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MARYLAND’S “WAL-MART” ACT:
POLICY AND PREEMPTION

Edward A. Zelinsky*

INTRODUCTION

In response to negotiations to bring a Wal-Mart regional
distribution center to Maryland,1 that state’s legislature passed, over
gubernatorial veto, a statute mandating that Wal-Mart expend a
minimum percentage of its Maryland payroll on health care for Wal-
Mart’s Maryland employees. The Maryland law is scheduled to take
effect on January 1, 2007 and has spurred interest in similar legislation
in other states.

The Maryland statute raises two fundamental questions: Is the
statute legal? Does the statute represent sound policy? I write to
explore both of these questions.

With respect to the legality of the Maryland statute, I conclude that
the Employee Retirement Income Security Act of 1974 (ERISA)2
preempts the Maryland law. I thus agree with the recent decision of
Judge Motz of the U.S. District Court for the District of Maryland,
holding Maryland’s Wal-Mart Act to be ERISA-preempted.3

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Professor Zelinsky has no financial or other ties to Wal-Mart or to opponents or supporters of
the Act (though, at any moment, it is possible that one of the mutual funds in Professor Zelinsky’s
403(b) accounts holds Wal-Mart stock). Professor Zelinsky has received no financial or other
assistance or encouragement from Wal-Mart or the Act’s opponents or supporters.

1 See Mike Billington & Patrick Jackson, Md. Health Care Requirements Could Send Wal-
Mart to Del.; Benefits Wouldn’t Cost as Much in First State, NEWS J., Jan. 23, 2006, at 1A.
3 Retail Indus. Leaders Ass’n v. Fiedler (RILA), 435 F. Supp. 2d 481 (D. Md. 2006). In
addition to the ERISA preemption issue, District Judge Motz addressed the procedural questions
of standing and ripeness, the jurisdictional import of the Federal Tax Injunction Act, and the
substantive status of the Wal-Mart Act under the Equal Protection Clause of the U.S.
Constitution. My analysis focuses only on the ERISA preemption question.
Since, as a matter of federalism, I favor state experimentation as to medical care, I regret this outcome on normative grounds. Maryland (or any other state) should be free to experiment in this area. However, under any of the plausible approaches to ERISA preemption, ERISA Section 514(a), as a matter of law, preempts the Maryland statute and others like it.

As a matter of policy, the Maryland statute is ill-conceived. The Maryland statute raises prices on Wal-Mart’s predominantly low-income customers and, for the long-run, will reduce Wal-Mart’s employment. Maryland, and other states, have far more compelling options for assisting low-income workers including expansion of state earned income tax credits. While states should be free to experiment, the Maryland statute, even if it passed muster under ERISA, would not be a compelling experiment.

In the final analysis, Maryland’s Wal-Mart Act is a poorly-designed exercise in political symbolism, rather than a carefully-crafted response to the pressing problem of health care in America.

I. THE MARYLAND ACT

Maryland’s Wal-Mart statute is formally denoted the “Fair Share Health Care Fund Act” and nominally covers all non-governmental employers with 10,000 or more employees in the State of Maryland. Substantively, the Act provides that, if a covered employer operates on a for-profit basis, the employer, as of January 1, 2007, must spend on “health insurance costs” an amount equal to at least “8% of the total wages paid” to the employer’s Maryland employees. If a covered employer is “a nonprofit organization,” the Act provides that the employer must spend on health insurance an amount equal to at least six percent of the total wages paid to the employer’s Maryland employees.

If a covered employer fails to spend the required amount on health insurance, the Act obligates the employer to pay to the Maryland Fair Share Health Care Fund the difference between the employer’s actual

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4 Fair Share Health Care Fund Act, 2006 Md. Laws ch. 3 (codified as amended at MD. CODE ANN., HEALTH-GEN. § 15-142 (West 2006); MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to 107(West 2006)).
5 In practice, the Act is aimed at a single employer: Wal-Mart. See infra note 14 and accompanying text.
6 Fair Share Health Care Fund Act § 1.
7 As a procedural matter, the Act requires that employers report on their payrolls and their outlays for health insurance costs and that summary reports be sent to the Governor and General Assembly. Id.
8 Id.
9 Id.
10 Id.; see also MD. CODE ANN., HEALTH-GEN. § 15-101(h) (West 2006) (defining the
health insurance outlays and the employer’s statutorily-required health
insurance outlays. The Fund, in turn, helps to finance the Maryland’s
Medicaid program for low-income residents. Employers are
specifically forbidden from deducting from their employees’ wages the
employers’ statutorily-mandated payments to the Fair Share Health
Care Fund.

While the Act raises several interpretative issues, the import of
the Act is clear: A covered employer must either devote a minimum
percentage of total payroll to employee health care or must pay the
shortfall to the Fund financing Maryland’s Medicaid program. Equally
clear is the target of the Act: Wal-Mart. In practice (and everyone
acknowledges this), the Maryland Act “applies only to one employer in
the state—Wal-Mart Stores Inc.—because the other employers” covered
by the Act “already provide [health] benefits that cost them more than
8% of payroll.” The adoption of the Act in Maryland has spurred

“program” as the “Maryland Medical Assistance Program”).

12 Fair Share Health Care Fund Act § 1.
13 For example, the Act counts as part of an employer’s health insurance outlays the
employer’s contributions to medical savings accounts, now technically labeled by the Internal
Revenue Code as Archer Medical Savings Accounts. However, under the Internal Revenue
Code, such accounts are limited to small employers, i.e., those with fifty or fewer employees.
Thus, no covered employer under the Act (with 10,000 or more Maryland employees) could ever
contribute to a medical savings account. Moreover, no new medical savings accounts can be
established after December 31, 2005. An employer covered by the Maryland Act can contribute
to health savings accounts, which are not limited to small employers. However, such health
savings accounts are not referenced by the Act. Id. (counting contributions to medical savings
accounts as “health insurance costs” and limiting the coverage of the Act to employers “with
10,000 or more employees” in Maryland); see also I.R.C. § 220(c) (2000) (restricting Archer
Medical Savings Accounts to employees of small employers); id. § 220(i) (prohibiting the
establishment of new medical savings accounts after December 31, 2005); id. § 223 (no
equivalent restrictions on health savings accounts).

Another curious feature of the Act is the discrepancy between the Act’s reporting
requirements and its substantive mandate. When reporting under the Act, a covered employer
may exclude from its reported wages both wages paid in an amount above Maryland’s median
household income and wages paid to an employee enrolled in or eligible to enroll in Medicare.
However, as a substantive matter, a covered employer is obligated to pay as health care outlays a
minimum percentage of “total wages” without these exclusions. Compare Md. Code Ann., Lab.
& Empl. § 8.5-103 (listing wage exclusions for reporting purposes), with Md. Code Ann., Lab.
& Empl. § 8.5-104 (using “total wages” as base for determining compliance with the Act).

It is widely believed that the special definition of wages in Section 8.5-103 removes
Northrop Grumman from the coverage of the Act. See Retail Indus. Leaders Ass’n v. Fiedler
(RILA), 435 F. Supp. 2d 481, 485 (D. Md. 2006) (“This exclusion permits Northrop Grumman to
meet the requirement.”). However, a careful reading of the Act suggests that, if this was the
Maryland legislature’s intent, it did not quite embody that intent in the actual statute.

Presumably these and other similar issues will be addressed by technical corrections
legislation or regulations. In the meantime, these interpretative issues do not impair the Act’s
basic message: Wal-Mart must either increase its medical insurance outlays as a percentage of
total wages paid to Maryland employees or it must pay the shortfall to the Fund to support
Maryland’s Medicaid program.

see also Letter from J. Joseph Curran, Jr., Md. Attorney Gen., to Michael E. Busch, Speaker of
II. DOES ERISA PREEMPT THE MARYLAND ACT?

ERISA’s preemption clause, ERISA Section 514(a), demonstrates how a seemingly straightforward statute can engender enormous legal controversy. With beguiling simplicity, Section 514(a) provides that ERISA “shall supereede any and all State laws insofar as they may now or hereafter relate to any” pension or welfare plan governed by ERISA. For ERISA purposes, employers’ arrangements for their

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16 See RILA, 435 F. Supp. 2d at 481; Miller, supra note 15 (discussing the lawsuit filed by the Retail Industry Leaders Association against the Maryland Act); Deloitte, supra note 15 (same); see also Karen Setze, Judge Hears Oral Arguments in Suit Against Maryland’s ‘Wal-Mart Bill,’ ST. TAX TODAY, June 23, 2006, at 122-18. 


employees’ medical coverage are “welfare plans,” subject to the strictures of ERISA. 20 Thus, state laws “relat[ing] to” employers’ ERISA-regulated medical plans are, per Section 514(a), preempted.

Despite the apparent simplicity of Section 514(a), in practice, the task of construing Section 514(a) has been anything but simple: “[R]elate to” has proved to be an elusive legal standard. However, under any of the plausible approaches to Section 514, that section preempts the Maryland Act. The Fourth Circuit should accordingly affirm the District Court’s decision holding the Act to be ERISA-preempted.

A. Shaw

During ERISA’s early history, the U.S. Supreme Court interpreted the language of Section 514(a) capaciously, 21 striking a host of state laws under Section 514(a) on the grounds that such state laws had “a connection with or reference to” ERISA-governed pension or welfare plans. 22 Under this expansive approach to Section 514(a) and its “relate to” terminology, ERISA preemption was nearly automatic whenever a state law touched an ERISA-regulated plan. The Court first articulated its broad understanding of Section 514(a) in Shaw v. Delta Air Lines, Inc. by striking as ERISA-preempted a New York State law which mandated that employers provide pregnancy disability benefits to their employees. 23 Under this broad understanding of Section 514(a), ERISA preempts the Maryland Act by referring to and connecting with covered employers’ ERISA-governed medical plans. The health care outlays regulated by the Maryland Act necessarily entail such plans while the employer’s liability under the Act can be determined only by considering the covered employer’s payments pursuant to such plans.

Typical of the expansive, Shaw-based approach to Section 514(a) (and particularly instructive as to the Maryland Act) is the last case of the Shaw line, District of Columbia v. Greater Washington Board of Trade. 24 The District of Columbia had amended its workers’ compensation law to require employers maintaining health care coverage for their current employees to also provide equivalent

20 ERISA § 3(1)(A) (codified as amended at 29 U.S.C. § 1002(1)) (ERISA-regulated welfare plans include any employer “plan, fund, or program” providing “medical, surgical, or hospital care or benefits” “through the purchase of insurance or otherwise.”).
21 This capacious understanding of Section 514(a) is discussed in Edward A. Zelinsky, Travelers, Reasoned Textualism, and the New Jurisprudence of ERISA Preemption, 21 CARDOZO L. REV. 807, 815-27 (1999).
23 Id.
coverage for injured former employees eligible for workers’ compensation payments. Following the capacious interpretation of Section 514(a) announced in Shaw, the Court struck the D.C. law as impermissibly “relat[ing] to” employers’ medical plans and as thus ERISA-preempted.

For eight Justices, Washington Board of Trade was an easy case, controlled by “the ordinary meaning of ‘relate to’” determinable from the dictionary.25 Since the D.C. workers’ compensation law “specifically refers to welfare benefit plans regulated by ERISA,” i.e., employers’ medical plans for their current employees, “on that basis alone” the D.C. law is preempted.26

Moreover, the Court observed, it is of no moment whether a challenged state law is “specifically designed to affect” ERISA-regulated plans or whether the challenged state law has an effect on such plans which “is only indirect.”27 By the same token, a state law is ERISA-preempted if it refers to or has a connection with an ERISA-regulated plan even if the challenged state “law is ‘consistent with ERISA’s substantive requirements.’”28

Under the original, Shaw-based understanding of Section 514(a) as applied in Washington Board of Trade, Section 514(a) preempts the Maryland Act since the Act refers to and has a connection with covered employers’ medical programs for their employees. Indeed, the Act intrudes directly upon such plans, mandating the minimum level of covered employers’ outlays for their employees’ medical coverage. The medical care expenditures regulated by the Maryland Act necessarily entail ERISA-governed employer plans while the employer’s obligations under the Act can be assessed only by taking into account the employer’s payments pursuant to such plans.

Consider initially the Act’s definitions of “health insurance costs:”

“Health insurance costs” means the amount paid by an employer to provide health care or health insurance to employees in the State to the extent the costs may be deductible by an employer under federal tax law.29

“Health insurance costs” includes payments for medical care, prescription drugs, vision care, medical savings accounts, and any other costs to provide health benefits as defined in Section 213(d) of the Internal Revenue Code.30

25 Id. at 129.
26 Id. at 130.
27 Id. (quoting Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 139 (1990)).
28 Id. (quoting Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985)).
29 Fair Share Health Care Fund Act, 2006 Md. Laws ch. 3, § 1 (codified as amended at Md. CODE ANN., HEALTH-GEN. § 15-142 (West 2006); Md. CODE ANN., LAB. & EMPL. §§ 8.5-101 to 107) (West 2006)).
30 Id.
These definitions of “insurance costs” sweep far more broadly than insurance to include any “health care” expense which is deductible for federal income tax purposes. In particular, an employer’s self-funded health care outlays from the employer’s general assets count as “insurance costs” under the Act. Thus, the Act’s term “insurance costs” is quite inelegant; more accurately, that term encompasses the totality of the covered employer’s health care outlays for its employees.

In light of these definitions, whether a covered employer has complied with the Act can only be ascertained with reference to the employer’s ERISA-regulated health care plans for its employees. The Act defines “health insurance costs” as the health care expenditures made pursuant to such plans. In this respect, the Maryland Act is like the D.C. workers’ compensation law struck as ERISA-preempted in Washington Board of Trade. The D.C. law referred to the employer’s programs for employee health care to determine the level of medical coverage required for injured former employees. Similarly, the Maryland Act refers to the employer’s outlays for employee health care to determine if the statutory minimum health care outlay has been satisfied. In Washington Board of Trade, the Supreme Court declared that the former reference triggers Section 514(a) and ERISA preemption. If that remains the test, then the similar reference under the Maryland statute to employers’ health care outlays likewise results in ERISA preemption of the Act.

Moreover, as a substantive matter, the Maryland Act intrudes deeply upon the operations of the covered employer’s ERISA-regulated medical plans. Under the D.C. workers’ compensation law, the employer’s medical arrangements for its employees merely served as a touchstone, a yardstick with which to measure the health coverage the employer owed to former employees receiving workers’ compensation payments. That connection between employers’ medical plans and the D.C. law was enough to trigger ERISA preemption under the expansive Shaw standard.

On the other hand, the Maryland Act constitutes a substantive regulation of the covered employer’s medical plan, a statutory directive either to expend a minimum percentage of payroll for medical coverage or to contribute the shortfall to the Fund. If the D.C. law, which referred to but did not regulate employers’ medical plans, is ERISA-preempted, a fortiori the Maryland Act, which both refers to and regulates such plans, is ERISA-preempted.

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31 As discussed infra, this inelegance may not be accidental but, rather, may be an unpersuasive effort to qualify the Act as insurance regulation, exempted from preemption under ERISA § 514(b). See infra Part II.D.

32 This observation proves particularly important when considering whether the Maryland Act survives ERISA preemption as an insurance regulation. See infra Part II.D.
In this context, District Judge Motz's observation is compelling: “The reference in the Fair Share Act to ERISA plans is direct and express.”

In contrast to my analysis and Judge Motz’s conclusion, Maryland’s Attorney General argues that ERISA does not preempt the Act because, he contends, the Act “does not specifically refer to employee welfare benefit plans.” Rather, the Attorney General asserts, the Maryland Act refers to the covered employer’s health care outlays including outlays made “outside the structure of a plan.” ERISA Section 514(a) only preempts state laws insofar as such laws “relate to” employers’ benefit plans, not insofar as such laws relate to employers’ benefit outlays. Hence, the Attorney General concludes, the Act, which regulates employer outlays but not employer plans, survives a preemption challenge under Section 514(a).

For four reasons, the Attorney General’s approach to Section 514(a) and the Act is unpersuasive. First, that approach eviscerates the Court’s ERISA preemption case law, rendering ERISA preemption easily avoidable through the semantic expedient of framing state regulation in terms of employers’ outlays. Second, under the statute, regulations, and case law, medical expenditures by an employer like Wal-Mart necessarily entail the kind of ongoing commitment which constitutes a “plan, fund, or program” for ERISA purposes. Third, Wal-Mart can determine its compliance with the Act and calculate any amount owed to the Fund only by considering each ERISA-regulated medical plan Wal-Mart maintains for its employees. Finally, even if the Act does not refer to the covered employer’s ERISA-regulated medical plans, the Act has a connection with such plans since, as just noted, only by considering such plans can the employer determine whether it has complied with the Act and, if not, the amount owed to the Fund, i.e., eight percent of payroll minus the employer’s outlays to its employee health care plans.

As an initial matter, the Attorney General’s argument proves too much. Indeed, the Attorney General’s interpretation of Section 514(a) eviscerates much of the Supreme Court’s ERISA preemption case law, rendering ERISA preemption a mere matter of the verbiage deployed by the state.

Take, for example, Shaw, under which the Court struck as ERISA-preempted the New York State law mandating pregnancy disability benefits. Under the Maryland Attorney General’s approach to Section 514(a), New York could mandate such benefits merely by getting the semantics right. All New York need do is phrase its requirement in

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33 Retail Indus. Leaders Ass’n v. Fiedler (RILA), 435 F. Supp. 2d 481, 494 n.12 (D. Md. 2006).
terms of mandated employer outlays, e.g., “any employer making disability outlays must make outlays for pregnancy-related disabilities.” According to the Attorney General, this verbal formulation makes the ERISA preemption problem disappear.

Washington Board of Trade becomes a similarly sterile exercise in semantics under the Attorney General’s theory of ERISA preemption. Under that theory, the District of Columbia’s requirement can be reframed in terms of employers’ expenditures for medical insurance, e.g., “any employer making medical expenditures for employees must also make medical expenditures for injured former employees.” In this case also, ERISA preemption is again overcome as ERISA preemption is merely a matter of the proper verbal formula, that is, referring to employer outlays rather than to employer plans.

Second, contra the Attorney General’s position, for an employer like Wal-Mart, employer expenditures for medical coverage necessarily entail the existence of a plan to implement ongoing coverage. The legal threshold for finding an ERISA welfare plan is low. Consequently, the health care expenses regulated by the Act necessarily imply the existence of one or more ERISA-regulated plans to undertake those expenses.

As a statutory matter, ERISA broadly defines a welfare “plan” as any “plan, fund, or program” that provides one or more of the kinds of benefits specified by the statute. Medical coverage is among these specified benefits. How can an employer like Wal-Mart provide medical coverage for its employees without, implicitly or explicitly, having a “plan, fund, or program” for such coverage?

If an employer spontaneously pays an employee’s medical expenses from the employer’s general assets, that isolated payment would not constitute an ERISA-regulated plan. However, short of that kind of isolated ad hoc outlay, employer expenses for employees’ medical care involve some kind of “program.”

Some have suggested that Wal-Mart, as the covered employer under the Act, could designate year-end bonuses as “health care bonuses” without thereby creating an ERISA plan for medical care. If this is done once on a spontaneous basis, perhaps so. However, under the statute, it takes little to turn this practice into an employer program for ERISA purposes. If the employer designates year-end payments as “health care bonuses” for a second year, the employer thereby demonstrates that it has a “program” to do so. And, in any event, such

year-end bonuses would not constitute “health insurance costs” within the meaning of the Maryland Act since those bonuses would not reimburse for specific health care outlays and since the employees could spend such bonuses as they see fit.37

It has also been suggested38 that an employer’s payments to health savings accounts (HSAs) would not constitute a “plan” for ERISA purposes.39 The Department of Labor (DOL) has indicated otherwise.40 If an employer, pursuant to the relevant regulations,41 merely collects employees’ voluntary contributions “through payroll deductions” and remits these employee contributions “without endorsing the program” or itself contributing to the health savings accounts, no ERISA plan exists.42 However, if the employer leaves this narrow safe-harbor—by endorsing the HSA program, by contributing its own funds to the employees’ accounts or by paying the premiums for the high deductible health coverage to which HSAs must be linked43—the employer establishes an ERISA-regulated plan. And, if Wal-Mart does not leave the regulatory safe-harbor by contributing its own funds, Wal-Mart has not paid any “health insurance costs” within the meaning of the Maryland Act.

The import of the controlling case law is the same, namely, that employer “health insurance costs” within the meaning of the Act necessarily entail an ERISA-governed medical plan. To buttress his argument that the Act escapes ERISA preemption, Maryland’s Attorney General cites *Fort Halifax Packing Co. v. Coyne*44 and argues that employers may make “health care expenditures” which are not “part of a plan.”45 However, a careful review of *Fort Halifax* confirms that, except in the rarest of cases, employer expenditures for medical coverage necessarily imply the existence of an ERISA-regulated “plan, fund, or program” to make such continuing expenditures.

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37 Fair Share Health Care Fund Act, 2006 Md. Laws ch. 3 (codified as amended at Md. Code Ann., Health-Gen. § 15-142 (West 2006); Md. Code Ann., Lab. & Empl. §§ 8.5-101 to 107 (West 2006)). The Act’s definitions of “health insurance costs” would not include a year-end bonus that does not reimburse for specific medical outlays and which the employee can spend for non-medical purposes.

38 Brandolph, *supra* note 36. For the reasons indicated in the text, Judge Motz of the U.S. District Court correctly rejected the claim that a covered firm could comply with the Act via HSAs that do not constitute an ERISA-regulated plan. *RILA*, 435 F. Supp. 2d at 491-92.

39 Such payments to health savings accounts would not count as “health insurance costs” for purposes of the Act. *See supra* note 13.


41 29 C.F.R. § 2510.3-1(j) (2006).


43 *See* I.R.C. § 223(c) (2000) (an individual is eligible for an HSA only if such individual is “covered under a high deductible health plan”).


The *Fort Halifax* Court sustained against an ERISA preemption challenge “a Maine statute requiring employers to provide a one-time severance payment to employees in the event of a plant closing.” In this context, the Court held, there was no employer plan within the meaning of ERISA. According to the Court, a welfare plan exists “with respect to benefits whose provision by nature requires an ongoing administrative program to meet the employer’s obligation.” In contrast, the Maine law requiring employers to pay severance payments on plant closings imposed a contingent obligation for the employer to make a single outlay:

The Maine statute neither establishes, nor requires an employer to maintain, an employee benefit plan. The requirement of a one-time, lump-sum payment triggered by a single event requires no administrative scheme whatsoever to meet the employer’s obligation. The employer assumes no responsibility to pay benefits on a regular basis, and thus faces no periodic demands on its assets that create a need for financial coordination and control. Rather, the employer’s obligation is predicated on the occurrence of a single contingency that may never materialize. The employer may well never have to pay the severance benefits.

An employer like Wal-Mart, with at least 10,000 Maryland employees, can provide medical care for those employees only by accepting continuing “responsibility to pay benefits on a regular basis” with the attendant “demands on its assets,” i.e., by having a plan. For a firm like Wal-Mart, the provision of ongoing medical benefits “by nature” implies the existence of a plan within the meaning of ERISA. Consequently, the Maryland Act refers to such a plan when it defines and regulates “health insurance costs.”

In short, the concept of “nonplan” medical expenditures by an employer like Wal-Mart is unpersuasive under ERISA’s statutory terminology, the relevant regulations interpreting that terminology, and the Supreme Court case that the Maryland Attorney General himself cites as authoritative.

Third, the Maryland Act requires Wal-Mart to monitor continually its health care outlays and to report annually the level of those outlays as a percentage of Wal-Mart’s Maryland payroll. Unless Wal-Mart makes absolutely no health care expenditures for its Maryland employees and pays the entire eight percent of payroll to the Maryland Fair Share Health Care Fund, Wal-Mart’s obligations under the Act

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46 *Fort Halifax*, 482 U.S. at 3.
47 Id. at 11.
48 Id. at 12.
must be determined with reference to every “plan, fund or program” Wal-Mart maintains for its workforce. Even if an employer like Wal-Mart can make contingent, one-time “nonplan” medical outlays for its employees (a premise of which I am skeptical), the employer’s obligation under the Maryland Act is determined by a calculation that offsets against eight percent of payroll any outlays to the plans under which Wal-Mart provides employee medical coverage.

Finally, even if the Attorney General correctly reads the Act as not referring to the covered employer’s medical plans for its employees, the Act in the alternative has a “connection with” such plans since, as just observed, the employer’s liability under the Act can only be assessed by comparing eight percent of the employer’s Maryland payroll with the employer’s outlays under any medical plans the employer maintains for its Maryland employees.

To summarize: Under the initial, expansive approach to Section 514(a) and its “relate to” clause announced in Shaw, the Maryland Act is ERISA-preempted for two reasons. The Act is preempted since it refers to employers’ health care outlays pursuant to their ERISA-regulated medical plans. Moreover, the Act, on its face, connects with employers’ ERISA-regulated medical plans. The health care expenditures regulated by the Maryland Act necessarily entail such plans while the employer’s obligations under the Act can be ascertained only by considering the covered employer’s payments pursuant to such plans.

B. Travelers

Ultimately, the Court’s original, Shaw-based approach to Section 514(a) points to ERISA preemption without discernible limit. Justice Scalia captured the core of the problem when he noted that “as many a curbstone philosopher has observed, everything is related to everything else.” From that vantage, the statutory term “relate to,” unless somehow cabined, is virtually limitless and Section 514(a) consequently preempts whatever it touches: An employer’s health care plan which refuses to pay rent to its landlord can plausibly resist eviction on the ground that, in this context, the state eviction statute relates to an ERISA-governed plan. This is a result most would consider unacceptable, though the Court’s expansive, Shaw-based case law points to such ERISA preemption without discernible limits.51

51 Zelinsky, supra note 21, at 815-27.
Confronted with the problematic consequences of its initial, capacious approach to Section 514(a), the Supreme Court contracted its construction of Section 514(a). The critical decision in the retreat from the broad Shaw standard was New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.\textsuperscript{52} Under this more restrained approach to Section 514(a) and its “relate to” language, ERISA still preempts the Maryland Act because the Act impacts, directly and acutely, upon the structure and administration of the covered employer’s medical plans.

Travelers involved an ERISA preemption challenge to New York State’s regulatory scheme, imposing upon hospital patients surcharges for their respective hospital stays. The surcharges varied depending upon the source of payment for the hospitalization. If a hospitalization was financed by Blue Cross/Blue Shield insurance, no surcharge was added to the bill for the hospital stay. If, on the other hand, a self-funded employer plan paid for the hospitalization from the employer’s own assets, a surcharge applied to the hospital’s fees. Similarly, if privately-purchased or employer-supplied commercial insurance paid for a New York hospitalization, a surcharge applied to the hospital’s fees. Likewise, if the patient himself paid for his hospitalization from his own resources, a surcharge was added to the patient’s bill.

The evident economic effect of the New York regulation was to incent employers maintaining medical coverage for their employees to use Blue Cross/Blue Shield insurance (rather than commercial insurance or self-funding) to avoid the hospital surcharges.

Given the breadth of ERISA preemption under the Shaw line of cases, it is unsurprising that the Second Circuit struck the surcharge scheme as unacceptably “relat[ing] to” employers’ ERISA-regulated medical plans.\textsuperscript{53} However, the Supreme Court reversed and sustained the New York surcharge scheme in a way which, decisively albeit not openly, departed from the Court’s prior case law under Section 514(a).

Many of the Shaw-based preemption decisions, the Travelers Court stated, “pre-empted state laws that mandated employee benefit structures or their administration.”\textsuperscript{54} In contrast, the New York hospital surcharge scheme was merely “[a]n indirect economic influence”\textsuperscript{55} on the choice made by ERISA-regulated medical plans, i.e., to self-fund, to use commercial insurance, or to purchase Blue Cross/Blue Shield coverage. Moreover, Congress did not intend for ERISA “to displace

\textsuperscript{52} 514 U.S. 645 (1995); see also Russell Korobkin, The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption, 51 UCLA L. REV. 457, 488 (2003) (“In 1995, after years of criticism of its broad preemption doctrine, the Supreme Court scaled back ERISA’s preemptive effect in [Travelers].”).

\textsuperscript{53} Travelers Ins. Co. v. Cuomo, 14 F.3d 708, 725 (2d Cir. 1993).

\textsuperscript{54} Travelers, 514 U.S. at 658.

\textsuperscript{55} Id. at 659.
general health care regulation, which historically has been a matter of local concern.56 And, the Travelers Court continued, preemption doctrine has traditionally started from the “presumption that Congress does not intend to supplant state law.”57 From these premises, the Travelers Court sustained the New York surcharge scheme as that scheme applied to ERISA-regulated welfare arrangements, that is, to employers’ medical plans for their employees.

Had the Travelers Court been writing on a blank slate, none of this would have been remarkable. However, in light of the Shaw line of cases, this approach to Section 514(a) and its “relate to” clause was remarkable indeed—though the Court itself did not acknowledge fully the extent to which Travelers represents a break from the cases which preceded it. While the Court did not advertise Travelers as departing from Shaw and its progeny, the cases tell a different story. Since Travelers, the Court has been far more likely than before to sustain state laws challenged as ERISA-preempted.58

As I suggest below,59 the Court’s more restrained approach to Section 514(a) under Travelers is not wholly persuasive, given the text and structure of Section 514. However, for the Maryland Act, the critical point is that, even under this more restrained understanding of ERISA preemption, Section 514(a) preempts the Act. For these purposes, the key post-Travelers decision is Egelhoff v. Egelhoff,60 a decision on which Judge Motz relied heavily and, I think, persuasively.61 Egelhoff indicates that, even after Travelers, Section 514(a) carries enormous preemptive force as to state laws like the Act that affect the benefits provided by ERISA-regulated welfare arrangements and that impair the nationally uniform administration of such welfare arrangements.

In Egelhoff, the U.S. Supreme Court struck on ERISA preemption grounds a Washington State law stating that divorce revokes any outstanding beneficiary designation of a former spouse as to non-probate property. Mr. Egelhoff was an employee of Boeing, which provided life insurance coverage for Boeing employees’ designated

56 Id. at 661 (citation omitted).
57 Id. at 654.
59 See discussion infra Part II.C.
beneficiaries. Like an employer’s medical coverage for its employees, this type of employer-provided death benefit constitutes an ERISA-regulated welfare plan. Mr. Egelhoff divorced his spouse who had previously been named as the beneficiary of his Boeing-provided life insurance. Mr. Egelhoff then died without changing this designation. Consequently, the former Mrs. Egelhoff received the life insurance proceeds pursuant to her deceased husband’s pre-divorce designation.

Mr. Egelhoff’s children from a prior marriage subsequently sued to obtain the insurance proceeds from the former Mrs. Egelhoff. The Egelhoff children invoked the Washington State statute providing that divorce revokes any beneficiary designation of the now former but previously-designated spouse. Mrs. Egelhoff defended against the claim of her former husband’s children by asserting that Section 514(a) preempts the Washington statute as to Boeing’s ERISA-regulated life insurance plan for Boeing employees, thus leaving the pre-divorce beneficiary designation in effect.

The U.S. Supreme Court agreed with the former Mrs. Egelhoff that Section 514(a) preempts the Washington statute as it applies to employer-provided plans governed by ERISA. The Washington statute, the Egelhoff Court observed, impermissibly intrudes upon “an area of core ERISA concern,” namely, the primacy of plan documents. Since Mrs. Egelhoff remained the designated beneficiary pursuant to the Boeing plan documents, Washington State was preempted from unsettling that designation, thereby forcing Boeing, as plan administrator, to look outside the plan documentation to determine the rightful recipient of Mr. Egelhoff’s insured death benefit.

By displacing the otherwise valid designation of the former Mrs. Egelhoff, the Washington statute purports to govern “the payment of benefits, a central matter of plan administration.” Thus, in Egelhoff the Court reiterated that, as Travelers had indicated earlier, “state laws that mandate[] employee benefit structures or their administration run afoul of Section 514(a).

Moreover, the Egelhoff Court declared, the Washington statute “interferes with nationally uniform plan administration” by prescribing a different rule for one state (divorce revokes beneficiary designation) than prevails in other states (no such revocation on

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63 Egelhoff, 532 U.S. at 147.

64 Id. at 148.


66 Egelhoff, 532 U.S. at 148.
divorce). As national uniformity is an important objective of ERISA in general and Section 514 in particular, the Court reasoned, this interference further indicates that the Washington law impermissibly “relate[s] to” an ERISA plan and, in the context of such a plan, is preempted by Section 514(a).

_Egelhoff_ demonstrates that, in particular cases, ERISA preemption retains potency even under the more restrained _Travelers_ approach to Section 514(a) and its “relate to” clause. Indeed, _Egelhoff_ indicates that the Maryland Act is preempted under _Travelers_: If Section 514(a) forbids Washington State from instructing an ERISA-regulated plan to whom the plan must pay welfare benefits (or not), Maryland cannot impose upon an ERISA-regulated plan the minimum level of welfare benefits which the plan must pay. In both instances, the state is “mandat[ing] employee benefit structures or their administration.” For Maryland to force an employer to spend at least eight percent of its total payroll on medical care is a classic instance of a state “mandat[ing an] employee benefit structure” in violation of Section 514(a) and its rule of preemption.

In addition, the Maryland Act, like the Washington statute, interferes with national uniformity in plan administration by forcing an interstate employer covered by the Act (i.e., Wal-Mart) to adopt policies in Maryland it need not adopt in other states. This again indicates the incompatibility between the Act and Section 514(a) as the Court has construed that section in _Travelers_ and _Egelhoff_.

Maryland’s Attorney General argues otherwise, contending that the Act “imposes no requirements that would interfere with uniform nationwide plan management or set up contradictory requirements between states.”67 This contention is unpersuasive as the Act requires Wal-Mart to do in Maryland something Wal-Mart need do in no other state, specifically, spend a minimum percentage of its total payroll costs on medical care. As Judge Motz correctly observed, the Maryland “Act creates health care spending requirements that are not applicable in most other jurisdictions.”68

Alternatively, Maryland could retort that the Act is less like the Washington statute struck in _Egelhoff_ and more like the New York hospital surcharge scheme sustained in _Travelers_, the kind of “general health care regulation, which historically has been a matter of local concern . . . .”69 The problem with this retort is that the Maryland Act is not like the New York hospital surcharge scheme, a generally-applicable regulation that impacted across-the-board upon all hospital patients. Rather, the Act is a narrowly-targeted regulation of

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69 _Travelers_, 514 U.S. at 661.
employers’ ERISA-governed medical plans—indeed, of a single employer’s ERISA-governed medical plans.

The New York regulation sustained in Travelers levied a hospital surcharge even if the hospitalized patient paid for his own stay or had private insurance funding that hospital stay. The New York regulation was thus a genuinely general medical regulation, applying broadly to all hospitalized patients, not just to patients covered by employers’ ERISA-regulated plans. The other examples of general health regulation invoked in Travelers—hospital “[q]uality control and workplace regulation”—are similarly broad in their coverage and effect, applying to all hospitals and affecting all patients, not just to those patients participating in their employers’ ERISA-regulated health plans.

The Maryland Act, by comparison, is targeted specifically at employer-provided medical plans, not at a broad class of health care consumers or providers. The Maryland Act represents no mere “indirect economic influence,” which increases costs for every consumer of medical care including employers’ medical plans. Rather, the evident purpose of the Act is a direct, focused financial impact on the covered employer and its ERISA-regulated medical plan, i.e., to force an increase in medical outlays to an eight percent minimum of payroll.

Also instructive in this context is the Supreme Court’s post-Travelers decision in Pegram v. Herdrich. In Pegram, the Court observed that states’ general medical malpractice liability laws are not ERISA-preempted when a medical mistake is made by a treating physician working for an employer-engaged HMO. This observation is fully consistent with the principle established in Travelers that “general health care regulation” does not run afoul of Section 514.

Suppose, in contrast, that Maryland were to adopt a state tort statute establishing malpractice liability only for doctors employed by ERISA-governed plans. Such a targeted law would not be protected from ERISA preemption as a general health regulation since it would not be general. The same is true of the Maryland Act.

It is, in short, unpersuasive to denominate the Maryland Act as a general health regulation when it is actually a targeted regulation of employers’ (indeed, a single employer’s) ERISA-governed medical plans. Even under the more restrained Travelers approach to Section 514(a), ERISA precludes states from mandating employer-provided benefit levels in this fashion.

Finally, some supporters of the Act, including Maryland’s Attorney General, focus upon the covered employer’s potential payment to the Fund and, from that focus, characterize the Act as a tax law with

70 Id.
only indirect impact on Wal-Mart’s ERISA-regulated medical plans. However, for four reasons, that characterization does not preserve the Act from preemption under *Travelers*. First, as a statutory matter, state tax laws as such are not protected from ERISA preemption. Only laws relative to insurance, banking, and securities as well as “generally applicable criminal law[s]” are shielded statutorily from such preemption. Thus, for ERISA preemption purposes, there is no talismanic effect from labeling a state statute as a tax law.

Second, the levy assessed by the Act, i.e., the payment to the Fund, is not a revenue-raising measure of general applicability, but is instead a narrowly-targeted penalty designed to force Wal-Mart to comply with Maryland’s statutorily-imposed “benefit structure[,]” namely, medical outlays of at least eight percent of total payroll. It is unconvincing for ERISA preemption purposes to characterize that penalty as a tax, given the penalty’s narrow focus and evident purpose, namely, to coerce Wal-Mart into increasing its health care outlays. Third, it is equally difficult to see how the “tax” imposed by the Act can be labeled as “indirect” in its impact upon Wal-Mart’s medical plans for its employees. Rather, that “tax” is specifically aimed at such plans and the level of health care coverage they provide.

Finally, under *Travelers*, even a law with “indirect” effect may have sufficiently harsh impact to be ERISA-preempted. In this connection, the *Travelers* Court specifically observed “that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage . . . .” “[S]uch a state law,” the Court noted, “might indeed be pre-empted under Section 514.” Even if the Act is properly characterized as a tax with only indirect effects on ERISA plans (a characterization of which I am skeptical), the economic effect of the Act and of the tax it imposes is indeed acute. The tax forces Wal-Mart to embrace Maryland’s substantive standard for health care coverage, i.e., a minimum outlay of eight percent of total payroll.

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72 Hakim et al., *supra* note 15 (quoting Jennifer Sung that New York’s proposed version of the Maryland Act “requires employers to pay a tax to the state or they can pay less tax to the state if they spend a certain amount on employee health care. It doesn’t have any direct relation to ERISA . . . .”); see also Attorney General’s Letter, *supra* note 14, at 3 (characterizing the Act as “a revenue raising measure rather than a regulation of employers”); Karen Setze, *Is Maryland’s ‘Wal-Mart Bill’ A Tax?*, Apr. 5, 2006, S T. TAX TODAY, at 65-11 (quoting attorney Marc I. Machiz that the Act establishes “a tax on employers—admittedly a very limited tax—to fund uninsured health care through the Medicaid program . . . .”).


74 *Travelers*, 514 U.S. at 658.

75 *Id.* at 668.

76 *Id.*
Consider in this context the marginal rate of the “tax” imposed by the Act: 100 percent. For each dollar that Wal-Mart’s medical outlays fall below the minimum threshold of eight percent of payroll, Wal-Mart must pay a dollar to the Fund. This dollar-for-dollar scheme is evidently designed to coerce Wal-Mart into raising its medical expenditures for its Maryland employees until Wal-Mart attains the statutory threshold. Even under the more restrained approach of Travelers, the Act, by virtue of its coercive nature, is ERISA-preempted, even if the Act is denominated as an indirect tax law.

In the context of the claim that the Act establishes an indirect tax that survives ERISA preemption, the Court’s post-Travelers decision in De Buono v. NYSA-ILA Medical & Clinical Services Fund is instructive. In De Buono, a self-insured ERISA welfare plan “own[ed] and operate[d] three medical centers . . . that provide[d] medical, dental and other health care benefits.” The plan challenged on ERISA preemption grounds a New York tax imposed “on gross receipts for patient services at hospitals, residential health care facilities, and diagnostic and treatment centers.”

Critical to the De Buono Court’s rejection of this preemption challenge was the “general applicability” of the challenged tax: the tax applied to all New York medical facilities, not just to those facilities operated by ERISA plans. Moreover, the tax statute questioned in De Buono did not “contain . . . provisions that expressly refer to . . . ERISA plans.”

In contrast, the Act, assuming it is a tax law, is a different kind of tax law. The Act only applies with reference to the covered employer’s ERISA plans for employee health care and is only triggered by the employer’s failure to contribute to such plans the statutory minimum of payroll decreed by the Act. Consequently, the Act is not a tax law of “general applicability,” raising funds neutrally from a broad swath of health care providers. Rather, the Act is a targeted penalty statute that only assesses liability with reference to an employer’s contributions to its ERISA-regulated medical plans for its employees. And, in the final analysis, the Act and its dollar-for-dollar tax are designed to force Wal-Mart to adopt Maryland’s “scheme of substantive coverage,” specifically, a minimum health care outlay of eight percent of total payroll.

77 520 U.S. 806 (1997).
78 Id. at 810.
79 Id. at 809-10.
80 Id. at 815.
81 Id.
In short, even under the more relaxed preemption standards announced in *Travelers*, the Act, even if denominated a tax law with only indirect effect, unacceptably coerces the covered employer as to the substance of the employer’s welfare plans’ coverage.

In summary, under the more restrained interpretation of Section 514(a) announced in *Travelers* and its progeny including *Egelhoff*, ERISA preempts the Maryland Act since the Act both mandates the level of Wal-Mart’s medical outlays and impairs national uniformity in the administration of Wal-Mart’s medical plans. The impact of the Act on Wal-Mart’s medical plans is direct and acute.

Judge Motz was understandably reluctant to discern a sharp break between the Supreme Court’s pre- and post-*Travelers* cases when the Court itself has been reluctant to acknowledge such a break. Nevertheless, Judge Motz’s reading of *Travelers* and its progeny is the same as that advanced by myself and others who do see a significant difference between the *Shaw* and the *Travelers* approaches to ERISA preemption. Even under the more relaxed *Travelers* standard, ERISA preempts any state law “mandating that an employer provide a certain type or monetary level of welfare benefits in an ERISA plan.” And this, Judge Motz correctly observed, is exactly what the Maryland Act does:

The Act is not merely tangentially related to ERISA plans but is focused upon them. Indeed, as the legislative history makes clear, the Fair Share Act is targeted directly at the ERISA plan of a particular employer. Moreover, the economic effect of the Fair Share Act upon Wal-Mart’s ERISA plan could not be more direct: it would require Wal-Mart to increase its health care benefits for Maryland employees and to administer its plan in such a fashion as to ensure that the statutory spending required by the Act is met.

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83 A similar conclusion emerges under the *Shaw* approach to ERISA preemption. Even if the Maryland Act is viewed as a tax law with only indirect impact, the tax imposed, i.e., the required payment to the Fund, is the difference between the covered employer’s statutorily-required outlays for health care and its actual outlays. Thus, labeling the Act (or any similar law) as a tax law with indirect impact does not avoid the central issue under *Shaw*: The Act and the tax it imposes both refer to and are connected with the covered employer’s payments (or lack thereof) to the employer’s ERISA-regulated welfare plan for employees’ medical coverage. Under *Shaw*, such reference and connection result in preemption of the Act per Section 514.

84 Judge Motz’s analysis of the Act is similar: “[T]he intended effect of the Act is to force Wal-Mart to increase its contribution to its health benefit plan, which is an ERISA plan, and the actual effect of the Act will be to coerce Wal-Mart into doing so.” Retail Indus. Leaders Ass’n v. Fiedler (RILA), 435 F. Supp. 2d 481, 495 (D. Md. 2006).

85 *Id.* at 495 (“[T]his court has no authority to disregard Supreme Court precedent on the basis of the prediction that the Court would overrule its decisions.”).

86 *Id.*

87 *Id.* at 496.
C. Reasoned Textualism

_Travelers_ and its progeny represent an important effort by the Court to reform the overly-expansive _Shaw_-based approach to ERISA preemption, albeit a reform effort the Court itself has so far declined to acknowledge fully. Nevertheless, _Travelers_, while preferable to the capacious _Shaw_-based approach to Section 514, is itself not a persuasive construction of that provision. A better approach to Section 514 can be denoted “reasoned textualism,” the effort to make the statute workable while engaging the statutory text respectfully. A reasoned textualist understanding of Section 514(a) again points to preemption of the Maryland Act since the Act intrudes upon employers’ autonomy as to medical plan participation and funding, topics ERISA reserves for employer discretion.

Fundamental to the interpretation of ERISA Section 514(a) is ERISA Section 514(b), which exempts from Section 514(a) states’ insurance, banking, and securities laws, as well as “generally applicable criminal law[s].” These exemptions belie the post-_Travelers_ notion, advanced by Justices Scalia, Ginsburg, Breyer, and Stevens, that Section 514(a) merely codifies traditional preemption doctrine, which is quite solicitous of state law. If that is so, from what are these exempted state laws exempt? And why would Congress have enacted a provision—ERISA Section 514(a)—which redundantly pronounced preemption doctrine that the Court would have applied anyway?

More plausibly, the exemptions of Section 514(b) are read as furnishing relief from the tougher preemption scrutiny otherwise imposed by Section 514(a).

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88 Zelinsky, _supra_ note 21.
90 ERISA § 514(b)(4).
92 _Dillingham_, 519 U.S. at 356-66; _Egelhoff_, 532 U.S. at 152.
93 _Egelhoff_, 532 U.S. at 153-61.
94 _Id._.
95 Zelinsky, _supra_ note 21, at 832.
96 Of similar import to the construction of Section 514 is what has come to be known as “the deemer clause,” ERISA § 514(b)(2)(B). This provision precludes states from deeming ERISA plans to be insurance companies. The evident purpose of this provision is to limit the insurance exemption of Section 514(b) to “true” insurance companies, thereby preventing states from intruding their insurance laws too far at the expense of ERISA. Again, this indicates that there is something from which Section 514(b) exempts state insurance laws, i.e., more searching preemption scrutiny under Section 514(a). The deemer clause cabins the insurance exemption. Zelinsky, _supra_ note 21, at 813. The deemer clause proves important when analyzing the Maryland Act as a purported regulation of insurance. _See discussion infra_ Part II.D.
For those who believe in legislative history, the congressional hoopla surrounding the adoption of Section 514(a) is equally hard to reconcile with the view that that section embodies nothing more than normal preemption doctrine. In the House of Representatives, a leading sponsor of ERISA, Congressman John Dent, effusively declared that Section 514 “is to many the crowning achievement of this legislation.”97 It is difficult to understand that encomium if Section 514(a) is nothing more than a redundant statement of preemption doctrine the Court would apply anyway.

Consequently, the critical task in the construction of Section 514(a) is to give content to the higher than usual level of preemption scrutiny mandated by Section 514(a) without succumbing to the potential indeterminacy of the phrase “relate to.” In simplest terms, the task is to find a middle way under which Section 514(a) is neither limitless (as it is under Shaw) nor redundant (as it is under the four justices’ conception of Travelers). The best resolution of this task is to interpret Section 514(a) as reversing the traditional presumption against preemption by establishing a statutory presumption for such preemption. Without surrendering to the potential indeterminacy of the “relate to” clause, this approach gives content to Section 514(a), mandating in the ERISA context a more searching preemption inquiry than normal. This approach also preserves the structure of ERISA, providing that there is something—the presumption for preemption established in Section 514(a)—from which state banking, insurance, securities, and criminal laws are exempted by Section 514(b).

The second component of the reasoned textualist approach to Section 514(a) stems from the much-discussed disparity in the structure of ERISA vis-a-vis pension and welfare plans. As has been frequently noted,98 ERISA, while it governs both pension and welfare plans, governs them quite differently. ERISA’s provisions pertaining to disclosure and reporting,99 fiduciary responsibility,100 and administration and enforcement101 apply to pension102 and welfare plans

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99 ERISA §§ 101-111.
100 Id. §§ 401-414.
101 Id. §§ 501-514.
102 ERISA’s definition of pensions includes profit sharing plans such as Section 401(k) arrangements. See id. § 3(2)(B) (providing that any plan which “results in a deferral of income”
alike. However, for pensions, ERISA provides elaborate rules as to funding\textsuperscript{103} and as to participation and vesting.\textsuperscript{104} In contrast, ERISA is silent on these subjects relative to welfare plans. Under the normal precepts of preemption, the presence in ERISA of such substantive regulation for pensions but not for welfare plans suggests greater scope for state regulation of such welfare plans since there is no federal regulation occupying the field.

However, a better reading of the statute\textsuperscript{105} infers from Section 514 and the structure of ERISA a zone of employer autonomy in the design and operation of employers’ welfare plans. As to the topics falling inside this zone, employers, while constrained \textit{vis-à-vis} pension plans, can determine the content of their welfare plans free of regulation. Under this approach, when a state law impacting employers’ welfare plans is challenged as ERISA-preempted, the appropriate inquiry is whether the state law intrudes upon a subject on which ERISA affirmatively regulates pensions. If so, there is a presumption that the challenged state law is preempted as intruding upon the employer’s discretionary zone of welfare plan autonomy. Thus, the scope of ERISA’s pension regulation determines the zone of autonomy for welfare plans.

For present purposes, my goal is not to persuade the reader that the reasoned textualist perspective on Section 514(a) is correct,\textsuperscript{106} but to observe that under this approach also, as under the Shaw and Travelers approaches, Section 514(a) preempts the Maryland Act. The Act, by mandating a minimum health care outlay of eight percent of total payroll, pressures Wal-Mart to extend employer-provided health care participation to more of Wal-Mart’s employees.\textsuperscript{107} This attempt to expand employee participation in employer-sponsored medical care intrudes upon an area where, as a textual matter, ERISA creates a zone

\textsuperscript{103} Id. §§ 301-306.
\textsuperscript{104} Id. §§ 201-211.
\textsuperscript{105} See Zelinsky, supra note 21, at 839-41.
\textsuperscript{106} Though I believe it is. See id.; Zelinsky, supra note 60.
\textsuperscript{107} Wal-Mart might respond to the Act in other ways. For example, Wal-Mart might decrease its Maryland payroll or employment (or both) or might increase its medical coverage for existing (or fewer) participants. Any of these approaches (or some combination of them) could place Wal-Mart outside the coverage of the Act (since Wal-Mart’s Maryland employment would drop below the 10,000 statutory threshold) or could bring Wal-Mart into compliance with the Act (by bringing Wal-Mart’s medical outlays to eight percent of payroll). Those possibilities, which suggest that the Act is poorly designed, do not alter the basic observation in the text, that the Act pressures Wal-Mart to increase medical plan participation, even though Wal-Mart might respond to that pressure in other ways. For a discussion of the possibility that Wal-Mart could respond to the Act by decreasing Maryland employment and medical coverage, see discussion infra Part IV.B.
of employer autonomy since ERISA mandates minimum participation rules for pensions but not for welfare arrangements.

Similarly, the Maryland Act pressures the covered employer to increase its funding for employees’ medical care or to persist in funding above the statutory requirement. Funding too is an area where ERISA creates for employers a zone of welfare plan autonomy since ERISA regulates pension funding, but not the financing of welfare plans. Maryland cannot overcome the presumption that its Act is preempted since the Act intrudes upon two topics—participation and funding—where ERISA, as a textual matter, provides detailed regulation of pensions but is best construed as reserving for employers a zone of welfare plan discretion.

Instructive in this context is Judge Motz’s observation that “no rational employer would choose to pay” to Maryland’s Fair Share Health Care Fund. Rather, confronted with the “Hobson’s choice” created by the Act, Wal-Mart is forced by the Act to “increas[e] its employees’ benefits,” i.e., to increase the participation in and/or the funding of Wal-Mart’s medical care plans.

In short, a reasoned textualist approach to Section 514(a) and ERISA preemption leads to the conclusion that the Maryland Act is incompatible with the ERISA-created zone of welfare plan autonomy. The Act intrudes upon employers’ decisions as to participation in, and the funding of, their medical arrangements for their employees. ERISA is best understood as creating a presumption for preemption, a presumption confirmed by the Maryland Act’s impact upon areas—welfare plan participation and funding—which ERISA reserves for employer discretion.

D. The Insurance Exemption

As previously observed, the Act’s definition of “health insurance costs” is inelegant. Included within that definition are covered employers’ self-funded health care outlays from the employers’ own resources. It is possible that the drafters of the Act used the term “insurance costs” inadvisably or colloquially when what they really meant instead was the totality of the covered employers’ medical-related expenses.

110 Retail Indus. Leaders Ass’n v. Fiedler (RILA), 435 F. Supp. 2d 481, 495 (D. Md. 2006).
111 Id. at 497.
112 Id.
113 See supra notes 29-32 and accompanying text.
It is, however, also possible that something subtler is involved in the Act’s use of the imprecise label “health insurance costs” to describe the entirety of employers’ medical expenditures including expenditures pursuant to self-funded plans. The drafters of the Act, by characterizing the subject of the Act as medical insurance, may have sought for the Act the protection of ERISA Section 514(b)(2)(A) and its exemption for state insurance laws. If so, the drafters missed their mark. Despite the Act’s labeling of employers’ medical expenses as “health insurance costs,” the Act, by virtue of ERISA’s “deemer clause,” does not “regulate[] insurance” within the meaning of Section 514(b)(2)(A) since the Act covers employers’ ERISA-governed, self-funded plans, i.e., arrangements under which Wal-Mart pays all medical outlays from its own resources without purchasing medical insurance coverage from an insurance company. Consequently, the Maryland Act is overly-broad and does not fall within the insurance exemption from Section 514(a).

The deemer clause provides that no ERISA-governed plan may be “deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate” insurance entities. As the Supreme Court observed in *FMC Corp. v. Holliday*, because of the deemer clause:

> Self-funded ERISA plans are exempt from state regulation insofar as that regulation “relate[s] to” the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not “saved” because they do not regulate insurance. State laws that directly regulate insurance are “saved” but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.

The Maryland Act does precisely what the deemer clause forbids: regulate a covered employer’s self-funded medical plan under the guise of insurance regulation. Specifically, the Act counts employers’ self-funded health outlays toward the required eight percent minimum of payroll and mandates a payment to the Fund if those self-financed outlays fail the statutory minimum.

Recall in this context the Act’s definitions of “health insurance costs.” These definitions are not limited to health insurance premiums. Rather, the definitions count against the eight percent

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115 ERISA § 514(b)(2)(B).


117 See *supra* notes 29-30 and accompanying text.
minimum\textsuperscript{118} any “health care” outlay that is deductible by the employer for federal income tax purposes as well as any employer “payments” for any “health benefits” as defined in Section 213(d) of the Internal Revenue Code. None of these qualifying outlays need be for insurance or otherwise have anything to do with insurers or insurance.

Thus, if Wal-Mart eschews all forms of medical insurance and pays all of its employees’ medical expenses from Wal-Mart’s general assets, the Act may deem Wal-Mart’s self-funded plans inadequate and consequently impose upon Wal-Mart a liability equal to the difference between the eight percent statutory minimum and the amount of Wal-Mart’s payments to Wal-Mart’s self-funded medical plans. Under the structure of ERISA Section 514, the Maryland Act could apply to self-funded plans in this fashion only if such plans are deemed to be in the business of insurance, a result the deemer clause forbids.

Confirming this conclusion is \textit{Kentucky Ass’n of Health Plans, Inc. v. Miller}\textsuperscript{119} in which the Supreme Court rejected an ERISA preemption challenge to Kentucky’s “any willing provider” statute. Kentucky’s statute, like similar laws in other states, requires every Kentucky HMO and every non-ERISA medical plan\textsuperscript{120} to reimburse for the medical services furnished by any doctor or other medical provider who agrees to accept the HMO’s or plan’s published fee schedule. The Kentucky statute does not apply to any self-funded, ERISA-governed plan.

In the face of an ERISA preemption challenge, the Court unanimously upheld the Kentucky “any willing provider” law as a regulation of insurance, protected from preemption by the insurance exemption of Section 514(b). Important for the Maryland Act is the fact that the Kentucky statute does not apply to self-funded plans regulated by ERISA.\textsuperscript{121} By limiting itself to true insurance entities such as HMOs and to plans outside the scope of ERISA coverage, the Kentucky statute survived ERISA preemption as a bona fide regulation of insurance.

Thus, Kentucky did what Maryland did not:\textsuperscript{122} enact a true insurance statute that keeps its distance from employers’ self-funded, ERISA-regulated medical plans. By virtue of the deemer clause, only a law which, in this fashion, eschews regulation of employers’ self-funded plans is a protected insurance law under Section 514(b)(2)(A).

\textsuperscript{118} Six percent for nonprofit employers.

\textsuperscript{119} 538 U.S. 329 (2003); see Zelinsky, \textit{Sequel, supra} note 58, at 1-9.

\textsuperscript{120} For these purposes, the most important plans not regulated by ERISA are church and government plans. \textit{See ERISA §§ 4(b)(1), (2)}.

\textsuperscript{121} \textit{Kentucky Ass’n}, 538 U.S. at 336 n.1.

\textsuperscript{122} A variant of this observation is that Hawaii did what Maryland did not: obtain an amendment to Section 514 to remove from the scope of ERISA preemption a state statute that would otherwise be ERISA-preempted. \textit{See ERISA § 514(b)(5)}. 
In contrast, the Act regulates Wal-Mart’s self-funded plans by requiring that they satisfy the eight percent of payroll test.

In sum, if the Act’s inelegant reference to “health insurance costs” is a deliberate effort to claim the insurance-related protection from preemption afforded by Section 514(b)(2)(A), that effort fails because of the deemer clause and the Act’s regulation of covered employers’ self-funded medical outlays, regulation the deemer clause forbids.

E. Summary

As a matter of positive law, the Act is preempted by virtue of ERISA Section 514(a). Under the original, capacious construction of Section 514(a) initially embraced by the Court in *Shaw* and in *Shaw*’s progeny including *Greater Washington Board of Trade*, the Maryland Act “relate[s] to” covered employers’ ERISA-regulated health plans by referring to the outlays of such plans and by having a connection with such plans. Under the more restricted construction of Section 514(a) advanced in *Travelers* and its offspring including *Egelhoff*, the Maryland Act is similarly ERISA-preempted by virtue of the Act’s effort to mandate the level of covered employers’ medical outlays and the Act’s impairment of nationally uniform welfare plan administration.

If Section 514(a) is interpreted through the reasoned textualist approach I favor, the Act is, again, preempted as a regulation of the participation in and the funding of covered employers’ welfare plans. From the reasoned textualist vantage, Section 514(a) creates a presumption that the Act is ERISA-preempted insofar as the Act affects such welfare plans. That presumption is confirmed by the Act’s intrusion upon the covered employers’ zone of welfare plan autonomy, a zone within which employers have discretion to determine who participates in their medical coverage and how that coverage is funded.

By virtue of ERISA’s deemer clause, the Act is not saved from ERISA preemption as a regulation of insurance since the Act regulates covered employers’ self-funded medical outlays, declaring such outlays inadequate if they are less than eight percent of Wal-Mart’s Maryland payroll. The deemer clause forbids such regulation.

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123 Quite independently of the legal controversy surrounding ERISA Section 514(a), another preemption debate swirls around ERISA Section 502. The Supreme Court has construed Section 502 as severely limiting the remedies available to injured ERISA plaintiffs. While the debate about the Supreme Court’s preemption approach to ERISA Section 502 is important, it has no direct relevance for the Maryland Act.

For commentary on the ERISA Section 502 preemption controversy, see *Langbein*, supra note 98, at 770; *Zelinsky, Sequel*, supra note 58; *Korobkin, supra* note 52.
For all these reasons, the U.S. District Court for the District of Maryland decided correctly when it held the Maryland Wal-Mart Act to be ERISA-preempted. The Fourth Circuit should affirm that decision.

III. SHOULD ERISA PREEMPT THE ACT?

The conclusion that, as a matter of positive law, ERISA preempts the Maryland Act leads to the normative question: Should ERISA preempt the Act? I answer this inquiry in the negative. As a normative matter, ERISA should not preempt the Maryland Act or any similar state statute regulating employers’ medical plans. I explain below my misgivings about the Maryland Act as a matter of policy. However, as problematic as the Act is in terms of policy, Maryland (or any other state) should be free to experiment with its own approach to employer-provided health care.

It is a truism of contemporary federalism that the states should serve as laboratories of experimentation. ERISA’s preemption of state law stops that experimentation by invalidating laws like the Act. Health care is today among the nation’s most urgent domestic concerns. To date, no one has convinced the American public that he has found the ultimate solution to the problems of controlling health care costs and of assuring access to such care. Under the circumstances, medical care is the kind of topic where state-by-state experimentation is appropriate to determine what works and what does not. Experimentation includes an acceptance of experiments that one considers inadvisable, as I think the Maryland Act is.

The countervailing policy, stressed by the Egelhoff Court, is the perceived need for national uniformity in the administration of welfare plans. For two reasons, I am, as a normative matter, not persuaded of the need for national standards that preclude experiments like the Maryland Act. First, in other areas, corporations operating across state lines adjust to different states’ varied laws, e.g., local land use ordinances, individual states’ workers’ compensation systems. There is no important distinction between these diverse laws, with which interstate corporations successfully cope, and a similarly pluralistic regime under which each state would formulate its own rules for health care. Given the ability of interstate businesses to adapt to varied state laws in other contexts, it is difficult to see an insurmountable problem if

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124 See discussion infra Part IV.
125 This celebrated metaphor comes from Justice Brandeis’ dissent in New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932). For further elaboration of the value of state-by-state experimentation as to the regulation of medical care, see Zelinsky, Against, supra note 58; Zelinsky, Sequel, supra note 58.
interstate corporations must similarly adapt to different state laws on medical coverage.

Indeed, interstate corporations that insure (rather than self-fund) their employees’ medical coverage already accommodate different state law regimes. Such corporations routinely purchase policies which vary from state to state in light of each state’s idiosyncratic regulation of its own insurance industry and its products. To illustrate these state-by-state variations among medical insurance policies, Cogan, Hubbard, and Kessler observe that

California requires insurance plans to cover both contraceptives and in-vitro fertilization; Virginia requires coverage of contraceptives but not in-vitro fertilization; and Florida, Indiana, and Pennsylvania require coverage of neither service.126

These kinds of state-by-state variations in insurance coverage have caused no perceptible problems for interstate corporations purchasing insurance for their employees. Interstate corporations could similarly adapt their non-insured, self-funded medical plans to different states’ respective regulations of those plans.

Such state-by-state adaptation will impose some costs on interstate corporations, both procedurally (e.g., legal fees to comply with each state’s own regulatory scheme) and substantively (e.g., greater payments to covered employees in states which mandate more coverage). However, if any particular corporation finds prohibitive the medical costs of operating in any state, that corporation has the same options for medical costs as the corporation does with respect to any other state-imposed costs, namely, to shift its operations elsewhere or to lobby for different state laws. There is no need for a single, federally-imposed standard.

Second, concern about national uniformity as to welfare plans largely stems from a false analogy to pensions. In light of employee mobility across state lines and the cumulative nature of pension entitlements, there is a strong conflict-of-laws argument for nationally uniform pension laws. Different state rules for pensions would engender confusion and complexity as employees relocate across state lines, bringing with them pension entitlements earned elsewhere. There is, however, no equivalent mobility-related problem for medical arrangements since, at any moment, an employee is covered by only one discrete set of medical benefits. When the employee moves to another state, he does not take cumulative medical rights with him and thus does

126 JOHN F. COGAN, R. GLENN HUBBARD & DANIEL P. KESSLER, HEALTHY, WEALTHY AND WISE: FIVE STEPS TO A BETTER HEALTH CARE SYSTEM 44 (2005). Cogan, Hubbard and Kessler take a dim view of these state-imposed requirements for medical insurance, arguing that they unacceptably increase the cost of such insurance.
not encounter any pension-type conflict-of-law problem as to his medical coverage.

To illustrate this difference between cumulative pension and discrete medical rights, consider a theoretical world in which every state can promulgate its own vesting rules for pensions. Suppose, for example, that in State $A$, an employee has an immediately nonforfeitable right to any pension benefit he has earned, that the law of State $B$ vests an employee in his accrued pension rights only after fifteen years of service with the sponsoring employer, and that State $C$’s rule is a particular form of graduated vesting, five percent additional vesting for each year of service, ending in full vesting at year twenty. Assume further that, over the course of a decade, an employee works for an employer in State $A$, then in State $B$ and, finally, in State $C$, accruing cumulative pension benefits in all three states.\textsuperscript{127}

Which vesting schedule or schedules apply to this employee and his cumulative pension benefit? State $A$’s immediate schedule on the theory that State $A$ is where his career began? State $C$’s graduated vesting schedule on the theory that that is where the employee is now? When the employee moves from State $A$ (where he was fully vested) to State $B$ (where he is not vested at all), should this movement to State $B$ unsettle the vesting the employee had previously earned in State $A$? Perhaps each state’s vesting rule should apply to the portion of the pension benefit earned in that particular state. This is a theoretically tidy solution that will prove messy in practice for employees who are highly mobile during their careers and thus must keep track of the different pension rules controlling in the different states in which they have worked.

In the face of these quandaries, a national approach to pension vesting is sensible since the employee can move from state-to-state without his pension rights being impaired or becoming unnecessarily complicated by conflicting state laws.

A similar story can be told as to pension participation. Suppose a world in which State $A$ requires immediate pension participation for all employees, State $B$ delays mandatory pension participation until the employee’s completion of the tenth year of service with the employer, and State $C$ requires the employee’s inclusion in the employer’s pension plan only upon his fifth year of employment. What happens in this world as the employee moves from $A$ to $B$ to $C$? Does he stay in the pension while living in $B$ and $C$ on the theory that his right of immediate participation from State $A$ carries over to other jurisdictions?

\textsuperscript{127} This example could be complicated further by having the employee reside in State $D$ when he works in State $A$, in State $E$ when he works in State $B$, and in State $F$ when he works in State $C$. As the state of residence, $D$, $E$, and $F$ might also assert the primacy of its respective vesting schedule.
Or does the employee drop from the plan as he moves from State $A$ to State $B$ with its tougher participation requirement? Again, federal legislation, providing nationally uniform participation rules, is a compelling solution to these conflict-of-law quandaries.

In contrast, medical coverage does not involve a cumulative right that grows over time in different states. Rather, the employee is, at any one time, a resident of only one state. Consequently none of the conflict-of-law issues that arise for pensions arise for medical care.

Assume now a world in which the states can regulate all employer-provided medical coverage including employers’ self-funded plans. In this hypothetical world, when an employee lives in State $A$, he is covered by whatever rules prevail there. When he moves to State $B$, his medical care entitlement may change under the laws of his new state, but there is no implication for the coverage he previously enjoyed in State $A$ (it is over) or for the coverage he will subsequently enjoy in State $C$ (it has not yet begun). Indeed, in the world as it exists today, if an employer purchases different medical insurance policies in States $A$, $B$, and $C$, this mobile employee may already receive different health care coverage as he moves from state to state.

In particular cases, those differences might be harmful to the employee, if, for example, the new state does not require a treatment the employee was receiving in his old state. Alternatively, state-by-state differentials might help the employee, if, for example, the new state requires coverage that the old state does not. In the former case, the employee might demand as a precondition of the transfer that the employer continue to pay for medical costs that were insured before the transfer. Or an interstate employer might, on its own, provide self-insured benefits in excess of the mandated state minima for insurance.

In any case, there is no conflict-of-law argument for federal regulation of medical care as there is for pensions. The entitlement to medical care is discrete, not cumulative. In the medical care context, movement to a new state with a different legal regime poses no difficult conflict-of-law problems, as it would for state-regulated pensions. There is, consequently, no compelling argument for national regulation of medical plans, as there is for pension plans.

I have previously urged abolition of Section 514(a) on federalism grounds. The Maryland Act reinforces the argument for such abolition of ERISA preemption. As a normative matter, Maryland should be free to experiment as to health care regulation—though, under Section 514(a), it cannot.

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128 See Zelinsky, Against, supra note 58; Zelinsky, Sequel, supra note 58.
IV. IS THE ACT SOUND POLICY?

This brings us to the final inquiry: Does the Maryland Wal-Mart Act, independent of its status under ERISA, represent sound policy? My conclusion is negative. While, as a matter of federalism, Maryland should be free to adopt the Act in the interests of experimentation, on the merits, the Act is an ill-conceived experiment. For the short-run, the Act hurts Wal-Mart’s predominantly low-income customers by raising Wal-Mart’s prices. For the long-run, the Act hurts those customers as well as workers, who forfeit employment with Wal-Mart as a result of the costs the Act imposes on Wal-Mart. In contrast to the Act, there are carefully-crafted means by which Maryland (and other states) can assist low-income workers, including the establishment and expansion of state earned income tax credits. The Act is designed not to mandate a broad expansion of employment-based medical coverage, but, rather, to make a largely symbolic attack on Wal-Mart.

A. The Act’s Short-Run Effects on Consumer Prices

To gauge the initial economic impact of the Act, let us start with the assumption that, for the short-run, Wal-Mart’s demand for labor is inelastic, that is to say, price-insensitive. As a first cut, this assumption is credible since the substitution of capital for higher-priced labor does not occur instantaneously. Thus, Wal-Mart (or any other covered employer), for the short-run, will respond to the Act by retaining all of its Maryland employees, though it is more expensive than before to do so.
Figure 1

The vertical curve $D_L$ in Figure 1 reflects this assumption about Wal-Mart’s demand for labor, i.e., that the Act and the costs it imposes on Wal-Mart will not initially depress the number of Wal-Mart employees in Maryland. $S$ is the labor supply curve Wal-Mart confronted before the adoption of the Act. $S'$ is $S$ shifted to the left to reflect the extra health care costs imposed upon Wal-Mart by the Act. $S'$ is the labor supply curve Wal-Mart confronts under the Act.

$P_1$ is the wage Wal-Mart paid prior to adoption of the Act. Wal-Mart’s total labor costs (including the cost of whatever medical care Wal-Mart furnished to employees before adoption of the Act) are represented by the rectangle $(P_1, X, Q_1, O)$. The rectangle $(P_2, Y, X, P_1)$ represents the extra health care costs Wal-Mart will pay in the short-run to comply with the Act.

Figure 1 captures the benign scenario promised by supporters of the Act. No one loses his job because of the costs the Act imposes on Wal-Mart. As a result of the Act, Wal-Mart finances health care for previously uncovered employees or increases its medical outlays for its already covered employees or does some of both. Given the assumption of short-run inelasticity in the demand for labor, it is plausible to conclude that, as an initial matter, the Act causes a certain number of Wal-Mart employees to obtain employer-provided medical coverage with no job loss to the Wal-Mart workforce.

It is, however, implausible to conclude that the Act’s short-run consequences end at this happy point. The Act increases Wal-Mart’s cost of doing business in Maryland by the amount $(P_2, Y, X, P_1)$. Wal-Mart will shift these increased costs to Wal-Mart’s customers.
Figure 2 represents Wal-Mart’s relationship with its customers, before and after the adoption of the Maryland Act. Prior to the adoption of the Act, Wal-Mart sold to its customers at prices (P₁) based on the costs reflected in initial supply curve S and the demand of Wal-Mart customers as represented by D_C. The Act increases Wal-Mart’s costs, resulting in S₁ and higher prices (P₂) for Wal-Mart consumers. Faced with these higher prices, the quantity of Wal-Mart goods demanded by Wal-Mart customers decreases from Q₁ to Q₂. The goods these consumers still buy from Wal-Mart are now higher priced (P₂ rather than P₁) because those prices embody the costs of the health care expenses mandated by the Act. The triangle ABC represents the well-known consumer dead-weight loss, i.e., the loss in consumer welfare to Wal-Mart shoppers who, responding to higher prices, transfer their purchases from the now more expensive Wal-Mart goods they previously bought to other less desirable goods.

Thus, the short-run welfare gain to Wal-Mart employees (more medical coverage) is counterbalanced by the economic cost to Wal-Mart customers (higher prices at Wal-Mart, dead-weight loss from the price-induced shift to other merchants).

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130 If these alternative non-Wal-Mart goods had been more desirable, consumers would have purchased these goods before the Act increased Wal-Mart’s costs and prices.
In public choice terms, the Act presents a politically compelling trade-off for Maryland’s legislators since the Wal-Mart workers acquiring health care coverage are a concentrated group of Maryland voters for whom the advantage of the Act will be apparent in the form of their new coverage. In contrast, the costs of the Act will be spread among a diffuse group (Wal-Mart customers) and will largely be hidden from the members of that group since those costs will be embedded in the prices charged by Wal-Mart. From a public choice perspective, the adoption of the Act reflects a straightforward political calculus. By enacting the Act, Maryland’s legislators bestowed visible largesse upon an identifiable group of voters while imposing the costs of that largesse on disorganized persons who will largely be unaware of those costs.

Indeed, in public choice terms, the Act is particularly attractive to Maryland legislators since at least some, perhaps most, of the Wal-Mart customers who will pay for the costs of the Act are not Maryland residents. Wal-Mart (like any other corporation likely to trigger the coverage of the Act) is an integrated, national firm. Hence, the costs of the Act will likely be shifted, not just to Wal-Mart customers in Maryland, but to Wal-Mart customers throughout the nation, perhaps even internationally.

While some of these Wal-Mart customers may be affluent, the typical Wal-Mart consumer in the United States is not. The

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132 Wal-Mart could try to disclose costs on price tags or in other forms of in-store publicity. I am skeptical of the efficacy of such efforts.

133 Some might be tempted to use this analysis to bolster the normative case for ERISA preemption: Maryland (or any other state) can export the cost of medical care for its residents to Wal-Mart’s customers in other states, indeed, maybe to Wal-Mart’s customers abroad. These externally imposed costs argue for federal, rather than, state regulation. The problem with this argument is that it proves too much. All state tax and regulatory policies affect national corporations and, as a matter of economics, are exported to out-of-state customers. If, for example, Maryland increases real property taxes to improve public schools, that cost too would be reflected in Wal-Mart’s prices for its non-Maryland customers. I see no reason to distinguish state policies vis-à-vis medical care from these other state tax and regulatory programs. Unless we are prepared to preempt all because they can be exported, I do not see why we should preempt some.

advocates of “living wage” proposals to increase the minimum wage often appeal to the image of the low-paid waiter working in a high-priced restaurant, imagery which many (myself included) find quite powerful: Wealthy and middle class restaurant customers can afford to pay a little more to help those less fortunate.\textsuperscript{135} However, for the Act, a quite different picture emerges. At least some (perhaps many) Wal-Mart customers earn less than Wal-Mart’s rank-and-file employees—and, for the short run, those customers will, via higher prices, finance the health care benefits provided to those employees under the Act.

Moreover, in public choice terms, there is a second, perhaps even more important, constituency benefiting from the Act—Maryland’s unions. Via the Act, Maryland’s unions protect the higher compensation standards those unions have obtained from Wal-Mart’s competitors. The Act, by forcing Wal-Mart to come closer to unionized standards for medical care, abates the downward pressure Wal-Mart would otherwise place on those standards in the labor market.

Both Wal-Mart and its critics agree that central to Wal-Mart’s business model is its militant opposition to unions, opposition which allows Wal-Mart to pay significantly lower compensation than is paid by Wal-Mart’s unionized competitors. This compensation differential is particularly salient as Wal-Mart, through its supercenters, becomes a dominant force in the grocery industry. “Wal-Mart’s labor cost advantage looms especially large in the grocery trade, where most big chains are locked into contracts assuring even their lowest-paid workers about 20 percent to 30 percent more than their counterparts make at Wal-Mart.”\textsuperscript{136}

Until recently, the compensation differential between Wal-Mart and its unionized competitors has presented two choices to the unions representing employees at those competitors. These unions can organize Wal-Mart’s workforce to achieve unionized compensation levels at Wal-Mart or can reduce the compensation paid by Wal-Mart’s competitors to permit them to compete with Wal-Mart. The first alternative has so far proved unavailing while the second alternative is understandably unappealing to unions and their members.

The Act gives Maryland’s unions a third alternative, a state-mandated minimum which forces Wal-Mart to come closer to the compensation packages provided to the unionized workforces of Wal-Mart’s rivals in the marketplace. As I discuss below,\textsuperscript{137} the Act and similar state laws present their own dilemmas for unions, dilemmas

\textsuperscript{135} Gertner, \textit{supra} note 134, at 45 (estimating that, to pay for the Santa Fe, New Mexico living wage, “restaurants and hotels and stores would probably need to raise prices between 1 and 3 percent”).

\textsuperscript{136} \textit{BIANCO, supra} note 134, at 200-01.

\textsuperscript{137} \textit{See discussion infra} Part IV.D.
which, I suggest, explain the Act’s more problematic features. For now, the point is that Maryland’s unions are, in public choice terms, a second (perhaps even the primary) beneficiary of the Act insofar as the Act forces Wal-Mart to move toward the compensation standards prevailing at Wal-Mart’s unionized competitors. The Act thereby protects unionized standards for medical care from the downward pressure Wal-Mart would otherwise exert in the labor market by decreasing the compensation differential between Wal-Mart employees and the unionized employees of Wal-Mart’s competitors. This, in turn, abates the competitive pressure on unions to reduce the medical benefits they have obtained for their members at Wal-Mart’s rivals in the marketplace.

This vantage helps to explain the AFL-CIO’s strong support for the Maryland Act and similar laws in other states. Unions affiliated with the AFL-CIO are prime beneficiaries of the Act as the Act protects unionized compensation standards for health care by diminishing the differential between Wal-Mart and its unionized competitors. And, as just observed, the political cost to a Maryland legislator of accommodating Maryland’s unions via the Act is minimal since those costs are spread in opaque fashion among an unorganized constituency, namely, Wal-Mart shoppers.

This vantage also explains why Giant Foods supports the Act. Although Giant Foods is a for-profit employer with more than 10,000 Maryland employees, Giant Foods’ medical care outlays exceed twenty percent of its Maryland payroll, far above the eight percent minimum required by the Act. By forcing Wal-Mart, a direct grocery competitor of Giant Foods, to meet that eight percent minimum, the Act reduces Wal-Mart’s competitive advantage vis-a-vis Giant Foods and, perhaps, lays the groundwork for a further reduction of that advantage in the future if the minimum is subsequently increased.

In response to this analysis, I can envision at least two responses by supporters of the Act, neither of which seems persuasive. First, such supporters might argue that Wal-Mart will absorb the costs of the Act, rather than pass those costs onto Wal-Mart’s customers. Second, supporters of the Act might argue that the magnitude of the cost imposed on each Wal-Mart customer is small relative to the benefit obtained by each newly-covered Wal-Mart employee.

138 See AFL-CIO, THE WAL-MART TAX, SHIFTING HEALTH CARE COSTS TO TAXPAYERS 2 (2006), http://www.aflcio.org/corporatewatch/walmart/upload/walmartreport_031406.pdf (“Maryland is the first state to hold giant companies such as Wal-Mart accountable for paying their fair share of workers’ health care costs.”).

139 See Retail Indus. Leaders Ass’n v. Fiedler (RILA), 435 F. Supp. 2d 481, 485 (D. Md. 2006) (“Giant Food, which actively lobbied for enactment of the legislation, spends substantially in excess of 8% of the total wages it pays to employees in Maryland on health insurance costs.”); see also Brandolph, supra note 36.
It is possible that Wal-Mart, confronted with consumer resistance to higher prices, will find it economically efficient to absorb some of the health care costs imposed by the Act. However, as a for-profit firm, Wal-Mart (or any other covered employer) will shift to its customers as much of those costs as is economically feasible. Ultimately, it is an empirical enterprise to identify the elasticity of Wal-Mart consumer demand and the consequent ability of Wal-Mart to shift the costs of the Act to its customers in the form of higher prices. However, it is implausible to assume that Wal-Mart will voluntarily absorb all costs of the Act and will shift none of those costs to Wal-Mart’s customers. Indeed, it is more compelling to assume that Wal-Mart, given its dominance in many markets and product lines, will largely shift the costs of complying with the Act to Wal-Mart customers.

I am also skeptical that the price impact of the Act on Wal-Mart’s customers should be dismissed as *de minimis*. In this context consider as an alternative to the Act a state income tax surcharge financing medical coverage. Assume that this hypothetical surcharge predominantly falls upon lower-income taxpayers and raises the same amount as the extra health care costs imposed by the Act on Wal-Mart. I doubt that many supporters of the Act would embrace such a tax surcharge. Indeed, I am confident that most of those supporters would criticize such a surcharge as regressive in impact, as indeed it would be.

However, in distributional terms, the Act and this hypothetical surcharge are similar. The principal difference between the two is transparency; the surcharge would be imposed openly on less affluent taxpayers to finance medical care. In contrast, the economic impact of the Act on that same group in their capacity as Wal-Mart customers is hidden since that cost is embedded in Wal-Mart’s prices. If the impact of the transparent tax surcharge cannot be dismissed as *de minimis*, neither should the equivalent effects of the more opaque Act.

**B. The Act’s Long-Run Effects on Employment**

While it is plausible to assume that Wal-Mart’s demand for labor is inelastic in the short-run, it is unconvincing to persist in that assumption for the long-run. For-profit businesses minimize their costs. Wal-Mart, in particular, has a hard-earned reputation for finding efficiencies in its operations.\(^\text{140}\) For the long-run, Wal-Mart will reduce its now higher-

\(^{140}\) See, e.g., CHARLES FISHMAN, THE WAL-MART EFFECT 8 (2006) (describing Wal-Mart’s “culture of looking for every penny of cost savings that could be wrung out of designs, packaging, labor, materials, transportation, even the stocking of stores. It is that cascade of frugality, questions, and pressure that creates the Wal-Mart effect.”); see also Brannon P. Denning & Rachel M. Lary, Retail Store Size-Capping Ordinances and the Dormant Commerce
priced Maryland workforce, by substituting capital for labor and by deploying workers in ways that were inefficient before the Act but that make sense after the Act raises Wal-Mart’s wage bill.

**Figure 3**

Thus, for the long-run, Wal-Mart confronts a downward sloping demand curve for labor. Figure 3 has the same supply curves as Figure 1, again reflecting Wal-Mart’s labor costs before (S) and after (S^1) the adoption of the Act. However, in Figure 3, the long-run demand curve for labor, D^L, slopes downward since Wal-Mart (or any other covered employer) will, for the long term, respond to higher prices for labor by purchasing less labor. For the long-run, Wal-Mart’s Maryland employment will drop from Q1 before the Act to Q2 after the Act is adopted.

Some supporters of the Act might acknowledge that Wal-Mart will employ fewer workers because of the costs imposed by the Act, but might view reduced employment as a price worth paying to increase the number of remaining Wal-Mart employees with medical coverage. Not so fast. Given the minimum mandated by the Act (eight percent of total payroll), it is possible that the Act could cause a net reduction in the number of Wal-Mart employees with medical coverage. By reducing the denominator of the relevant fraction (total payroll), Wal-Mart could comply with the Act while decreasing the scope of its medical coverage.

\[ \text{Clause Doctrine, 37 Urb. Law. 907, 941 (2005) ("Volume buying enables Wal-Mart to command preferential pricing from its suppliers, the savings of which are passed along to the customer.".)} \]
A numerical example confirms this possibility: Suppose that, prior to the adoption of the Act, a covered, for-profit employer has 20,000 Maryland employees, that the total annual payroll for this workforce is $20,000,000, that the covered employer pays $1,200,000 yearly for employee medical coverage, and that that coverage extends to 4,000 employees. On these numbers, the employer flunks the Act’s test since the employer only devotes six percent of total payroll to medical care.141

Suppose further that, after the Act is adopted, the employer, responding to the now-higher price for Maryland labor, reduces its Maryland workforce to 14,000 employees, that 200 of the employees terminated had medical coverage, that the cost of such coverage consequently drops to $1,120,000 and that the total payroll for this now-reduced workforce declines to $14,000,000.

In this hypothetical, the employer, by reducing its workforce and payroll, complies with the Maryland Act since the employer’s reduced medical costs ($1,120,000) satisfy the statutorily-required eight percent of total payroll ($14,000,000). Even though total medical outlays and the number of covered employees have both declined, total payroll has declined relatively more. The covered employer has thus complied with the Act, not by extending medical coverage, but by reducing its payroll. In a world of unintended consequences, a scenario along these lines cannot be dismissed. Indeed, Maryland’s Attorney General cites this possibility in his defense of the Act from ERISA preemption.142

In any event, a long-run increase in employee medical coverage, should it occur, will be purchased by sacrificing the jobs of some persons who otherwise would be employed by Wal-Mart and by increasing prices for Wal-Mart customers. Consequently, for the long-run, the Act engenders a trade-off between the consumer welfare of Wal-Mart’s predominantly low-income customers and the well-being of Wal-Mart’s comparably unaffluent workforce. To the extent the costs of the Act are shifted forward to Wal-Mart’s customers in the form of

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141 $1,200,000/$20,000,000=6%. Note that, if this employer is a nonprofit entity, it passes muster under the Maryland Act, which imposes a lesser requirement on nonprofit employers. As I discuss infra Part IV.E, there is no policy justification for this lesser standard for large nonprofits.

142 Attorney General’s Letter, supra note 14, at 3 (Wal-Mart can comply with the Maryland Act by “reduc[ing] the number of employees it has in the State [or reduc[ing] pay . . . .” The Attorney General argues that these possibilities indicate that the Act is not ERISA-preempted. For the reasons discussed in the text, I disagree, i.e., under Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983), the Act refers to and has a connection with Wal-Mart’s ERISA-regulated medical plans; under N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995), the Act mandates Wal-Mart’s level of medical outlays and impairs nationally uniform administration; under the reasoned textualist approach, the Act intrudes upon Wal-Mart’s zone of welfare plan autonomy by regulating medical plan participation and funding.

Nevertheless, I agree with the Attorney General that Wal-Mart might respond to the Act by reducing Maryland employment or compensation, even though I disagree with the Attorney General as to the legal implications of that possibility.
higher prices, jobs are preserved at the expense of those customers. To the extent the costs of the Act are shifted back to the persons who would otherwise have worked for Wal-Mart, customers are spared higher prices but those unemployed persons bear the impact of the Act in the form of lost job opportunities. A particularly ironic possibility is that some of these unemployed persons, who otherwise would have worked at Wal-Mart and been covered by Wal-Mart’s medical plans, will instead utilize Maryland’s Medicaid program. There is, as the old proverb has it, no free lunch.

In contemporary debate about “living wage” proposals, many advocates of such proposals deny that there is any reduction of employment when such proposals are enacted. In effect, these advocates suggest that Figure 1 with its inelastic demand curve for labor reflects, not just the short-run, but the long-run as well. No doubt, there are defenders of the Maryland Act who believe this also and who deny that the Act will have any impact on Wal-Mart’s employment in Maryland.

I find this characterization of Wal-Mart’s long-term demand for labor implausible. But, in any event, even if this characterization is correct, it poses a dilemma for supporters of the Act. If Wal-Mart’s demand for labor is indeed inelastic for the long-run, the Act will not diminish Wal-Mart’s Maryland employment but, instead, the costs of the Act will be shifted onto Wal-Mart’s mostly unaffluent customers in the form of higher prices.

Again, the question must be asked: Would the Maryland legislature have openly voted for a transparent program achieving this result, such as a tax surcharge impacting principally on lower income persons? I doubt it. As noted earlier, public choice theory suggests a favorable political calculation underlying the Act. Legislators, through the Act, bestow perceptible largesse upon their Maryland constituents who work for Wal-Mart and who obtain medical coverage because of the Act. Legislators, through the Act, also advantage unions which benefit from the Act insofar as the Act protects unionized compensation standards by forcing Wal-Mart to come closer to the medical care coverage such unions have negotiated at Wal-Mart’s competitors. The costs of this largesse, embedded in Wal-Mart’s prices, will largely be obscured from most Wal-Mart customers who pay it. Quite probably, many of those customers live outside of Maryland. In pure political terms, this is an attractive trade-off: grateful voters and unions receiving benefits, largely ignorant (often out-of-state) consumers bearing the costs.

In contrast, a tax surcharge, or other more transparent proposal in lieu of the Act, changes the political calculus. Those paying the taxes

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143 See discussion supra Part IV.A.
for increased medical coverage are more likely to perceive the costs inflicted upon them.

Behavioral economics\textsuperscript{144} suggests a more benign explanation for the Maryland legislature’s willingness to adopt the Act, but not an equivalent tax surcharge. From this perspective, some legislators succumb to “framing effects,” viewing economically comparable programs as substantively different depending upon the way those programs are framed. Such legislators may genuinely, if naively, view the Act as different from an economically comparable tax program.

In enacting the Act, the Maryland legislature likely had some members who made the political calculation predicted by public choice theory while others were the financially naive decision makers of behavioral economics. The members of a legislative majority need not reason to their respective results in the same way.

Consider finally the possibility that Wal-Mart will shift the costs of the Act to Wal-Mart’s suppliers by demanding lower prices to offset those costs. Wal-Mart is well-known for the pricing pressure it exerts on the companies that sell to it.\textsuperscript{145} Perhaps the costs of the Act will ultimately be passed on to those companies in the form of Wal-Mart’s demand for even lower prices.

I doubt that many (perhaps any) supporters of the Act intend for the costs of that law to be foisted onto Wal-Mart’s suppliers. Wal-Mart’s often-brutal price pressure on its suppliers is one of the most compelling elements of the anti-Wal-Mart narrative.\textsuperscript{146} It is unlikely that the Maryland legislators who voted for the Act sought complicity in this aspect of Wal-Mart’s business model.

Nevertheless, at first blush, Wal-Mart’s customers and employees will be spared the costs of the Act if Wal-Mart can pass those costs to its suppliers in the form of even lower prices as the precondition for selling to Wal-Mart. On second thought, however, this merely moves the costs of the Act onto the suppliers’ employees and non-Wal-Mart customers who, in turn, will themselves engage in further cost-shifting. The ultimate impact of the Act is thus opaque and likely quite regressive, particularly insofar as the costs of the Act fall upon the nonaffluent employees of Wal-Mart’s suppliers in the form of reduced wages and decreased employment.


\textsuperscript{145} BIANCO, supra note 134, at 182 (“For suppliers, doing business with Bentonville is a Faustian bargain.”).

\textsuperscript{146} \textit{Id.}
C. Alternatives to the Act: State Earned Income Tax Credits

It is instructive to compare the Maryland Act with the alternatives available to legislators seeking to assist low-income workers in Maryland and in other states. Chief among these alternatives is the expansion (or establishment) of state earned income tax credits (EITCs) for such workers. This comparison confirms the superiority of the tax credit to the Act as a device for helping less affluent workers.

States’ EITCs are modeled on the federal EITC\(^\text{147}\) and usually piggy-back on the federal credit. Maryland’s EITC is typical, pegged at the lesser of fifty percent of the taxpayer’s federal EITC or the taxpayer’s Maryland income tax liability.\(^\text{148}\) The credit constitutes both financial support from the public fisc and a reward for work since the credit is bestowed only on low-income taxpayers who have earned income. Since the EITC is financed by the public treasury, rather than by private businesses, the credit does not distort business behavior, forcing firms to raise prices, to reduce employment, or some of both. Such credits, financed by state income tax revenues, are (unlike the Act) funded by middle- and upper-income taxpayers, not by less affluent Wal-Mart shoppers paying higher prices.

The Maryland legislature, if it seeks additional succor for low-income workers, could increase the size of the Maryland EITC, now limited to half of the federal credit. Maryland, for example, could enlarge its credit to, say, seventy percent of the federal credit to which the taxpayer is entitled. Alternatively (or in addition), the Maryland legislature could eliminate the ceiling which caps the Maryland credit at the taxpayer’s Maryland income tax liability. Maryland could instead make its EITC, like the federal credit, refundable. Thus, if the credit exceeds the taxpayer’s Maryland tax liability, the Maryland treasury would send the taxpayer a check for the excess.

States like Connecticut, which lack a state EITC, could amend their respective income tax statutes to include such a credit.\(^\text{149}\)

Why would a Maryland legislator, concerned about the welfare of low-income workers, prefer the Act to an expansion of the EITC? On the merits, the EITC prevails in any comparison. The EITC applies to all low-income workers, not just to those hired by a particular firm. The credit does not dampen employment nor is it paid for by persons who themselves are struggling financially.

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\(^{148}\) MD. CODE. ANN., TAX-GEN. § 10-704(b) (West 2006).

On the negative side of the ledger, the EITC has proved complex and difficult to administer.\textsuperscript{150} On the other hand, important laws are often complicated and hard to implement.\textsuperscript{151} Moreover, in a case like Maryland’s, the basic administrative costs of implementing the EITC are already incurred at the credit’s current level. While those administrative costs might increase somewhat if the credit is expanded or made refundable, those incremental administrative costs do not seem significant.

Some supporters of the Act no doubt feel that the state should force low-income workers to take their compensation in the form of medical care rather than cash. But even that objection to an expanded EITC could be met by allocating EITC refunds to state-administered medical accounts upon which each low-income worker could draw for health care for him and his dependents.

From this comparison, the Act emerges as an essentially symbolic gesture, politically attractive because bashing Wal-Mart is a good sound bite today and because the Act’s costs are largely obscured from those who pay such costs as higher prices and reduced long-run employment. In contrast to the Act, expanding or establishing the state EITC is a politically-accountable action since the legislature, reducing tax collections via an enlarged credit, must in response either decrease public spending or raise other revenues. As a device to help the working poor, expanding (or establishing) a state EITC wins hands down.

The EITC is not the only option available to Maryland’s legislators if they seek to go beyond symbolism and genuinely assist Maryland’s working poor. Another compelling model is the federal tax credit for low-income workers who contribute to individual retirement accounts, 401(k) plans and similar arrangements.\textsuperscript{152} Maryland (or any other state) could easily adapt that model to provide broad tax-based assistance to low-income workers to help them defray their outlays for medical insurance premiums and co-payments.

In short, if the legislature of Maryland (or of any other state) seeks to provide broad assistance to the working poor, there are good options,

\textsuperscript{150} See, e.g., Dorothy A. Brown, The Tax Treatment of Children: Separate But Unequal, 54 EMORY L.J. 755, 767 (2005) (“EITC errors are made by taxpayers, tax preparers, and IRS staff.”); see also Dustin Stamper, Treasury, IRS Programs Get Fair Marks on New OMB Report Card, 110 TAX NOTES 699 (2006) (“The credit has long been a lightning rod for criticism for both its high alleged abuse rates and the number of eligible taxpayers who do not claim it.”).

\textsuperscript{151} For example, the Homestead Act, justly celebrated as one of the great success stories of American history, had more than its share of administrative problems. See LOUIS S. WARREN, BUFFALO BILL’S AMERICA: WILLIAM CODY AND THE WILD WEST SHOW 72 (2005) (“Settlers had their own share of tricks. After 1862, the federal government deeded 285 million acres to homesteaders. Half their claims were fraudulent, backed by false identities, fake improvements, or worse.”).

\textsuperscript{152} I.R.C. § 25B.
options preferable to the Act. When the Act is compared with possible
tax credits to help low income individuals and families, the Act emerges
as an essentially symbolic gesture, rather than a carefully-crafted
program to help the poor.

D. The Design of the Act

The final policy argument against the Act is the Act’s poor design. Assume for purposes of this discussion a decision in favor of state-mandated, employer-provided medical insurance. Given the decision
to pursue this course, the Act implements it quite poorly.

We have already seen how the Act creates a perverse incentive
for a covered employer to decrease its total payroll, thereby elevating its current (or even reduced) medical outlays to the statutory requirement, eight percent of total payroll.

Other features of the Act are equally problematic. A covered employer under the Act is one with 10,000 or more Maryland employees. There is no pretense here that the Act mandates broad medical coverage for the Maryland workforce. The Act is a gerrymander, narrowly targeted to reach Wal-Mart and Wal-Mart alone. If the Maryland legislature seriously believes that Maryland should require employer-financed medical care, why should Maryland not mandate such care for employees of smaller firms? Why establish the threshold for mandated health coverage at 10,000 employees? Why not at 5000 employees? Or 1000 employees? Why exempt other large firms and just concentrate on Wal-Mart? Except for Wal-Mart’s symbolic attractiveness, there is no reason for the Act’s arbitrary coverage.

Equally arbitrary is the Act’s mandate that a covered employer
must expend at least eight percent of total payroll for medical care. Again, the Maryland legislature adopted this number because Wal-Mart falls below this statutory threshold while other firms the legislature chose to spare already exceed it.

Particularly intriguing in this respect is the special rule for
nonprofit employers with 10,000 or more Maryland employees. Under
the Act, these nonprofit firms need devote only six percent of total payroll to medical care. In practice, this special treatment for large nonprofit employers extends to a single institution, Johns Hopkins


154 See discussion supra Part IV.B.
University, the only Maryland nonprofit that employs 10,000 or more employees.\footnote{See Attorney General’s Letter, supra note 14, at 2 (noting that the only Maryland employers with more than 10,000 employees are “Giant Food, Wal-Mart, and Johns Hopkins University”).} By virtue of the lower requirement (six percent of payroll) applying to it, Johns Hopkins need not expand its medical coverage while Wal-Mart must. Why, it must be asked, is a clerk employed by Johns Hopkins less worthy of state-mandated employer-financed medical care than is a clerk engaged by Wal-Mart?

In public choice terms, there are two (mutually compatible) explanations for the arbitrary decisions embodied in the Act. First, exempting Maryland’s other major employers dampened or deflected such employers’ potential opposition to the Act. The second explanation stems from the dilemma confronting the unions embracing the Act as a device that protects unionized compensation standards against Wal-Mart’s downward pressure in the marketplace.\footnote{See discussion supra Part IV.A.}

On the one hand, these unions desire the Act as a state-mandated floor that reduces the differential between Wal-Mart’s compensation standards and the higher, unionized standards prevailing at Wal-Mart’s competitors. On the other hand, these unions do not want the state to displace them as the guarantors of their members’ compensation packages. If Maryland, by statute, assures everyone in Maryland of employer-provided health care, collective bargaining for such care becomes superfluous.

Thus, the unions want an Act that solves (or at least abates) their Wal-Mart problem by lifting Wal-Mart’s compensation package closer to unionized standards, thereby reducing the pressure on the unions to make concessions. However, the unions do not want an Act which extends any further than Wal-Mart since they want the collective bargaining the unions provide (not the legislature) to be the forum to which their members look for compensation improvements.

Ultimately, the nicest characterization of the Act is that it is a jumble of compromises, reflecting the rough-and-tumble of practical politics and Wal-Mart’s symbolic attractiveness as a target. Less diplomatically, as a matter of policy, the Act’s design makes no sense.

E. Summary

In a world without ERISA preemption, the Maryland Act would still be ill-conceived. As a matter of policy, the Act imposes its costs on Wal-Mart’s predominantly low-income customers who will pay higher prices because of the Act and on workers who would, but for the Act,
have jobs with Wal-Mart. A legislature genuinely seeking to improve
the condition of the working poor has available better-crafted alternatives, including expansion (or establishment) of the state EITC. On the merits, it is difficult to view the narrowly-targeted, poorly-designed Act as other than an exercise in political symbolism.

CONCLUSION

Under any of the plausible approaches to ERISA Section 514(a), ERISA preempts the Maryland “Wal-Mart” law and other laws like it. While I favor a world in which Maryland (or any other state) is free to experiment in the area of employer-provided health care, that is not the legal world as it exists today. As a matter of law, Section 514(a), as it has been and as it could reasonably be construed, precludes state legislation like the Maryland Act. The U.S. District Court for the District of Maryland decided correctly when it held the Maryland Act to be ERISA-preempted.

As a matter of policy, the Maryland statute is ill-conceived. The Maryland legislature would not, in lieu of the Act, have adopted a politically transparent program (such as a tax surcharge) with similar impact upon lower-income persons. Maryland and other states have far more compelling options for assisting low-income workers including expansion of state earned income tax credits. In the final analysis, Maryland’s Wal-Mart statute is a poorly-designed exercise in political symbolism, not a carefully-crafted response to the urgent problem of health care in America.