Case Nos. 07-17370, 17372

Decision: September 30, 2008

Panel Members: Goodwin, Reinhardt, and W. Fletcher

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

GOLDEN GATE RESTAURANT ASSOCIATION, Plaintiff/Appellee, vs. CITY AND COUNTY OF SAN FRANCISCO, Defendant/Appellant, and SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 1021; SEIU UNITED HEALTHCARE WORKERS-WEST; AND UNITE HERE! LOCAL 2, Intervenors/Appellants.	(U.S. District Court (N.D. Cal.) Case No. C06-6997 JSW)

On Appeal from the United States District Court
For the Northern District of California

BRIEF OF AMICUS CURIAE IN SUPPORT OF PLAINTIFF/APPELLEE'S PETITION FOR REHEARING EN BANC

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CORPORATE DISCLOSURE STATEMENT

Amicus curiae the American Benefits Council is incorporated in the state of Connecticut and has no parent company, subsidiaries, or affiliates to identify for purposes of Rule 26.1 of the Federal Rules of Appellate Procedure.

Dated: October 31, 2008

Respectfully submitted,

American Benefits Council

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STATEMENT REGARDING CONSENT OF PARTIES TO FILE BRIEF AMICUS CURIAE

The American Benefits Council ("Council") requested consent to file this amicus brief from the Golden Gate Restaurant Association, the City and County of San Francisco, and the Intervenors in this case. The Council has received verbal or written consent from each of these parties.

STATEMENT OF INTEREST OF AMICUS CURIAE

The Council submits this amicus brief urging the Ninth Circuit Court of Appeals to review en banc the decision of a panel of this court in *Golden Gate Restaurant Association v. City and County of San Francisco, et al.*, Nos. 07-17370, 07-17372, 2008 U.S. App. LEXIS 20574 (9th Cir. Sept. 30, 2008) (hereinafter "Decision" or "*GGRA*"). The Decision held that the San Francisco Health Care Security Ordinance ("Ordinance") is not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"). As a result, the Decision creates a split with the United States Court of Appeals for the Fourth Circuit on an issue of national importance.

The Council is a broad-based, nonprofit trade association founded in 1967 to protect and foster the growth of the Nation's privately sponsored employee benefit plans. The Council's members are primarily large employer-sponsors of employee benefit plans, including many Fortune 500 companies. Its members also include employee benefit plan support organizations, such as actuarial and consulting

firms, insurers, banks, investment firms, and other professional benefit organizations. Collectively, the Council's more than 250 members sponsor and administer plans covering more than 100 million plan participants and beneficiaries.

This case is of significant nation-wide importance to employer-sponsors of health benefits plans and their employees. Council members offer some of the Nation's most generous and well-managed health benefit plans, virtually all of which cover employees that reside in many states, counties, and cities. These multi-state plans are complex undertakings. If the Ordinance and other similar "pay-or-play" laws are allowed, it will create a "regulatory balkanization" that would strike at the heart of the purpose of ERISA preemption, which is to encourage employers to establish comprehensive health plans for their employees without regard to the particular state or locality in which they live. If this Court does not find that ERISA preempts the Ordinance, a roadmap will be set for thousands of jurisdictions to enact similar laws, each with individual requirements necessitating the allocation of significant resources to ensure compliance. This result will increase employer costs for providing health and welfare benefits. Higher employer costs are inevitably shared with employees through increased premiums, deductibles or other out-of-pocket costs. The result may also compel employers to reduce their health coverage or drop it altogether.

ARGUMENT

I. En Banc Review Is Warranted Because the Decision Cannot Be Reconciled With Supreme Court Precedent and Because the Decision Creates a Clear Division Among the Circuits

The panel in this case misgauged the scope of ERISA preemption when it found that the Ordinance was not preempted. The panel reasoned that the Ordinance was not preempted because employers could comply with the law without amending their existing health plans or setting up new ones by using the option of simply writing a check to the City. *GGRA*, 2008 U.S. App. LEXIS 20574, at *53. Since compliance could occur without a mandated plan change, the panel concluded that ERISA preemption was not implicated.

But this reasoning misreads the scope of ERISA preemption and Supreme Court precedent by not fully considering the legal significance of a law compelling employers to make a choice about their benefit plans.

In *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), the Court rejected the view that states can avoid preemption by offering employers a theoretical means to avoid changing their ERISA plans. 532 U.S. at 147-48 & n.1. The Court held that a state law automatically revoking spousal beneficiary designations upon divorce had a "connection with" the ERISA plan and was therefore preempted. *Id.* at 150. The Court made this determination even though employers were able to opt out of the state law requirement, if the plan document expressly stated that the state's

automatic beneficiary change was not effective. *Id.* at 150-51. The very fact that the statute forced plans and employers to make choices at all, the Court held, was objectionable. *Egelhoff,* 532 U.S. at 151. "The statute is not any less of a regulation of the terms of ERISA plans simply because there are two ways of complying with it. Of course, simple noncompliance with the statute is not one of the options available to plan administrators." *Id.* According to the *Egelhoff* Court, allowing a state to pose that choice, would strike at the heart of ERISA because plan administrators could be forced potentially to account for the opt-out provisions in all 50 states. *Id.*

All of the Council's members that are subject to the Ordinance already sponsor an ERISA-covered group health plan, and most of those plans are extremely generous under any standard. But many, if not most, of those plans probably do not comply with every aspect of the Ordinance. For example, a member's plan may use different waiting periods for new employees than for other employees, or a member may decide to direct its limited health care dollars towards full-time employees instead of part-time, temporary, or seasonal workers.

Thus, the Council's members have the following options for compliance. Some Council members could amend their ERISA plans to either change the spending allocation they have made among classes of employees or redirect funding from other benefit programs to health benefits to meet the City's minimum

health care spending requirement for each of their "covered employees." Though unlikely, some Council members could terminate coverage for all of their "covered employees," leaving them to make their own way in the City's new and untested Health Access/*Healthy San Francisco* program. Other Council members might choose to protect their "covered employees" within their existing ERISA plans and pay the City the difference between the minimum health care spending requirement and the actual amount they spend on their ERISA plans for each of their "covered employees."

The Ordinance places employers in the same box the Supreme Court squarely rejected in *Egelhoff*; employers cannot simply elect to not comply with the Ordinance. *See Egelhoff*, 532 U.S. at 150-51. For that reason alone—the fact that employers must tailor their employee benefit plans and their conduct in response to the Ordinance's requirements—ERISA preempts the Ordinance. *See Egelhoff*, 532 U.S. at 151. En banc review should be granted on this basis alone.

The panel asserts that its holding does not conflict with the Fourth Circuit's conclusion in *Retail Industry Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007), which held that the Maryland Fair Share Health Care Fund Act ("Maryland Act") was preempted. *GGRA*, 2008 U.S. App. LEXIS 20574, at *51. The Maryland Act required a covered employer to either spend at least 8% of the employer's total payroll for Maryland employees on health insurance costs or pay

the difference between the amount the employer actual spent on health insurance costs and an amount equal to 8% of the employer's total Maryland payroll. *Fielder*, 475 F.3d at 184 (citing Md. Code Ann., Lab. & Empl. § 8.5-104(b)). The Fourth Circuit struck down the Maryland Act as preempted by ERISA, holding that the only rationale choice a covered employer had was to modify its existing employee benefit plan because payments to the State would in no way benefit the employer's workforce. *Fielder*, 475 F.3d at 193. In contrast, the panel in this case placed great weight on its view that, unlike the payment to the State under the Maryland Act, the option to pay the City as a means of complying with the Ordinance was a real choice because in its view the Ordinance provides benefits to employees that the Maryland Act lacked. *GGRA*, 2008 U.S. App. LEXIS 20574, at *54. But the panel misses the Fourth Circuit's point. The *Fielder* court did not hold that if covered employers under the Maryland Act had a real choice the law would have been saved from preemption. Rather, the *Fielder* court expressly stated that even if a covered employer had "non-ERISA health spending options to satisfy the [Maryland Act], it would need to coordinate those spending efforts with its existing ERISA plans," causing the state law to violate ERISA's preemption provision. *Fielder*, 475 F.3d at 196-97. The *Fielder* court further grounded its decision on the fact that the Maryland Act, coupled with a proliferation of other similar laws (like the Ordinance), would force employers to constantly monitor

state law developments and "manipulate health care spending to comply with them", directly running afoul of the Supreme Court's *Egelhoff* decision. *Id.* at 197. The Council's members disagree strongly with any contention that providing employers with a non-ERISA health spending option (paying the City) means the Ordinance does not relate to ERISA plans. The option of paying the City is little more than a coercive tax designed to force employers to spend more on health care plans that are already expensive.

In fact, the parallels between the Maryland Act and the Ordinance are too striking to miss. Both laws establish arbitrary mandated minimum spending targets for health care benefits. Both laws compel employers to make up any shortfall by making their own plans more generous or by making payments to the government. Both laws require employers to keep new records and make a myriad of new reports to the government. Both laws impose penalties for noncompliance. Despite the remarkable similarities between these laws, the panel broke from the rationale expressed in *Fielder* and held that ERISA did not preempt the Ordinance. En banc review should be granted to more closely scrutinize the Decision in light of this split.

II. Providing Coverage Through the City Establishes An ERISA Plan And Implicates Preemption

The Decision concedes that if the payments to the City created an ERISA plan, the Ordinance would be preempted. The panel, however, incorrectly

concluded that the payments to the City do not create a plan that is subject to ERISA. Based on this erroneous conclusion, the panel held that the Ordinance did not implicate preemption.

ERISA covers all employment-based pension and welfare plans. A "welfare plan" is broadly defined to include, among other things, "*any* plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits . . .." ERISA § 3(1); 29 U.S.C., § 1002(1) (emphasis added). "Because this definition of an ERISA 'plan' is so expansive, nearly any systematic provision of healthcare benefits to employees constitutes a plan." *Fielder*, 475 F.3d at 190-91.

An employer's welfare plan is covered by ERISA, even if an employer merely purchases insurance and delegates many of the plan's administrative duties (*e.g.*, claims payment) to the insurer. *See, e.g., Brundage-Peterson v. Compcare Health Servs. Ins. Corp.*, 877 F.2d 509, 511 (7th Cir. 1989). Likewise, where multiple employers participate in the same central administrative arrangement, each participating employer is treated as if it has established its own plan, which is subject to ERISA. *Donovan v. Dillingham*, 688 F.2d 1367, 1374-75 (11th Cir. 1982) (en banc). *See also* DOL Adv. Op. 96-25A (Oct. 31, 1996); DOL Adv. Op. 90-07A (Apr. 6, 1990). An employer's plan does not even need to be established

through a formal plan document; an employer's actions alone may be sufficient to constitute "establishing" a plan within the meaning of section 3(1) of ERISA. *Dillingham*, 688 F.2d at 1372-73 (holding that ERISA does not require a formal, written plan document to create an employee benefit plan and establishing a test for determining whether a plan exists); *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1504 (9th Cir. 1985) (following the *Dillingham* test).

Private employer benefit plans are not exempt from ERISA just because a state or local law mandates the establishment of such a plan.[1] The Supreme Court has indicated that where a state law "requires an ongoing administrative program to meet the employer's obligations" under the law, Congress's concern that the "advantages of a uniform set of administrative procedures governed by a *single set of regulations*" are realized. *Fort Halifax Pack'g Co. v. Coyne*, 482 U.S. 1, 11-12 (1987) (emphasis added). *Fort Halifax* demonstrates that where a state law imposes on-going and regular administrative obligations, including the handling of "periodic demands on [employer] assets that create a need for financial coordination and control," the law would create a plan subject to ERISA. 482 U.S. at 13.

[1] The exceptions for governmental plans enumerated in section 4 of ERISA apply only to plans sponsored by governments for their own employees. *See* ERISA §§ 3(32) (defining governmental plans), 4(b) (excluding governmental plans).

The Decision cites *Fort Halifax* to support its conclusion that payments to the City do not create an ERISA plan, but in doing so turns the case on its head. In *Fort Halifax*, the Court addressed a state law that required employers to make a one-time severance payment to their employees in the event of a plant closing. *Fort Halifax*, 482 U.S. at 3. In contrast, under the Ordinance, a covered employer who chooses to satisfy the Ordinance's spending requirements by making payments to the City is required to keep records of its workforce and its health care expenditures, evaluate the generosity and terms of its existing welfare benefit plan, and make ongoing eligibility determinations based on statutory criteria. The covered employer is compelled to determine appropriate contribution levels for each of its covered employees and, if the employer's own health care spending (re: ERISA plan expenditures) is deemed insufficient, make regular quarterly payments to the City, which the City uses on behalf of the employer's employees.

Thus, covered employers must maintain ongoing recordkeeping systems to track eligibility, enrollment, and fee payments. They also will have to prepare new electronic plan communications, new paper communications, broader and new reporting and disclosure materials, new distribution processes, new record retention mandates, new training materials, and much more.

In short, payments to the City are not analogous to the state mandated payment addressed in *Fort Halifax*. Rather, the Ordinance compels a covered

employer to carry out the same functions the employer would carry out in buying an insurance policy to provide health coverage to its employees. *Cf. Brundage-Peterson v. Compcare Health Services Ins. Corp.*, 877 F.2d 509, 511 (7th Cir. 1989). Thus, when an employer decides to pay the City instead of complying with the Ordinance by making additional health care expenditures, the employer is participating in exactly the same type of state-mandated, on-going administrative scheme that creates a forced ERISA plan that is prohibited by ERISA. *Fort Halifax*, 482 U.S. at 13-14.

ERISA preemption was designed to prevent states and local governments from requiring employers to establish and maintain welfare plans. In fact, the Supreme Court has not hesitated to find that state laws that require employers to offer health coverage "relate to" ERISA plans and is preempted. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96 (1983) (finding New York law mandating pregnancy benefits "relates to" ERISA plans); *Dist. of Columbia v. Gr. Wash. Bd. of Trade*, 506 U.S. 125, 129-30 (1992) (preempting District of Columbia law requiring employers to provide inactive employees on workers' compensation with the same health benefits as active employees); *Local Union 598, Plumbers & Pipefitters Indus. Journeymen & Appr'ship Train'g Fund v. J.A. Jones*, 846 F.2d 1213, 1221 (9th Cir. 1988) (preempting Washington law mandating minimum apprenticeship training funds); *Agsalud v. Stnd. Oil Co.*, 454 U.S. 801 (1981), *aff'g* 633 F.2d 760

(9th Cir.) (affirming without opinion that Hawaii law mandating health benefits law was preempted). *See also Aloha Airlines v. Ahue*, 12 F.3d 1498, 1505 (9th Cir. 1993) (finding Hawaii law requiring airlines to pay for certain medical exams for pilots to be "related to" ERISA plans because it forced the airlines to determine eligibility, modify existing plans or establish new plans).

III. The Decision Undermines Congress' Intent to Embrace Preemption to Promote the Efficient Operation of Multi-State Health Plans

ERISA's preemption provision represents a conscious policy choice by Congress that was characterized by one key sponsor as the "crowning achievement" of the ERISA legislation. 120 Cong. Rec. 29197 (1974) (Statement of Rep. Dent). The purpose of preemption is clear enough—to guarantee that employers can "establish a uniform administrative scheme . . . provid[ing] a set of standard procedures to guide processing of claims and disbursement of benefits" for their plans. *Fort Halifax*, 482 U.S. at 9. *See also New York State Conf. of Blue Cross and Blue Shield Plans. v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995). In addition to being an administrative necessity, uniformity ensures that multi-state employers can offer all of their similarly situated employees the same benefits, thereby ensuring continuity in benefit programs when employees move from one location to another location. Uniformity is a critical part of ensuring that employees understand exactly what benefits to which they are entitled and how to obtain them.

The Ordinance adds a level of complexity to the administration of multi-state plans that Congress clearly sought to limit. It mandates certain defined spending targets, which vary for different sized employers and it sets its own specific rules as to which employees are covered. Reporting and record retention requirements are imposed, as are substantial civil penalties. If the Ordinance is not preempted, then multi-state employers will have to administer their existing complex health plans while simultaneously monitoring the City's spending targets and eligibility rules. They will have to make quarterly calculations of health care expenditures for covered employees. Employers will have to stay abreast of the varying definitions for full-time, part-time, seasonal, and temporary employee. They will have to track the eligibility waiting periods required under their own health plans, which may be 30 days, 60 days, or 90 days, as well as the 90-day period before an employee is considered a "covered employee" under the Ordinance.

Multiply the impact of the Ordinance by thousands, and one can understand the critical importance of ERISA preemption and how it encourages employers to offer health care coverage. If the Ordinance is allowed to stand, it will provide a roadmap for 50 states, 3034 counties, and over thirty thousand city and town governments to impose their own requirements on employers to fund or provide

health coverage.[2] Indeed, there are 478 cities and towns in California alone.[3] If even a fraction of these jurisdictions enact pay-or-play laws, hundreds of different reporting and filing requirements, eligibility rules, effective dates of coverage, and benefit provisions, could be enforced through hundreds of different compliance and penalty regimes. Forcing plan administrators to constantly stay informed about the laws in multiple jurisdictions, and to create and run duplicative payroll and other administrative systems, while attempting to run their own complicated plans, is clearly and exactly what Congress sought to prohibit through ERISA's preemption provisions.

CONCLUSION

There are a range of actions that state and local governments can take to address the problem of the uninsured in a meaningful way without running afoul of ERISA. States may reform the individual and group insurance markets, establish state high risk pools for uninsurable groups, establish government agencies that make insurance coverage available to individuals and small employers, create or

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[2] *See* Government Organization, 2002 Census of Governments at 6 (Vol. 1, No. 1) (Dec. 2002), *available at* http://www.census.gov/prod/2003pubs/gc021x1.pdf (stating that in 2002 there were 38,967 general purpose governments in the United States, including "3,034 county governments, and 35,933 subcounty general-purpose governments (including 19,429 municipal governments and 16,504 town or township governments)").

[3] *See* http://www.cacities.org/index.jsp?displaytype=&section=allabout&zone=locc&sub_sec=allabout_facts.

expand government sponsored health insurance programs (*e.g.*, SCHIP, Medicaid) and fund those programs with general tax revenues or assessments on hospital bills, and impose requirements that all individuals obtain health insurance coverage. But, what state and local governments cannot do—what ERISA forbids—is to single out a class of employees and require their employers to establish a plan, change their existing plans, or administer a separate government-designed program just for that class.

The Council understands the desire to alleviate the problems associated with the uninsured; in many respects, the Council's members are on the front lines of that battle. The Council and its members are actively working with Congress as it considers this issue. Indeed, the issue of the uninsured is central to the current Presidential election, and it is all but certain that legislation to address the issue will be a significant focus of the next Administration and the 111th Congress.

The Council urges this court to review the Decision so as not to contravene the clear policy preferences of the 93rd Congress, which chose a voluntary system for providing benefits and the preemption of state law, in a misplaced effort to allow San Francisco to adopt its own approach to health care reform.

Dated: October 31, 2008

Respectfully submitted,

American Benefits Council

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CERTIFICATE OF COMPLIANCE

I certify that this brief has been prepared using proportionally double-spaced 14 point Times New Roman type. According to the "Word Count" feature on my Microsoft Word software, this brief contains 3,594 words up to and including the signature lines that follow the brief's conclusion.

I declare under penalty of perjury that this Certificate of Compliance is true and correct and that this declaration was executed on October 31, 2008.

Dated: October 31, 2008 American Benefits Council

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CERTICATE OF SERVICE

I hereby certify that on October 31, 2008, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

I further certify that some of the participants in the case are not registered CM/ECF users. I have mailed the foregoing documents by First-Class Mail, postage prepaid, to the following non-CM/ECF participants:

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