *9th Circuit's Stay Lets S.F. Force Bosses to Fund Health Care*, THE RECORDER, Jan. 10, 2008, *available at* http://www.law.com/jsp/article.jsp?id=1199873138218&rss=newswire.

V. STATE ALTERNATIVES TO EMPLOYER MANDATED HEALTH INSURANCE

A. New York State

In New York State, health care reform is an especially important issue because of its large population and costly Medicaid program.[125] According to recent numbers, New York has the most expensive Medicaid program in the United States at $50 billion, covering approximately forty million people and forty-three percent of the state's budget.[126] Not only is the cost and number of people using Medicaid staggering in comparison to other states, but New York also faced many problems with fraud by both providers and recipients.[127] To combat this overwhelming cost to the state's budget, many measures have been taken by the New York legislature and governors to crack down on Medicaid fraud.[128] Despite the Medicaid issues on both a statewide and local scale, New York State government has acted to increase health insurance coverage to its many residents through means other than Medicaid.[129]

1. Medicaid: Friend or Foe?

According to New York State's Department of Health, Medicaid "is a program for New Yorkers who can't afford to pay for medical care."[130] This generalization, however, is overly simplistic because there are many factors determining eligibility for Medicaid in addition to low income.[131] Specifically, a single adult with monthly

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[125] *See* Francis J. Serbaroli, *New York Declares War on Medicaid Fraud,* N.Y.L.J., Nov. 30, 2007, at 3.

[126] *Id.*

[127] *Id.*

[128] *Id.*; *see also* N.Y. PUB. HEALTH LAW § 31 (McKinney Supp. 2008) (noting that the Office of the Medicaid Inspector General ("OMIG") was created in 2006 to prevent, detect, investigate, and recover funds from improperly paid Medicaid claims).

[129] New York State "is interested in proposals that build on these initiatives for achieving health system reform, increasing access to health insurance coverage and determining ways that universal coverage can be achieved." New York State, Partnership for Coverage, http://www.partnership4coverage.ny.gov (last visited June 2, 2009).

[130] New York State Department of Health, Medicaid in New York State, http://www.nyhealth.gov/health_care/medicaid/index.htm (last visited June 2, 2009).

[131] For example, people with low income but having other resources available exceeding a certain amount are ineligible for Medicaid, but if the person is a child, pregnant, or has a specific disability with high medical bills, the income cap is much higher. *See id.*

income of $700 and other financial resources under $4,200 meets income eligibility for Medicaid.[132] For those people that do qualify for Medicaid, their options and quality of health care are not always the same as privately insured individuals. Specifically, "[m]any established specialists in [New York] city do not take Medicaid patients in their private practices. Instead, those patients . . . are likely to go to 'specialty clinics' at teaching hospitals, and be treated by less experienced residents and interns."[133]

a. Medicaid and Quality of Care

Although Medicaid provides comprehensive health care coverage by providing preventative care, treatment, hospital services, nursing-home care, psychiatric care, prenatal care, psychiatric services, emergency ambulance services, and prescription drugs, it is not universally accepted at every health care or service provider.[134] Most health insurance plans are not universally accepted at every health provider either, but those with private insurance have many more options than those with Medicaid.[135] For example, according to the *New York Times*, a woman with a high risk pregnancy was unable to see a doctor-referred specialist because the office did not accept her type of Medicaid, and thus she could not afford to see the doctor with her own funds.[136] In contrast, depending on the privately insured's financial situation, he or she may be financially able to pay for the health service on his or her own, or submit receipts to his or her insurance for later reimbursement. A Medicaid patient, as described above, most likely cannot do this because he or she is on Medicaid due to his or her financial situation. Additionally, privately insured individuals may have some choice in which company or plan insures them, if their employer offers different insurance options. But a Medicaid recipient has no option; if the person is unable to obtain health

[132] *Id.*

[133] Richard Pérez-Pena, *Trying to Get, and Keep, Care Under Medicaid; Navigating System Takes More Persistence Than Many Clients Have*, N.Y. TIMES, Oct. 18, 2005, at B1 (commenting on Medicaid patient's eligibility and quality of health care in New York City during her brain tumor and high risk pregnancy).

[134] New York State Department of Health, Medicaid in New York State, http://www.nyhealth.gov/health_care/medicaid/index.htm (last visited June 2, 2009).

[135] Pérez-Pena, *supra* note 133 (chronicling story of woman with brain tumor's fluctuating eligibility for Medicaid program).

[136] Medicaid has a special program for pregnant women covering more services than the standard Medicaid recipient, and this office accepted the pregnant women's plan but not the regular Medicaid. *See* Pérez-Pena, *supra* note 133.

insurance through his or her employer or privately pay health insurance premiums, his or her options are limited to Medicaid or no insurance at all.

Although increased Medicaid controls and enforcement halt the rising health care costs to taxpayers,[137] the increased oversight may also further limit a Medicaid patient's options in what health providers he or she may see. Since the fraud and overpayments may go back several years, the providers that must repay those wrongly paid Medicaid claims take on huge financial burdens that may lead to bankruptcy or reduced capacity. As a result, fewer health care providers may voluntarily take the risk of accepting Medicaid patients for fear of an audit leading to a huge overpayment or civil liability.[138] Furthermore, Medicaid's reimbursement rate as compared to private insurance forces some health care providers to dispense medication or provide services at cost, which reduces the taxpayers' burden but makes operating a health related business less profitable.[139] Based on the current system of health care in America, it is ultimately a business and few people may take on the enormous risk of serving Medicaid patients for such little return.[140] Therefore, Medicaid patients in such areas will have to find other providers, and the quality of care may suffer tremendously by crowding and over-capacity.[141]

b. The High Costs of Medicaid: Fraud, Abuse, and Enforcement

In New York State, Medicaid's high costs are shared by federal, state, and local governments.[142] Specifically, "[r]oughly half of New York's Medicaid expenditures are funded by the federal government. Two-thirds of the remainder is contributed by the state and the remaining one-third is paid for by counties."[143] In affluent counties such as Westchester, Suffolk, and Nassau,

[137] *See infra* Part V.A.1.b.

[138] *See* Alexander G. Bateman Jr., *The Coming Wave of Health Care Fraud and Abuse Prosecutions*, N.Y.L.J., July 23, 2007, at 10 (explaining increased Medicaid enforcement requires health care attorneys to advise their provider clients to intimately know the applicable Medicaid regulations and statutes).

[139] *See* Elizabeth Solomont, *N.Y. Doctors Among Lowest in Medicaid Reimbursement*, N.Y. SUN, Sep. 6, 2007, at 4.

[140] *See id.*

[141] *See News*, NAMI-NYS NEWS (National Alliance on Mental Illness-New York State, Albany, N.Y.), Apr. 2006, at 9–10, http://www.naminys.org/April06News.pdf.

[142] *See* Richard Pérez-Pena & Michael Luo, *Program Disorder: Crisis in the Counties: As Medicaid Rolls Grow, Costs Take a Local Toll*, N.Y. TIMES, Dec. 23, 2005, at A1.

[143] Serbaroli, *supra* note 125, at 3.

Medicaid expenditures are high based on a state tax level,[144] but smaller, rural counties in upstate New York have a huge burden to undertake locally because a greater proportion of its population is on Medicaid.[145] Furthermore, fraud in the Medicaid system especially hits less populated counties hard as a major contributor to rising health care costs.[146] As a result, county governments raise taxes to combat Medicaid's rising costs as well as limiting other local expenses, such as libraries, arts, and other public improvements.[147]

In response to rising costs and Medicaid problems, New York State government is taking cost-controlling measures to lessen the detrimental impact of rising health care costs on other public works statewide.[148] Additionally, the federal government partnered with New York State to improve the Medicaid system; the main priority is to reduce Medicaid fraud by recovering fraudulent overpayments and other expenditures.[149] In addition, New York's Office of the Medicaid Inspector General has also worked to improve the quality of health care Medicaid recipients receive among other duties including combating Medicaid fraud by recovering overpayments.[150] Although New York State's various government agencies have taken steps to halt the rising fraud and costs of the Medicaid system, significant change will take several years to accomplish until the system is running smoothly. Furthermore, employer mandates are preempted by ERISA, calling for national level reform. Until then, other measures or an alternative to Medicaid should be explored for those without employer-provided health insurance.

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144 *See* Pérez-Pena & Luo, *supra* note 142.

145 As of 2005, "ten percent of the people in [Suffolk, Westchester, and Nassau] counties are on Medicaid, compared with 15 percent upstate, 20 percent in Chemung, and 34 percent in [New York] [C]ity." *Id.*

146 *See* Pérez-Pena & Luo, *supra* note 142; Serbaroli, *supra* note 125.

147 *See* Pérez-Pena & Luo, *supra* note 142; Serbaroli, *supra* note 125.

148 *See generally* Serbaroli, *supra* note 125 (noting that Medicaid Fraud Control Unit bolstered to address rising costs).

149 Medicaid fraud is usually discovered through audits, and a significant amount of inappropriate billing and inflated cost estimates are found through hospital and nursing home audits, resulting in an arrangement with the Office of the Medicaid Inspector General to compensate Medicaid for these overpayments due to fraud. *See* Serbaroli, *supra* note 125.

150 Current Medicaid Inspector General James Sheehan has demonstrated that "a failure to provide appropriate care, particularly when it results in actual harm to a patient, can be treated as fraud" and thus would lead to recovery of Medicaid payments for poor quality care. *Id.*

2. Partnership for Coverage[151]

In 2007, former New York State Governor Eliot Spitzer announced Partnership for Coverage, a combination of Medicaid reform and other publicly funded health insurance programs to help New York State residents obtain universal health insurance coverage.[152] Other New York publicly funded health insurance than Medicaid is available for children, adults who are ineligible for Medicaid due to higher financial resources, or do not receive health coverage through their employer (if applicable), but cannot afford privately paid health insurance.[153] However available these plans are, the problem of working people who are unable to afford self-pay insurance will still persist unless more employers contribute to their employees' health care costs. Until national universal health care is mandated or at least employer-provided health insurance is mandatory, these programs will assist in helping more people obtain some health insurance.

For low income individuals with income too high to qualify for Medicaid, one program, Family Health Plus, is available to uninsured adults between nineteen and sixty-four.[154] It also provides comprehensive health care coverage and some co-payments like Medicaid, but a single person can earn up to $867 a month and have other financial resources of $13,050.[155] This program is helpful for uninsured employed individuals, but the income requirements are still relatively low so it may not be a viable option to those with decent employment but no health insurance through an employer. Additionally, self-employed individuals would not qualify for this if their business was successful because still they earn too much money.

Another option for self-employed or small business owners is

[151] New York State, Partnership for Coverage, http://www.partnership4coverage.ny.gov (last visited June 2, 2009).

[152] *See* Press Release, New York State, Governor Spitzer Announces Contract with National Public Policy Institute on Universal Health Coverage (Dec. 4, 2007), http://www.ny.gov/governor/press/1204072.html; New York State, Partnership for Coverage, *supra* note 151.

[153] *See* New York State, Health Insurance: Partnership for Coverage, http://www.partnership4coverage.ny.gov/health_insurance.htm (last visited June 2, 2009).

[154] *See* New York State, Family Health Plus: What is Family Health Plus?, http://www.nyhealth.gov/nysdoh/fhplus/what_is_fhp.htm (last visited June 2, 2009); *see also supra* note 132 and accompanying text.

[155] New York State, Family Health Plus: Who Can Join?, http://www.nyhealth.gov/nysdoh/fhplus/who_can_join.htm (last visited June 2, 2009); *see supra* note 132 and accompanying text.

Healthy NY, a publicly funded program for those with higher income but without employer-provided insurance.[156] Healthy NY is also available to small business owners and their employees, but is only a reduced cost program with limited coverage,[157] not a majority subsidized plan like Family Health Plus and Medicaid.[158] Furthermore, the plan includes premiums, deductibles and co-payments, beneficiaries are limited to innetwork providers only, and there is a $3,000 annual maximum for prescription drug coverage.[159] Healthy NY is very similar to other private insurance based on these restrictions, but again the issue of meaningful choice presents itself. There are still financial guidelines for the coverage, so that a single adult earning up to $2,167 per month can purchase the health insurance.[160] This plan is at a reduced cost and functions like a private insurer, but the applicant must be employed and without health insurance for one full year prior to application based on specific events.[161] Although Healthy NY is a commendable program and an affordable option for working individuals, the requirement that a person must have been uninsured for a full year prior to applying is questionable, because the potential financial burden and failure to seek appropriate medical care can lead to much higher health care costs in the future. Additionally, people with pre-existing conditions may have up to a one year waiting period before they are fully covered under Healthy NY.[162] An employer providing substandard health insurance to employees is still an available alternative because an employee faces no insurance at all or poor coverage, because one would not be eligible for Healthy NY. As a result, the problem of quality health care

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[156] New York State, Healthy NY, Welcome to Healthy NY, http://www.ins.state.ny.us/website2/hny/english/hny.htm (last visited June 2, 2009).

[157] Limited coverage under Healthy NY excludes ambulances, mental health services, and alcohol and substance abuse treatment, which is questionable because many of these treatments can halt further problems in individual's lives that will lead to higher public costs, e.g., crime, joblessness leading to welfare, and Medicaid.

[158] NEW YORK STATE, HEALTHY NY: GUIDEBOOK AND APPLICATION FOR INDIVIDUALS AND SOLE PROPRIETORS 3 (2007), http://www.ins.state.ny.us/website2/hny/stdapp/hny_gd_app_soleind.pdf; New York State, Healthy NY: Eligibility Requirements for Individuals, http://www.ins.state.ny.us/website2/hny/english/hnyeci.htm (last visited June 2, 2009).

[159] NEW YORK STATE, *supra* note 158, at 2–3.

[160] *Id.* at 7.

[161] These events include divorce, annulment, loss of employment, and aging off a parent's health insurance plan, among others. NEW YORK STATE, *supra* note 158, at 8.

[162] The pre-existing condition includes pregnancy for those individuals who purchase Healthy NY, although one of the covered services includes maternity care. NEW YORK STATE, *supra* note 158, at 4.

coverage still lies with some employers' failure to provide comprehensive quality health insurance to their employees.

B. Massachusetts: Mandatory Health Insurance

1. Individual Mandates and Compliance Problems

Another program to combat the uninsured rate on a state level exists in Massachusetts. In 2006, Massachusetts adopted a comprehensive health care reform program composed of mandatory health insurance for individuals and employer requirements.[163] Specifically for individuals, "[a]s of July 1, 2007, [Massachusetts residents] age 18 and over shall obtain and maintain creditable coverage so long as it is deemed affordable under the schedule set by the board of the connector . . . ."[164] For those individuals who fail to obtain affordable coverage, he or she forfeits the personal exemption for tax return purposes as a penalty.[165] Since the Massachusetts law is still in its early stages of implementation,[166] its success has yet to be determined. One study compared the statistics of mandatory automobile insurance with health insurance, and the prognosis is bleak.[167] Specifically in 2004, 14.6% of American drivers remained uninsured despite 47 states mandating auto insurance, while 17% of Americans are without health insurance without any state mandate in force.[168] Since 47 million Americans were without health insurance in 2006, health insurance mandate compliance is not likely to succeed more than automobile insurance.[169] Fortunately, "[s]ince the passage of health reform, about 216,130 people have become newly insured."[170] Based on this figure, it appears mandatory health insurance for individuals may lead to universal coverage for Massachusetts residents after all.

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[163] MASS. GEN. LAWS ch. 111M, § 1–5 (2008).

[164] *Id.* § 2(a).

[165] *See id.* § 2(b).

[166] Some provisions of the law only went into effect in June 2007, others as of January 1, 2008.

[167] *See* GREG SCANDLEN, NAT'L CTR. FOR POLICY ANALYSIS, WILL MANDATORY HEALTH INSURANCE WORK? 1 (2006), http://www.ncpa.org/pub/ba/ba569/ba569.pdf.

[168] *Id.*

[169] *See id.* at 2*; see also* DENAVAS-WALT ET AL., *supra* note 1, at 18 (noting that the number of uninsured Americans Increased to forty-seven million in 2006).

[170] CHRISTOPHER BARBER & MICHAEL MILLER, COMMUNITY CATALYST INC., REVISITING MASSACHUSETTS HEALTH CARE REFORM: 18 MONTHS LATER 6 (2007), http://www.communitycatalyst.org/doc_store/publications/revisiting_MA_health_reform_dec07.pdf.

2. Employer Mandates: Avoiding ERISA Preemption

The provision that may impose an ERISA preemption challenge mandates "[e]ach employer with 11 or more full-time equivalent employees in the commonwealth shall adopt and maintain a[n] [IRS-defined] cafeteria plan . . . ."[171] In contrast to the employer mandates of Maryland and Suffolk County, New York, Massachusetts only requires employers provide *a* plan, not a specific health care expenditure or percentage based on the number of employees hired.[172] However, those employers who do not contribute enough to a group health plan[173] are required to pay an annually adjusted amount per employee known as the "fair share employer contribution;"[174] more similar to the traditional "pay-or-play" laws. Despite the varying calculation, the maximum amount an employer is required to contribute annually is only $295 per employee.[175] Specifically, "a 'fair and reasonable' contribution [is] either an employer with 25% of employees enrolled in a group health plan, or an employer that offers to pay 33% of a full-time employee's health premium."[176] This requirement is not asking much, considering the average employer contributes 84% to individual health care premiums.[177]

3. Employer Mandates: Facing Noncompliance

Although there is yet to be an ERISA challenge to this law, "[b]ecause of the modest—or weak—penalty associated with the fair share contribution, it will likely survive an ERISA preemption challenge because it is a mere indirect economic incentive for a plan administrator to make certain choices with respect to its health care

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171 MASS. GEN. LAWS ch. 151F, § 2 (2008).

172 *See generally* discussion *supra* Parts IV.A–B.

173 *See* MASS. GEN. LAWS ch. 149, § 188(a) (2008) (defining "contributing employer" as "an employer that offers a group health plan, as defined in 26 U.S.C. 5000(b)(1), to which the employer makes a fair and reasonable premium contribution, as defined in regulation by the division of health care finance and policy"); *see also* I.R.C. § 5000(b)(1) (2008) (defining "group health plan" as "a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families").

174 MASS. GEN. LAWS ch. 149, § 188(b) (2008) (explaining the calculation of employer's required contribution).

175 *See id.* § 188(c)(10) (2008).

176 BARBER & MILLER, *supra* note 170, at 4.

177 *See id.* at 4 (citing KAISER FAMILY FOUND., SURVEY OF EMPLOYER HEALTH BENEFITS 2007 ex. 5, *available at* http://www.kff.org/insurance/7672/upload/7693.pdf.

plan."[178] Unlike Maryland and Suffolk County, where no rational employer would actually pay the penalty to the state rather than pay for employee health care, the Massachusetts alternative to pay the $295 fee instead of make contributions to employee benefits is reasonable and does not require the employer have an ERISA plan.[179] On this basis, if challenged, the law may be upheld as a permissible "indirect economic effect" rather than a direct regulation of ERISA plans.[180]

Although the law may survive preemption, its effectiveness in encouraging employers to actually provide meaningful health insurance is unlikely. Clearly, employers that already provide good insurance to their employees are unaffected by this plan, but a modest $295 penalty is insufficient to encourage non-insurance-providing employers to begin to offer insurance. With health care premiums already spinning out of control, realistically, the cost to insure employees will far exceed the penalty. Again, an ERISA problem arises because the Massachusetts plan, although not a mandate, is too weak to accomplish meaningful change, while the Maryland and Suffolk County, New York plans were strong enough to provide meaningful compliance, but so forceful they were preempted by ERISA. This dilemma further illustrates why state health care reform attempts will ultimately fail to provide meaningful health care coverage to the 47 million uninsured Americans.

VI. DECISION 2008: HOW THE ELECTION FOR THE 44TH U.S. PRESIDENT IMPACTED HEALTH CARE REFORM DISCUSSION

In 2008, Americans voted to elect the nation's 44th President, Barack Obama. During various stages of their campaigns, all of the candidates acknowledged several pressing issues, including health care.[181] In fact, one New York Times reporter observed that "[t]here is no better measure of the power of the health care issue than this: Sixteen months before Election Day, presidential candidates in both

[178] Amy B. Monahan, *Pay-or-play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 U. KAN. L. REV. 1203, 1214 (2007).

[179] *See* Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 193 (4th Cir. 2007); Retail Indus. Leaders Ass'n v. Suffolk County, 497 F. Supp. 2d 403, 417 (E.D.N.Y. 2007); Monahan, *supra* note 178 at 1215–16.

[180] N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 668 (1995).

[181] *See* Robin Toner, *2008 Candidates Vow to Overhaul U.S. Health Care*, N.Y. TIMES, July 6, 2007, at A1.

parties are promising to overhaul the system and cover more—if not all—of the 44.8 million people without insurance."[182] Clearly health care reform was not just on the agenda, it was a primary concern of voters.

Although Barack Obama was elected the 44th President of the United States in November 2008, the various candidates' proposals for health care programs were important to health care reform discussions. Despite the intricacies of all the prior candidates' individual plans, basically Democrats advocated some combination of public insurance and employer mandates resulting in universal healthcare for all Americans, while Republicans encouraged tax deductions and credits for more affordable private health insurance without major government involvement.[183] Since each candidate proposed health care reform on a national level, ERISA probably will not pose a preemption issue. But one model, a universal mandate plan proposed by former Democratic candidate and now Secretary of State Hillary Clinton, was likely to have the greatest chance of success in reducing the amount of uninsured Americans by overcoming the four obstacles outlined above.

A. Health Reform Plan Overview[184]

Hillary Clinton advocated universal coverage for all Americans during her 2008 Presidential campaign in her "American Health Choices Plan: Ensuring Quality, Affordable Health Care for All Americans."[185] On its face, the American Health Choices Plan covered all the major obstacles facing state level health care reform: ERISA preemption, mandate compliance, continuity of coverage, and quality of care problems.[186] Similarly, "Barack Obama's Plan for a Healthy America" also proposes an affordable health care option for uninsured Americans, including mandates for children.[187] Both plans provide meaningful health care reform available to every American; Clinton's plan required every American obtain health

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[182] *Id.*

[183] *See id.*

[184] *See* Asiaing.com, The American Health Choices Plan, Hillary Clinton, http://www.asiaing.com/the-american-health-choices-plan-hillary-clinton.html (last visited June 2, 2009). Although Hillary Clinton is no longer a candidate for President in 2008, her proposed health care reform plan will also be analyzed as a form of universal coverage.

[185] *See id.*

[186] *See id.*

[187] *See* Barack Obama and Joe Biden: The Change We Need—Health Care, http://www.barackobama.com/issues/healthcare (last visited June 2, 2009) (follow "Read the Plan" under "More on Health Care").

insurance, hereinafter referred to as a "universal-mandate plan" but Obama's plan only mandates children have coverage, thus referred to hereinafter as a "child-mandate plan". This difference between these proposals may permit some Americans to voluntarily remain uninsured. [188]

B. ERISA Preemption: Not a Problem

Since ERISA preempts only State laws "relating to" employee benefit plans, neither national plan threatens uniform administration of benefits, or interacts with ERISA's authority over employee benefits.[189] Specifically, the universal-mandate plan to cover every American requires "large employers . . . to provide health insurance or contribute to the cost of coverage,"[190] basically a "pay-or-play" employer mandate similar to that of Maryland's Fair Share Health Care Fund Act and Suffolk County, New York's Fair Share for Health Care Act.[191] The child-mandate plan is nearly identical to the Maryland Fair Share Health Care Fund Act, as it mandates employers "contribute a percentage of payroll toward the costs of the national plan."[192] ERISA's broad sweep preempted both state employer mandates as impermissible connections or relations to an employee benefit.[193]

However, both plans propose employer mandates on a federal level, which ERISA has no authority over. As discussed above, employer mandates, if successfully implemented, will likely bridge the gap for uninsured working Americans who cannot afford private pay insurance without employer assistance. Furthermore, both plans requiring employers across the nation to contribute to their employees' health care costs further ERISA's policy of uniform administration of employee benefits, unlike varying state

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[188] *See* Christopher Lee, *Simple Question Defines Complex Health Debate*, WASH. POST, Feb. 24, 2008, at A10. Despite these differences in the former candidates' proposals, the election of Barack Obama in 2008 allows me to hereinafter refer to Obama's plan as a "child-mandate" and Clinton's plan as a "universal-mandate"; focusing on the attributes of the respective plans, as opposed to the person who proposed each plan.

[189] Specifically, ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan," but does not mention preemption with any federal law. 29 U.S.C. § 1144(a) (2000).

[190] Asiaing.com, The American Health Choices Plan, Hillary Clinton, http://www.asiaing.com/the-american-health-choices-plan-hillary-clinton.html (last visited June 2, 2009).

[191] *See* discussion *supra* Part IV.A–B.

[192] Barack Obama & Joe Biden, *supra* note 187.

[193] *See* discussion *supra* Part IV.A–B.

requirements defeating its policy. Therefore, on the ERISA obstacle, both plans present a viable solution to the ERISA preemption problem facing many state health care reform attempts.

C. Compliance and Individual Mandates

Compliance for health insurance mandates may be an issue in both the universal-mandate plan and the child-mandate plan as well as in Massachusetts, just as with the required automobile insurance all American drivers must have, but not all drivers actually carry.[194] Although Massachusetts requires individuals obtain health insurance, "state officials had to exempt tens of thousands of people on the grounds that it would be unfair to require them to buy a policy if they could not afford one."[195] One facet of both plans that will encourage compliance, that Massachusetts's individual mandate does not, is their focus on affordability.[196] Similar to Massachusetts's individual mandate, the universal-mandate plan also requires individuals to obtain health insurance.[197] However, this plan does not detail a penalty for noncompliance like Massachusetts residents' forfeiture of their personal tax exemption. The child-mandate plan contains a mandate also, but as its name implies, it only applies to children, not adults.[198] This difference is quite significant because the child-mandate plan allows adults to voluntarily decline health insurance, although they can afford it, while a universal-mandate plan, as its name implies, requires both adults and children to obtain affordable health insurance.[199]

In contrast to the Massachusetts individual mandate, the universal-mandate plan contains several methods to make health care more affordable, including tax credits, health care premium limits based on a family's income, and promising that the government "will ensure that health insurance is always affordable and never a crushing burden on any family and will implement

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[194] *See* Lee, *supra* note 188.

[195] *Id.*

[196] *See* Asiaing.com, The American Health Choices Plan, Hillary Clinton, http://www.asiaing.com/the-american-health-choices-plan-hillary-clinton.html (last visited June 2, 2009); Barack Obama & Joe Biden, *supra* note 187.

[197] *See* Asiaing.com, The American Health Choices Plan, Hillary Clinton, http://www.asiaing.com/the-american-health-choices-plan-hillary-clinton.html (last visited June 2, 2009).

[198] Barack Obama & Joe Biden, *supra* note 187.

[199] *See* Lee, *supra* note 188.

reforms to improve quality and lower cost."[200] Since the forty-seven million uninsured Americans ultimately make premiums and other health care costs more expensive for insured Americans, under the universal-mandate plan more people can afford health care and are required to get it, so the health care costs per insured American will ultimately decrease.[201] Furthermore, the federal government clearly has greater resources and political power to set affordability measures and enforce individual mandates than a state legislature like Massachusetts' can achieve on its own.[202] Therefore, the universal-mandate plan to combine individual mandates with affordable health insurance will ultimately be more successful than a state health insurance mandate alone.

On the other hand, the child-mandate plan advocates affordability also so more Americans are able to buy health insurance, either into a public plan or a private plan.[203] Specifically, this plan advocates federal subsidies for working, uninsured individuals and families above the Medicaid earnings cap to buy health insurance.[204] Theoretically, more people will obtain health insurance if it is affordable, but young, healthy, uninsured adults often forego health insurance as an unnecessary expense, so this population may continue to pass costs on to the insured.[205] Although the child-mandate plan gives all Americans the option to feasibly obtain health insurance, requiring only children to be covered allows many people to remain uninsured, so a universal-mandate plan will likely have greater success in combating the forty-seven million uninsured Americans.

D. Continuity of Coverage

Another major reform both plans address is the type of coverage Americans should have available. Many presently available insurance plans, including New York State's Healthy NY program, have waiting periods and may temporarily or permanently deny

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[200] Asiaing.com, The American Health Choices Plan, Hillary Clinton, http://www.asiaing.com/the-american-health-choices-plan-hillary-clinton.html (last visited June 2, 2009).

[201] *See* Lee, *supra* note 188 (noting "taxpayers foot the bill for much of the care that those without insurance get in emergency rooms").

[202] *See id.* (explaining politics and lobbyists will play a major role in what minimum services the government requires).

[203] Barack Obama & Joe Biden, *supra* note 187.

[204] *Id.*

[205] *See* Lee, *supra* note 188.

coverage for people with preexisting conditions.[206]

Specifically, the child-mandate plan addresses these concerns by guaranteeing coverage to everyone and allowing Americans "to move from job to job without changing or jeopardizing their health care coverage."[207] The universal-mandate plan also seeks to rectify these problems by prohibiting insurance companies from "discriminat[ing] based on pre-existing conditions or expectations of illness" and "ensur[ing] that no American is denied coverage, refused renewal, unfairly priced out of the market, or forced to pay excessive insurance company premiums."[208] Assuming these models are both financially and administratively feasible, Americans will remain insured regardless of life situation, including job loss, aging of a parent's insurance plan, and exceeding prior earning capacity. Additionally, more otherwise eligible uninsured Americans, especially young working adults, will not face obstacles to obtaining coverage that currently exist in America's health care system, which will further decrease the number of uninsured Americans.[209] Therefore, both individual mandates coupled with essentially guaranteed health care coverage form a required combination to truly achieve universal coverage in America.[210]

E. Quality of Care

Not only do both plans provide every American with health care coverage, but they also advocate quality of care reform.[211] Currently America's health care services may vary depending on financial resources and availability of health care options, specifically the problems associated with Medicaid patient care versus privately insured care.[212] The universal-mandate plan advises reforming both Medicaid and State Children's Health Insurance Program for "affordable, quality care," and offers working, higher income

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[206] *See supra* notes 156–62 and accompanying text.

[207] Barack Obama & Joe Biden, *supra* note 187.

[208] Asiaing.com, The American Health Choices Plan, Hillary Clinton, http://www.asiaing.com/the-american-health-choices-plan-hillary-clinton.html (last visited June 2, 2009).

[209] Specifically, many young, healthy Americans decide to forego health insurance because they think they do not need it, but when they become ill, some insurance companies may deny them coverage based on a preexisting condition. *See* Lee, *supra* note 188.

[210] *See id.*

[211] Asiaing.com, The American Health Choices Plan, Hillary Clinton, http://www.asiaing.com/the-american-health-choices-plan-hillary-clinton.html (last visited June 2, 2009); Barack Obama and Joe Biden, *supra* note 187.

[212] *See supra* text accompanying notes 130–41.

Americans the same quality plan members of Congress currently use.[213] Specifically, the universal-mandate plan's "Health Choices Menu" requires insurance companies to cover many preventative services as well as mental health and dental care; benefits not currently offered for many privately insured individuals.[214] Similarly, the child-mandate plan proposes comprehensive health coverage like the Federal Employees Health Benefits Program, covering both preventative and mental health care.[215] Additionally, the child-mandate plan advocates eliminating "differences in access to health coverage[,] . . . promoting prevention and public health," and implementing other methods of quality control in hospitals.[216] Both plans' reform attempts clearly address the inherent inequities with different insurance providers, reform states, particularly New York, have struggled with in the past. [217]

VII. CONCLUSION

Based on the foregoing discussion, the only health care reforms with a high probability of escaping ERISA preemption are in Massachusetts and San Francisco, California. However, the probability of significantly decreasing the number of uninsured Americans through state health reform is low. Since meaningful health care reform is doomed to fail in insuring more Americans due to ERISA preemption, Medicaid fraud, abuse, and quality of care problems, intermittent coverage by publicly funded plans, and noncompliance with State mandates, health care reform remains with the federal government.

As a result, President Barack Obama and Secretary of State Hillary Clinton proposed comprehensive health care reform addressing these problems, in their 2008 Presidential campaigns, and ultimately Clinton's "universal-mandate" plan containing individual mandates has the greatest chance of providing coverage to the 47 million uninsured Americans. Although Barack Obama was elected as the nation's 44th President in November 2008, the fate of health care coverage in the United States ultimately remains with his ability to successfully implement health care reform,

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[213] Asiaing.com, The American Health Choices Plan, Hillary Clinton, http://www.asiaing.com/the-american-health-choices-plan-hillary-clinton.html (last visited June 2, 2009).

[214] *Id.*

[215] Barack Obama & Joe Biden, *supra* note 187.

[216] *Id.*

[217] *See supra* text accompanying notes 130–41.

among other issues facing the country.[218] Until then, one can only hope Congress realizes the regulation vacuum ERISA has created for health insurance coverage and amend the statute to allow states to regulate employer provided health insurance, to truly combat the health care crisis in America.

[218] In any event, the analysis of the former candidates' plans remains relevant to universal health care reform discussion because the legislature's failure to act requires the President's leadership in spearheading health care reform.