Overcoming Fears of ERISA Preemption to Cover the Working Uninsured: Lessons Learned from Hawaii, California, and Massachusetts

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Introduction

As the debate for national health care reform continues to evolve, the question remains to what extent will national reform leave room to preserve state-level experimentation, especially in light of ERISA (Employee Retirement Income Security Act) preemption. ERISA preemption has remained a formidable obstacle to state efforts. However, three states, Hawaii, California and Massachusetts, have been successful in expanding health insurance coverage at the local level. Although each state utilizes different objectives to cover their uninsured population, each faces the same threat of ERISA preemption. Nonetheless, these states have come up with unique ways to avoid ERISA preemption. This paper explores Hawaii’s nearly four decade experience, as well as two recent efforts by San Francisco and Massachusetts to expand health insurance coverage at the local level without preemption by ERISA.

In 1974, Hawaii enacted a bold and innovative statute that compelled employer-sponsored health insurance be extended to Hawaii’s workers in order to increase the numbered of insureds. Hawaii was the first state to provide comprehensive medical care for uninsured and underinsured workers. As a result of the Prepaid Health Care Act (“PHCA” or “the Act”), Hawaii has enjoyed one of the lowest uninsured rates in the

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1 HAW. REV. STAT. §§ 393-1 to -51 (1974).
nation for many years. Hawaii was also the first state to provide federal insight to employer benefit plans and avoid piecemeal state by state regulations and mandates.

However, the enactment of ERISA during the same year threatened PHCA’s survival. After PHCA was enacted, Congress enacted ERISA in an attempt to nationally standardize employee benefit plans. ERISA included a preemption clause superseding all state laws that “relate to” employee benefit plans. Thus, any state that attempted to pass legislation relating to the provision or administration of health insurance benefits, for example, would be preempted.

While ERISA’s main purpose was to protect retirement benefits for employees across interstate commerce, the inclusion of health care benefits brought unintended consequences for states such as Hawaii that wanted to provide health insurance benefits for uninsured workers. Thus, PHCA soon faced a legal challenge on the grounds that it fell within ERISA’s preemption. Standard Oil Co. v. Agsalud was the first case to test ERISA’s preemption clause against the PHCA and in the end, the Ninth Circuit held that the PHCA was preempted.

The setback was short-lived. In order to save PHCA, Hawaii’s Congressional Delegation successfully pushed Congress for a waiver from ERISA preemption which was eventually granted in 1983. The waiver, specifically for Hawaii’s PHCA, provided

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5 Standard Oil Co. of California v. Agsalud, 633 F.2d 760 (9th Cir. 1980) [hereinafter Standard Oil].

that any amendment that “provides for more than the effective administration” of the PHCA as originally enacted in 1974 would be subject to ERISA preemption.\textsuperscript{7} This essentially “froze” the PHCA by preventing any substantial amendments.

As a result, conflicts between PHCA and ERISA preemption have contributed to a growing number of uninsured employees working full-time.\textsuperscript{8} PHCA requires that private employers provide prepaid health care benefits for employees working at least 20 hours per week for 4 consecutive weeks.\textsuperscript{9} As the cost of health care premiums continue to rise,\textsuperscript{10} businesses, especially smaller ones, face the difficult challenge of fulfilling PHCA mandates while trying to remain viable in a weakening economy.\textsuperscript{11} Consequently, employers are hiring more part-time workers, independent contractors, and other types of employees who are exempt from the PHCA and thus, are not required to provide prepaid

\textsuperscript{7} Id.

\textsuperscript{8} In 2005, the total uninsured population in Hawaii was 9.6 percent or 120,740 people (including adults and children). HAWAII HEALTH INFO. CORP., HEALTH TRENDS IN HAWAII: HEALTH MARKET—UNINSURED (2006), available at http://healthtrends.org/healthmarket_uninsured.aspx [hereinafter HHIC Uninsured Data]. Of the total uninsured population, 52,657 are full-time, part-time or sole proprietors. HAWAII UNINSURED PROJECT, HEALTHCARE COVERAGE UPDATE (2006), http://healthcoverage hawaii.org/pdf/Coverage%20Update.Feb%202006.pdf [hereinafter HUP Coverage Data].

\textsuperscript{9} HAW. REV. STAT. § 393-3 (West, Westlaw through 2008 Sess.).

\textsuperscript{10} Between 1996-2006, annual insurance premiums for individual coverage in Hawaii increased by approximately 76 percent from $2005 to $3530 or an average of 5 to 7 percent annually. During the same period nationally, annual individual coverage increased by approximately 125 percent from $1992 to $4488 or an average of 9 percent annually. HAWAII HEALTH INFO. CORP., HEALTH TRENDS IN HAWAII: HEALTH MARKET—INSURANCE PREMIUMS (2006), available at http://healthtrends.org/healthmarket_precremiums.aspx [hereinafter HHIC Premium Data].

\textsuperscript{11} Twenty-six percent (or 12,448) of uninsured full-time employees work for smaller businesses (less than 10 employees). HUP Coverage Data.
health care benefits. As a result, out of the total working adult uninsured population in Hawaii, approximately 39 percent are full-time.

The complexities of PHCA and ERISA continue to stymie Hawaii’s lawmakers as they seek to address the growing uninsured population. To date, there has been little case law and scholarly analysis on PHCA. As a result, concerns surrounding the scope of PHCA’s ERISA waiver remain nebulous. PHCA stands at odds with ERISA, and in seeking to protect its 1983 waiver, health care reform efforts have been stifled. Nonetheless, PHCA has been amended several times over the years without ERISA preemption.

Recently, San Francisco and Massachusetts have enacted laws to address the uninsured populations. The San Francisco and Massachusetts strategies for avoiding ERISA’s preemption are strikingly different. San Francisco attempted to carefully draft legislation that would likely pass preemption based on a spending model. Massachusetts, on the other hand, adopted a political model by collaborating with private

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12 See HAW. REV. STAT. §§ 393-3, -5 (West, Westlaw through 2008 Sess.).

13 In 2005, the total working adult (ages 19-64) uninsured population in Hawaii was 93,404. This group of adults represents 75 percent of the overall uninsured population in Hawaii. The number of uninsured full-time employees (defined as working 20 hours or more per week) in Hawaii was 36,726. HUP Coverage Data. However, these numbers could be overestimates as some employees may be covered as a dependent, which is a category exempted from the PHCA. HAW. REV. STAT. § 393-17(a)(2) (West, Westlaw through 2008 Sess.).

14 In conducting research, there were only three cases in which the Hawaii Supreme Court has addressed ERISA and/or the PHCA: Hawaii Laborers’ Trust Funds v. Maui Prince Hotel, 81 Hawaii 487 (1996); Garcia v. Kaiser Found. Hospitals, 90 Hawaii 425 (1999); and Hawaii Mgmt. Alliance Ass’n v. Ins. Comm’r, 106 Hawaii 21 (2004). However, these cases involved collective bargaining agreements, worker’s compensation, or denial of health insurance coverage, which is not the scope of this article.

15 Brian P. Goldman, The San Francisco Health Care Ordinance: Universal Health Care Beyond ERISA’s Reach?, 19 STAN. L. & POL’Y REV. 361, 369 (2008) (noting the San Francisco Ordinance was drafted in “hope[s] of circumventing ERISA” by “regulating only the amount employers spend on health care, not benefit plans themselves”).
and public stakeholders to draft a plan regardless of preemption. Thus, three different ways to navigate the shoals of ERISA’s preemption have now emerged.

In addition, the Supreme Court decisively narrowed the scope of ERISA’s preemptory powers in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co. (“Travelers”), and has subsequently been adopted by the Supreme Court, as well as the Ninth Circuit case, Golden Gate Rest. Ass’n v. City & County of San Francisco (“Golden Gate III”), that held San Francisco’s employer mandate was not preempted by ERISA. These pivotal decisions suggest that states (and municipalities) are gaining leverage over ERISA preemption.

This article will articulate the lessons learned from three very different state and local efforts to solve the health insurance crises. While national health care legislation has heated up in recent months, there remains a place for local and state solutions for the uninsured. In particular, Hawaii remains in a unique position as PHCA is exempt from the current Senate and House versions of the national health care reform bill. Hawaii,  

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16 Mary Ann Chirba-Martin & Andres Torres, Universal Health Care in Massachusetts: Setting the Standard for National Reform, 35 FORDHAM URB. L.J., 409, 410 (2008) (indicating how “such a disparate group of supporters agree[ing] to any state-wide health care reform proposal is remarkable” but it was more impressive “that such depth and breadth of support have coalesced for a plan that is largely untested.”).


19 Golden Gate Rest. Ass’n v. City & County of San Francisco, 535 F.Supp.2d 968 (N.D. Cal. 2007), rev’d, 546 F.3d 639 (9th Cir. 2008), and reh’g denied, 558 F.3d 1000 (9th Cir. 2009).

20 The Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 1560(b) (2009), reads:

(B) Rule of Construction Regarding Hawaii’s Prepaid Health Care Act- Nothing in this title (or an amendment made by this title) shall be construed to modify or limit the application of the exemption for Hawaii’s Prepaid Health Care Act (Haw. Rev. Stat. 393-1 et seq.) as provided for under section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)).
San Francisco, and Massachusetts legislation suggests a shifting of health care reform from the federal government to states and signals an opportunity states to enhance and enact legislation without fear of ERISA preemption.

Although *Golden Gate III* is currently at the Supreme Court, states should take action sooner rather than be shackled by ERISA and wait for a federal solution. Hawaii’s PHCA, San Francisco’s Health Ordinance and Massachusetts Health Care Act all serve as a general model to invite other states to enact similar legislation—states cannot afford to wait as the uninsured continues to rise and the economy worsens.

Part I of this article provides a general overview of ERISA and the impact of ERISA’s preemption on PHCA. ERISA’s preemption clause only allows limited amendments to PHCA. Part II identifies the weakness of PHCA, highlighting loopholes employers use to avoid the Act’s mandates. These weaknesses have contributed to the growing number of uninsured full-time workers in Hawaii and eroded the promise of PHCA when first enacted. Part III explores the strategies San Francisco and Massachusetts have employed to successfully establish universal health care legislation with attention to ERISA preemption. Finally, Part IV considers the future of PHCA by examining amendments made to PHCA that survived ERISA preemption and offers recommendations to other states to experiment with their own legislation that will have a strong likelihood of surviving ERISA preemption based on legal precedent and experiences from San Francisco and Massachusetts.

I. **Overview of the Prepaid Health Care Act**

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Hawaii’s employers have a unique, deeply rooted tradition of providing adequate health care to employees, stemming back to the early plantation era. The political influence of Hawaii’s labor unions arising in the 1960’s further encouraged employer based health care coverage. On the federal level, while Congress had meaningful discussions on nationalized health insurance, nothing materialized into legislation, but Hawaii, on the other hand, was poised by the 1970’s to tackle the issue of healthcare.

Hawaii was ready to lead the nation by becoming the first state to mandate employers to provide health care insurance and enacted prepaid health care legislation in 1974. Just as PHCA was newly enacted in Hawaii, ERISA threatened its survival.

A. About PHCA

The purpose of PHCA was to provide comprehensive health care benefits for full-time employees defined as working 20 hours or more per week for 4 consecutive weeks. Employers are required to provide qualified employees a prepaid health care plan that includes at least 5 kinds of “health care benefits” including hospital, surgical, diagnostic services, maternity, and substance abuse treatment. PHCA also includes a detailed payment scheme where employers contribute at least 50 percent of the health care premium and employees contribute up to 1.5 percent of their wages.

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23 Id.
24 Id.
26 HAW. REV. STAT. § 393-14 (West, Westlaw through 2008 SESS.).
27 Id. § 393-7.
28 Id. § 393-13.
1.5 percent contribution is less than 50 percent of the premium, the employer pays the remaining portion of the premium.\(^{29}\) For example, if an employee’s monthly salary is $1000 and the health insurance premium is $250 per month, the employee’s maximum contribution is $15, leaving the employer to contribute the remaining $235.

The Act excluded a large group of employees. PHCA excluded “seasonal workers,” unionized employees and public employees from its benefits.\(^{30}\) PHCA also left out those who received state or federal benefits.\(^{31}\) Thus, if an employee already receives Medicare benefits or coverage as a dependent under an existing prepaid health care plan, the employer is not required to provide health benefits.\(^{32}\) PHCA also includes an enforcement provision where employers who fail to comply with the Act are subject to fines of at least $25 or $1 per employee for every non-compliant day.\(^{33}\) Finally, PHCA establishes a “premium supplementation fund” managed by the Department of Labor and Industrial Relations (“DLIR”) to subsidize premium payments for small businesses with less than 8 employees.\(^{34}\)

B. The Enactment of ERISA Threatens PHCA

1. Legislative History of PHCA

\(^{29}\) \textit{Id.}


\(^{31}\) For example, Medicaid or military healthcare benefits. See Stefan A. Riesenfeld, \textit{Prepaid Health Care in Hawaii} 47-48 (State of Hawaii Legislative Reference Bureau, Report No. 2, 1971) [hereinafter Riesenfeld Study].

\(^{32}\) HAW. REV. STAT. § 393-17 (West, Westlaw through 2008 SESS.).

\(^{33}\) \textit{Id.} § 393-33(a).

\(^{34}\) \textit{Id.} §§ 393-45 to -48.
By 1967, the “spiraling” cost of health care had resulted in such a rise in premiums that the number of uninsured was increasing. Individuals and employers could barely afford health insurance. In response to the astronomical cost of medical care contributing to high uninsured rates, the Hawaii State Legislature in 1967 commissioned a study on “Prepaid Health Care in Hawaii” to better understand the uninsured population within the public and private workforce sectors.\textsuperscript{35} The Riesenfeld Study determined that in the late 1960s, Hawaii had an adjusted uninsured rate among private sector employees of approximately percent.\textsuperscript{36} Based on findings prompted by the Riesenfeld Study, Hawaii’s legislators enacted the PHCA in 1974.\textsuperscript{37} The Act was meant to mandate employers to offer prepaid health care plans to employees as a “certain measure of protection against such [medical] emergencies.”\textsuperscript{38} Furthermore, according to bill sponsors, its intent is to “extend prepaid health care insurance to workers who do not have that kind of protection or have only inadequate prepaid health care insurance. The workers who will benefit from the legislation are regular members of the labor force whose employment is not subject to collective bargaining agreement.”\textsuperscript{39}

2. **Enactment of ERISA**

\textsuperscript{35} *Riesenfeld Study*, supra note 31, at 2-9.

\textsuperscript{36} The “raw” or unadjusted uninsured rate for private employees was 32 percent. *Id.* at 26. By adjusting for dependent coverage, the uninsured rate was 11 percent. *Id.* at 27.

\textsuperscript{37} HAW. REV. STAT. §§ 393-1 to -51 (West, Westlaw through 2008 Sess.).

\textsuperscript{38} *Id.* § 393-2.

\textsuperscript{39} *Senate Report*, supra note 30.
Three months after PHCA was passed, Congress enacted ERISA on September 2, 1974. The purpose of ERISA was to regulate employee welfare benefits, including health care. Considered to be a “crowning achievement” in Congress, ERISA was enacted to establish a uniform set of employee benefit laws with the goal of “minimizing the administrative and financial burden of [employers] complying with conflicting directives among States or between States and the Federal Government.” To accomplish this goal, ERISA included a preemption clause under 29 U.S.C. § 1144(a):

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

Therefore, ERISA put into jeopardy of preemption, all state laws that related to employee benefit plans.

Sponsors of ERISA from the House of Representatives and Senate described the intent of the preemption clause as to “eliminate the threat of conflicting or inconsistent State and local regulation of employee benefit plans.” Its main purpose was to “avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.” For example, businesses that operated in multiple states would only have to provide one standard plan of benefits for all employees without

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41 Id. § 1001.
44 Id. at 142; Shaw, 463 U.S. at 105 n.25.
45 Travelers, 514 U.S. at 657.
having to comply with various state benefit laws. Thus, ERISA’s preemption clause was meant to be applied in its “broadest sense.”

While the main purpose of ERISA was to protect retirement benefit across interstate commerce, the inclusion of health care benefits in ERISA created unintended consequences for Hawaii and later other states that passed legislation mandating employer-based health benefits. With the passage of ERISA, a major legal battle ensued to enforce ERISA’s preemption clause against the PHCA in an effort to invalidate it.

C. Challenges to the PHCA

1. ERISA Preemption: *Standard Oil v. Agsalud*

It was not long before Hawaii’s PHCA was challenged as preempted by ERISA. The Ninth Circuit’s holding in Standard Oil was a major blow to the PHCA by affirming the federal district court’s ruling that ERISA preempted the PHCA. Standard Oil Company, a California-based company, conducted business operations in Hawaii and was required to provide benefits to its Hawaii employees under the PHCA. However, Standard Oil’s medical plan did not meet PHCA’s requirements. PHCA required

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46 *Shaw*, 463 U.S. at 99.


48 Prior to litigation, Hawaii’s Legislature amended the PHCA in 1976 to include mandated coverage for alcohol and substance abuse. 1976 Haw. Sess. Laws 28 (amending HAW. REV. STAT. §393-7 by adding subsection (c) to mandate prepaid health care plans to include substance abuse benefits). The PHCA mandate is set forth in HAW. REV. STAT. § 393-11, mandating employers to provide their “regular employees . . . prepaid group health care plan.” Regular employees are paid “monthly wages in an amount of at least 86.67 times the minimum hourly wages.” Sections 393-3 and 393-14 further defines a regular employee as one who works at least twenty hours per week for four consecutive weeks.
coverage for alcohol and substance abuse which Standard Oil did not provide.\textsuperscript{49} The State of Hawaii ("State") filed suit to enforce this provision of the PHCA and Standard Oil filed for summary judgment on the grounds that ERISA preempted the application of PHCA.\textsuperscript{50} In affirming the district court’s decision, the Ninth Circuit reiterated that state laws regulating health care benefits were preempted by ERISA and regulation of such benefits did “relate to” ERISA.\textsuperscript{51} The State argued that the preemption language under 29 U.S.C. § 1144(a) was “not broad enough to encompass the [PHCA],” based on the premise that ERISA was “concerned primarily with the administration of benefit plans” rather than the PHCA’s intent of “pertaining principally to benefits.”\textsuperscript{52} However, the court indicated that there was “nothing in the statute to support such a distinction between the state laws relating to benefits as opposed to administration.”\textsuperscript{53} The court further noted the district court’s conclusion that the “language of the statute provides that ERISA shall supersede ‘any and all State laws’ and that does not mean ‘some but not all the State laws.’”\textsuperscript{54} Consequently, the court affirmed the district court’s decision.

\textsuperscript{49} See HAW. REV. STAT. § 393-7(c)(6) (1976); see also Standard Oil Co. of California v. Agsalud, 442 F.Supp. 695, 696 (N.D. Cal. 1977).

\textsuperscript{50} Standard Oil Company claimed that ERISA preempted both the amended substance abuse benefit mandate and the PHCA as a whole. Standard Oil, 633 F.2d at 696-97.

\textsuperscript{51} Standard Oil, 633 F.2d at 760. For further discussion of the terms “relate to,” see infra Part III.A.2.

\textsuperscript{52} Id. at 765 (emphases added).

\textsuperscript{53} Id.

\textsuperscript{54} Id. (emphasis added) (quoting Standard Oil, 442 F.Supp. at 707).
The State’s final appeal to the Supreme Court was unsuccessful. The Court issued a memorandum decision affirming the decisions of the lower courts.\textsuperscript{55} Since the \textit{Standard Oil} case, the PHCA on its face has not been challenged again.\textsuperscript{56}

2. Congressional Efforts to Waive the PHCA from ERISA Preemption

During the \textit{Standard Oil} litigation, Hawaii turned to its congressional delegation, including Senators Inouye and Matsunaga, seeking relief. The Senators introduced a bill in 1977 to save PHCA should the courts decide that ERISA preempted it. The bill aimed to grant PHCA a waiver from ERISA preemption by making ERISA’s preemption clause “inapplicable to employee plans maintained solely for the purpose of complying with ‘health insurance laws.’”\textsuperscript{57} It took three efforts to pass PHCA’s ERISA waiver.\textsuperscript{58}

In 1983, ERISA was finally amended to specifically exempt the PHCA from preemption. The amendment came with an unusual provision which waived the PHCA from preemption as initially effective on September 2, 1974. Codified as 29 U.S.C. § 1144(b)(5)(B)(ii), the amendment stated, in part:

\begin{quote}
Nothing in subparagraph (A) shall be constructed to exempt from subsection (a) of this section . . . any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.\textsuperscript{59}
\end{quote}

\textsuperscript{55} \textit{Agsalud v. Standard Oil Co. of California}, 454 U.S. 801 (1981).

\textsuperscript{56} \textit{See supra} note 14.


\textsuperscript{58} Senators Inouye and Matsunaga unsuccessfully introduced a second bill entitled, “ERISA Improvement Act of 1979,” to broaden the waiver’s scope to exempt the PHCA and “any other state law found to be substantially identical to Hawaii’s.” \textit{Id.}

Thus, the waiver essentially froze PHCA in 1974. Any substantive change would not enjoy the waiver of preemption.

The ERISA amendment, more commonly known as the “ERISA waiver,” was a proactive response against the Standard Oil ruling that preempted Hawaii’s 1976 substance abuse coverage amendment to PHCA and PHCA in its entirety. In granting the ERISA waiver, Congress explicitly stated that the purpose of the ERISA waiver was meant “only as a narrow exception” as Hawaii’s PHCA was an “unusual special case”\(^{60}\) and “not expected to do violence to the strong Federal preemption scheme.”\(^{61}\) It was Congress’ intent that the ERISA waiver “shall not be considered a precedent with respect to extending such amendment to any other State law.”\(^{62}\) Such strong language suggested to the “federal courts that congressional allowance of state law waivers [was] reserved for Congress, and that Hawaii received a waiver only because it was explicitly granted.”\(^{63}\)

This sentiment was further expressed by the House in its amendment to the ERISA waiver by changing the effective date of the waiver back to September 2, 1974,\(^{64}\) which was meant to “reaffirm the broad Federal preemption of state law as they relate to

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\(^{63}\) Groves, *supra* note 60, at 634.

employee benefit plans as was the original intent of ERISA." Thus, only the originally enacted PHCA was preserved. As a result, PHCA remained “frozen” in time.

II. Current State of PHCA: Why Are Full-Time Employees Uninsured?

Hawaii’s PHCA is far from perfect. Although the Hawaii State Legislature sought to mandate health care coverage for as many Hawaii residents as possible, the Riesenfeld Study acknowledged universal health care would not be achievable. However, even for employees that qualify for health insurance under PHCA by working twenty or more hours for four consecutive weeks, many remain uninsured. There are various reasons why employers do not provide coverage for employees, but critics of PHCA have identified three common shortcomings that have contributed to a growing number of uninsured workers: (1) PHCA’s payment provision is outdated and should be adjusted for inflation to keep up with the rising costs of health insurance premiums; (2) too many types of workers are excluded; and (3) employees with irregular hours become ineligible for coverage under PHCA.

A. PHCA is Obsolete

65 Id. at 456 n.9 (emphasis added).

66 Over an average of 5 years (2001-2005), 36,726 full-time workers were uninsured. HUP Coverage Data.

67 Only three types of “employees” will be addressed in this article: (1) “Regular employee” as covered by the PHCA and defined in HAW. REV. STAT. § 393-3 (West, Westlaw through 2008 Sess.); (2) part-time private sector workers (working less than 20 hours per week for four consecutive weeks); and (3) sole proprietors and the self-employed (working full-time or part-time).

68 See supra note 10.

The first problem deals with an obsolete payment provision in PHCA that employers are mandated to follow. PHCA provides employers are required to contribute at least 50 percent and employees no more than 1.5 percent of their wages. The employees’ contribution is commonly referred to as the “1.5 percent cap.” If the employee’s share reaches the cap but the contribution is less than 50 percent of the total premium, the employer is required to make up the difference and pay the remaining portion of the premium. According to critics of PHCA, a major problem is that the employee-employer percent contributions have remained static since 1974 and has not been adjusted for inflation to keep up with increasing costs of health insurance. Due to fears of ERISA preemption, legislators have remained hesitant to amend the contribution percentages. However, these fears have been largely unfounded as very few ERISA preemption challenges were made regarding enforcement or amendments to PHCA. Consequently, the dearth of case law leaves ERISA’s preemptive language in the context

70 HAW. REV. STAT. § 393-13 (West, Westlaw through 2008 SESS.).


72 HAW. REV. STAT. § 393-13 (West, Westlaw through 2008 SESS.). For example, if an employee makes $1000 per month, the contribution is capped at 1.5 percent or $15. If monthly premiums cost $300, the employee’s $15 contribution is less than 50 percent of the premium so the employer must pay the remaining $285.


75 The PHCA has been amended multiple times without legal challenges since its enactment. For further discussion of these amendments, see infra Part IV.A.
of the PHCA open for interpretation. In response to this uncertainty, legislators have taken the cautious route of not amending any major sections of PHCA to avoid possible ERISA preemption.

PHCA’s contribution scheme has left employers shouldering an ever increasing proportion of rising premiums. Employers are currently subsidizing almost 100 percent of the premium. For example, an employee making $4000 per month in gross wages ($48,000 a year) will only have to contribute up to $60 per month (or equivalent up to the 1.5 percent wage cap). Assuming health care premiums are $120 per month, the employer will contribute 50 percent or $60. The 1.5 percent wage cap may have worked during the early years of enactment; however, it was unanticipated that premiums would rise more quickly than wages. Health insurance premiums have annually increased by approximately 5 to 7 percent, leaving employers to contribute a larger share each year while employee contributions remain fixed. Smaller businesses are impacted the most as data indicates a rise in employer spending such that small businesses with less than ten employees spend more on health care premiums as a percent of payroll expenses.

76 29 U.S.C. § 1144(b)(5)(B)(ii) states that: “any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date” will be preempted by ERISA (emphasis added).


78 In determining the 1.5 percent wage cap, the Riesenfeld Study did not address the possibility of premiums rising faster than annual wages. Riesenfeld Study, supra note 31, at 48-52.

79 In 2006, annual health insurance premiums for “single coverage” or individuals were $3530, amounting to $294 per month. HHIC Premium Data; see also supra note 10.
compared with large businesses (100 or more employees) (13.9 percent vs. 8.6 percent, respectively).  

Faced with paying the lion’s share of premiums, many businesses, particularly smaller ones, opt to forgo health insurance by finding loopholes or on rare occasions, disregarding the law to avoid PHCA’s mandates and assume the risk of a financial penalty.  Because the penalties for noncompliance are insignificant, amounting to the greater of either $25 or $1 per employee for every day the violation continues, and enforcement of PHCA is almost nonexistent, employers are willing to take a gamble with the law. Data supports this contention as a large proportion of uninsured full-time

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80 HUP Coverage Data, supra note 11.

81 A statewide telephone survey conducted among 451 Hawaii employers found 55 percent identified that the number one concern about health insurance was the cost of health insurance, compared to cost of health care and quality of services. HAWAII UNINSURED PROJECT, EMPLOYER SURVEY: BEHAVIORS & OPINIONS ABOUT HEALTH INSURANCE FOR EMPLOYEES (2003), http://healthcoveragehawaii.org/research/ Employer_Survey.PDF [hereinafter HUP Employer Survey]; see also HAW. REV. STAT. § 393-33 (West, Westlaw through 2008 Sess.).

82 HAW. REV. STAT. §§ 393-33 and -34 (West, Westlaw through 2008 Sess.) reads:

§393-33 Penalties; injunction. (a) If an employer fails to comply with section 393-11, 393-12, 393-13, or 393-15 the employer shall pay a penalty of not less than $25 or of $1 for each employee for every day during which such failure continues, whichever sum is greater. The penalty shall be assessed under rules and regulations promulgated pursuant to chapter 91 and shall be collected by the director and paid into the special fund for premium supplementation established by section 393-41. The director may, for good cause shown, remit all or any part of the penalty.

(b) Any employer, employee, or prepaid health care plan contractor who willfully fails to comply with any other provision of this chapter or any rule or regulation thereunder may be fined not more than $200 for each such violation.

(c) Any employer who fails to initiate compliance with the coverage requirements of section 393-11 for a period of thirty days, may be enjoined by the circuit court of the circuit in which the employer's principal place of business is located from carrying on the employer's business any place in the State so long as the default continues, such action for injunction to be prosecuted by the attorney general or any county attorney if so requested by the director.

§393-34 Penalties. (a) Any person who, after twenty-one days written notice and the opportunity to be heard by the director, is found to have violated any provision of this chapter or rule adopted thereunder for which no penalty is otherwise provided, shall be fined not more than $250 for each offense.

(b) All fines collected pursuant to this chapter shall be deposited into the special premium supplementation fund created by section 393-41.
employees are employed by small businesses with less than ten employees. They are
Consequently, the combination of the employee contribution cap and rising costs of
dependent on employees to take matters into their own hands. To
alleviate expenses, employers, for better or for worse, have found ways to avoid
compliance with the PHCA by exploiting its loopholes.

B. **Employers Exploit Loopholes in PHCA**

The remaining two major shortcomings of PHCA involve the types of employees
who are excluded from the law. Unfortunately, PHCA’s “gap groups” include
individuals in lower income brackets (i.e. minimum wage earners) and those who might
need employer-based coverage the most. These include: (1) the self-employed; (2) part-
time workers who work less than twenty hours per week; (3) full-time students twenty-
one years of age and older; and (4) a couple with a single income earner (e.g., coverage
already provided for by a spouse or dependent coverage). Employers have commonly exploited these so-called loopholes by recruiting
individuals and structuring jobs to fit within the gaps. For example, employers will hire
more part-time workers, outsource work to independent contractors, or classify full-time
employees as “seasonal” or on-call employees, all workers that are excluded from

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83 Twenty-six percent of employees working in a private firm with less than 10 employees are
uninsured, compared to 6.6 percent for businesses with 500-999 employees and 17.5 percent for businesses
with 25-99 employees. *HUP Coverage Data, supra* note 11.

84 *Riesenfeld Study, supra* note 31, at 64.

85 Sang-Hyop Lee, Gerard Russo, Lawrence H. Nitz, & Abdul J. The Effect of Mandatory Employer-
Sponsored Health Insurance on Health Insurance Coverage and Labor Force Utilization in Hawaii:
workingpapers/WP_05-12.pdf (describing how the PHCA has impacted the labor market by causing a
“sectoral shift of labor from full-time to part-time labor”) [hereinafter *Labor Force Study*].
PHCA.\textsuperscript{86} In fact, savvy employers hire individuals as part-time employees, allow them to work more than twenty hours per week for three consecutive weeks but reduce their hours to nineteen hours in the fourth week.\textsuperscript{87} There are endless creative work schedules that can be established to avoid the twenty hours per week, four consecutive week requirement.\textsuperscript{88}

Critics suggest that PHCA is outdated as the contribution allocation has placed an increasingly disproportionate share on the employer. From the employer’s perspective, it is unfair that their share of the premium contribution continues to rise while the employee’s contribution remains capped at 1.5 percent. Inflation and rising health care costs has placed a financial burden on employers, particularly for smaller businesses, that was likely unanticipated when PHCA was enacted. Another contributing factor is that wages have not kept up with the rise in health premiums. Together, these elements have generated the perfect storm for employers.

At the same time, however, employees also need health care insurance and without the purchasing power of employers, many would be faced with higher premiums and unlikely to afford it on their own. Employers could argue that lower income employees may be able to qualify for a government assistance program, such as Medicaid. However, financially-strapped states, including Hawaii, have reduced

\begin{footnotesize}
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\item Id.
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eligibility and benefits in state supported health care for the poor.\textsuperscript{89} Thus, the low paid working poor may not be eligible for state assistance if PHCA dropped them.

Despite shortcomings of PHCA, majority of employers do provide prepaid health care to qualified employees.\textsuperscript{90} PHCA’s strengths also include affordable health insurance for employees.\textsuperscript{91} However, the Act needs to be updated to address the employer’s burden of subsidizing the increasing costs of health care premiums and close the loopholes that have resulted in a growing number of uninsured full-time workers.\textsuperscript{92} Examining what other states have done to address their uninsured population in light of ERISA preemption provides useful models for Hawaii and other states, especially as the scope of ERISA preemption has been narrowed by the Supreme Court, paving the way for states to gain more leverage over health care reform efforts.\textsuperscript{93}

### III. Surviving Preemption and Harnessing the Political Will for Health Care Access Legislation: The San Francisco and Massachusetts Experience

The San Francisco’s Health Care Security Ordinance (the “Ordinance”)\textsuperscript{94} and Massachusetts’ Health Care Reform Act (the “Act” or “Plan”)\textsuperscript{95} exemplify two different

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\textsuperscript{89} See infra note 257 and accompanying text.

\textsuperscript{90} Among the 451 employers surveyed, 96 percent offered health insurance to full-time employees and 86 percent offered health insurance to part-time employees working 20 or more hours. \textit{HUP Employer Survey}.

\textsuperscript{91} From 1996-2003, Hawaii employees on average paid about 8 percent of the premium for individual coverage compared to a national average of 18 percent. \textit{HHIC Premium Data}.

\textsuperscript{92} It remains unclear how the national health care legislation proposed by the Senate and House will impact Hawaii’s uninsured population. However, according to Representative Mazie Hirono, author of PHCA’s exemption from the House version of the health care bill, the intent is to cover the “gap groups” not covered by PHCA such as “some part-time employees, seniors on Medicare, those without health insurance, government employees, or those covered by collective bargaining agreements.” \textit{Abercrombie, Hirono back ‘historic’ bill}, \textit{The Honolulu Advertiser}, Nov. 8, 2009, at A2.

\textsuperscript{93} O’Reilly, supra note 47 at 397 (describing the significance of the Traveler’s decision in its “divergence from precedent”).

models for Hawaii to consider in addressing the growing uninsured working population
to strengthen PHCA without fear of ERISA preemption. San Francisco adopted a
spending model that would likely survive ERISA preemption. Massachusetts, on the
other hand, focused on a collaborative, political grassroots model to develop bipartisan
universal health care legislation based on the state’s needs rather than on trying to survive
ERISA preemption. Regardless of the strategy, ERISA preemption will continue to be
an obstacle in state-level health care reform efforts. However, decisions by the Supreme
Court and Ninth Circuit that upheld laws against ERISA preemption signal a possible
movement towards narrowing ERISA’s scope. Consequently, there is an opportunity for
states to take action now rather than wait for federal health care reform.

A. The 800 Pound Gorilla: Surviving ERISA Preemption

Numerous articles have effectively analyzed in detail major Supreme Court cases
addressing ERISA preemption and need not be duplicated in this paper. However, the

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97 Mary Ann Chirba-Martin & Andres Torres, Universal Health Care in Massachusetts: Setting the Standard for National Reform, 35 FORDHAM URB. L.J., 409 (2008) (noting how incredible that “such depth and breadth of support [for the Massachusetts Act] have coalesced for a plan that is largely untested” in court).

98 See infra note 113 and accompanying text.

99 See Golden Gate Rest. Ass’n v. City & County of San Francisco, 546 F.3d 639 (9th Cir. 2008) [hereinafter Golden Gate III],

lack of guidance regarding ERISA preemption in the context of PHCA will be addressed and serve as a roadmap for future health reform efforts in Hawaii. There are three “preemption prongs” to consider depending on whether PHCA will be amended, whether a new law will be established, or whether an existing law will be amended: (1) in amending PHCA, does the amendment provide for “more than the effective administration” of PHCA; (2) in establishing new laws or amending other existing laws, does the intended law “relate to” ERISA plans;\(^\text{101}\) and (3) does item (1) or (2) fall within an exemption under ERISA. These prongs serve as the legal framework to guide the development of state legislation intended to regulate some form of employee health benefits.

1. **“Effective Administration”**

*Council of Hawaii Hotels v. Agsalud*, 594 F.Supp. 449 (D.C. Haw.1984) is the only case to date that addressed the term “effective administration” within the context of ERISA. Plaintiffs in this case challenged an amendment to PHCA mandating collective bargaining agreements to provide health benefits similar to PHCA. Due to the lack of case law on PHCA, the exclusivity of the term “effective administration,” and the restriction from making any amendments to PHCA after its enactment date,\(^\text{102}\) the court

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\(^{101}\) 29 U.S.C.A. § 1144(a) (West 2008), states in pertinent part: “[e]xcept as provided in subsection (b) of this section . . . this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . .” (emphases added).

\(^{102}\) § 1144(b)(5)(B)(ii), reads in part (emphasis added):

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section--
relied on legislative histories of PHCA and ERISA to reach its conclusion that the amendment was preempted by ERISA. The court reasoned that based on the overall intent of ERISA, the “plain language” of PHCA,\textsuperscript{103} and the Ninth Circuit holding in \textit{Standard Oil}, “Congress intended the term ‘effective administration’ to be construed strictly” and “to ‘operate only as a narrow exception.’”\textsuperscript{104} The court further asserted that because Congress “could easily have provided that the non-preemption date of the [PHCA] would be 1978, rather than 1974” but decided on the contrary, “indicate[d] that ‘effective administration’ \textit{should not} be construed to include the substantive change enacted by the Hawaii Legislature in 1978.”\textsuperscript{105} Accordingly, an amendment that provided for “more than the effective administration” constituted a “substantive change” and was therefore preempted.\textsuperscript{106}

Despite the ambiguous meaning of “effective administration,” the Ninth Circuit’s analysis in \textit{Golden Gate III} does proffer some guidance.\textsuperscript{107} In concluding that a provision in San Francisco’s Ordinance requiring an employer to make payments to or on behalf of their employee for health coverage was not preempted by ERISA, the Ninth Circuit

\textsuperscript{103} \textit{Council of Hotels}, 594 F.Supp. at 453.

\textsuperscript{104} \textit{Id.} at 455 (citation omitted).

\textsuperscript{105} \textit{Id.} at 456 (emphasis added).

\textsuperscript{106} \textit{Id.} at 452. The court did not further elaborate on the meaning of “substantive change” nor provided any examples to illustrate their point.

\textsuperscript{107} For further details on \textit{Golden Gate III}, see infra Part III.B.
applied a “modicum of discretion” standard. A modicum of discretion defers to the exercise of discretion by the federal government, states or municipalities to impose “administrative obligations” or “duties” on employers such as “income tax withholding, social security, and minimum wage.” Accordingly, employer payment obligations, including the one included in San Francisco’s Ordinance, are considered an employer’s administrative duties. The court maintained that in order to be preempted by ERISA, the obligation “must require the employer to apply more than ‘some modicum of discretion’” such that “[t]here must be ‘enough ongoing, particularized, administrative, discretionary analysis to make the plan an ongoing administrative scheme.’” Thus by analogy, the term “effective administration” can imply that amendments that impact an employer’s administrative duties to effectively administer PHCA constitutes no more than a modicum of discretion.

Notwithstanding its final decision in Council of Hotels, the Hawaii Supreme Court may have signaled that its precedent is limited. In pointing out that the “Secretary of Labor, the federal agency charged with administering ERISA, has taken no position on the meaning of [the] . . . ‘effective administration’ provision in the context of this litigation,” possibly suggests deference to Hawaii’s courts in deciding how ‘effective administration’ provision in the context of this litigation,”

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108 Golden Gate III, 546 F.3d at 650; see also S.F., CAL., ADMIN. CODE § 14.3(a) (2008).

109 Golden Gate III, 546 F.3d at 650.

110 Id.

111 Id. at 651 (emphases added) (quoting Velarde v. PACE Membership Warehouse, Inc., 105 F.3d 1313, 1317 (9th Cir. 1997)). Thus, the Ordinance was not preempted. The court further stated that the Ordinance imposed obligations that were “mechanical record-keeping” and payments to the City were “typically fixed” and due at “known times” that were not “outside the employee’s control.” Id. (quoting Massachusetts v. Morash, 490 U.S. 107, 109 (1989)). Such “subjective judgments” in making “calculations” to determine an employer’s payments and keeping track of records was “nothing more than the exercise of a ‘modicum of discretion[]’” and therefore not preempted by ERISA. Id.
administration’ would be applied in a broader context beyond collective bargaining as the waiver is specific to only Hawaii. To date, no additional legal challenges have been made arguing the “effective administration” term. Consequently, future amendments to the PHCA remain open for judicial interpretation by Hawaii’s courts such as applying the Ninth Circuit’s modicum of discretion standard in defining effective administration.

2. “Relate to”

In establishing a state law impacting employee benefits or pension, the threshold question to answer is whether the law “relate[s] to any employee benefit plan” under ERISA. The broad, sweeping preemptive language under 29 U.S.C. § 1144(a) has generated a flood of litigation to the Supreme Court and federal courts to evaluate the term “relate to.” The leading case authority defining “relate to” is Shaw v. Delta Air Lines, Inc., in which the Supreme Court held that a state law was preempted if “[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.” The Court noted that it was Congress’ intent to apply “relate to” in its “broadest sense to all action of State or local

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112 Id. at 456 n.10.


114 Shaw, 463 U.S. at 96-97 (emphases added).
governments.” However, the Court also suggested in a footnote that “[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.” Nonetheless, the Court stopped short of drawing the “appropriate” line. Subsequently, for over a decade, the Supreme Court “consistently cited Shaw as an authority for the breadth of the relates-to clause.”

In Travelers, the Supreme Court narrowed the scope of ERISA’s preemptory powers to curb its otherwise limitless scope. The Court recognized that it was never the intent of Congress to “derogue state regulation,” particularly when state laws “clearly operate[d] in a field that has been traditionally occupied by the States.” As such, claims of preemption have been addressed “with the starting presumption that Congress [did] not intend to supplant state law.” Accordingly, the Court concluded that in interpreting “relate to,” it “must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.”

As a result, Travelers, has been touted by legal scholars “as a prime example of the current Supreme Court’s interest in realigning the federal balance more on the side of

115 Id. at 98-99.  
116 Id. at 100 n.21.  
117 Id.  
118 Groves, supra note 60, at 618.  
119 Travelers, 514 U.S. at 655.  
120 Id. at 654; see De Buono v. NYSA-ILA Medical & Clinical Services Fund, 520 U.S. 806, 814 (1997) (quotation marks omitted).  
121 Travelers, 514 U.S. at 654.  
122 Id. at 656 (emphasis added).
the states” and amounts “to an open invitation for states to become creative in using
different kinds of assessments to pay for health care.” Surviving preemption appeared
to be less problematic against state laws as the Supreme Court and other federal and state
courts have narrowed ERISA’s preemptory powers. However, even if an amendment
or law provided for “more than the effective adminstration” or “relates to” ERISA, it still
may be saved from preemption by an exemption.

3. Exemptions Under ERISA Preemption: Savings and Deemer Clauses

The third “preemption prong” actually determines whether a law is exempted
from ERISA preemption. In acknowledging that there are certain areas of law
specifically reserved for the states, Congress explicitly exempted state laws that regulated
“insurance, banking, or securities” from preemption. Codified as 29 U.S.C. §
1144(b)(2)(A), the exemption reads:

Except as provided in subparagraph (B), nothing in this subchapter shall be construed to
exempt or relieve any person from any law of any State which regulates insurance, banking, or
securities.

Commonly known as the “savings” clause, the Supreme Court in Kentucky Ass’n
of Health Plans, Inc. v. Miller analyzed the exemption clause similarly to the Court’s
approach in Travelers with a “common-sense” approach to identify practical factors
“which regulate[d] insurance” rather than construct a legal definition. By applying
concepts from insurance law in which the Court considered as the business of spreading

123 Id. at 400.

124 But see Retail Industry Leaders Ass’n v. Fielder, 475 F.3d 180 (4th Cir. 2007) [hereinafter RILA].
The Fourth Circuit held that Maryland’s Fair Share Care Fund Act (commonly known as the “Wal-Mart
bill”) which mandated employers with 10,000 or more employees spending less than eight percent of total
wages on health insurance to pay the State of Maryland the difference, was preempted by ERISA.

risk, the “Miller factors” were adopted: (1) a “state law must be specifically directed
towards entities engaged in insurance” and (2) a “state law must substantially affect the
risk pooling arrangement between the insurer and insured.” The Miller factors were
subsequently adopted by the Hawaii Supreme Court in Hawaii Management Alliance
Ass'n v. Insurance Commissioner (“HMAA”).

Under the “deemer” clause, an insurance plan will not be “deemed” as an insurer
for the purposes of being exempted from the savings clause. The purpose of the clause
is to ensure that states cannot affect employee benefit plans under the guise of insurance
regulation. It is a preemptive clause to be read in conjunction with the “savings”
clause as it refers to the “regulation of insurance companies, banks, trust and investment
companies.” Additionally, the “savings” clause explicitly mentions that the “deemer”

126 Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979) (quoting 1 GEORGE G.
Couch, Cyclopedia of Insurance Law § 1:3 (2d ed. 1959 (“It is characteristic of insurance that a number
of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as
to enable the insurer to accept each risk at a slight fraction of the possible liability upon it.”)).

127 Miller, 538 U.S. at 342.

128 In defining the “business of insurance,” the Hawaii Supreme Court in HMAA adopted the Miller
factors: (1) the state law must be specifically directed towards entities engaged in insurance and (2) the
state law must substantially affect the risk pooling arrangement. Hawaii Management Alliance Ass'n v.

129 The “deemer” clause reads, in pertinent part:

Neither an employee benefit plan described in section 1003(b) of this title . . . shall be
deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for
purposes of any law of any State purporting to regulate insurance companies, insurance
contracts.

29 U.S.C.A. § 1144(b)(2)(B) (West 2008); see also Groves, supra note 60, at 622.

130 Groves, supra note 60, at 622.

131 Id.
clause is an exception from exemption. In other words, the “deemer” clause will preempt any state laws that “relate to” an employee benefit plan that “regulates insurance.”

Nationally, challenges to ERISA preemption have appeared across many states in response to health care reform efforts, with state and federal courts reaching various results. However, with the Supreme Court playing a major role in defining the scope of ERISA preemption that culminated in a monumental decision in Travelers, states have become more successful in establishing health care reform laws by surviving legal challenges of ERISA preemption or not allowing the possibility of ERISA preemption to serve as an obstacle in passing comprehensive health care access legislation. San Francisco’s Health Care Security Ordinance and Massachusetts’ Health Care Reform Act exemplify two different models to consider in addressing a growing uninsured employee population.

132 In the “savings” clause, its reference to “subparagraph (B)” refers to the “deemer” clause. 29 U.S.C.A. § 1144(b)(2)(A) (West 2008).

133 As national health care reform slowly continues to progress in Congress, states have begun to take a proactive role to address the uninsured problem. By mid-2005, thirty-one states had pending bills relating to employer-based health insurance coverage. 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. Lab. & Emp. L. 387, 388 (2006) (describing how states have reacted to health care reform in light of recent Supreme Court decisions that have narrowed the scope of ERISA preemption).

In addition, ERISA preemption challenges in federal district and court of appeals has potentially reached a circuit split (e.g., 4th Circuit vs. 9th Circuit) and is later discussed in this article. Petition for Writ of Certiorari, Golden Gate Rest. Ass’n, 2009 WL 1630302 at *15-23; see infra notes 175-82 and accompanying text.

134 In 1992, Justice Stevens noted that “[a] recent LEXIS search indicates that there are now over 2,800 judicial opinions addressing ERISA preemption.” District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 135 n.3 (1992) (Stevens, J., dissenting).

135 Sharon Jacobs, Recent Developments in Health Law: On the Mend: The Ninth Circuit Gives San Francisco’s Health Care Security Ordinance the Green Light (For Now), 36 J.L. Med. & Ethics 431, 433 (2008) (describing that during the Golden Gate III proceeding in 2006, at least thirty states were contemplating legislation mandating employers to “either provide minimum levels of health care to their employees or to pay the shortfall into public programs.”).
B. The San Francisco Health Care Security Ordinance

The *Golden Gate III* decision is significant because the Ninth Circuit effectively narrowed the scope of ERISA preemption by upholding a San Francisco ordinance.\(^{136}\) Furthermore, the court distinguished *Golden Gate III* from *Standard Oil* to preserve its decision that ERISA preempted the PHCA.\(^{137}\) The precedent established in *Golden Gate III* can provide a useful model for future legislation.

1. About the San Francisco Ordinance

The City and County of San Francisco (“the City”) unanimously passed and signed into law the San Francisco Health Care Security Ordinance in July 2006. Based on a spending model, the Ordinance contains two main features: (1) Healthy San Francisco (formerly called “the Health Access Plan”) and (2) the “Employer Spending Requirements” (“ESR”).\(^{138}\) Healthy San Francisco (“HSF” or “the Program”) is a health care program administered by the San Francisco Department of Public Health with the purpose of providing selected “medical services for the prevention, diagnosis, and treatment of medical conditions” for “uninsured San Francisco residents, regardless of employment status.”\(^{139}\) Healthy San Francisco “prioritize[s] services for low and moderate income persons.”\(^{140}\) However, the Ordinance explicitly states that HSF is “not

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\(^{137}\) *Standard Oil*, 633 F.2d at 696-97.

\(^{138}\) Codified as S.F., CAL., ADMIN. CODE §§ 14.1-14.8 (2008); see *Golden Gate III*, 546 F.3d at 642-43; see also Healthy San Francisco, About Us, http://www.healthy sanfrancisco.org/about_us/Reports.aspx (last visited Feb. 28, 2009).

\(^{139}\) S.F., CAL., ADMIN. CODE § 14.2(c), (f) (2008).

\(^{140}\) *Id.* § 14.2(d).
an insurance plan.

141 Funding for HSF is supported by contributions from employers, individuals and the City. The Ordinance also requires employers to maintain records of expenditures, allow the City to access these records, and provide annual reports to the City. Employers are prohibited from “reducing the number of employees” below threshold requirements of a “covered employee” in order to avoid the obligations of the Ordinance. A monetary penalty is imposed on employers who violate any provisions of the Ordinance or fail to comply with the ESR.

Under the ESR, the Ordinance requires “covered employers” to make “health care expenditures to or on behalf of their covered employees each quarter” based on the hourly rate for each hour worked. “Covered employers” are for-profit medium and large businesses “engaging business within the City” with at least 20 employees or a nonprofit with at least 50 employees. “Covered employees” are employees who: (1) work in the City; (2) are “entitled to payment of a minimum wage from an employer under the Minimum Wage Ordinance;” (3) worked for the employer for 90 days; and (4) worked at least 8 hours per week. The hourly rate or “health care expenditure rate” depends on the number of employees the employer has and whether the employer is for-

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141 Id. § 14.2(a) (emphasis added).
142 Id. § 14.2(d).
143 Id. § 14.3(b).
144 Id. § 14.4(c).
145 Id. § 14.2(e).
146 Id. § 14.3(a).
147 Id. § 14.1(b)(3), (11), (12).
148 Id. § 14.1(b)(2).
profit or non-profit. Qualified health care expenditures that satisfy the ESR include, but are not limited to, payments to third parties to provide health care services, contributing to a health savings account, directly reimbursing covered employees for health care expenses incurred, paying costs incurred for direct the delivery of health care services, and payments to the City to fund the HSR or provide a medical reimbursement account for covered employees. A “covered employer has discretion as to the type of health care expenditure it chooses to make for its covered employees.” As of January 8, 2010, about two-thirds of San Francisco’s 73,000 uninsured population or 49,578 individuals have enrolled in the HSF program.

2. **Golden Gate III: Summary of Findings**

The highly anticipated Ninth Circuit’s reversal of the district court’s ruling declaring that the Ordinance was not preempted by ERISA signals a major victory for state-level health care reform legislation. In refuting the Golden Gate Restaurant Association’s (“the Association”) claims that ERISA preempted the Ordinance, the court

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149 **S.F., CAL., OFFICE OF LABOR STANDARDS ENFORCEMENT, REGULATION S IMPLEMENTING THE EMPLOYERS SPENDING REQUIREMENT OF THE SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE, REGULATION 5.2(A) (2008) [hereinafter ESR Reg.].** For example, large businesses that comprise of 100 or more employees and are required to “make a health care expenditure of $1.76 per hour for each hour paid for each of its covered employees” and non-profits and for-profit businesses with 20-99 employees pay $1.17 per hour per employee. *ESR Reg. 5.2(A)(1) (2008).*

150 **ESR Reg. 4.2(A) (2008); see S.F., CAL., ADMIN. CODE § 14.1(b)(7) (2008).**

151 **ESR Reg. 4.2(A) (2008).**

concluded that: (1) the ESR was not an ERISA plan and (2) the Ordinance in its entirety did not relate to ERISA.\textsuperscript{153}

As to the first conclusion, the ESR or “City-Payment Option” imposed on employers did not create an ERISA plan because employers did not have to “establish their own ERISA plans or [ ] make any changes to any existing ERISA plans.”\textsuperscript{154} The payment option was considered an employer’s administrative obligation amounting to a “modicum of discretion” that was similar to paying income taxes or social security.\textsuperscript{155} Further, employers had the option to pay the City directly or make a qualified health care expenditure.\textsuperscript{156} If employers paid the City, their employees they paid for on their behalf were “entitled to receive either discounted enrollment in the [HSF] or medical reimbursement accounts with the City.”\textsuperscript{157} Once payments were made under either option, no additional burdens were imposed on the employer.\textsuperscript{158}

For the second conclusion, the court applied arguments from \textit{Travelers} to hold that the Ordinance did not “relate to” ERISA because it was “not concerned with the nature of the health care benefits an employer provides its employees.”\textsuperscript{159} Rather, the

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\item[\textsuperscript{153}] \textit{Golden Gate III}, 546 F.3d at 646-47.
\item[\textsuperscript{154}] \textit{Id.} at 646; see S.F., CAL., ADMIN. CODE § 14.1(b)(7)(e) (2008); see also ESR Reg. 4.2(A)(6) (2008).
\item[\textsuperscript{155}] \textit{Golden Gate III}, 546 F.3d at 650; see supra text accompanying notes 108-110. The court argued that “federal, state and local laws” that impose financial burdens on employers such as taxes do not constitute ERISA plan even though an employer is obligated to pay. \textit{Golden Gate III}, 546 F.3d at 650.
\item[\textsuperscript{156}] S.F., CAL., ADMIN. CODE § 14.1(b)(7)(e) (2008); ESR Reg. 4.2(A)(6) (2008).
\item[\textsuperscript{157}] \textit{Golden Gate III}, 546 F.3d at 646.
\item[\textsuperscript{158}] \textit{Id.} at 650 (holding that the employer is not responsible for “ensuring that the payments are actually used for [health care] purpose[s]”).
\item[\textsuperscript{159}] \textit{Id.} at 647.
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Ordinance was based on the *monetary amount of contribution* and “d[id] not look beyond the dollar amount spent” nor “evaluate[d] benefits derived from those dollars.” 160

Further, based on prior Ninth Circuit cases on what constituted an “employee welfare benefit plan,” the court considered the Ordinance as a “government entitlement program” available to lower income San Francisco residents, “regardless of employment status” and where employers had “no control over whether its employees [we]re eligible for the [HSF].” 161 Whether or not an employer had an ERISA plan was irrelevant as the Ordinance relied on the “employer’s obligations to the City [ ] measured by reference to the *payments* provided by the employer to an ERISA plan or to another entity specified in the Ordinance” 162 and “d[id] not force employers to provide any particular employee benefits or plan, to alter their existing plans, or to even provide ERISA plans or employee benefits at all.” 163 Thus, “[w]here a law is fully functional even in the absence of a single ERISA plan . . . it does not make an impermissible reference to ERISA plans.” 164 In other words, the HSF was *not an insurance plan.* 165 Finally, the Ordinance was not meant to replace or duplicate existing state and federal health services nor establish

160 *Id.*

161 *Id.* at 653 (applying factors established from a prior Ninth Circuit case to define an “employee welfare benefit plan”: (1) the existence of a “plan, fund or program” and (2) that “the plan be ‘established or maintained by an employer through the purchase of insurance or otherwise’” (quoting *Patelco Credit Union v. Sahni*, 262 F.3d 897, 907 (2001))).

162 *Id.* at 658 (emphasis added).

163 *Id.* at 659 (citing *WSB Electric, Inc. v Curry*, 88 F.3d 788, 793-94 (9th Cir. 1996)).

164 *Id.*

165 *See* S.F., CAL., ADMIN. CODE § 14.2(a) (2008).
universal health insurance. Rather, the goal was to provide universal health care access.

a. Other Key Issues

In reaching its decision, the court attempted to avoid legal inconsistencies in two aspects: (1) by distinguishing its prior ruling in *Standard Oil* from *Golden Gate III* and (2) deflecting a circuit split in a recent Fourth Circuit holding that a state health care law was preempted by ERISA. As to the first issue, the court was cautious to avoid overruling *Standard Oil* by distinguishing the present case from *Standard Oil* and other Supreme Court cases. The court found that in contrast to the PHCA, the Ordinance did not require employers to “adopt an ERISA plan or other health plan” nor to “provide specific benefits.” If anything, the court held that the Ordinance exerted an “even less direct [influence]” than in *Travelers* as employers were given multiple options to meet its required health care expenditures. Even the perceived burdens that the Ordinance imposed were not unique to ERISA plans and applied to the employer rather than on the

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167 *Id.*

168 See supra note 124.

169 *Golden Gate III*, 546 F.3d at 655 (in reaffirming why the PHCA was preempted by ERISA, the court indicated that the PHCA “directly and expressly regulated employers and the type of benefits they provide employees” (quoting *Standard Oil*, 633 F.2d at 766) (brackets omitted)).

170 *Id.*

171 *Id.*
Accordingly, the Ordinance “thus preserve[d] ERISA’s uniform regulatory regime” and did not impact “the administrative practices of a benefit plan.”  

Under the second issue, the court concluded that its holding was not inconsistent between RILA and the present case. In RILA, the Maryland Fair Share Care Fund Act mandated that large employers could either increase its healthcare contribution to a specified percent of its wage expenses or pay the State of Maryland the difference. Essentially, the bill specifically targeted Wal-Mart as other the large employers already provided the proposed minimum health care contributions. The Fourth Circuit held that the bill was preempted by ERISA and therefore invalid. In avoiding a circuit split, the Golden Gate III court indicated that it “neither adopt[ed] nor reject[ed]” the Fourth Circuit’s analysis in RILA. Rather, it contrasted how the Ordinance differed from the Wal-Mart bill in two aspects. First, “the City-payment option offer[ed] employers a meaningful alternative that allows them to preserve the existing structure of their ERISA plans.” Such “realistic alternative[s]” did not “effectively mandate that employers

172 Id. at 657.
173 Id. at 656 (quotation marks omitted).
174 Id.
175 See supra note 124.
176 RILA, 475 F.3d at 194. Large employers were defined as employing at least 10,000 employees which only applied to 4 companies: Johns Hopkins University, Giant Food, Northrop Grumman, and Wal-Mart. Except for Wal-Mart, the rest were either unionized or contributed more than the minimum proposed spending level for health care benefits. Id.
177 Id. at 180.
178 Golden Gate III, 546 F.3d at 659.
179 Id. at 660 (emphasis added).
structure their employee healthcare plans to provide a certain level of benefits." The Ordinance provided “tangible benefits” to employees such that in return for the employer’s payment to the City, their employees could enroll in the HSF or be eligible for a medical reimbursement account with the City. In contrast, the court noted that in the Wal-Mart bill, Wal-Mart had no “practical” choice as the option to provide more health benefits or pay the State of Maryland essentially forced Wal-Mart to pay the State.

In sum, the court held that the Ordinance was not preempted by ERISA. However, it cautions that their conclusion should be interpreted narrowly on grounds relating to the employer spending requirements. Nonetheless, the Ninth Circuit’s holding in Golden Gate III was decisively sealed in its recent rejection of the Association’s en banc appeal. The Association unsuccessfully appealed to the Supreme Court to grant an emergency stay to suspend the required employer payment, and is now currently waiting on whether the Supreme Court will grant certiorari.

In the meantime, the number of uninsured will continue to rise, further constraining the already financially exhausted health care system. It should be

180 Id. (quoting RILA, 475 F.3d at 193).
182 RILA, 475 F.3d at 193.
183 Golden Gate III, 546 F.3d at 662.
184 Golden Gate Rest. Ass’n v. City & County of San Francisco, 558 F.3d 1000 (9th Cir. 2009). In denying the Association’s petition for an en banc rehearing, the Ninth Circuit essentially reiterated its arguments set forth in Golden Gate III and rebutted the dissent’s arguments holding that the majority’s decisions did not: (1) create a circuit split with the Fourth Circuit in RILA; (2) conflict with two Supreme Court decisions; and (3) go against the intent of ERISA. Id. at 1002-1004.
185 Egelko, supra note 21; see Petition for Writ of Certiorari, Golden Gate Rest. Ass’n, 2009 WL 1630302.
imperative for states (especially in the Ninth Circuit) that are interested in implementing a law similar to the Ordinance, to do so sooner rather than later. Hawaii, in particular, should work to strengthen PHCA and come up with innovative solutions that could serve as a model for other states and Congress as national health care legislation is being considered.\textsuperscript{186} Massachusetts has taken a bold step in passing comprehensive health care legislation and has so far successfully demonstrated that states can make sweeping changes now rather than wait for the federal government to act on health care reform.

C. Massachusetts Health Care Reform Act

In contrast to San Francisco, Massachusetts took a different approach in establishing health care coverage. Based on a collaborative model, a comprehensive plan was created despite the possibility of ERISA preemption through political grassroots effort with over eighty stakeholder public and private groups and bipartisan support from the Massachusetts legislature.\textsuperscript{187} The plan was enacted on July 1, 2007, entitled, “An Act Providing Access to Affordable, Quality, Accountable Health Care” (the Massachusetts “Act” or “Plan”).\textsuperscript{188} Touted as the “boldest plan for achieving universal coverage” to date, Massachusetts has already exceeded its expectations with 430,000 enrolled, equating to approximately 80 percent of the uninsured population having insurance.\textsuperscript{189}

\begin{footnotesize}
\begin{enumerate}
\item In the district court’s decision in \textit{Standard Oil}, the majority did mention that the PHCA “has been held up as a model for a national health insurance plan which the federal government should study.” \textit{Standard Oil}, 442 F.Supp at 710 n.14. However, despite the court’s support of “social experimentation” at the state level, it held that the PHCA was contrary to the intent of ERISA and was preempted. \textit{Id.}
\item Chirba-Martin & Torres, \textit{supra} note 16, at 410.
\item 2006 Mass. Acts ch. 58.
\item Health insurance enrollment goals have exceeded its target within less than two years since the Act was enacted. Commonwealth Connector, Health Care Reform: Overview, http://www.mahealthconnector.org/portal/site/connectorf (follow “Health Care Reform” hyperlink; then follow “Overview” hyperlink) (last visited April 22, 2009).
\end{enumerate}
\end{footnotesize}
As a result, Massachusetts now has the lowest uninsured rate in the nation at 2.6 percent.\textsuperscript{190} An analysis of Massachusetts’ health care law provides guidance in how Hawaii and other states can overcome fears of ERISA preemption to successfully develop an innovative, comprehensive piece of legislation.

1. Overview of the Massachusetts Act

The Act has four main components: an individual mandate, an employer mandate, the “Commonwealth Connector” and a health insurance program. The individual mandate requires that all uninsured individual residents must have some form of health care coverage as of July 1, 2007 or face an increasing state income tax penalty for each year the individual has no health insurance.\textsuperscript{191} This is similar to state-mandated automobile insurance. Under the Act, residents are broadly defined and those with “sincerely held religious beliefs” are exempted from the mandate.\textsuperscript{192} To ensure that individuals comply with the mandate, the remaining portions of the Act provide various ways for individuals to afford health insurance.

The employer mandate requires that businesses employing more than 10 employees must offer a “cafeteria plan” as promulgated under the Internal Revenue Code (“IRC”) section 125.\textsuperscript{193} In addition, employers must make a “fair and reasonable

\begin{itemize}
\item \textsuperscript{190} \textit{Id.}
\item \textsuperscript{191} \textit{Mass. Ann. Laws} ch. 111M, § 3 (LexisNexis 2008). The tax penalty is “50 per cent of the minimum insurance premium for creditable coverage” per month. \textit{See id.} § 2.
\item \textsuperscript{192} \textit{Id.} § 3. However, the Act does exclude individuals who become residents of Massachusetts “for the sole purpose of securing health insurance.” \textit{See id.} § 1.
\item \textsuperscript{193} \textit{Mass. Ann. Laws} ch. 151F, § 2 (LexisNexis 2008). Examples include health savings accounts and flexible spending accounts.
\end{itemize}
premium contribution” to a “group health plan” as defined in IRC section 5000(b)(1).\(^{194}\) The Massachusetts Division of Health Care Finance and Policy is delegated with the task of determining what constitutes “fair and reasonable,”\(^{195}\) and set forth two tests based on the percent of full-time employees enrolled in the employer’s health plan or the percent of the premium contribution for each full-time employee.\(^{196}\) Full-time employees are defined as employees who work at least 35 hours per week.\(^{197}\) If the employer meets one of these percentage criteria, it has met the standard of a “fair and reasonable premium contribution.” Like the PHCA, independent contractors, temporary workers, and seasonal employees are excluded from the Act.\(^{198}\) Employers who fail to offer a cafeteria plan or meet the fair and reasonable premium contribution criteria are assessed a “fair share employer contribution” of up to $295 annually per employee payable to the “Commonwealth Care Trust Fund” which subsidizes a state “uncompensated care pool” for low-income uninsured and underinsured individuals.\(^{199}\) In addition, employers may

\(^{194}\) MASS. ANN. LAWS ch. 149, § 188(a) (LexisNexis 2008); see also I.R.C. § 5000(b)(1) (2000). A qualified group health plan also includes an employer’s self-insured plan.

\(^{195}\) MASS. ANN. LAWS ch. 149, § 188(a) (LexisNexis 2008).

\(^{196}\) 114.5 MASS. CODE REGS. 16.03(1) (2007). Employers are required to either enroll at least 25 percent of full-time employees in its health plan or contribute at least 33 percent of the premium for each full-time employee.

\(^{197}\) MASS. ANN. LAWS ch. 149, § 188(b) (LexisNexis 2008).

\(^{198}\) MASS. ANN. LAWS ch. 151F, § 1 (LexisNexis 2008).

\(^{199}\) MASS. ANN. LAWS ch. 149, § 188(b), (d) (LexisNexis 2008). Seasonal employees work up to 16 weeks per year. Temporary employees work up to 12 consecutive weeks during the twelve-month period ending on the last day of the reporting quarter.
also be assessed a “free rider” surcharge if their uninsured employees frequently benefit from the uncompensated care pool.\textsuperscript{200}

The Commonwealth Connector (“the Connector”) is an independent public entity with the purpose of assisting small businesses with less than 50 employees, non-employer groups including any “labor union, educational, professional, civic, trade, church, non-profit, or social organization”\textsuperscript{201} and individuals find affordable private insurance.\textsuperscript{202} In general, the Connector is authorized to select qualified health benefit plans, subsidize the purchase of health insurance, oversee compliance of the Act’s mandates, and establish a state pool to maximize economies of scale for purchasing insurance on behalf of a large number of individuals and small businesses.\textsuperscript{203} One of the Connector’s key features is its emphasis on continuity of health care coverage.\textsuperscript{204} Once an individual has insurance through the Connector, he or she is free to change jobs without losing any health insurance benefits provided through a former employer’s participation in the Connector—in essence, the Connector-based insurance is “portable.”\textsuperscript{205}

Finally, the Commonwealth Care Health Insurance Program provides subsidized health insurance through the Connector for low-income individuals who are not eligible

\begin{footnotesize}
\textsuperscript{200} \textit{Mass. Ann. Laws} ch. 118G, §18(B) (LexisNexis 2008). The free-rider surcharge is triggered when an employee or his or her dependent receives free care more than 3 times a year, or when a company has 5 or more instances of employees or their dependents receiving free care in a year.

\textsuperscript{201} \textit{Mass. Ann. Laws} ch. 176a, §§ 1, 4 (LexisNexis 2008).


\textsuperscript{204} Zelinsky, \textit{supra} note 203, at 237.

\textsuperscript{205} \textit{Id.}
\end{footnotesize}
to receive any government-sponsored health plan (e.g., Medicare or Medicaid).\textsuperscript{206} A federal poverty level sliding-scale determines whether an individual qualifies to purchase subsidized health insurance and how much he or she will have to contribute.\textsuperscript{207} Funding for the Program is provided through the Commonwealth Care Trust Fund.\textsuperscript{208}

2. **Key Successes**

Contributing to the success of achieving broad support for the Act is due in part to several factors: Massachusetts has a relatively small uninsured population of 10 percent, 68 percent of employers already provided residents with health coverage, an uncompensated care fund was in place since 1985, and the health insurance market is highly regulated.\textsuperscript{209} Perhaps the most intriguing rationale that ultimately led to broad support of the Act was the federal government’s threat to “withhold $385 million in Medicaid funding unless Massachusetts developed a plan to apply federal resources more

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\textsuperscript{206} See MASS. ANN. LAWS ch. 118H, § 1 (LexisNexis 2008).

\textsuperscript{207} See id. § 3. Individuals or families with household incomes up to 300 percent of the federal poverty level qualify for the subsidized health insurance.

\textsuperscript{208} See id. §§ 1, 5.

\textsuperscript{209} Elizabeth A. Weeks, *Failure to Connect: The Massachusetts Plan for Individual Health Insurance*, 55 U. KAN. L. REV. 1283, 1297 (2007) (discussing how Massachusetts’ “politic[al], population and business climate” may have aligned themselves in such a way that facilitated passage of the Act).
strategically.” The combination of these factors together with the increasing costs of health insurance premiums, created the perfect storm for health care reform.

3. **Major Problems**

Notwithstanding its successes, the Act has its skeptics and problems. The biggest concern is affordability of the Act and inevitably its sustainability, especially as enrollment in the Connector and Health Insurance Program was largely underestimated. Legislators will likely face challenges in raising additional revenues to fund the Act. Another concern is whether employers are able to afford to comply with the Act. Similar to employer reactions to the PHCA, employers in Massachusetts have found ways to avoid compliance in numerous ways. One employer, for example, has expanded coverage to more employees but decreased its level of contribution. Another employer increased the minimum number of hours needed to work in order to qualify for health insurance benefits while a small employer decided to split his business

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210 Chirba-Martin & Torres, *supra* note 16, at 413. Medicaid is a federal-state health care program for low-income individuals up to 200 percent of the federal poverty level (FPL) in which the federal government matches state funding if states comply with certain guidelines. *Weeks, supra* note 209, at 1291 (describing Medicaid and the section 1115 waiver). States may however, apply for a Medicaid § 1115 waiver which allows states to expand coverage for individuals beyond the FPL by establishing “experimental, pilot, or demonstration [Medicaid] projects.” 42 U.S.C.A. § 1315(a) (West 2000). Massachusetts applied for and received a Medicaid § 1115 waiver in 1997 and has since spent $1 billion per year to subsidize its uninsured population. Chirba-Martin & Torres, *supra* note 16, at 412-13. Such a financial strain on the federal Medicaid system led the federal government to take action against Massachusetts by threatening to deny future funding. *Id.* at 413.

211 Chirba-Martin & Torres, *supra* note 16, at 411 (noting that “premium costs would continue to increase at double-digit rate and increasing costs would incite more small and medium-sized businesses to drop employee health benefits.”).

212 *Id.* at 418-19 (pointing out that projected enrollment was between 140,000 – 160,000 in 2006, but by January 2008, 169,000 enrolled. With this rate of enrollment, costs to the state could amount to $1.35 billion by 2011).

213 *Id.* (suggesting that lawmakers may raise revenues through cigarette taxes and increasing employer penalties).

into separate corporations that each employed less than 11 employees.\textsuperscript{215} Finally, it remains unresolved as to whether the Act will be preempted by ERISA.\textsuperscript{216} General consensus indicates that the employer mandate will likely be preempted\textsuperscript{217} while other sections of the Act have diverging perspectives. To date, no legal challenges have been raised.

In sum, the San Francisco and Massachusetts experience present two divergent views of passing health care reform legislation in light of ERISA preemption. Both have its strengths and weaknesses and are unique to each respective state. Hawaii and other states can examine lessons learned to address its own uninsured population. In fact, the current national health care reform bills are based on the Massachusetts model.\textsuperscript{218} For Hawaii, we must look to the PHCA as a starting point.

\textbf{IV. \hspace{1em} Future Direction of the PHCA: Have We Reached a Tipping Point?}

Short of universal health care, the PHCA is Hawaii’s only piece of comprehensive health insurance coverage legislation. There are no viable alternatives, and it is difficult to rely on government programs as costs of health care continue to rise. Despite the PHCA’s weaknesses, its strengths are invaluable. There are provisions in the PHCA that could be amended to alleviate the rising costs of health insurance premiums for

\begin{itemize}
\item \textsuperscript{215} Id.
\item \textsuperscript{216} \textit{See} Chirba-Martin & Torres, \textit{supra} note 16, at 436-42; \textit{see also} Zelinsky, \textit{supra} note 203, at 250-76.
\item \textsuperscript{217} The employer mandate portion of the Massachusetts Health Care Security Ordinance will likely be found to directly “relate to” ERISA. \textit{See} Chirba-Martin & Torres, \textit{supra} note 16, at 437; Zelinsky, \textit{supra} note 203, at 253.
\item \textsuperscript{218} \textit{See} Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. (2009).
\end{itemize}
businesses. Additional legislation could also be enacted to expand prepaid health coverage to more individuals. These notions are supported by San Francisco’s recent success in *Golden Gate III* and Massachusetts’ Health Care Reform Plan. States, especially in the Ninth Circuit, should look to implementing a law modeled after the Ordinance, especially in light of the pending *Golden Gate III* appeal. Although some may argue that taking action before the resolution of *Golden Gate III* is premature and a waste of resources, there is no guarantee that that Supreme Court will accept *certiorari* and reverse the Ninth Circuit’s decision. Further, current national health care legislation efforts face tremendous obstacles. In the meantime, states must continue to deal with the rising costs of health insurance premiums and a growing number of uninsured individuals and families in an economy where businesses are barely surviving and job losses are rising. The health care financing system will eventually reach a breaking point. Thus, Hawaii should continue to work with the PHCA and come up with innovative solutions that could serve as a model for other states and Congress. Accordingly, Hawaii can tailor examples from San Francisco and Massachusetts to strengthen the PHCA through amendments and additional legislation that will likely survive ERISA preemption.

A. The PHCA Can Be Amended

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219 In fact, there are unfamiliar provisions in the PHCA that could be enforced without amendments. For example, there is a Premium Supplementation Fund that was solely created to subsidize premiums for small businesses with less than 8 employees. *See HAW. REV. STAT. §§ 393-41 to -48* (West, Westlaw through 2008 Sess.). From personal interviews with labor law experts and legislators, many were unaware of the Fund’s existence as it quietly operates under the administration of the DLIR.

220 *Golden Gate III* held that a San Francisco ordinance mandating large and medium sized businesses to pay for health care expenses for their employees was not preempted by ERISA. *Golden Gate III*, 546 F.3d at 646-47.

221 In the district court’s decision in *Standard Oil*, the majority did mention that the PHCA “has been held up as a model for a national health insurance plan which the federal government should study.” *Standard Oil*, 442 F.Supp at 710 n.14. However, despite the court’s support of “social experimentation” at the state level, it held that the PHCA was contrary to the intent of ERISA and was preempted. *Id.*
Contrary to fears that any amendments to the PHCA will preempt it, the PHCA itself is safe from preemption. The language in the ERISA waiver protects the originally enacted PHCA in 1974—only amendments to the original PHCA are subject to ERISA preemption. In fact, since the enactment of the PHCA, at least ten different sections of the PHCA have been amended, including some sections amended multiple times over the years. Of the amendments, only two have been preempted. How did the others survive preemption? Although no legal challenges have been raised to preempt any of these amendments, the Hawaii Supreme Court interpreted the “more than the effective administration of” language in the ERISA waiver to mean that any amendments constituting a “substantive change” would be preempted by ERISA. Thus, all amendments made to the PHCA must satisfy the “effective administration” preemption prong and constitute a non-substantive change in order to survive ERISA preemption. Examining these amendments through the effective administration lens will provide a framework to support future amendments to the PHCA.

The surviving amendments can be separated into three types: (1) provided technical and non-substantive changes; (2) enhanced enforcement; and (3) clarified or removed unintended results, and/or complemented existing provisions. As to the first

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222 29 U.S.C. § 1144(b)(5)(B)(ii) states in part: “any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date” is subject to preemption (emphasis added).

223 See, e.g., HAW. REV. STAT. §§ 393-3, -5, -6, -7, -13, -21, -24, -33, -34, -48 (West, Westlaw through 2008 Sess.).

224 See Standard Oil, 633 F.2d at 696 (substance & drug abuse benefits); Council of Hotels, 594 F.Supp. at 453 (equivalency requirements for unions).

225 Council of Hotels, 594 F.Supp at 452; see also text accompanying notes 109-112.
category, amendments included name changes and adding gender-neutral terms. These amendments clearly provided for the “effective administration” of the PHCA as no substantial changes were made. Under the second category, compliance with the PHCA was strengthened by adding additional penalties to enhance existing ones or creating new penalties. Amendments to enforce penalties and fines are also a form of effective administration. In order for the PHCA to be successfully implemented, some method of enforcement is necessary and could be considered an application of modicum of discretion. However, it is arguable that new penalties should not be too onerous as to single out a particular employer, like the Wal-Mart bill or place an extreme burden on employers that would jeopardize its existence. The third category included amendments to clarify definitions or the intent of a provision, remove unintended or unforeseeable effects, and strengthen existing rights. To justify these amendments,

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226 1987 Haw. Sess. Laws 1117 (amended section 393-5 to revise the name of a state department referenced in the statute).


228 1977 Haw. Sess. Laws 412 (amended section 393-33 to allow employers outside the State of Hawaii to be enjoined from doing business in Hawaii as long as the employer continues to be noncompliant with the PHCA’s coverage requirements).

229 1991 Haw. Sess. Laws 241 (added a new section 393-34 to impose a monetary fine in violation of any provision that did not have an existing penalty).

230 See supra text accompanying notes 108-110.

231 See supra note 176 and accompanying text.

232 See, e.g., Travelers, 514 U.S. at 664 (noting that imposing an “exorbitant tax” may leave ERISA plan sponsors “with a Hobson’s choice” that would essentially impose a “substantive amendment”).

233 2007 Haw. Sess. Laws 840 (amended section 393-5 to narrow the scope of domestic caregivers to exclude only caregivers who are independent contractors provide services for developmental disabilities and mental retardation).

234 2003 Haw. Sess. Laws 579 (amended section 393-7(d) to clarify “representatives of” the prepaid health care advisory council to exclude health insurers and individuals “employed by a health maintenance
no new legal mandates were created nor were the amendments contrary to the original intent of the PHCA. Thus, these amendments simply clarified ambiguities to improve the PHCA’s effectiveness.

It is therefore observed that successful amendments, at least on its face, did not directly impact employers in terms of their rights and duties nor did they substantially alter the PHCA. Consequently, there are instances in which the PHCA can be amended, although it appears that the scope is quite narrow.

B. **Suggested Amendments to the PHCA**

Other amendments have been suggested to the Hawaii Legislature, such as eliminating the employee’s contribution cap or adjusting the employer-employee contribution for inflation, but unfounded fears of ERISA preemption have essentially prevented meaningful legislation. Instead of applying the narrow “effective administration” standard, the alternative is to determine whether amendments to the PHCA would be exempted from ERISA preemption. In other words, if an amendment can be shown as regulating the “business of insurance” under the HMAA two-part standard, it may escape ERISA preemption. Three recommended amendments to the organization or other similar plan.”

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235 1978 Haw. Sess. Laws 3 (added a new section 393-48 to require the “premium supplementation fund” to subsidize prepaid health care benefits for eligible employees whose employer is bankrupt or noncompliant).


238 *See supra* note 128.
PHCA will be examined to determine whether any will fall under an existing PHCA amendment category and survive preemption or whether it will be exempted.

1. Increase the 1.5 percent Employee Contribution “Cap” or Include an Inflation Adjustment

As mentioned in Part II, a major limitation of the PHCA is an outdated employee-employer contribution provision, particularly the 1.5 percent cap. Prior to enactment of the PHCA, a questionnaire was distributed to employers representing small to large sized businesses. Based on the results, it was determined that including a 50 percent employer contribution in the PHCA would not severely impact employers as a majority was already contributing this amount.

The 1.5 percent cap was derived from laws relating to federal tax and public benefits. Drafters of the PHCA were careful to balance the employee’s interest in providing some contribution while not jeopardizing potential federal tax and public assistance benefits. At the time the PHCA was drafted, federal tax deductions for medical expenses averaged 3 percent. This figure was also determined to be affordable for even those in the lowest wage bracket and would not replace federal benefits (i.e., Aid to Families with Dependent Children benefits). Based on data from the Riesenfeld

\[\text{HAW. REV. STAT. §§ 393-13 (West, Westlaw through 2008 Sess.).}\]

\[\text{The questionnaire included questions such as type of business, whether they provided employee health insurance, what type of employees were covered and excluded, and types of plans were offered. Riesenfeld Study, supra note 31, at 28.}\]

\[\text{Out of the 3020 returned responses, 75.5 percent of businesses contributed at least 50 percent towards “insurance subscriber costs” for their employees. Id. at 30-31.}\]

\[\text{Id. at 57.}\]

\[\text{Id.}\]

\[\text{Id.}\]
Study, the 3 percent was split in half (1.5 percent employer and 1.5 percent employee), and was subsequently codified under sections 393-13 and 393-45.

By understanding the rationale that led to employer-employee contributions, the recommended amendment to increase the 1.5 percent employer contribution cap to account for inflation may survive preemption in terms of clarifying an existing provision.\(^{245}\) One could contend that the increase in employee contribution is not preempted because it does not create a new mandate nor impose additional burdens on an employer. Rather, it is arguably an indirect tax imposed on employees.\(^{246}\) In Travelers, the Supreme Court held that assessing surcharges to hospital patients were “indirect economic influence[s]” and considered within the traditional powers of the state to impose a financial assessment.\(^{247}\) Further support is demonstrated Golden Gate III as requiring employers to pay for health care expenditures amounted to a modicum of discretion to impose an administrative obligation.\(^{248}\) Accordingly, tying the employee’s contribution with the current federal tax deduction rate for medical expenses may help clarify the intent for employee contribution and could be considered within the effective administration of the PHCA. On the other hand, amending the 1.5 percent cap could be more than the effective administration of the PHCA. Arguably, increasing the employee’s contribution could be a substantive change by requiring employees to pay

\(^{245}\) See supra note 233 and accompanying text.

\(^{246}\) In Travelers, the Supreme Court held that a New York State Statute mandating hospital to collect “surcharges” from patients covered by certain commercial insurers in the form of a bill was not preempted by ERISA. \textit{Id.}, 514 U.S. at 649. The Court held that these patient surcharges were “indirect economic influence[s]” and considered within the traditional powers of the state to impose a financial assessment. \textit{Id.}

\(^{247}\) \textit{Id.} at 668; see also De Buono, 520 U.S. at 806 (holding that New York State’s Health Facility Assessment tax on gross receipts for patient services was “not preempted because it is a tax of general application having only an incidental impact on benefit plans.”).

\(^{248}\) Golden Gate III, 546 F.3d at 650; see also supra text accompanying notes 108-110.
more. However, this is a weak argument as the purpose of ERISA is to regulate private welfare plans, not employees.\textsuperscript{249} In this instance, the recommended amendment impacts the employee, not the employee benefit plan, and therefore not subject to ERISA regulation.\textsuperscript{250} Further, increasing the cap can also be justified as an unintended or unforeseeable effect due to escalating costs of health care premiums.\textsuperscript{251} Thus, it is likely that amending the cap will not be preempted.

2. Eliminate or Decrease the Twenty Work Hours Requirement

Another issue with the PHCA is the minimum 20 hours per week requirement which has led some employers to hire less “full-time” employees.\textsuperscript{252} The PHCA was intended to provide coverage to “regular workers” that were uninsured or underinsured.\textsuperscript{253} As to employees who worked less than 20 hours, drafters of the PHCA presumed that these “part-time workers” earned lower incomes and probably received some form public assistance such as Medicare or Medicaid.\textsuperscript{254} Consequently, to avoid a “duplication of benefits,” three categories were explicitly excluded from the PHCA, including employees on public assistance.\textsuperscript{255} The PHCA was drafted to cover the “middle

\textsuperscript{249} \textit{Golden Gate Rest. Ass'n v. City & County of San Francisco}, 558 F.3d 1000 (9th Cir. 2009). The Ninth Circuit concluded that “[t]he purpose of ERISA is not to require national uniformity in the provision of health care. Rather, its purpose is to ‘ensure that the administrative practices of a benefit plan will be governed only by a single set of regulations.’” (emphases added) (citing \textit{Fort Halifax Packing Co. v Coyne}, 482 U.S. 1, 11 (1987)); see also 29 U.S.C.A. § 1001 (West 2008).

\textsuperscript{250} \textit{Golden Gate III}, 546 F.3d at 647.

\textsuperscript{251} See \textit{HHIC Premium Data} (between 1996-2006, insurance premiums for individual coverage increased by approximately 76 percent).

\textsuperscript{252} See supra text accompanying notes 84-86.

\textsuperscript{253} \textit{HAW. REV. STAT.} § 393-14 (West, Westlaw through 2008 SESS.); see \textit{Senate Report, supra} note 28.

\textsuperscript{254} \textit{Riesenfeld Study, supra} note 31, at 48-51, 54.

\textsuperscript{255} Exemptions were provided for the following employees:
group” who were not able to qualify for federal or state health insurance benefits. However, even if the drafters of the PHCA were correct in their assumption about income employees qualifying for government benefits, presently, due to State budgetary constraints, Hawaii’s Medicaid program, called Med-QUEST, instituted an enrollment cap at 125,000 adults. Clearly, the drafters of the PHCA did not anticipate that the most vulnerable populations could potentially be denied government assistance.

Based on the original intent of the PHCA, amending the “regular employee” definition by lowering the minimum hours per week threshold will likely face tremendous opposition from employers and be preempted. A weak argument in support of preemption survival is that the amendment eliminates the unintended effects of precluding any uninsured or underinsured workers who are not eligible to receive federal or state health insurance benefits. Reducing the number of hours to expand prepaid

[(1)] an employee already protected by health insurance under federal law (e.g. [M]edicare), [(2)] is covered as a dependent under a plan providing the benefits required by the bill, or [(3)] is a recipient of public assistance (e.g., a working mother entitled to aid to dependent children). The bill also expressly permits an employee to pay a greater part of his wages for providing prepaid health care benefits for his dependents.

Senate Report; see also Riesenfeld Study, supra note 31, at 50-51.

256 Riesenfeld Study, supra note 31, at 48 (stating that the PHCA was “an extension” of existing health plans based on “the prevailing community standards”).

257 The enrollment cap was implemented in 1995. This does not include children and certain classes of individuals. Currently, the cap is still in effect, impacting approximately 26,000 adults who would have met the eligibility criteria. HAWAII UNINSURED PROJECT, PROPOSALS TO INCREASE HEALTH CARE ACCESS IN HAWAII (2005), http://www.healthcoveragehawaii.org/pdl/Pathways_to_Coverage_0105.pdf [hereinafter HUP Access Study].

258 A senate bill was introduced to eliminate the 20 hours per week work requirement in the PHCA, but the bill died in committee due concerns of ERISA preemption and the viability of small business if more employees were required to cover more workers. See S.B. 173, 25th Leg. (Haw. 2009).

259 See HAW. REV. STAT. § 393-2 (West, Westlaw through 2008 Sess.).
health coverage to more employees is meant to clarify the intent of the PHCA. However, this amendment will likely be preempted because expanding the scope of the PHCA does not clarify regular employees, but rather, regulates employers to cover new entities (i.e., general/independent contractors, individuals in performing arts) not originally intended to be covered. Consequently, reducing the number of work hours per week provides for more than the effective administration of the PHCA. Further, there are more affordable alternatives, including passing legislation to remove the enrollment cap. Accordingly, amending the definition of regular employee to include employees who work less than 20 hours per week constitutes a substantive change and will be preempted. The amendment is also not protected by the savings clause as changing the number of work hours to qualify for the PHCA does not directly regulate the business of insurance nor substantially alters terms of insurance policies.

3. **Expand the Premium Supplementation Fund Eligibility Criteria**

Another alternative in addressing the static employer-employee contribution provision is a novel amendment to expand another relatively unknown provision in the PHCA called the Premium Supplementation Fund (the “Fund”). Modeled after a State rent supplementation statute, the Fund was established as part of the original PHCA to

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260 See supra note 233 and accompanying text.


262 Employers can argue that technically, some uninsured employees do qualify for QUEST health insurance but are unable to receive benefits due to the enrollment cap. Thus, excluding employers who work less than 20 hours does not contravene the spirit of the PHCA as the problem lies with the QUEST enrollment cap, not the eligibility criteria. See supra note 257 and accompanying text.

263 Should an amendment like this pass, the business community will likely challenge it.

264 29 U.S.C. § 1144(b)(2)(A); see Miller, 538 U.S. at 341.
subsidize prepaid health care benefits for certain eligible employers and employees. In drafting the PHCA, the Fund was created to “avoid an oppressive burden on low-wage earners” and provide some “health protection.” A special benefit of the Fund is that it is held in trust for the exclusive use for the purposes of the PHCA, meaning that moneys in the Fund are protected from the State, even during tough economic times.

Two groups are entitled to the Fund’s subsidy: (1) eligible employers and (2) covered employees. Eligible employers are defined as having 8 or less employees whose share of the premium paid (a) “exceeds 1.5 percent of the total wages payable” and (b) “if the amount of such excess is greater than [5] percent of the employer’s income before taxes directly attributable to the business.” The employers are responsible to

265 See HAW. REV. STAT. §§ 393-41 to -48 (West, Westlaw through 2008 Sess.). The Hawaii State rent supplementation statute provided an annual rent supplement for “qualified tenants” based on a fixed monthly rate. See id. § 356D.

266 Riesenfeld Study, supra note 31, at 49.

267 HAW. REV. STAT. § 393-41, reads , in part (emphasis added):

There is established in the treasury of the State, separate and apart from all public moneys or funds of the State, a special fund for premium supplementation which shall be administered exclusively for the purposes of this chapter. The fund shall consist of (1) all money appropriated by the State for the purposes of premium supplementation under this part and (2) all fines and penalties collected pursuant to [the PHCA].

HAW. REV. STAT. § 393-42 stipulates how the funds are to be used (emphases added):

The director of finance shall be the treasurer and custodian of the premium supplementation fund and shall administer the fund in accordance with the directions of the director of labor and industrial relations. All moneys in the fund shall be held in trust for the purposes of this part only and shall not be expended, released, or appropriated or otherwise disposed of for any other purpose. Moneys in the fund may be deposited in any depositary bank in which general funds of the State may be deposited but such moneys shall not be commingled with other state funds and shall be maintained in separate accounts on the books of the depositary bank.

268 HAW. REV. STAT. § 393-45 (West, Westlaw through 2008 Sess.).

269 Id. § 393-48.

270 Id. § 393-45(a).
file a claim with the administering agency (the DLIR) and “shall have the burden of proof of establishing [their] entitlement.”271 Eligible employee includes all employees covered under the PHCA (defined as “regular employee”), but cannot receive benefits because the employer: (a) becomes bankrupt or (b) is noncompliant with the PHCA.272 Employees are responsible to report either occurrence to the DLIR and the DLIR director will take appropriate administrative and legal actions to recover benefits for the employee.273

A recommended amendment to the Fund focuses on expanding its access by increasing the number of employers to become eligible for the Fund.274 This amendment arguably removes the unforeseeable effects of the rising costs of health care premiums and growth of smaller businesses, and therefore could survive preemption.275 Such an amendment resembles a 1978 amendment that added a new section to expand the use of the Fund for employees working for employers in bankruptcy.276 Both the 1978 and recommended amendments supplement what employers are already required to do. No new or additional burdens are imposed on the employer. Rather, the issue is about affordability by providing a subsidy to help employers fulfill the PHCA mandate. In fact, any amendment to the Fund does not directly impact the employer as the “Director of

271  Id. § 393-47.
272  Id. § 393-48.
273  Id.
274  Id. § 393-45(a).
275  See supra note 234 and accompanying text. While it would be an interesting exercise to address the ideal number of employees to include, it is beyond the scope of this article. Ideally, the legislature, industry experts, leaders in health care and business, and other concerned stakeholders should collaborate together to outline the details of Fund eligibility.
276  See supra note 235.
Finance” is responsible for administering the Fund. Accordingly, amending the number of covered employees is not a substantial amendment and falls entirely within the effective administration of the PHCA.

Alternatively, a simple solution requiring no amendments could immediately help employers and employees if amending the number of eligible employees for the Fund is preempted by ERISA. Raising awareness of the existence of the Fund through educational efforts by the DLIR to employers and employees can be easily implemented and creates a win-win situation for small businesses, employees and the DLIR as funds are immediately available and a claims process currently exist. Support for educational outreach to employers and employees are supported by financial data. According to the DLIR’s “Report on Non-General Fund Information” which outlines the Fund’s annual budget, an average of only 8.7 percent of the “cash balance” exclusively set aside for eligible employers and employees was spent. The data also substantiates a need for the Fund as firms with less than 10 employees comprise the single largest group of uninsured employees at 26 percent. For those smaller employers who do

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277  HAW. REV. STAT. § 393-42 (West, Westlaw through 2008 Sess.).

278  For example, employers and employees can be informed about how the Fund works, the eligibility criteria for the Fund, how employers can file a claim to collect premium supplementation, and reporting noncompliance. In addition, maximizing use of available resources reduces administrative costs.


280  This is a classic example of economies of scale: the larger the employer, the greater the bargaining power against health insurers to lower premiums. As a result, the rate of uninsured ranges from 6.6 percent to 21.7 percent for firms employing more than 10 employees. HUP Coverage Data.
provide health insurance, their contribution accounts for 13.9 percent of payroll expenses compared to an average of 9.9 percent for larger employers.\textsuperscript{281} Thus, applying this “low hanging fruit” recommendation can be an ideal starting place to help smaller firms.

In sum, it appears amendments relating to expanding the scope of the PHCA to include additional employees working less than 20 hours per week will be preempted by ERISA. On the other hand, amendments that clarify an existing provision to more accurately reflect its original intent such as increasing the employee contribution cap or adjusting it for inflation, and amendments that supplement existing rights by increasing access to the Fund, are within the effective administration of the PHCA. These amendments have a high probability of surviving preemption, especially in light of several amendments made to the PHCA over the years. However, amending the PHCA is merely one strategy to increase coverage for the working uninsured. The growing numbers of uninsured part-time employees and sole proprietors also raises concerns.\textsuperscript{282} Passing legislation to cover individuals excluded from the PHCA should be the other part of Hawaii’s health care reform strategy.\textsuperscript{283}

C. Establish Legislation to Support the PHCA

Limitations in amending the PHCA warrant additional legislation to complement the PHCA. What lessons from San Francisco and Massachusetts can Hawaii and other states apply towards its own health care reform efforts to reduce the working uninsured population? Because there are limited Hawaii Supreme Court cases that have addressed

\textsuperscript{281} \textit{Id.}

\textsuperscript{282} In 2005, the uninsured population among part-time employees constituted 7.5 percent (3944) while sole proprietors constituted 22.8 percent (11,986). \textit{Id.}

\textsuperscript{283} It is the intent of the Patient Protection and Affordable Care Act to cover the “gap groups” left out of the PHCA. \textit{See supra} note 92.
PHCA issues in light of ERISA preemption, there is room for experimentation to test the limits of preemption. Nationally, states and municipalities are also challenging ERISA, with San Francisco and Massachusetts leading the way in an effort to narrow the scope of preemption. Further, legal precedent established by the Supreme Court in [Travelers](#) and the Ninth Circuit in [Golden Gate III](#), support efforts to create legislation that will likely survive ERISA preemption.

1. **Recipe for Success: Key Factors from *Golden Gate III* and Massachusetts**

   Several suggestions are listed below to provide a general framework for states in drafting legislation to increase the probability of surviving the “preemption prongs” and strategies to obtain buy-in from various stakeholders:

   a. **A Legal Framework To Develop Health Care Access Legislation**

      (1) Focus on *access* to health care, not on mandating benefits or health insurance. A plan that appears to regulate insurance will be preempted.

      (2) Consider whether the law will still be effective or relevant without the existence of an ERISA plan.

      (3) The statute should not require employers to modify or replace an existing plan or to establish a new plan.

      (4) The statute should only require the employer to fulfill a payment requirement without additional responsibilities.

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284 See Jacobs, *supra* note 135 and accompanying text.

285 See *supra* text accompanying note 161.

286 In providing health care under the Ordinance, employers are not responsible for “ensuring that the payments are actually used” or “entrusted to fulfill the benefits promises the employer made to its employees” and does not “make no promises to its employees with regard to . . . coverage.” *Golden Gate III*, 546 F.3d at 654.
(5) The provision and regulation of health care benefits should be administered by a public entity.287

(6) Consider linking payments under traditional state laws such as minimum wage laws and taxes.288

(7) Provide “meaningful” and “realistic alternatives” for employers that result in “tangible benefits” for employees.289

In addition to drafting legislation, it is important to obtain support from various stakeholders in the public and private sectors, particularly with entities that may be impacted by the legislation and ones that will likely challenge it.

b. Strategies For Stakeholder Buy-in and Support

(1) Obtain bipartisan support to increase the probability that the legislation will be adopted.

(2) Promote the idea of “shared responsibility” by individuals, employers and government.290

287 The San Francisco Department of Public Health is responsible for administering the HSF program including defining covered services to provide and implementing the medical reimbursement accounts. See S.F., CAL., ADMIN. CODE § 14.2 (2008). Likewise, the Massachusetts Division of Health Care Finance and Policy regulates and monitors group health plan and cafeteria plan payments by employers and the Connector is responsible for assisting businesses, non-employer groups and individuals find private insurance. See MASS. ANN. LAWS ch. 149, § 188(a) (LexisNexis 2008); MASS. ANN. LAWS ch. 176a, §§ 1, 4; MASS. ANN. LAWS ch. 176Q, § 1.


289 For example, the Ordinance requires that employers make “qualified health care expenditures” for their employees and provides a non-inclusive list of examples such as payments to third parties to provide health care services, contributing to a health savings account, directly reimbursing covered employees for health care expenses incurred, paying costs incurred for direct the delivery of health care services, and payments to the City to fund the HSR or provide a medical reimbursement account for covered employees. S.F., CAL., ADMIN. CODE § 14.1(b)(7) (2008); ESR Reg. 4.2(A) (2008).

An example of a “tangible benefit” to employees is in return for the employer’s payment to the City, their employees could enroll in the HSF or be eligible for a medical reimbursement account with the City. Golden Gate III, 546 F.3d at 660; see S.F., CAL., ADMIN. CODE § 14.1(b)(7) (2008).

290 Chirba-Martin & Torres, supra note 16, at 414.
(3) Emphasize comprehensive reform instead of piecemeal efforts.

(4) Leverage existing federal and state programs as an administrative and financial resource (e.g., uninsured pool, Medicaid § 1115 waiver).²⁹¹

These recommendations listed above are by no means exhaustive and may need to be altered, depending on the jurisdiction, political climate, and how uninsured programs are funded and structured. Regardless of the strategy, the end point is the same: to decrease the uninsured population.

V. Conclusion

Hawaii’s response to universal health care by enacting the PHCA was a ground-breaking event. It took a collective effort by the people of Hawaii, state lawmakers and Congressional representatives who had the foresight and courage to become the first state to implement a comprehensive health care model. However, PHCA critics have expressed that it is outdated.²⁹² In addition, as health premiums continue to rise, employers either struggle to comply with the PHCA or avoid compliance by exploiting loopholes. Fears of ERISA preemption have stifled health care reform efforts. Despite these problems, Hawaii continues to have a lower uninsured rate compared to the rest of the nation.²⁹³ Instead of criticizing the PHCA, it should be strengthened and serve as a model for other states to adapt to their own needs. First, legal precedent in Travelers and Golden Gate III suggest a narrowing of ERISA preemption and supports efforts to amend

²⁹¹ For example, Massachusetts converted its uncompensated free care pool from a “hospital reimbursement fund into a premium assistance support resource for the uninsured.” Id. at 413.


²⁹³ HUP Coverage Data, supra note 8.
the PHCA and create additional legislation to support the PHCA. Second, the PHCA can be amended and has been amended multiple times over the years. Finally, San Francisco and Massachusetts successfully applied two different strategies to test the limits of ERISA preemption and have been able to reduce their uninsured populations. In fact, the national health care bills proposed by the House and Senate adapted the Massachusetts’ individual mandate model. Specifically, suggestions to strengthen the PHCA should consider the following: (1) expanding educational efforts to maximize use of the Premium Supplementation Fund; (2) amending the employer-employee contribution provision to account for inflation; (3) drafting legislation carefully to increase the likelihood of surviving preemption; and (4) harnessing the political will through a shared vision of achieving universal access to health care to overcome fears of ERISA preemption. With these recommendations, Hawaii and other states could serve as a model in the timely debate for national health care reform.

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