A world in which most people have medical insurance that requires third parties to pay for “medically necessary” treatment as determined, ultimately, by the judiciary, but in which a significant segment have neither insurance, nor money, nor a right to government care is a recipe for trouble. The existence of the benefit schemes and private insurance, coupled with growing international norms on the subject, fosters the sense that at least minimal health care is a positive right, and the medical industry that grows up in reliance on the private insurance and public benefit regimes both internalizes and fosters that norm as well.

And yet, the cost of implementing such a positive right to virtually all who live within a nation is rather daunting. Even the limited prescription drug benefit enacted by the federal legislature recently is estimated to cost at least $50 billion per year. And this plan provides only limited prescription drug benefits to only a small segment of the population with various deductibles, co-pays and donut holes used to both minimize federal expense and deter against excessive consumption. A back of the envelope computation shows that at $2,000 a person, a conservative estimate of what it costs to deliver current levels of health care in the United States, and 40 million uninsured persons, a similar conservative estimate, the cost of extending care to the uninsured would, at least at first blush, amount to some $80 billion per year. (A more elaborate computation of the net costs of such a program may be found at http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.250v1/DC1) And, while some or all of this expense might be offset by various other forms of savings – fewer trips to the emergency room, higher short term and long term productivity, federal politicians have not yet shown the courage to ask taxpayers to wait for these benefits to materialize as they raise taxes to pay for the immediate costs. Nor have they been oblivious to the fact that the ultimate bill might be an order of magnitude higher as various current private payors for medical care began to question continuing to pay for health insurance when some sort of general federal entitlement exists.

Over the past several years, states and some municipalities have attempted to bypass the resulting federal stalemate on the subject by enacting a variety of laws intended to increase access to health care. Yet they have undertaken the same sort of political computation as their federal confreres. Rather than impose some sort of general tax and either provide care itself or finance some system of more universal health care, the states have tended to approach the matter indirectly by creating obligations on some classes of employers. One of the more popular approaches to the matter, and one pushed by the AFL-CIO labor federation, are Fair Share Plans, which generally require large employers either to provide limited health care benefits or (if they are particularly spiteful) to pay the equivalent amount to a government fund. See Kris Hudson, Maryland Votes to
In July, 2006, a federal district court in *Retail Industry Leaders Association v. Fielder*, 2006 WL 20076654 (D. Md. 2006), struck down one of the more recent attempts in this direction, that of Maryland, as violating a statutory right of homogenized treatment created by ERISA. Maryland had enacted the “Fair Share Health Care Fund Act,” that required non-governmental, for-profit employers of more than 10,000 employees within the state (there were only three) to pay the state any positive difference between 8% of the wages paid to employees in the state and the amount the employer spent on health care on behalf of those employees. As Maryland legislators knew, Wal-Mart, which has long been subject to criticism for its failure to provide much in the way of health benefits to its employees\(^1\) was the only employer in the state that would have to pay. Because most states have no such 8% requirement, the court concluded that the requirement would violate “ERISA's fundamental purpose of permitting multi-state employers to maintain nationwide health and welfare plans, providing uniform nationwide benefits and permitting uniform national administration.” The court, distinguished recent United States Supreme Court cases such as *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) and *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997), in which the Court appeared to have been more tolerant of state laws affecting ERISA plans, as involving far more tangential blows than Maryland’s Fair Share Health Care Fund Act.

As interesting as the arguments the court accepted were those that it rejected. The court rejected arguments that the federal Tax Injunction Act stripped the court of jurisdiction to issue an injunction against enforcement of the statute, which required the court to rule that the requirement that employers pay the state was not, in fact, a “tax.” The court also rejected an argument that the Equal Protection clause of the United States constitution barred Maryland from creating an obligation that, in effect, hurt only one company. Although the court noted that “the legislation enacted by the General Assembly may well have been more thoughtfully considered (and the members of the Assembly more politically accountable) if it had subjected more than a single employer to its spending requirement,” and although the court expressed some skepticism about the sense of drawing a line at 10,000 employees – no evidence existed in the legislative record to support that particular line – it was unwilling to find any protection under the Equal Protection clause for even intentional targeting of groups not seen, like gay people and the mentally retarded, as politically vulnerable. And despite the attainted imposed by Maryland, Wal-Mart was unwilling to liken itself to either of these groups.

The *Fielder* case brings together many strands of contemporary health finance law and policy. It points to the weakness of the Equal Protection clause of the United States Constitution in challenging laws developing curious methods for financing even limited assumptions of responsibility to provide health care to the poor. It points again to the

\(^1\) A website devoted to such criticism may be found at [http://walmartwatch.com/fairshare](http://walmartwatch.com/fairshare).
instability of using the quicksand of ERISA’s vague text and essentially useless legislative history to resolve major issues of health policy or the role of states in creating entitlements to health care. It points to the desperation of the states and municipalities in addressing or appearing to address the current inequality in health care – the statute’s most likely consequence (assuming it withstood legal challenge) would be some sort of corporate fragmentation of Wal-Mart within Maryland, some sort of exit of Wal-Mart from the state, some yet greater substitution of capital or off-shore labor from domestically employed labor, or some sort of clever reduction in other forms of compensation paid by Wal-Mart to its workforce (Maryland did not repeal the law of supply and demand). And it points to the political weakness of more aggressive calls for reform either at the federal or state level. Why would people working for companies of 9,000 employees have any lesser moral or economic interest in at least minimal health insurance than employees at companies with a few more workers? And if there were a right to health care, a requirement that Wal-Mart pay about $1,000 a year for health care would be unlikely to implement what many would consider a particular full instantiation of that right. Until Americans are willing to face up more honestly both to the costs of its confusion about what sort of positive right to health care should exist, and the economic costs of creating such a right, we should expect many more actions like those in Maryland and many more efforts of courts to untangle their legitimacy within the current health law thicket.

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