

ERISA and Federalism: Limits on State and Local Health Reform

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Abstract

The United States Supreme Court is considering whether to grant a petition to review a case involving the validity of a local ordinance requiring employers to make certain expenditures on employees' health care benefits. In 2008, the Ninth Circuit Court of Appeals held that the ordinance did not violate the provisions of the Employee Retirement Income Security Act (ERISA) that exempt certain employer financed employee health benefits plans from state regulation. The petitioner seeking review in the Supreme Court claims the Ninth Circuit ruling contradicts a 2007 ruling by the Fourth Circuit invalidating a Maryland statute requiring employer expenditures for employee health benefits.

Whether or not the Supreme Court accepts the Ninth Circuit case, it is now time to articulate the purposes of ERISA as a health policy statute. ERISA's purpose must be understood in the context of incremental attempts to contain the costs of health care through private market mechanisms. So understood, the validity of local or state health benefit expenditure mandates under ERISA depends upon the institutional context in which those mandates are imposed and the "choice architecture" chosen by local and state policy makers.

The Employee Retirement Income Security Act of 1974ⁱ ("ERISA") has emerged as an important health policy statute, even though employee health benefits plans, were not the central focus of Congressional debate and action. ERISA created a national system for regulating both employer sponsored retirement plans and "employee welfare benefit plans"ⁱⁱ (including health benefits programs). In a bow to federalism, Congress provided statutory language delineating which matters of health policy were left to the states and which were governed by ERISA "rules of engagement." Interpretation of these statutory provisionsⁱⁱⁱ has given rise to the confusing and often criticized "ERISA preemption doctrine."

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Some scholars^{iv} have identified the ERISA preemption doctrine as an obstacle to state and local governments' recent efforts to deal with the access, cost, and quality conundrum that plagues the American health system. These commentators have framed the issues and established a locution for characterizing state or local health reform measures that masks deeper issues about the role of law and politics in American health policy. For example, several states have tried to deal with the revenue shortfalls in their Medicaid budgets by imposing additional taxes on employers. The large retailer, Walmart,^t was the political bad guy in this reform narrative. The perception that many of its lower wage employees had to rely upon Medicaid for health insurance fueled the image of irresponsible employers "dumping" its part-time workers onto the Medicaid rolls. Reformers considering the validity of these new taxes under the ERISA preemption doctrine labeled these taxes "play or pay" laws. When a federal appellate court invalidated one of these taxes under ERISA^v, we might assume that any new tax on employers related health care is invalid without considering the changing institutional context of health reform^{vi} There may, however, be an opportunity to rethink the framework and locution of ERISA preemption in *Golden Gate Restaurant Association v. City & County of San Francisco*,^{vii} where a different federal appellate court rejected an employer group's challenge to a San Francisco ordinance imposing a tax on employers to help finance a health care access program in the city. The United States Supreme Court is considering whether to grant a petition for certiorari by the employer group.

In 2008, the Ninth Circuit ruled in *Golden Gate* that the San Francisco Health Security Ordinance requiring most employers to spend a minimum amount on employee

health care benefits did not violate ERISA. In doing so, the court distinguished a 2007 ruling from the Fourth Circuit invalidating Maryland's Fair Share Law^{viii} and a district court ruling invalidating Suffolk County's Fair Share for Health Care Act,^{ix} both of which required employers of a certain size to spend a minimum on employee health care. The Ninth Circuit is essentially making an argument that the institutional context of a particular state or local tax on employers makes a difference under ERISA preemption doctrine, at least as the doctrine applies to health care benefits.^x Whichever way the Supreme Court rules on the petition, there may be a major shift in ERISA preemption doctrine with regard to local and state reforms.

Accepting the petition would allow the Court to articulate why the Fourth Circuit view is correct or offer a definitive explanation of how the Maryland statute and San Francisco Ordinance should be distinguished. Alternatively, the Court could deny the petition as a way of indicating that the Ninth and Fourth Circuits' interpretations of ERISA preemption are both correct in the changing institutional environment of health reform in this country. I propose the latter approach, a denial of the petition.

I begin by providing a description of the "institutional context" of the San Francisco Ordinance in Part I. Part II argues that *Golden Gate* can be distinguished from the Fourth Circuit result if the ERISA preemption health cases are characterized as an "institutional experiment" with employer cost containment. Part III proposes that local and state public officials make health policy in different institutional contexts. As a result, particular local officials will offer private employers different incentives and

disincentives. In some cases, local policy makers will decline to offer any specific health care incentives for one of two reasons. First, state and federal officials have already provided the optimal level of incentives and disincentives to private employers in the locale. I hypothesize, for instance, that Boston may be such a locality after the recent Massachusetts health reform.^{xi} Second, there may be no institutional incentives that encourage local officials to even put health reform on the policy agenda, not to mention actually pass any ordinances. In other words, under my framework, even if San Francisco's health reform is found ultimately to be valid under the ERISA preemption doctrine, it is not necessarily a model that other localities could rapidly adopt.

Federal courts using the ERISA preemption doctrine to scrutinize state or local health reforms should analyze both the federal statutory structure and the local and state health policy structure, including the possibility that markets in localities differ. Under the framework I suggest for ERISA preemption, we might begin to characterize the complex policy structure of federal, state and local incentives and disincentives as presenting employers with a "choice architecture."^{xii} Whether the particular range of choices designed by state and local officials is a valid institutional choice^{xiii} is the question of statutory interpretation before courts. Such an approach leaves open a number of empirical and analytical questions that will not be addressed in this paper.

I

The "Institutional Context" for Health Policy Making

Rather than simply ask, “What was the intent?” of the city councilman and mayor who enacted the San Francisco Health Care Security Ordinance in 2006, I propose we ask an alternative question: “What was the institutional context for health policy making in San Francisco at the beginning of the 21st century?” The question I ask determines what “facts” should be salient in the courts’ development of the ERISA preemption doctrine. The approach is more akin to asking, what did the public actors in fact do to the legal landscape, as opposed to what did they say there were doing. What public actors say may in fact influence what they do, but local and state political bodies have proposed many health reforms that have failed to be enacted into law over the past decade.

A. A Medical Home for the Underinsured and Uninsured

In reading the actual documents in the *Golden Gate* litigation, one is immediately struck by the fact that ordinance created the “Health Access Plan,” (HAP) a “city-administered healthcare plan.”^{xiv} This was a network of physicians, the public hospital, and other providers built on the “medical home” model.^{xv} Each enrollee in HAP is assigned to either a primary care physician, nurse practitioner, or physician assistant. The enrollees are entitled to variety of health care services ranging from preventive services and outpatient hospital care to home health care and prescription drug benefits. Enrollees must pay participation fees based on a sliding scale and make copayments for medical visits. These fees do not, of course, cover the full cost of the services provided. The city uses general tax revenues and the employer payments required by the ordinance to cover

the bulk of the costs. Viewing the facts from this perspective, it is apparent that local policy makers focused on access to care for a certain portion of the population.

Assuming, however, that politicians in San Francisco are not more altruistic than the average local law maker, one might ask what institutional forces, both public and fiscal, might have led policy makers to even put the Ordinance on the policy agenda? There are at least three interrelated factors that may have pushed the entire ordinance onto the policy agenda. First, California statutes require that a city/county like San Francisco provide for the care of indigent persons who are incapacitated by disease.^{xvi} At one time, this obligation might have been carried out by a public hospital system, but the statute allows flexibility on how this care can be provided.^{xvii} A system in which the city reimbursed private hospitals for care of the indigent, for instance, would meet this statutory obligation.

Second, Medicaid, a federal and state partnership for financing both out patient and hospital care for a portion of the city's population, was not designed to meet the health care needs of all of those whom the city was obligated to meet. Those ineligible for Medicaid, those unable to afford to pay for private care out of pocket, or purchase health insurance in the private market, were increasingly viewed as without access to health care. By the beginning of the 21st century, there was a "crisis" in the escalation of health care costs that affected all financing mechanisms for health care delivery, including California's form of Medicaid managed care, Medi Cal. By 2006, there were an estimated 82,000 individuals in the city without health insurance coverage.^{xviii}

Third, the only public hospital in the city was absorbing a large share of the uninsured. There are two possible explanations for this disproportionate number of non-paying uninsured patients in the public hospital. On the demand side, it is possible that individuals without health insurance went to the public hospital for health care concerns that could have been more cheaply provided by primary care physicians, nurse practitioners, or physician assistants. This may reflect the practice on the part of some of the city's residents to treat the emergency room as the "safety net" for all health care needs. On the supply side, it is possible that other hospitals and ambulance drivers in the city sent or transferred most indigent patients to the public hospital because of the institutional incentives provided by the Emergency Medical Treatment and Active Labor Act (EMTALA).^{xix} Whatever the reasons for the "red ink" at the public hospital, public officials chose to respond. The medical home concept was thus a way for public officials in the city to lower their health care costs.

The establishment of HAP was thus not simply a result explained by San Francisco having a majority of "liberal" or "blue" voters. Starting with the institutional context in thinking about "the facts" tends to explain why many other cities with "liberal voters" did not even put a city-administered health care delivery plan on the policy agenda in the early part of the 21st century. San Francisco policy makers were able to enact this particular change in health policy while other urban areas with liberal voters were unable to consider such a proposal because this other groups of policy makers were influenced by different structures of the legal landscape and market forces. The next

question in San Francisco was, how to pay for this public program in an era of “no new taxes?”

B. “Fair” Taxing Policies

According to the city’s brief before the Court, the San Francisco Controller’s Office estimated that roughly “90% of the medium and large businesses already provided health insurance to their employees.”^{xx} The problem facing policy makers was to devise a scheme that did not inadvertently provide incentives for these employers to discontinue their coverage. San Francisco varied the impact of the new tax according to how much the employer expended on health care benefits for particular employees.

Some employers—those with relatively generous health benefits plans—would obviously pay nothing and others would be required to pay various amounts of taxes. One can imagine businesses in the City of San Francisco where fulltime employees receive benefits, but part time employees do not, for instance, a hotel. One can also imagine businesses where part-time employees do receive benefits such as Starbucks.^{xxi} Through the various stages of the litigation, the city argued that this flexible tax on employers was similar to other regulations of employers such as minimum wage laws. The city sought to make the actual impact of the ordinance on employers through its allies in the litigation. One of the amicus briefs filed in support of the city’s position in the petition currently before the Court came from a large construction firm that does some business in San Francisco.^{xxii}

This amicus, who provided health insurance to its workers, also supported the city's assumption that the reporting of individual employee information required by the tax imposed few burdens on employers, particularly those with employees in San Francisco and other counties in the area. The amicus claimed that "with modern computer systems" and standard business and accounting practices, keeping track of different wage regulations for employees working in various jurisdictions was "simple."^{xxiii} The presence of this employer, who had an ERISA health benefit plan for its employees, in support of the city is some evidence that the policy makers considered the local "employer market" in designing the tax. In effect the reporting requirements provided a flexible means of employer compliance that was consistent with the overall and diverse regulatory environment in that local metropolitan area. Furthermore, in ERISA locution the tax had no direct influence or relationship to an existing ERISA benefit plan.

The other employer amicus in support of the city's position came from two restaurants.^{xxiv} Their presence on the city's side of the case illustrates first that the plaintiff restaurant association had opposition to its litigation position within its own organization.^{xxv} More important, however, from the Court's institutional position, the restaurants' claims that they were unable to provide health benefits to their employees until the enactment of the ordinance highlights the fact that it had been in operation for a number of years. The Ninth Circuit had overturned an earlier district court decision enjoining the tax under ERISA and allowed the ordinance to go into effect during the

lengthy appeals process.^{xxvi} Both the restaurant owners' brief and the construction firm's brief are explicit about the "politics" involved in disturbing the Ninth Circuit's ultimate ruling upholding the ordinance. Both briefs claim the ordinance allowed employers who wanted to provide health benefits to compete on a level playing field with those employers unwilling to provide health insurance.^{xxvii} More important, the Court is being reminded of the consequences of forcing a local government to find a different financing scheme for a health care delivery system it is mandated to provide by state law.

C. Employee Benefits

What the amicus briefs highlight even more dramatically is that those employers who pay the tax to the city see a direct health care benefit to their employees—i.e., *eligibility* for discounted enrollment fees in HAP, the city's administered health care plan. The restaurant amicus pointed out the advantages of the flexibility for employers since one of them had provided some health benefits to full-time employees but not to part-time employees, until the city instituted HAP. An employer who pays the tax on behalf of any employees is obligated to notify them of their eligibility for discounted enrollment fees, but there is no "mandate" that the employee actually enroll. The net result of the ordinance is that private employers with 20 or more employees, and not-for-profit firms with more than 50 employees, must pay a certain amount for employee health benefits or pay a tax for each employee not covered by the mandated expenditure amount.

II

ERISA Preemption as an “Institutional Experiment”

In *Retail Industry Leaders Association v. Fiedler*,^{xxviii} the Fourth Circuit used the ERISA preemption doctrine to invalidate Maryland’s Fair Share Law requiring employers with at least 10,000 employees to spend a certain amount on employee health benefits. Whether the Fourth Circuit and the Ninth Circuit’s decision in *Golden Gate* are in conflict depends first, on whether the Maryland taxes were imposed in an institutional context significantly different than the one as outlined above, and second on the underlying purpose of the ERISA preemption doctrine. There is near unanimous agreement that health benefits were not the primary focus of Congress’ concern in enacting ERISA. This observation leads many commentators on the ERISA preemption doctrine in health care delivery cases to call for greater clarity from the Court about the purpose or congressional amendment of the statute.^{xxix} I am going to assume, without detailed justification in this paper, that neither Congress nor the current Court will act in response to these criticisms of the ERISA preemption doctrine.

Under my assumption, I begin the analysis of the purpose of ERISA with an institutional question: What was the health care policy and legal landscape in the early 1970s when Congress enacted ERISA? The health policy agenda in the early 1970s was driven by a need to control health care costs through private market mechanisms. The federal Health Maintenance Organization Act of 1973^{xxx} was enacted during the Nixon administration as an early attempt to control costs through federal incentives for restructuring the financing and organization of health care delivery. Even though

managed care did not become a dominant form of financing and delivery of health care until after the failed Clinton reforms, we should not ignore the significance of the incremental reform of HMO legislation during Nixon's abbreviated second term. The political process had produced an alternative to the Democratic Party's goal of universal health care access through incremental health reform after Medicare and Medicaid were enacted in 1965. Nixon's goal was to control health care costs over time by providing enough incentives and disincentives to get 90% of Americans into some type of health maintenance organization.

At least one Justice of the Court has noted the linkage between the HMO Act and the ERISA preemption doctrine in terms of the shared goal of constraints on health care costs through private market forces.^{xxxix} When Congress inserted the language allowing employers to establish employee health benefit plans in the midst of establishing a regulatory structure for employee retirement plans, Congress used the same policy framework it used to enact the HMO statute. One could argue, of course, that this particular policy framework established as a default a broad notion of non-regulation of any ERISA health plan by states. Such a position, however, seems contrary to some, but not all, of the Court's interpretations of the preemption doctrine. I do not need to enter the debate about whether the preemption doctrine is, or normatively should be, narrowly or broadly construed by the Court. Rather, I suggest the Court should treat the statutory text and its subsequent development as an institutional experiment^{xxxix} in health care cost containment by employers.

I call this an institutional experiment because the actual effect of legal intervention into the health care market was, to some degree still is, unknown. For instance, Nixon and his cohort were just starting to realize the fiscal effects of Medicare and Medicaid on state and federal budgets, not to mention the inflationary aspects of Medicare on the private cost of health care. Of course, ideology drives political actors such as presidents, but courts encounter the actual practice that develops out of the legal institutional forces and market forces. Those market conditions, including the political climate surrounding health policy, change over time. Court decisions seem confusing if our metaphor for the federal/state regulation system established by the ERISA preemption doctrine is a clear demarcation between the federal regulatory sphere and the state regulatory sphere.

Under this experimental metaphor for the ERISA doctrine, whether or not a particular state incentive or disincentive is preempted by ERISA depends upon the institutional context in which an employer is asked to respond to the state incentive. The problem with *Fielder* under this view is that the tax expenditures do not operate to continue the experiment on the part of employers. In fact, it could be distinguished on the very narrow ground suggested by the Ninth Circuit that the Fourth Circuit read the statute to apply to only one employer in the state, Walmart®.

III

Public Actors' "Institutional Choices"

The opinions of the Ninth and Fourth Circuits are full of discussions about the range of choices that employers have under the two different health care expenditure requirements. The federalism question from an institutional perspective is what policy tools are available to local and state policy makers. Their choices—the institutional decision to allow state and local political decisions about health policy—are more significant in this age of incremental national health reform or failed national health reform. Whatever happens with the current health care reforms, there will be unresolved health care policy issues that will impact various local communities, particularly urban areas. For instance, the failure of our current efforts to address the issue of health care access for undocumented immigrants could have a major impact on some, but not all, urban areas.^{xxxiii} Some urban communities may have institutional incentives to address these issues either directly or indirectly. The approach chosen by a local community is dependent upon the institutional context, including the market conditions in the employer market and its particular demographics.

The ERISA preemption doctrine forces policy analysts, including judges, to acknowledge that private employers have had a large role in structuring health care delivery and financing in America since at least World War II. The ERISA preemption doctrine is one of several attempts to provide a governance system for our fragmented or broken health system. Greater attention to an institutional analysis of ERISA will help to foster greater understanding of ERISA as a health policy statute.

Of course, America stands out as an anomaly compared to the governance process for organizing and financing the health system in other industrialized nations. America is the only industrial nation attempting to control health care costs, provide access to care, and maintain quality without a governmental or collective mechanism for constraining costs. Our current health care debate should make it painfully obvious why enactment of some form of “universal health care” is not on the policy agenda. The institutional framework I propose for ERISA is a starting point for understanding when local reforms that move towards better access are possible in our complex governance system.

The Bush administration had instructed the Department of Labor to support the employer group in the prolonged *Golden Gate* litigation in the Ninth Circuit in 2007. The Court, early in the current term, asked the Obama administration to give its views on whether the petition should be granted.^{xxxiv} So far, the administration has not provided the Court with any guidance.^{xxxv} The Solicitor General’s delay could be a function of the workload of her newly organized office. On the other hand, it is possible the administration is waiting to see what shape Congressional health reforms take before it responds. Urging the Court to refrain from entering the political fray of health reform through an ERISA preemption ruling would surely be dependent upon the administration’s view of the role of states in the next stages of reform.

ⁱ [29 U.S.C. §§ 1001-1461 \(2006\)](#).

ⁱⁱ 29 U.S.C. § 1002(1).

ⁱⁱⁱ *See* 29 U.S.C. § 1144. The “preemption clause,” § 1144(a) states that ERISA is to “supersede any and all State laws [that] relate to any employee benefit plan....” This is qualified by a “savings clause,” § 1144(b)(2)(A), which provides that ERISA is not to

preempt any state laws regulated “insurance, banking, or industries.” The savings clause is further qualified by the “deemer clause,” § 1144(b)(2)(B), which provides that employee benefit plans cannot be termed to be “insurance” for purposes of the savings clause

^{iv} See, e.g., Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, J. Law Med. Ethics, Fall 2009, Supp. 2, at 86; Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption and Experimentation*, 49 WM. & MARY L. REV. 229 (2007).

^v See, e.g. *Retail Industry Leaders Association v. Fielder*, 475 F. 3d 180 (4th Cir. 2007).

^{vi} As of this writing, the House of Representatives has passed the Affordable Health Care for America Act, H.R. 3962, 111th Congress (passed by House November 7, 2009) and the Senate has passed the Patient Protection and Affordable Care Act, H.R. 3590, 11th Congress (passed by Senate December 24, 2009).

^{vii} 546 F.3d 639 (9th Cir. 2008), *petition for cert. filed*, No. 08-1515 (U.S. June 5, 2009).

^{viii} *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180 (4th Cir. 2007).

^{ix} *Retail Indus. Leaders Ass’n v. Suffolk County*, 497 F. Supp.2d 403 (E.D.N.Y. 2007).

^x *Whether Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), invalidating a state statute directing how an ERISA retirement plan should be divided in a divorce, states a general theory of ERISA preemption applicable to the health policy questions addressed here will be addressed in other works.

^{xi} An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts Ch. 58. Scholars have question whether the Massachusetts Act could survive an ERISA challenge. See, e.g. Jacobson, *supra* note 4, at 93-94; David A. Hyman, *The Massachusetts Health Plan: The Good, the Bad, and the Ugly*, 55 KAN. L. REV. 1103, 1110 (2007).

^{xii} See RICHARD H. THALER & CASS. R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008) (describing how the context in which humans make decisions as a “choice architecture” that can heavily influence decision making). Sunstein is currently the Administrator of the White House Office of Information and Regulatory Affairs. See, http://www.whitehouse.gov/omb/infoрег_administrator/.

^{xiii} See NEIL K. KOMESAR, *LAW’S LIMITS: THE RULE OF LAW AND THE SUPPLY AND DEMAND OF RIGHTS* (2001) (describing how law is not simply a matter of abstract principles but how courts make decisions in the context of political institutions, markets, and communities.) See also, Larry I, Palmer, *What is Urban Health Policy and What’s Law Got to Do With it?* 15 Geo. J. Poverty Law & Pol’y, 635 (Fall 2008) (using Komesar’s institutional analysis to distinguish health policy from law.)

^{xiv} Mazda K. Antia, Kathlynn Bulter Polvino, Heather C. Meservy, and Payal Patel Cramer, *Overcoming ERISA as an Obstacle: The Ninth Circuit’s Approval of San Francisco’s Fair Share Legislation*, 2 Journal of Health & Life Sciences Law 115, 123 (July 2009)

^{xv} See Position Paper, Michael Barr, American College of Physicians, *The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care* (2006), available at http://www.acponline.org/advocacy/where_we_stand/policy/adv_med.pdf.

^{xvi} Cal. Welf. & Inst. Code § 17000-17001 (2009); Cal. Health & Safety Code § 1447 (2009).

^{xvii} See Cal. Health & Safety Code §§ 1440-1498(2009) (authorizing counties to adopt different means, including county hospitals, to fulfill its obligation to provide medical care. See also *Hunt v. Superior Court*, 987 P.2d 705 (Cal. 1999) (“[T]his provision confers upon a county broad discretion to determine eligibility for – and the types of – indigent relief....”).

^{xviii} Brief for the Respondent in Opposition, p. 1

^{xix} 42 U.S.C.A. § 1395dd. See also Thomas A. Gionis, Carlos A. Camargo, Jr., and Anthony S. Zito, Jr. The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA), 52 AM. U. L. REV. 173 (2002) (describing the incentives that lead to patient dumping—the refusal to treat or transfer to another hospital of a patient for non-medical reasons, usually inability to pay—and the persistence of patient dumping in spite of EMTALA and other efforts to limit the practice).

^{xx} Respondent’s Brief in Opposition to the Petition for Certiorari in the United States Supreme Court, *Golden Gate Rest. Ass’n v. City & Count of San Francisco*, 130 S. Ct. 357 (order filed Oct. 5, 2009) page 8

^{xxi} http://news.starbucks.com/article_display.cfm?article_id=225

^{xxii} Brief in Opposition to the Petition for Certiorari in the United States Supreme Court filed by Amicus Curiae Nibbi Brothers Associates, Inc, *Golden Gate Rest. Ass’n v. City & Count of San Francisco*, 130 S. Ct. 357 (order filed Oct. 5, 2009)

^{xxiii} *Ibid.* p. 22

^{xxiv} Brief in Support of the Respondents on the Petition for Certiorari in the United States Supreme Court filed by Amicus Curiae Zazie and Medjool Restaurants, *Golden Gate Rest. Ass’n v. City & Count of San Francisco*, 130 S. Ct. 357 (order filed Oct. 5, 2009)

^{xxv} *Ibid.* p. 1. One of the restaurant was a member of the petitioner, Golden Gate Restaurant Association and the other was not.

^{xxvi} *Golden Gate Rest. Ass’n v. City & County of San Francisco*, 512 F. 3d. 1112, 1119-23 (9th Cir, 2008)

^{xxvii} *Supra* note 3 at 19.

^{xxviii} 475 F. F. 3d 180 (4th Cir. 2007)

^{xxix} See, Jacobson, *Supra* note 4.

^{xxx} 42 USC 300(e)

^{xxxi} *Rush Prudential HMO, Inc v Moran*, 536 U.S. 355,368 (2002) (holding a state statute regulating the method an ERISA health plan decided claims for benefits not exempt under ERISA)

^{xxxii} Larry I. Palmer, “Research on Human Subjects as a Paradigm for Teaching,” 16 *American Journal of Law Medicine & Ethics*, Issues 3-4, pp. 183-189 (1989, published on line 2007)

^{xxxiii} “Hospital Falters as Refuge for Illegal Immigrants, *New York Times*, November 20, 2009

^{xxxiv} *Golden Gate Rest. Ass’n v. City & Count of San Francisco*, 130 S. Ct. 357 (order filed Oct. 5, 2009) (inviting the Solicitor General to file a brief expressing the views of the United States). An updated docket of the filings and orders in this case can be found at <http://origin.www.supremecourtus.gov/docket/08-1515.htm>.

^{xxxv} The Solicitor General is given no specific time limit in responding to such an invitation. Historically, the government has often taken ninety days or more to respond. See Jack C. Auspitz et al., *U.S. Supreme Court Invites Solicitor General's Views on Whether to Grant Review of Important Securities Fraud Case*, Jan. 19, 2010, <http://www.mondaq.com/unitedstates/article.asp?articleid=92108>.