IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Nos. 07-17370, 07-17372
Decided September 30, 2008
Panel Members W. Fletcher, Reinhardt, Goodwin

GOLDEN GATE RESTAURANT ASSOCIATION,
Plaintiff-Appellee,
v.
CITY AND COUNTY OF SAN FRANCISCO,
Defendants-Appellants
and
SAN FRANCISCO CENTRAL LABOR COUNCIL,
SERVICE EMPLOYEES INTERNATIONAL UNION
LOCAL 1021, SEIU UNITED HEALTHCARE
WORKERS-WEST, and UNITE-HERE! LOCAL 2,
Intervenors-Appellants.

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

BRIEF FOR THE SECRETARY OF LABOR AS AMICUS CURIAE SUPPORTING PETITION FOR REHEARING

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STATEMENT PURSUANT TO RULES 29 AND 35 OF THE FEDERAL RULES OF APPELLATE PROCEDURE

Petitioner Golden Gate Restaurant Association seeks en banc reconsideration and reversal of the panel decision in this case holding that the employer health care spending requirements in San Francisco's Health Care Security Ordinance ("HCSO"), S.F. Cal. Admin. Code, Ch. 14 (2006 & 2007), are not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 et seq., as amended. The Secretary of Labor, who has primary authority for enforcing and administering Title I of ERISA, 29 U.S.C. §§ 1002(13), 1136(b), filed an amicus brief and presented oral argument in support of preemption, and files this brief in support of rehearing en banc.

Rehearing en banc is appropriate under Fed. R. App. P. 35(a)(2) and (b)(1)(B) because the extent to which ERISA permits state or local governments to require employers to pay for or provide medical benefits for their employees is a question of exceptional importance due to the significant, disruptive consequences of a ruling that undermines the federal ERISA scheme by exposing employers to the complexity of complying with a potential myriad of state and local laws similar but not identical to the HCSO. Rehearing en banc is also appropriate because the panel's decision conflicts with preemption principles applied by the Supreme Court, including in Egelhoff v. Egelhoff, 532 U.S. 141 (2001), and by the Fourth

Circuit in Retail Industry Leaders Ass'n v. Fielder, 475 F.3d 180 (4th Cir. 2007). See Fed. R. App. P. 35(b)(1)(A).

The panel decision also threatens uniformity of this Court's decisions. See Fed. R. App. P. 35(a)(1). In concluding that the law's City-payment option does not create an ERISA plan, the panel failed to address Qualls v. Blue Cross of Cal., 22 F.3d 839, 843 (9th Cir. 1994), which held that an employer establishes an ERISA plan when it makes payments to a third-party insurer-plan administrator, and incorrectly applied a heightened test for determining when a plan exists by improperly deeming Scott v. Gulf Oil Corp., 754 F.2d 1499, 1503-04 (9th Cir. 1985), to be overruled. Moreover, the panel mischaracterized the Secretary's argument. The panel viewed the Secretary as arguing that the City-run program to which employers make payments is itself an ERISA plan. Panel Op. at 13,927, 13,935. The Secretary never made that argument. Instead, the Secretary argued that when an employer chooses that option, the employer establishes an ERISA plan in the same way that the employer's payment to an insurer established a plan under Qualls.

STATEMENT

This case arose after San Francisco enacted the HCSO to provide health care for uninsured residents. See generally Panel Op. at 13,916; Pet. for Reh'g at 1. The law establishes a City-run Health Access Program ("HAP," now called "Healthy San Francisco") for uninsured residents and by requiring covered employers to make specified health care expenditures on behalf of their employees for each hour paid to covered employees. Current rates are $1.76 per hour for large for-profit employers, and $1.17 per hour for medium-size for-profit employers and certain non-profit employers. Id. § 14.1(b)(8).

The HCSO defines "health care expenditure" to mean "any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees." S.F. Admin. Code § 14.1(b)(7). That definition includes payments to entities that are indisputably ERISA plans. See 29 U.S.C. § 1002(1), (7) (ERISA welfare benefit plan includes any plan, fund, or program providing, among other things, medical benefits to participants (employees or former employees) and their beneficiaries); Panel Op. at 13,940 ("A covered employer may choose to adopt or to change an ERISA plan" to comply with the law). The definition also includes

payments to the City-run HAP to be used on behalf of covered employees. S.F. Admin. Code § 14.1(b)(7).

Golden Gate challenged the HCSO as preempted by ERISA. The district court agreed with Golden Gate that ERISA preempts the health care spending requirements. Golden Gate Restaurant Ass'n v. City and County of San Francisco, 535 F. Supp. 2d 968 (N.D. Cal. 2007). In January 2008, the panel stayed the district court's decision. Golden Gate Restaurant Ass'n v. City and County of San Francisco, 512 F.3d 1112 (9th Cir. 2008).

The Secretary filed an amicus brief supporting Golden Gate. The Secretary argued that ERISA preempts the employer spending requirements for two independent reasons: it mandates employee benefit structures or their administration, and it interferes with uniform plan administration. Sec'y Amicus Br. 8-9. On the first point, the Secretary argued that all of the options for compliance require an employer to create or alter an ERISA plan, including the City-payment option that the panel, in its stay decision, had assumed did not require the creation or alteration of an ERISA plan. Id. at 9. The Secretary explained that an employer must establish an ERISA plan to comply with the City-payment option, the same way an employer establishes a plan through, among other things, purchasing group insurance. Id. at 13-17 (discussing, among other cases, Qualls, 22 F.3d at 843). On the second point, the Secretary argued that the

panel's stay decision, which concluded that the HCSO imposes permissible administrative burdens on employers, was incompatible with controlling precedents, record evidence, the realities of employee benefit plan administration, and the Fourth Circuit Fielder decision. Sec'y Amicus Br. 23.

In its decision on the merits, the panel held that ERISA does not preempt the San Francisco law. Panel Op. at 13,916, 13,924-46. The panel did not dispute the Secretary's assertion that all of the non-City payment options require an employer to create or alter an ERISA plan. The panel also concluded that if the City-payment option creates an ERISA plan, the HCSO "almost certainly makes an impermissible 'reference to' an ERISA plan." Panel Op. at 13,927. The panel, however, rejected the argument that the City-payment option requires employers to establish ERISA plans because, in its view, the administrative burdens it imposes on employers are not enough to create a plan and those burdens do not require employer discretion or run the risk of mismanagement of funds or other abuses. Id. at 13,927-34. Addressing an argument not previously raised by the Secretary or Golden Gate, the panel also concluded that the HAP itself is not an ERISA plan but instead is a government entitlement program funded in part by the employer payments but primarily by taxpayer dollars and available to low- and moderate-income San Francisco residents regardless of employment status, and, as such, is beyond the reach of ERISA preemption. Id. at 13,934-37.

The panel also rejected the argument that the HCSO impermissibly interferes with uniform plan administration. Panel Op. at 13,938. The panel concluded that San Francisco's law is consistent with ERISA's goal of promoting plan uniformity because, based on its analysis of the City-payment option, the HCSO does not require any employer to adopt or alter an ERISA plan or require any employer to provide specific benefits through an existing ERISA plan or the HAP. Id. at 13,940. The panel recognized that the law may "influence[]" an employer to choose to adopt or change an ERISA plan instead of making the required health care expenditures to the City, but concluded that such an "influence" is permissible because it does not bind ERISA plan administrators to a particular choice of benefits or rules for determining plan eligibility, id. at 13,940-41, and because the administrative burden is on the employer and not on the plan. Id. at 13,942.

The panel further concluded that its decision is consistent with Fielder. In Fielder, the Fourth Circuit held that ERISA preempts a Maryland law that targeted WalMart by requiring employers with 10,000 or more Maryland employees to spend at least 8% of their total payrolls on employees' health insurance costs or pay the shortfall to the state Medicaid fund. Fielder, 475 F.3d at 183. The panel reasoned that its decision is consistent with Fielder because the San Francisco law,

unlike the Maryland law, gives employers a realistic way to comply other than by creating or altering ERISA plans. Id. at 13,948.

ARGUMENT

Rehearing en banc should be granted because this case raises a recurring issue of exceptional importance concerning the extent to which ERISA permits recent attempts by state or local governments to require employers to pay for or provide medical benefits for their employees. See Supp. Excerpts of Record 49-53 (National Conference of State Legislatures listing of 2006-2007 Fair Share Health Care Fund or "Pay or Play" Bills); Pet. for Reh'g En Banc 2. Until now, the two courts that have addressed such laws have concluded that ERISA preempts them. See Fielder, 475 F.3d at 193-97 (4th Cir. 2007); Retail Indus. Leaders Ass'n v. Suffolk County, 497 F. Supp. 2d 403, 416-18 (E.D.N.Y. 2007). As Golden Gate argues, Pet. for Reh'g En Banc 2-3, the panel's contrary decision opens the door to potentially inconsistent state and local regulation of employer-provided healthcare that cannot be reconciled with ERISA's preemption, in the interest of maintaining a nationally uniform scheme of applicable legal requirements, of state and local laws that mandate employee benefit structures or their administration or that interfere with uniform plan administration. The panel's decision also threatens intra-circuit uniformity on the nature of ERISA plans and conflicts with preemption principles recognized by the Supreme Court and the Fourth Circuit's decision in Fielder.

A. Introduction

ERISA regulates the provision of health benefits by private employers. An ERISA covered plan is simply an arrangement by which private employers provide their employees covered benefits, either directly through a self-administered plan or indirectly through a third party. 29 U.S.C. § 1002(1), (7) (definition of "welfare plan"). The purpose of ERISA's preemption provision, id. § 1144(a), is to ensure the primacy of the federal regulatory scheme. The San Francisco law, however, takes aim at the same conduct that ERISA regulates – private employers' provision of health benefits. S.F. Admin. Code § 14.3(a). It plainly relates to ERISA covered plans because whether and how much an employer is required to pay into the City program is directly related to whether the employer has an ERISA plan and if so the level of benefits under that plan. Consequently, it is preempted because it intrudes upon what is supposed to be an exclusively federal scheme. In holding the HCSO not to be preempted, the panel misunderstood the threshold for when an employer establishes an ERISA plan and, in conflict with the statute and prevailing precedent, set the bar for ERISA preemption substantially too high.

B. The panel inadequately addressed circuit precedents in its analysis of the City-payment option and mischaracterized the Secretary's position

Although it upheld San Francisco's law, the panel failed to identify any way an employer can comply with its spending requirements without creating or altering an ERISA plan, other than through the City-payment option. Whether the

City-payment option requires an employer to create an ERISA plan is thus critical because, if it does, there is no question that the City's law is preempted. See Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 16 (1987); Panel Op. at 13,927. The panel's conclusion that this option severs any possible relationship between the law and ERISA plans, rendering the law non-preempted, not only overlooks the obvious fact that the HCSO is premised on what the City has determined to be inadequate behavior on the part of some employers in their provision of ERISA-covered health benefits to employees, but, in its analysis of the City-payment option, fails to apply the established test or reach the correct conclusion regarding whether the option itself entails the creation of ERISA plans.

The Secretary argued in support of Golden Gate that the City-payment option meets the test generally used by this and other courts to determine whether an employer has established an ERISA plan. Sec'y Amicus Br. 13-17. Under that relatively low-threshold test, a plan exists if there is an ongoing administrative program and a reasonable person can ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits. Id. at 13 (citing Winterrowd v. Am. Gen. Annuity Ins. Co., 321 F.3d 933, 939 (9th Cir. 2003)). This low-threshold test implements ERISA's objective of a uniform body of benefits law but is also central to accomplishing ERISA's remedial purposes. While it ensures the statute's broad reach it also prevents employers from

sponsoring benefit programs "through the purchase of insurance or otherwise" (29 U.S.C. § 1002(1)) that evade ERISA's protective requirements merely due to a lack of formality.

The Secretary explained that when an employer chooses to fund health benefits for its employees by making payments to the City under the HAP program, the employer establishes an ERISA-covered plan for its employees, just as an employer establishes an ERISA-covered plan when it provides health benefits for its employees through the purchase of insurance. Id. at 13-14 (citing Qualls v. Blue Cross of Cal., 22 F.3d 839, 843 (9th Cir, 1994) (holding that an employer's purchase of insurance for its employees creates a plan because of the "complex ongoing relationship between the insureds and the insurer which require[s] the constant administrative attention by the insurer").

There is no relevant difference between an employer's decision to provide benefits through HAP or to provide benefits through the purchase of insurance – in both cases, the employees receive their benefits from a third party and the program is substantially administered by a third party. Nothing in the statute or the case law turns on whether the particular benefit arrangement relies upon a private insurer for the administration of benefits, rather than public employees or contractors hired by the City. Whether the employer provides benefits through private insurance or

HAP, it has elected an arrangement for providing ERISA-covered benefits to its employees that meets the established test for determining whether a plan exists.

The Secretary agrees with Golden Gate that the panel erred in deviating from the generally-accepted test for determining whether a plan exists and deciding that the case from this Court originally applying that test "is almost certainly no longer good law" in light of Fort Halifax. Panel Op. at 13,932 (discussing Scott, 754 F.2d at 1503-04). As Golden Gate argues (Pet. for Reh'g 11-12), Scott has never been overruled, and the Supreme Court cited Scott without disapproval in Fort Halifax, 482 U.S. at 7 n.5. The Secretary and other courts of appeals have also generally accepted that test. See, e.g., Sec'y Amicus Br. 13; Kenney v. Roland Parson Contracting Corp., 28 F.3d 1254, 1257 (D.C. Cir. 1994) (citing cases). Indeed, as recently as 2003, in Winterrowd, 321 F.3d at 939, this Court reaffirmed the test; it certainly did not hold that the Scott test was no longer good law in light of Fort Halifax.[1]

Moreover, the panel erroneously heightened the test for determining when an "ongoing administrative scheme" exists. The Supreme Court has recognized

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[1] Citing dicta from Sandstrom v. Cultor Food Science, Inc., 214 F.3d 795, 797 (7th Cir. 2000), the panel questioned whether the criteria for determining whether a plan exists, first established in Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc), survive the requirement in Fort Halifax for an ongoing administrative scheme. Panel Op. at 13,934. That requirement is consistent with the Dillingham requirement for a reasonably ascertainable claims procedure. See, e.g., Williams v. WCI Steel Co., 170 F.3d 598, 604 (6th Cir. 1999).

that a state-required "benefit whose regularity of payment necessarily required an ongoing benefit program" necessarily requires administration of a plan. Fort Halifax, 482 U.S. at 18 n.12; see also id. at 14 n.9 (payment of death benefits requires a plan because "[t]he ongoing, predictable nature of this obligation therefore creates the need for an administrative scheme to process claims and pay out benefits"). The panel required not only employer conduct sufficient to establish or maintain a plan, but enough employer discretion in the ongoing administration of the arrangement to run the risk of employer mismanagement of funds or other employer abuse. Applying this heightened standard, the Court then concluded that an employer's obligations under the City-payment option do not present the supposedly required risks. Panel Op. at 13,931. By requiring that level of risk, however, the panel altered the standard for determining when a plan exists and failed to address possible abuses that ERISA was designed to address that could result from employer choice of the City-payment option. See Sec'y Amicus Br. 19 (explaining that the City-payment option provides no fiduciary standards to ensure that money employers pay to the City is properly used for employee health accounts or benefits or is subject to any of the constraints imposed by ERISA to protect employees).

The panel's errors, however, run deeper. The panel simply failed to address the Secretary's argument that, under this Court's Qualls decision, a plan may exist

even though a third party's responsibility for ongoing administrative activities limits the employer's actual discretion. See Qualls, 22 F.3d at 843. It appears that the panel incorrectly viewed the Secretary as arguing that the City-run program was itself a plan. The Secretary never made that argument. Instead, the Secretary argued that an employer who chooses the City-payment option establishes an ERISA plan "in the same manner . . . as when it provides health benefits through the purchase of insurance." Sec'y Amicus Br. 16; see id. at 6, 13-17. At oral argument, counsel for the Secretary specifically stated, in response to a question from the Court, that the City-run program was not an ERISA plan. See http://www.ca9.uscourts.gov (Audio Files, No. 07-17370, first entry, 44:45 minutes).[2] The Secretary was therefore making the same argument that Golden Gate made, i.e., that ERISA preempts the City-payment option because it requires employers to establish an ERISA plan. Qualls is an additional authority that at a minimum is in significant tension with the panel decision: no meaningful distinction can be made between a private insurer acting as a third-party administrator and a public agency or its independent contractor acting as a third-party administrator; and structuring the arrangement as a payment to a

[2] Under the Secretary's view, each employer paying the City to partially fund the HAP, thereby guaranteeing its employees access to the HAP's medical benefits under favorable terms, has established a plan, but this does not mean that the HAP is an ERISA plan, making the City a plan sponsor or fiduciary, or the HAP a plan, subject to ERISA.

government-created entitlement program does not mean the arrangement is not a plan from the employer's perspective or carve out an exception to ERISA preemption that the statute nowhere provides.

C. The panel failed to apply the Supreme Court's test for determining when a state law interferes with uniform plan administration and reached a result that is inconsistent with the Fourth Circuit's Fielder decision on that issue

The Supreme Court has repeatedly explained that ERISA's preemption provision, 29 U.S.C. § 1144(a), is "intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . ., [and to prevent] the potential for conflict in substantive law." New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995) (citation omitted) (emphases added). The Supreme Court's test therefore requires an assessment not only of the burdens of the local law at issue but of the potential for conflict if other state or local governments enacted similar laws. See, e.g., Egelhoff v. Egelhoff, 532 U.S. 141, 151 (2001). The Supreme Court's test also looks not just to potential burdens on plans and plan administrators, but to burdens on employers in their capacity as plan sponsors. See id. ("This tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction is exactly

the burden ERISA seeks to eliminate") (citation and internal quotations omitted; emphasis added).

The Secretary explained to the panel that permitting the City to enforce San Francisco's health care spending requirements creates an obvious potential for conflict with pay-or-play laws that other jurisdictions have enacted or have considered, and imposes an impermissible burden on plan sponsors and administrators to monitor, coordinate, and comply with such differing obligations. Sec'y Amicus Br. 25-28. Golden Gate made a similar argument. Appellee's Answering Br. 27-33. That potential is acute when an employer may be faced not only with having to comply with (or even keep track of) multiple state laws, but with a potentially much greater number of varying municipal laws such as the one San Francisco enacted. Even if the administrative burden imposed by a single law may be tolerable, the cumulative burden could be staggering and runs directly counter to ERISA's goal of encouraging employers, who may operate nationally, voluntarily to provide uniform employee benefits under the legal framework provided by a federal scheme with intentionally broad preemptive force.

The panel nonetheless failed to consider the potential for conflict from other pay-or-play laws. Pet. for Reh'g En Banc 14-15. Instead, it simply stated that San Francisco's HCSO does not impose "on plan administrators" any burden of complying with conflicting directives relating to benefits law, without providing

any analysis of how other pay-or-play laws may differ and interact. Panel Op. at 13,942. It also failed to consider burdens on employers as plan sponsors. It recognized that the law imposes burdens on employers, but decided that they are permissible because "these burdens exist whether or not a covered employer has an ERISA plan. Thus, they are burdens on the employer rather than on an ERISA plan." Id. Under a proper analysis, the panel should have considered the burdens the HCSO imposes on employers who already have or may establish ERISA plans (i.e., plan sponsors) and determined that it interferes with their ability to maintain plan uniformity to the extent they operate in different jurisdictions.

Accordingly, the panel's decision conflicts with the Fourth Circuit's analysis of the uniformity issue in Fielder. As Golden Gate explains in its rehearing petition (Pet. for Reh'g En Banc 15-16), there were two holdings in the Fourth Circuit's conclusion that ERISA preempts Maryland's Fair Share Health Care Fund Act, which required certain large employers to spend 8% of their payroll for employee health care or pay the shortfall to the state Medicaid fund. First, the court held that ERISA preempts the law because the law effectively mandated that covered employers pay for health care for their employees because no rational employer would pay the state rather than cover its own employees directly. Fielder, 475 F.3d at 193-94. Second, the court held that employers had no meaningful other way to pay for their employees' health care without affecting

ERISA plans but even if there were a meaningful non-ERISA way to comply with the law, "we would still conclude that the Fair Share Act had an impermissible 'connection with' ERISA plans." Id. at 196. The court reasoned that because "the vast majority of any employer's healthcare spending occurs through ERISA plans...the primary subjects of the [law] are ERISA plans, and any attempt to comply with the [law] would have direct effects on the employer's ERISA plans." Id. The court further reasoned that "a proliferation of similar laws in other jurisdictions would force [employers] to monitor these varying laws and manipulate [their] healthcare spending to comply with them, and that such effects would deny covered employers a uniform nationwide administration of their healthcare plans." Id. at 197.

The panel's decision addresses only the Fourth Circuit's rejection of the state-payment option as a realistic way to comply with the Maryland law at issue in Fielder. Panel Op. at 13,946-49. However, the panel failed to address the Fourth Circuit's conclusion that even if an employer has meaningful ways to comply with a healthcare spending requirement without affecting ERISA plans, the law is still preempted because of its interference with the employer's ability to administer a uniform nationwide healthcare plan. Rehearing en banc is warranted because the panel's finding of no preemption is inconsistent with the Fourth Circuit's correct analysis on the uniformity issue.

CONCLUSION

The petition for rehearing en banc should be granted.

Respectfully submitted.

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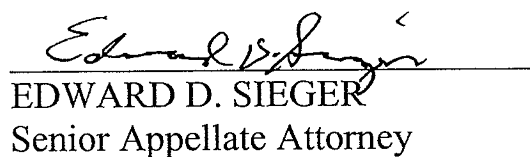
CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7), I hereby certify that the Brief for the Secretary of Labor is proportionally spaced in 14-point type and contains 4,058 words as determined by the Microsoft Word software program used to prepare the brief.



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I hereby certify that on this 31st day of October 2008, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit 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, or have dispatched it to a third party commercial carrier for delivery within 3 calendar days, to the following non-CM/ECF participants:

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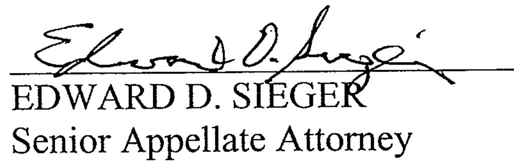

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