No. 08-1515

In The Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,

Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO,

Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION ("SEIU"), LOCAL 1021; SEIU UNITED HEALTHCARE WORKERS-WEST; and UNITE HERE! LOCAL 2,

Intervenors/Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR RESPONDENT IN OPPOSITION

PAUL R.Q. WOLFSON
WILMER CUTLER PICKERING HALE AND DORR LLP
1875 Pennsylvania Avenue, NW
Washington, D.C. 20006
Telephone: (202) 663-6390
Facsimile: (202) 663-6363

DENNIS J. HERRERA
City Attorney
WAYNE SNODGRASS
VINCE CHHABRIA
Counsel of Record
CHRISTINE VAN AKEN
Deputy City Attorneys
City Hall, Room 234
One Dr. Carlton B. Goodlett Place
San Francisco, CA 94102
Telephone: (415) 554-4674
Facsimile: (415) 554-4747

Attorneys for Respondent

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTION PRESENTED

San Francisco's universal health care ordinance contains two interlocking components: a comprehensive public health care program available to all uninsured residents at sliding scale fees, and a general health care spending requirement for medium and large employers. Employers may comply with the spending requirement either through their own health care plans, or by paying into the public program. If employers choose the public option, their employees receive a substantial discount on the health care services available through that program. The question presented is:

Does ERISA preempt the portion of San Francisco's universal health care ordinance that imposes a general health care expenditure requirement on medium and large employers, where every employer may readily comply without adopting an ERISA plan or altering an existing plan, and where the option of paying into the public program is a rational choice for employers rather than a penalty?

TABLE OF CONTENTS

TABLE OF CONTENTS – Continued

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

STATEMENT

A. The Health Care Security Ordinance

In 2006, San Francisco was in the midst of a health care crisis. An estimated 82,000 people were without coverage. *See* Resp. App. 11. Tens of thousands more only had coverage under bare-bones "safety-net" programs, such as Medicaid, that provided limited care to indigent residents. *Id.* Not only did this threaten the health and well-being of many San Francisco residents; it put tremendous strain on the taxpayers, who were forced to bear the cost when the uninsured used public hospital emergency rooms for preventable illness or injury. *Id.* at 28.

To address this crisis, San Francisco's Board of Supervisors enacted the Health Care Security Ordinance ("HCSO" or "ordinance"). The ordinance has two interlocking components – a public health care program, and an employer health care spending requirement.

The public program is operated by the City's Department of Public Health ("DPH"). Its primary feature is the Health Access Program ("HAP"), which delivers health care to participants from a network of public and private providers. Pet. App. 113a (S.F., Cal., Admin. Code § 14.2(a) (2007)).[1] The HAP assigns

---

[1] The City has changed the name of the program from the HAP to "Healthy San Francisco." For purposes of litigation, the parties have continued to use the name contained in the ordinance.

a primary care physician, nurse practitioner or physician assistant to each participant. Among the specific services provided are preventive care, inpatient and outpatient hospital services, diagnostic and laboratory services, radiological services, mental health services, home health care, and prescription drug benefits. Pet. App. 114a (Admin. Code § 14.2(f)). The value of this care is substantial – DPH estimated that in 2008 it cost the City an average of $261 per participant per month to provide. Resp. App. 13.

The HAP is funded primarily by City tax dollars and partly by employer payments. It is available to uninsured San Francisco residents, regardless of whether they are employed. Enrollees must pay quarterly participation fees on a sliding scale, and must make co-payments for medical visits.

The other component of the ordinance is a mandate that medium and large businesses make minimum health expenditures on behalf of employees who work more than a specified number of hours. Specifically, in 2009, private employers with 20-99 employees, and nonprofit employers with 50 or more employees, must spend $1.23 per hour on behalf of any employee who has been employed for 90 days and works more than eight hours per week. Private employers with 100 or more employees must spend $1.85 per hour for each such employee. The requirement is capped at 40 hours per week. Pet. App. 111a-12a (Admin. Code § 14.1(b)(8), (10); Pet.

App. 138a (S.F., Cal., Office of Labor Standards Enforcement Reg. 5.2(A)(1)).

According to studies compiled by the San Francisco Controller's Office, roughly 90% of medium and large businesses already provided health insurance to their employees when the ordinance was enacted. Resp. App. 15. And the average monthly insurance premium in California at that time was $379. *Id.*

To comply with the mandate, employers may spend money through their own health care plans, or make payments to the City on behalf of their workers. *Id.* They may also fulfill the expenditure obligation through a combination of methods. For example, an employer may prefer to keep its full-time employees in a private ERISA plan while selecting the public option for its part-time employees.

The program is structured so that, if an employer chooses the city payment option, it need only write a check, and all employees on whose behalf payment is made are eligible to participate in the City's program. Contrary to petitioner's representation, the employer does not "enroll [its] employees with the City." Pet. 10. The employer simply pays the City on behalf of specified workers, and notifies the workers that it has done so. Pet. App. 144a (OLSE Reg. 7.2(A)(5)). The rest (enrollment, the type of care provided,

copayments) is purely between the City and the individual.[2]

Employees who qualify for HAP membership are, if their employers choose to satisfy the spending requirement by paying the City, entitled to enroll in the program at a 75% discount on the quarterly participation fees they would otherwise be required to pay. Resp. App. 53-54 (DPH Reg. 7(f)). As discussed more fully below, the result is that, when an employer pays the City, the employer knows its workers will be eligible for comprehensive care at a far lower cost than what it would have to pay for private insurance.

The City also adopted two regulatory provisions – unmentioned by petitioner – that facilitate compliance for large, multijurisdictional employers. The first may be utilized by employers that provide traditional health insurance to their workers, such as Kaiser or Blue Shield. It allows these employers to establish compliance without keeping track of the health care dollars spent on each individual employee, and without making any separate calculations for their San Francisco employees. Pet. App. 141a (OLSE Reg. 6.2(B)(1)). An employer that purchases

---

[2] Individuals who work in San Francisco but live elsewhere do not qualify for HAP participation, but the City uses employer payments to provide medical reimbursement accounts for such individuals. They may draw from their accounts to obtain reimbursement for medical expenses, including payments of health insurance premiums. Pet. App. 110a, 114a-15a (Admin. Code §§ 14.1(b)(7), 14.2(g)); Resp. App. 55 (DPH Reg. 7(g)(i)).

insurance for its employees in San Francisco and in other parts of the country need only divide its total payments to the insurance company for all those employees by the total number of employees. Assuming the amount per employee is greater than the spending obligation (and private health insurance is far more expensive than the spending obligation), this establishes compliance.

The second regulatory provision allows employers that operate "self-insured" plans (through which the employer bears the risk of employee health care costs on its own rather than paying an insurance company a set rate to bear that risk) to establish compliance in similar fashion. It provides that such employers comply "if the preceding year's average expenditure rate per employee meets or exceeds the applicable expenditure rate . . . for that employer." Pet. App. 141a (OLSE Reg. 6.2(B)(2)). Accordingly, an employer with a self-insured plan may establish compliance simply by showing that it has spent a certain amount per employee on a plan-wide basis.

The medium and large employers subject to the ordinance must also keep records. These records are generally already kept in the normal course of business, and employers are not "required to maintain such records in any particular form." Pet. App. 116a. Once per year, employers must file a one-page report with the City, identifying the total amount paid for health care and the manner in which the money was spent. Pet. App. 144a (OLSE Reg. 7.3).

Since the HCSO became fully operational in January 2008, San Francisco has taken great strides towards the achievement of universal health care. In less than 1½ years, the number of residents without health coverage dropped from 82,000 to fewer than 23,000, and that number continues to go down. Resp. App. 25. Following enactment of the ordinance, emergency room visits at San Francisco General Hospital dropped almost seventy percent in one year – from 29,976 to 8,944. *Id.* at 28.

B. Procedural History

Petitioner filed suit in the Northern District of California, alleging that the Employee Retirement Income Security Act of 1974 ("ERISA") preempts the health care spending requirement. The district court granted summary judgment for petitioner, reasoning that the ordinance was "designed to act immediately upon, and cannot operate successfully without the existence of [ERISA] plans." Pet. App. 93a. At the same time, however, the court rejected petitioner's contention that monetary payments by employers to the City themselves create a "*de facto* ERISA plan." Pet. App. 94a.

The Ninth Circuit granted the City's application for a stay of the district court's ruling. The court ruled that, given the availability of a non-ERISA compliance option for every type of employer (namely, payment to the City), the district court was wrong to conclude that the ordinance acts immediately upon

ERISA plans or interferes with plan uniformity. *Golden Gate Rest. Ass'n v. City & County of San Francisco*, 512 F.3d 1112, 1119-23 (9th Cir. 2008). The court noted that legal requirements like San Francisco's – that "only relate[ ] to ERISA plans at the election of an employer" – are regularly upheld against ERISA preemption challenges. *Id.* at 1122 (quotations omitted). The court also concluded that the balance of hardships tipped in favor of the City, and that the public interest weighed in favor of a stay pending appeal. *Id.* Petitioner filed an application to this Court to lift the Ninth Circuit's stay order, which was denied by the Circuit Justice.

After the parties briefed and argued the case on the merits, the Ninth Circuit reversed the district court. This time, petitioner and its allies focused on the argument that an employer actually creates an ERISA plan when it writes a check to the City, thereby leaving employers with no non-ERISA means for complying with San Francisco's requirement. The Ninth Circuit rejected this argument, determining that the city payment option lacks most *indicia* of an ERISA plan. The court observed that the employer's obligations under the city payment option "do not run the risk of mismanagement of funds or other abuse," which was the original concern that led to ERISA's passage. Pet. App. 20a. It observed that the HAP is a government entitlement program, funded primarily by taxpayer dollars, that is available to residents regardless of employment status. Pet. App. 24a-25a. And the court described the key differences between

the city payment option and an employer's purchase of health insurance from a third party, which does involve the creation of an ERISA plan. *Id.* at 26a.

Petitioner also persisted in the argument that, even if payments to the City do not create an ERISA plan, the spending requirement was preempted because it had an improper "connection with" ERISA plans. The court rejected this argument, explaining that the existence of the city payment option meant no employer was required to adopt an ERISA plan, or to provide specific benefits through an existing ERISA plan. Pet. App. 29a. The court also rejected the argument that the HCSO has a forbidden "reference" to ERISA plans, observing that "[w]here a law is fully functional even in the absence of a single ERISA plan . . . as it is in this case, it does not make an impermissible reference to ERISA plans." Pet. App. 36a.

Petitioner sought en banc rehearing, which was denied. Petitioner then filed an application to this Court for a stay pending a petition for certiorari, which was also denied.

ARGUMENT

The Court of Appeals correctly upheld San Francisco's program, because ERISA does not preempt local requirements that give employers a reasonable option for complying that does not involve the adoption or alteration of an ERISA plan. The

option to pay the City is a reasonable choice for employers, and it does not create an ERISA plan.

The city payment option is reasonable, indeed attractive, because the employers' payments make their workers eligible for comprehensive health services, funded primarily by City tax dollars, for far less than the employers would have to pay for comparable benefits on the private market. As such, this case is clearly distinguishable from *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007), which struck down a Maryland law that imposed a bare penalty on Wal-Mart for failing to provide an adequate ERISA plan for its employees.

Nor does the employer create an ERISA plan by exercising the city payment option. This arrangement neither meets the statutory definition of such a plan nor implicates ERISA's central concern – ensuring that benefits promises by private employers to their employees are kept. As the Ninth Circuit explained in detail, writing a check to the City on behalf of specified employees is not remotely analogous to third-party health insurance contracts, which *are* ERISA plans.

At the end of the day, petitioner's argument rests on a faulty premise: that ERISA immunizes employers from being required to spend money in areas, like health care, mentioned in the ERISA statute. As this Court has already explained, ERISA preemption protects only plan uniformity for employers, not general expenditure uniformity.

Because the ordinance in no way interferes with plan uniformity, the Ninth Circuit's ruling that it is not preempted is consistent with this Court's ERISA preemption jurisprudence.

This case is the wrong vehicle, at the wrong time, to consider an employer's claim that ERISA preempts general health care spending requirements. Petitioner presented no evidence that the city payment option is not a rational choice for employers. Nor did it present evidence that the ordinance, even if replicated elsewhere, would impose anything but a *de minimis* administrative obligation on employers. Indeed, the only evidence in the record on these issues contradicts petitioner's claims.

Nor is there any immediate threat that numerous similar laws will sprout up throughout the country, particularly with Congress considering federal health care reform legislation. And the serious possibility that federal legislation will moot the ERISA preemption issue in this case weighs heavily against the Court granting certiorari now. Finally, if federal legislation is not enacted, and if other jurisdictions were then to enact laws similar to San Francisco's in the future, this Court would have the opportunity to address the arguments presented by petitioner and its allies at that time, and on a better record.

I. THERE IS NO CONFLICT WITH THE FOURTH CIRCUIT.

There is widespread agreement that ERISA does not preempt a local requirement if employers have a reasonable non-ERISA means to comply with that requirement. *See, e.g., Keystone Chapter, Associated Builders & Contractors v. Foley*, 37 F.3d 945, 960 (3d Cir. 1994) ("[w]here a legal requirement may be easily satisfied through means unconnected to ERISA plans, and only relates to ERISA plans at the election of an employer, it affects employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan") (internal quotations, citations and brackets omitted). *See also Fielder*, 475 F.3d at 193 (state laws that "do not bind the choices of employers or their ERISA plans [are] generally not preempted"); *WSB Elec., Inc. v. Curry*, 88 F.3d 788, 795 (9th Cir. 1996) ("nothing in California's scheme requires the establishment of a separate benefit plan in order to comply with the state law. California's statute does not require public works contractors to modify their benefits plans at all").

The above rule is grounded firmly in this Court's precedents, which make clear that while ERISA preempts laws that dictate employer choices about employee welfare benefit plans, it does not preempt generally applicable laws that merely influence choices with respect to ERISA plans. Thus, ERISA prevents states from dictating *which benefits* must be contained in plans. *See, e.g., Shaw v. Delta Air Lines,*

Inc., 463 U.S. 85, 96-97 (1983) (striking down law that required plans to include pregnancy benefits). It prevents states from forcing employers to *adopt* ERISA plans in the first place. *See, e.g.*, *Standard Oil v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1980), *summarily aff'd*, 454 U.S. 801 (1981) (striking down Hawaii law that required employers to adopt ERISA plans with specified benefits). And it prevents states from dictating *who* must benefit from ERISA plans. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (state law preempted because it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status").

In contrast, ERISA does not preempt health care surcharges that exert a strong influence on decisions about ERISA plans. *See N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659-60 (1995). It does not preempt imposition of a generally applicable tax upon facilities owned by ERISA plans. *De Buono v. NYSA-ILA Med. & Clinical Services Fund*, 520 U.S. 806, 816 & n.16 (1997). And it does not preempt state laws that give powerful incentive to ERISA apprenticeship programs to seek regulatory approval from the state, and to make the changes necessary to obtain such approval, as long as the laws do not force them to do so. *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 332-33 (1997).

Obviously, if employers may readily comply with a requirement without adopting or altering ERISA plans, such a requirement does not dictate choices

with respect to plans. As set forth below, the Fourth and Ninth Circuits merely applied this well-established principle in the specific context of health care spending, and reached consistent results.

Fielder involved a preemption challenge to Maryland's Fair Share Act, which provided that any Maryland for-profit employer with more than 10,000 employees that does not spend up to 8% of its payroll on health insurance (*i.e.*, Wal-Mart) must make up the deficiency by paying it to the Maryland Secretary of Labor. 475 F.3d at 184. Wal-Mart's employees would not receive any benefits, services, or cost savings in return for such payments. *Id.* at 193.

The Fourth Circuit held that this law effectively required Wal-Mart to alter its ERISA plan because no rational employer would choose to pay the money to the State when the employer could instead increase health care spending in a manner that benefited its employees:

> An employer would gain from increasing the compensation it offers employees through improved retention and performance of present employees and ability to attract more and better new employees. In contrast, an employer would gain nothing in consideration of paying a greater sum of money to the State. Indeed, it might suffer from lower employee morale and increased public condemnation.

> In effect, the only rational choice employers have under the Fair Share Act is to *structure their ERISA healthcare benefit plans* so as to meet the minimum spending threshold. The Act thus falls squarely under *Shaw*'s prohibition of state mandates on *how employers structure their ERISA plans*.

Id. at 193-94 (emphasis added).

As the Ninth Circuit explained, San Francisco's ordinance, "[i]n stark contrast to the Maryland law, . . . offers employers a meaningful alternative that allows them to preserve the existing structure of their ERISA plans." Pet. App. 38a-39a. Workers whose employers comply through payments to the City, rather than by establishing or altering ERISA plans, receive "tangible benefits" in return. *Id.*

Highlighting the reasonableness of the city payment option, almost nine hundred medium and large businesses selected it in the first 1½ years of its existence. Resp. App. 33. That so many employers have selected this option is not surprising, since it allows employers to avoid the inconvenience of setting up their own ERISA plans, while knowing that their workers will receive comprehensive health

coverage from the City at a price far lower than it would cost the employers in the private market.[3]

In short, the option to pay the government in *Fielder* was a penalty that no rational employer would choose. The city payment option here is not a penalty, because it gives employers a meaningful, non-ERISA compliance alternative that allows them to maintain plan uniformity. San Francisco's ordinance, in other words, is utterly indifferent to whether an employer has an ERISA plan. Thus, under the Fourth Circuit's analysis, an ordinance like San Francisco's would survive a preemption challenge. While the Fourth Circuit concluded that Maryland's law "directly regulat[ed] the structuring or administration of an ERISA plan," 475 F.3d at 192, it could not have made the same statement about the HCSO. The two decisions operate in harmony, and they are both consistent with established ERISA precedent from other contexts.

---

[3] The City presented unrebutted evidence in the district court that the health benefits received by employees from the City are extraordinarily generous in relation to the amount paid by the employer, and in comparison to the amount the employer would be required to pay on the private market. The average insurance premium in California was $379 per month when the ordinance took effect. In contrast, for a medium-sized employer with an employee who works 20 hours per week, the employer could satisfy its spending obligation in 2008 by paying the City $ 93.60 per month, even though it would cost the City much more than that to provide the care. In short, the city payment option gives employees a HAP membership that provides comprehensive health services at pennies on the dollar for the employer.

Notwithstanding this, petitioner claims a circuit conflict based on the Fourth Circuit's discussion of an issue that was not presented to, or considered by, the Ninth Circuit. Specifically, after holding that the option of paying the government was nothing more than a penalty that forced Wal-Mart to alter its ERISA plan, the Fourth Circuit turned to Maryland's alternative argument that Wal-Mart had other, private non-ERISA alternatives for complying. According to Maryland, Wal-Mart could satisfy the spending requirement through the creation of on-site medical clinics or Health Savings Accounts. The court rejected this argument on the ground that the purported alternatives were unrealistic. 475 F.3d at 196. And *then* the court observed that even if Wal-Mart could avail itself of these options, they would necessarily also produce a change in the company's ERISA plan:

> If Wal-Mart were to attempt to utilize non-ERISA health spending options to satisfy the Fair Share Act, it would need to coordinate those spending efforts with its existing ERISA plans. For example, an individual would be eligible to establish a Health Savings Account only if he is enrolled in a high deductible [ERISA] health plan. *See* 29 U.S.C. § 223(c)(1). In order for Wal-Mart to make widespread contributions to Health Savings Accounts, it would have to alter its package of ERISA health insurance plans to encourage its employees to enroll in one of its high deductible health plans. From the employer's perspective, the categories of ERISA and non-ERISA healthcare spending

> would not be isolated, unrelated costs. Decisions regarding one would affect the other and thereby violate ERISA's pre-emption provision.

Id. at 196-97. This is not, as petitioner asserts, an alternative holding by the Fourth Circuit that *any* spending mandate in the health care area must be preempted – *i.e.*, that every conceivable non-ERISA compliance option would become entangled with ERISA plans and necessarily interfere with ERISA plan uniformity. It is a rejection of the specific arguments presented by Maryland.[4]

Finally, the implications of a rule preventing local governments from imposing any general health care spending requirement on employers show that the Fourth Circuit could not have intended to adopt such a rule. San Francisco's ordinance goes out of its way to avoid giving employers an incentive to adopt or alter ERISA plans. If, instead, San Francisco imposed a payroll tax on employers to fund a comprehensive public health care program *without regard* to whether employers already have health care plans (that is, without giving employers credit for the health care spending they already make), this

---

[4] Petitioner omits the sentences from the above passage which show that the Fourth Circuit was addressing Maryland's specific argument about the non-ERISA compliance options it offered. As Judge William Fletcher pointed out in his opinion concurring in the denial of rehearing en banc, the eight dissenting judges from the Ninth Circuit did the same thing. Pet. App. 45a-46a.

would create a significant incentive for employers to drop their ERISA plans, to avoid spending substantial sums on health coverage that their employees could instead obtain for free. Nobody could reasonably argue that such a payroll tax would be preempted. It would be ironic, then, if ERISA were held to preempt a law that imposed far fewer incentives with regard to plans. Given the backwards legal regime that would result from the broad rule that petitioner ascribes to *Fielder*, there is no basis for concluding that the Fourth Circuit intended to adopt it.[5]

II. THERE IS NO CIRCUIT CONFLICT ON WHETHER PAYMENTS TO THE CITY INVOLVE THE CREATION OF AN ERISA PLAN.

Petitioner and some *amici* also argue that the Ninth Circuit created a conflict by rejecting the argument that when an employer opts to comply with the HCSO by writing a check to the City, this itself

---

[5] As discussed by the Brief of *Amicus Curiae* Nibbi Bros. Associates, Inc., courts have reached the same conclusion about the many prevailing wage laws that allow employers to comply in part by providing ERISA benefits to their employees. If ERISA preempted prevailing wage laws that gave employers credit for ERISA spending, while leaving undisturbed prevailing wage laws that refused to give credit for ERISA spending, this would incent employers to drop ERISA plans, which is precisely the opposite of what the preemption provision intended. Petitioners seek a result that would disturb the settled understanding among the circuits that prevailing wage laws with benefits components are not preempted.

involves the creation of an ERISA plan. But no other appellate decision even considers whether a public payment option is an ERISA plan. Accordingly, to create the illusion of a conflict, petitioner and its allies rely on cases which hold that an employer creates an ERISA plan when it contracts with a health insurance company to provide health care to its workers. *See, e.g.*, *Brundage-Peterson v. Compcare Health Servs. Ins. Corp.*, 877 F.2d 509, 511 (7th Cir. 1989). They attempt to analogize these insurance contracts to the city payment option, and contend a circuit conflict exists because the Ninth Circuit rejected the analogy. That is not a real conflict. And the Ninth Circuit was right to reject the analogy, which is inapt, is contrary to the purposes of ERISA, and would, if adopted, create serious problems in ERISA preemption law.

ERISA defines an "employee welfare benefit plan" as "any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise," specified benefits. 29 U.S.C. § 1002(1). The specified benefits include, among others, vacation, disability, unemployment, severance, and, of course, medical benefits. *Id.*

In *Massachusetts v. Morash*, 490 U.S. 107 (1989), this Court explained that because the reach of the above definition of an employee welfare benefit plan is – like the preemption provision – potentially limitless, the determination whether a particular

arrangement is the type of "plan" that falls within ERISA's ambit must be made with reference to "'the provisions of the whole law, and to its object and policy.'" *Id.* at 115 (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 51 (1987)). Applying this principle, the Court in *Morash* determined that vacation benefits paid out of general assets did not present the types of risks that Congress intended to address when it enacted ERISA and, therefore, that it would not read the statute to encompass such an employer policy to pay vacation benefits. *Id.*

Here, an examination of ERISA's "object and policy" demonstrates why the Ninth Circuit was right to reject petitioner's analogy to an insurance contract. While petitioner and its *amici* paint ERISA as a law whose central purpose is to preserve some undefined "uniformity" for employers, in actuality the statute's "primary concern" is "with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits . . . " *Morash*, 490 U.S. at 115 (internal citations omitted). *See also* 29 U.S.C. § 1001(b). In other words, the primary purpose of ERISA is to ensure that private employers' benefits promises to their employees are kept.

These concerns are clearly implicated by an employer's promise to provide health insurance to its employees, because under this arrangement the employer remains ultimately responsible for "providing" the benefits. 29 U.S.C. § 1002(1). The employer, when negotiating the health insurance contract, gives shape to the plan by deciding, for

example, which treatments will be covered or how claims will be processed. And if the insurance company does not fulfill its contractual obligation to deliver the contemplated benefits to the employees, the employer, as an ERISA fiduciary, can sue the insurer to make sure that the employer's promise to the employees is kept. *See* 29 U.S.C. §§ 1132(a)(2), (3).

As the Ninth Circuit explained, with the city payment option, "[t]he employer never negotiates or signs a contract with the City, and the employer has no control over the City's coverage decisions. When the City administers the HAP, it does not act as the employer's agent entrusted to fulfill the benefits promises the employer made to its employees." Pet. App. 26a. Nor does the employer enroll its employees with the HAP. The mere act of writing a check to the City on behalf of specified employees, and informing those employees that the check has been written, is not remotely comparable to a contractual relationship between an employer and a health insurance company.

And because the Ninth Circuit explained why third party insurance arrangements are ERISA plans even while the city payment option is not, Pet. App. 25a-26a, there is no basis for petitioner's assertion that the decision will cause courts to begin ruling that third-party contracts are not ERISA plans. *See* Pet. 36 ("employers will be able to avoid ERISA's fiduciary duty rules and its civil and criminal enforcement provisions merely by hiring a third-party to perform the bundle of plan-design and

administrative-and-fiduciary tasks inherent in any plan"). If a litigant had the audacity to make such an argument in a future case, the first authority a court would cite to reject it is the Ninth Circuit's decision below.

In fact, had the Ninth Circuit concluded that an employer creates an ERISA plan when it calculates its health care spending obligation and makes payments to the government, *this* would have created major problems in ERISA preemption law. For example, imagine that a local government, instead of adopting a program like San Francisco's, simply imposed a payroll tax to be used to fund a public health program for all persons who work in the jurisdiction. Nobody could reasonably contend that an employer creates an ERISA plan when it pays this payroll tax. Yet petitioner here has advocated a definition of "ERISA plan" that would include this scenario – the employer creates a plan simply by determining its spending obligation and satisfying that obligation by making a payment to the government, which the government then uses to fund a public health program that includes the employer's workers.

Another consequence of deeming the city payment option a "plan" would be that federal obligations (and liabilities) could be imposed on employers with respect to matters over which they have no control, such as the obligations to act as a fiduciary with respect to benefits provided to HAP participants, and to create and operate a system for

processing claims by HAP participants. Equally problematic, San Francisco public health officials who operate this entitlement program could be subjected to ERISA's regulatory regime simply because some employers chose to satisfy their health care spending obligations by writing a check to the City. These consequences underscore the serious flaws in the argument that the city payment option creates an ERISA plan.

Petitioner makes much of an *amicus* brief filed below by the former Secretary of Labor agreeing that the city payment option creates an ERISA plan. More noteworthy, however, is that none of the 28 judges involved in the proceedings below adopted this novel argument – not the district judge who ruled against the City, and not the eight circuit judges who dissented from denial of rehearing en banc. Moreover, the current Department of Labor has stated it is "considering issues in the case," Bob Egelko, *Obama administration mum on S.F. health plan*, S.F. Chron., July 20, 2009, at C1, so it would be wrong to assume that the former Secretary's brief is reflective of the current Administration's views.

Once it is understood that the city payment option does not create an ERISA plan, the language permeating the petition to the effect that the ordinance intrudes on "plan regulation" is revealed to be widely off the mark. *See, e.g.*, Pet. 28 (arguing decision below allows local governments to "regulate ERISA plans themselves by first requiring their establishment and then dictating what benefits the

plan provides . . . "). Such assertions depend on the assumption that the city payment option creates a plan, and the petition unravels when that assumption is removed.

III. THE DECISION BELOW IS CONSISTENT WITH THIS COURT'S ERISA PREEMPTION RULINGS.

At the end of the day, petitioner's preemption argument is based on the assumption that employers are entitled to *expenditure* uniformity in areas mentioned by the ERISA statute. That assumption is wrong – ERISA does not insulate businesses from being required to spend money in these areas. ERISA protects *plan* uniformity for employers, but "cost uniformity was almost certainly not an object of pre-emption . . . " *Travelers*, 514 U.S. at 662.

This is illustrated by *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), which makes clear that states and localities may regulate expenditures on benefits mentioned in ERISA (in that case severance pay), so long as they do not require adoption or alteration of ERISA plans:

> Appellant's basic argument is that any state law pertaining to a type of employee benefit listed in ERISA necessarily regulates an employee benefit plan, and therefore must be pre-empted. Because severance benefits are included in ERISA, *see* 29 U.S.C. § 1002(1)(B), appellant argues that ERISA pre-empts the Maine statute. In effect,

> appellant argues that ERISA forecloses virtually all state legislation regarding employee benefits. This contention fails, however, in light of the plain language of ERISA's pre-emption provision, the underlying purpose of that provision, and the overall objectives of ERISA itself. . . . ERISA's pre-emption provision does not refer to state laws relating to "employee benefits," but to state laws relating to "employee benefit *plans*". . . . The words "benefit" and "plan" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic difference between a "benefit" and a "plan," Congress' choice of language is significant in its pre-emption of only the latter.

482 U.S. at 7-8 (emphasis in original).

Two other cases in which the Court upheld local regulation of benefits mentioned in ERISA were *Dillingham* and *Morash*. In *Dillingham*, the state's regulation of apprenticeship programs created powerful incentives for those programs to alter their conduct, and may have affected employer costs, but that was not sufficient to establish preemption. 519 U.S. at 332. In *Morash*, the state's requirement that employers reimburse employees for unused vacation time obviously affected employers' costs, but there was no preemption in that case because the requirement did not regulate ERISA plans. 490 U.S. at 114-15.

In the area of health care itself, ERISA contemplates that employers will be subject to disparate costs across jurisdictions. If the goal of

ERISA preemption had been health care expenditure uniformity, Congress would not have included the savings clause, which exempts from preemption state laws regulating insurance. 29 U.S.C. § 1144(b)(2)(A). The savings clause has resulted in the enactment of more than 1,961 mandates on health insurance, and no two states impose identical sets of coverage mandates. Victoria Craig Bunce et al., *Health Insurance Mandates in the States*, Council for Affordable Health Insurance (2008 ed.) at 1. Accordingly, the cost of employer-provided health insurance varies dramatically from state to state. *Id.* at 3-5. "Such disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985). And that is why "cost uniformity was almost certainly not an object of pre-emption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA *plans*." *Travelers*, 514 U.S. at 662.[6]

---

[6] Petitioner asserts that the preemption provision was meant to preclude bare health care spending requirements at the state or local level. Pet. 4-5 & n.13. But it does not point to a single word in ERISA's voluminous legislative history to support this conclusion. And although one former Congressional staffer has claimed that the provision was designed in part to preempt the Hawaii health care statute in existence at the time, *id.*, that statute was not a general expenditure requirement; it required that employers actually adopt employee welfare benefit plans. *See Agsalud*, 633 F.2d at 766.

Petitioner also makes much of the possibility that a local requirement in one jurisdiction might affect an employer's decisions about benefit expenditures in other jurisdictions. But the local severance and vacation pay requirements in *Fort Halifax* and *Morash*, the hospital surcharges upheld in *Travelers*, and the apprentice regulations upheld in *Dillingham* may all provide employers with some incentive to decrease spending on benefits in other jurisdictions. These cases demonstrate that ERISA's preemption provision was never intended to provide employers with umbrella protection against laws that might simply change the mix of economic incentives to increase or reduce benefit expenditures.

Petitioner and its allies disregard all of this, and instead rely upon an analytical sleight-of-hand that blurs the distinction between "expenditures" or "benefits" on the one hand, and "plans" on the other. For example, one brief asserts that "[t]he need to monitor *expenditures* in multiple jurisdictions is squarely at odds with ERISA's purpose of establishing a uniform system of *plan* regulation."[7] Similarly, petitioner quotes *Travelers* as saying that the purpose of ERISA preemption is to "'avoid a multiplicity of regulation in order to permit the nationally uniform

---

[7] Brief for the Retail Industry Leaders Association and the Chamber of Commerce of the United States of America as *Amici Curiae* in Support of Petitioner ("RILA") at 14 (emphasis added).

administration' of employee benefits." Pet. 22 (quoting *Travelers*, 514 U.S. at 657). What *Travelers* actually says is that the purpose of ERISA preemption is to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of *employee benefit plans*." *Travelers*, 514 U.S. at 657 (emphasis added).

When the distinction between expenditures and plans is brought back into focus, it becomes clear that there is no conflict with the two decisions primarily relied upon by petitioner and its allies: *Egelhoff* and *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992).

The Washington statute in *Egelhoff* provided that, in the event a couple divorces, and then one member of the couple dies after the divorce, the survivor is not entitled to the benefits of the dead spouse's ERISA plan, even if the plan does not include such a limitation on the rights of the divorced survivor. 532 U.S. at 147. Washington argued the statute was not preempted because it exempted ERISA plans which explicitly provided that divorced spouses should receive plan benefits. Thus, Washington argued, there were two ways plan administrators could comply with the statute: (1) by administering their plans differently in Washington; or (2) by changing the terms of their plans to include specified language. But the Court held this did not save the statute from preemption, because *both* compliance options required plan administrators to

change the way they wrote or administered their plans: "Plan administrators must either [disregard the language of their plans and] follow Washington's beneficiary designation scheme or alter the terms of their plan so as to indicate that they will not follow it." *Id.* at 150.

And it is in this context that the *Egelhoff* Court expressed concern with the need to "maintain a familiarity with the laws of all 50 States." 532 U.S. at 151. If a law forces a plan administrator to *change its ERISA plan* in a given state, that goes to the core of what ERISA's preemption provision guards against – the possibility of plan administrators being forced to "maintain a familiarity with the laws of all 50 States so that they can *update their plans* as necessary to satisfy the opt-out requirements of other, similar statutes." *Id.* at 151 (emphasis added). Under the HCSO, employers must track their health care expenditures, just as they must already keep track of wages and other payroll matters. But they are not forced to change anything in their plans to comply with the ordinance.[8]

---

[8] Similarly, the statement in *Egelhoff* that the "tailoring of plans *and employer conduct* to the peculiarities of the law of each jurisdiction is exactly the burden ERISA seeks to eliminate" does not have the broad meaning petitioner gives it. 532 U.S. at 151 (citation and quotations omitted, emphasis added). ERISA does not protect employers from tailoring their conduct to local requirements with respect to everything; it protects them from tailoring their conduct with respect to plans.

Nor does the decision below conflict with *Greater Washington*. Petitioner argues that both the HCSO and the ordinance struck down in *Greater Washington* make unlawful "reference to" ERISA plans because they involve measuring compliance with reference to an existing ERISA plan. However, as the Court explained in *Dillingham*, a local law makes an unlawful "reference to" an ERISA plan if the law "acts immediately and exclusively upon ERISA plans," or if the "existence of ERISA plans is essential to the law's operation." *Dillingham*, 519 U.S. at 325. That was true of the ordinance in *Greater Washington* because an employer's obligation was triggered *directly by* the benefits it offered through an ERISA plan – whatever ERISA benefits the employer offered, the employer had to provide those same benefits to injured employees on workers' compensation. 506 U.S. at 126-27. If the employer had no ERISA plan, there was no obligation. Here, the HCSO operates on employers "irrespective of the existence of an ERISA plan." *Dillingham*, 519 U.S. at 328 (quotations and ellipses omitted).

Finally, some *amici* attempt to conjure up a conflict with Supreme Court precedent by selectively quoting the language of a Ninth Circuit decision that this Court summarily affirmed: *Local Union 598 v. J.A. Jones Constr. Co.*, 846 F.2d 1213 (9th Cir.), *summarily aff'd*, 488 U.S. 881 (1988). *See* RILA Br. at 8. They argue that the HCSO, by generally

mandating health care expenditures, is imposing a "contribution" mandate of the kind struck down in *J.A. Jones*. RILA Br. at 8. But again, this blurs the distinction between general expenditures and plans. The full quotation from *J.A. Jones* further underscores this distinction:

> [The statute] mandates a particular level of contributions by employers *to employee benefit plans*. . . . A statute which mandates employer contributions *to benefit plans* and which effectively dictates the level at which those required contributions must be made has a most direct connection with an employee benefit plan.

846 F.2d at 1219 (emphasis added).

In sum, no Supreme Court decision invalidates a bare expenditure requirement that provides employers with a reasonable, non-ERISA compliance option. To the contrary, the Ninth Circuit's ruling is fully supported by this Court's precedent.

IV. NUMEROUS OTHER FACTORS COUNSEL AGAINST A GRANT OF CERTIORARI.

A. Petitioner Greatly Exaggerates The Impact Of The Ninth Circuit's Ruling.

Petitioner and its *amici* contend the Ninth Circuit's ruling will cause an avalanche of "pay or play" laws to crumble down upon multijurisdictional employers. They dramatically overstate both the

possibility this will occur, and the impact it would cause.

As a preliminary matter, petitioner and its allies focus primarily on *proposals*, not actual laws. And their primary citation is to a law review article from 2006 – two years prior to when the Ninth Circuit first upheld the HCSO. *See, e.g.*, Pet. 20. Most of those proposals are long dead.[9]

As for the four measures that actually became law, petitioner and its *amici* neglect to discuss whether the Ninth Circuit's reasoning applies to those laws. It does not. The first law, from Suffolk County, New York, has already been struck down on the same ground relied upon by the Fourth Circuit: none of the purported non-ERISA compliance options was truly available to Wal-Mart, thereby effectively forcing Wal-Mart to alter its ERISA plan. *See Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403, 417-18 (E.D.N.Y. 2007). The second law creates a board charged with establishing a universal health care program in Connecticut by mid-2010, but does not mention an employer spending requirement

---

[9] *See* H.R. 1316, 2d Reg. Sess. (Colo. 2006); S. 1618, 107th Reg. Sess. (Fla. 2006); S.B. 87, 94th Leg., 1st Reg. Sess. (Mich. 2007); S.B. 2684, 2006 Reg. Sess. (Miss. 2006); A.B. 1966, 213th Leg. (N.J. 2008); H.B. 258, 2006 Sess. (Va. 2006); H.B. 2517, 59th Leg., 2d Sess. (Wash. 2005); H.B. 4024, 77th Leg., 2d Sess. (W. Va. 2006); A.B. 860, 97th Leg., 2005-06 Sess. (Wis. 2005); H.B. 1703, 159th Sess., 2d Year (N.H. 2006).

or explain how the program will be funded. *See* 2009 Conn. Legis. Serv., Pub. Act No. 09-148 (West). Finally, Massachusetts, Vermont and New York City adopted employer health care spending requirements that include an option of making a payment to the government, but those payments, to use the words of the Ninth Circuit, give "nothing in return – either to an employer or its employees – for the employer's payment to the State," beyond what any other qualifying resident would receive. Pet. App. 37a. *See* 2006 Mass. Legis. Serv. Ch. 58 (West); 114.5 Mass. Code Regs. 16.01-.05; Vt. Stat. Ann. tit. 21, § 2003 (2009); N.Y.C. Admin. Code § 22-506.

That no other jurisdiction has enacted a program like San Francisco's, either before or after the Ninth Circuit's initial published opinion in January 2008, is unsurprising. It would be extraordinarily difficult for other jurisdictions to establish the type of non-ERISA compliance option provided by San Francisco's ordinance: payment into a comprehensive, government-run health care program that the City invested significant public dollars to build, and spends significant tax dollars to maintain. And as discussed further below, other jurisdictions are particularly unlikely to make such investments while Congress debates national health care reform, which could well include a uniform federal employer health care mandate.

Petitioner goes on to assert that if additional San Francisco-type programs do come into being, this would "overload the largest human resources

departments and the most expensive software-systems." Pet. 38. That is preposterous. As discussed above, employers commonly face differing cost (and recordkeeping) requirements in different jurisdictions, including severance pay requirements, minimum and prevailing wage requirements, vacation pay requirements, apprenticeship and/or training program requirements, taxes, tax credits, fees, and sick leave requirements. Such is the unavoidable, unremarkable consequence of doing business in multiple jurisdictions in the United States. And as discussed more fully by *amicus curiae* Nibbi Bros. Associates, multijurisdictional employers already regularly use payroll and other human resources software, provided by companies like ADP and Oracle, that are geared to facilitate compliance with disparate local requirements of this kind.

Petitioner and its allies also fail to account for the HCSO regulations that make it particularly easy for multijurisdictional employers to establish compliance. For example, one *amicus* brief asserts the ordinance will "require employers [with self-insured plans] to create a special pool of funds for San Francisco employees that is separate from the rest of the employees covered by the company plan." RILA Br. at 13. In truth, a large, multijurisdictional employer with a self-insured plan need only establish that it has spent a certain amount per employee *plan-wide*. *Supra* at 4-5. The same is true of a large employer that provides uniform health coverage to its employees through a traditional insurance plan. *Id.*

Of course, if petitioner is correct that numerous laws will sprout up and that they will be unworkable for employers, this also means the Court will have ample opportunity to consider this ERISA preemption issue in future cases. And as discussed below, future cases would have much better records.

B. The Case Is A Poor Vehicle For Consideration Of Most Arguments Made By Petitioner And Its Allies.

Two key contentions in this case have been: (i) the city payment option is not a rational choice for employers; and (ii) the ordinance imposes intolerable administrative burdens on employers. Although there was discovery in the district court, petitioner proffered no evidence to support either contention. Indeed, the record contains significant evidence to refute them both. Accordingly, this case presents a poor vehicle for consideration of an employer's claim that a general health care spending requirement is preempted by ERISA.

With respect to the argument that the city payment option is not a "rational decision" for employers,[10] petitioner had the burden of making this showing. *See, e.g., Dillingham*, 519 U.S. at 333 ("it has not been demonstrated here that the added

---

[10] Brief of *Amici Curiae* the ERISA Industry Committee and National Business Group on Health in Support of Petitioner at 17.

inducement created by the wage break available on state public works projects is tantamount to a compulsion upon apprenticeship programs"); *Travelers*, 514 U.S. at 664 ("no showing has been made here that the surcharges are so prohibitive as to force all health insurance consumers to contract with the Blues"). However, in contrast to *Fielder*, where Wal-Mart presented unrebutted evidence that Maryland's law would force it to alter its ERISA plan, 274 F.3d at 193, petitioner submitted no evidence and made no showing that the choice between setting up an ERISA plan and using the city payment option was remotely a "Hobson's choice" for any employer. *Travelers*, 514 U.S. at 664. In fact, at oral argument in the Ninth Circuit, counsel for petitioner conceded that, if anything, employers had an incentive to *choose* the city payment option, which contradicted the central contention in petitioner's briefs in the district court and the Ninth Circuit.[11] And in contrast to petitioner's non-showing, the City presented unrebutted evidence that the city payment option provides a reasonable alternative. *Supra* note 3.

Petitioner also relies heavily on the argument that the HCSO's recordkeeping and other administrative obligations are burdensome. Again, this argument is made only at the highest level of abstraction. Petitioner presented no evidence to

---

[11] *See* http://www.ca9.uscourts.gov (Audio Files, No. 07-17370, first entry, minutes 31:00-34:20).

refute the common-sense notion that employers keep records of hours worked, and health care dollars spent, in the normal course of business. Nor did it present any other evidence of the exorbitant administrative burden it now alleges. The only evidence below demonstrated that one of petitioner's member restaurants – Max's – already kept the key records, including hours worked per employee and health care expenditures per employee. Resp. App. 60-62. There is no basis, on this record, to conclude that the HCSO's recordkeeping obligations are anything other than *de minimis* for employers.

C. The Result Sought By Petitioner And Its Allies Would Have A Devastating Impact On The People Of San Francisco.

In contrast to the abstract assertions by petitioner and its allies about the impact of the Ninth Circuit's ruling, the result they advocate would have a real and devastating impact on San Francisco and its residents: the City would be thrust back into the health care crisis that left more than 82,000 people without coverage, and that imposed a tremendous strain on the taxpayers by forcing public emergency rooms to treat illnesses and injuries that could have been prevented. In just 1½ years, the number of uninsured declined from roughly 82,000 to under 23,000, and the number continues to go down. Use of public emergency rooms declined *seventy percent.* Resp. App. 25-30.

Nor is the care provided by the City to the previously uninsured limited to traditional "safety net" care. Those enrolled in the HAP are receiving essential preventive and diagnostic treatment for chronic conditions such as asthma, heart disease, diabetes, hypertension or cancer. Resp. App. 25-26.

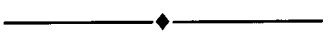
To cite just one example, a former restaurant worker with a chronic heart condition, mitral valve prolapse, was unable to obtain health insurance. She needed surgery for her condition, which would have cost her more than $100,000 if performed at a private facility, rendering it unaffordable for her. Because this person was able to join the HAP, she obtained the surgery, and believes she might not still be alive today if she had been unable to obtain this service from the City's new program. Resp. App. 26-27.

As the City showed in its response to the stay application, the universal health care program cannot survive without the employer spending requirement. Resp. App. 28-29. *See also* Brief for Zazie Restaurant as *Amicus Curiae* in Support of Respondents. Thus, the result petitioner and its allies seek is to terminate San Francisco's successful, first-of-its-kind universal health care program, based on speculation and exaggeration about the as-yet unfelt impact of the Ninth Circuit's ruling on multijurisdictional employers.

D. The Potential Enactment Of Federal Health Care Legislation Counsels Against A Grant Of Certiorari.

Finally, the question presented by the petition may be mooted by national health care reform, so granting certiorari would not be a good use of the Court's resources. As petitioner and its allies point out, Congress is considering federal legislation that would include a national employer mandate. If the predictions of petitioner and its *amici* about the enactment of such a law are correct, it would be that new law, not ERISA, that preempts the City's health care spending requirement. And if that new law preempts local health care spending requirements, the ERISA preemption issue presented here would be relevant only for a relatively brief gap period, until the effective date of the legislation.

By the same token, if Congress does not enact health care reform legislation in the next several years, and if other localities then seek to emulate San Francisco's solution to the health care crisis, the Court will have another opportunity to take up the question at that time. Either way, the present state of flux regarding national health care reform counsels against Court intervention.



CONCLUSION

The Court should deny the petition for a writ of certiorari.

Respectfully submitted,

DENNIS J. HERRERA
City Attorney
WAYNE SNODGRASS
VINCE CHHABRIA
Counsel of Record
CHRISTINE VAN AKEN
Deputy City Attorneys

Attorneys for Respondents