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, ET AL.,
Intervenors/Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE AMERICAN BENEFITS COUNCIL AND HR POLICY ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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BRIEF OF THE AMERICAN BENEFITS COUNCIL AND THE HR POLICY ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

The American Benefits Council (the "Council") and the HR Policy Association (the "Association") (together, "*amici*") submit this amicus brief urging this Court to review the Ninth Circuit's decision in *Golden Gate Restaurant Association v. City and County of San Francisco, et al.*, 546 F.3d 639 (9th Cir. 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"). The Decision disregards Supreme Court precedent and conflicts with the United States Court of Appeals for the Fourth Circuit's decision on an issue of national importance.

INTEREST OF *AMICI*

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.[1] The Council's members are primarily

[1] No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae*, its members, or its counsel made a monetary contribution to its preparation or submission. Counsel of record for all parties received notice at least 10 days prior to the due date of the *amici curiae*'s intention to file this brief.

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.

HR Policy Association brings together the chief human resources officers of more than 270 of the largest corporations in the United States. Representing every major industrial sector, the Association's member companies employ more than 18 million employees. All of HR Policy's member companies operate employee welfare benefit plans. In addition, many of the companies also provide similar health benefits to retired employees and dependents.

This case is of significant national importance to employer-sponsors of health benefits plans and their employees. Members of the Council and the Association offer some of the Nation's most generous and well-managed health benefit plans which cover employees that reside in many states, counties, and cities. 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

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The parties' letters consenting to the filing of this brief have been filed with the Clerk's office.

for their employees without regard to the particular state or locality in which they live. This decision creates a roadmap for thousands of jurisdictions to enact similar laws, each with individual requirements necessitating the allocation of significant resources to ensure compliance. The result will be to increase employer costs for providing health and welfare benefits—costs which are inevitably shared with employees through increased premiums, deductibles or other out-of-pocket expenses.

SUMMARY OF ARGUMENT

Congress is in the midst of enacting comprehensive legislation for the national health care problem. The legislation will be implemented through a variety of measures that will inevitably conflict with the scheme adopted by the City. This fact alone counsels this court to accept this case to minimize such future conflicts. Moreover, even if Congress fails to adopt comprehensive federal health care legislation, left uncorrected, the Decision fundamentally undermines ERISA preemption for all employee benefit plans, not just health plans. *Golden Gate Restaurant Association v. City and County of San Francisco, et al.,* 558 F.3d 1000, 1007, 1008 (9th Cir. 2008) (hereinafter "*GGRA II*") (*en banc* dissent from rehearing concluding that the Decision "strike[s] at the heart of ERISA" and "greatly revises ERISA preemption case law.") Following the reasoning of the Ninth Circuit's decision, there is nothing to prevent states or localities from establishing similar "pay or play" schemes for any type of employee benefit—including pension plans, disability plans, life insurance plans—whenever state or local officials determine. Simply put, as a result of this Decision, the field that was

once entirely occupied by the federal government—pension and welfare plan benefits—will be divvied up between a myriad of federal, state and local governmental interests.

The dissent to *en banc* rehearing recognized as much, noting that the Decision "allows San Francisco to create an ordinance that effectively requires 'ERISA administrators to master the relevant laws of 50 States'—which in turn 'undermine[s] the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately born by the beneficiaries.'" *Id.* (quoting *Egelhoff v. Egelhoff,* 532 U.S. 141 (2001)). Such a result contravenes Supreme Court precedent and creates a split of authority with the Fourth Circuit. Further, following this Decision, "similar laws will become commonplace, and the congressional goal of national uniformity in the area of employer-provided healthcare will be thoroughly undermined, with significant adverse consequences to employers and employees alike." *Id.* at 1004.

ARGUMENT

I. RESOLVING THIS CASE WILL FOSTER CONGRESSIONAL EFFORTS TO ADOPT COMPREHENSIVE HEALTH CARE REFORM.

It might be argued that pending federal health care legislation weighs in favor of this Court declining certiorari in this case. But failing to take this case at this time would undermine federal efforts and will be disastrous for employers that provide health benefits. It is essential that this Court grant the Petition to address this nationally significant

question and to reaffirm the long-standing interpretation of ERISA's preemption provisions.

Congress is poised to enact comprehensive legislation to address the national health care problem. Such legislation would be implemented through a variety of measures that will inevitably conflict with the scheme adopted by the City. For example, the 852 page health care bill released by the House Democrats[2] would

- reform the insurance markets, requiring insurers to guarantee issue all coverage and imposing federal rating restrictions,
- establish new consumer protections relating to appeals, external review, prompt payment and remedies,
- require all Americans to purchase insurance or otherwise face federal tax penalties (the "individual mandate"),
- require all employers to provide minimum health care coverage or else otherwise pay substantial federal penalties (the "pay or play" mandate),
- establish a comprehensive new federal regulatory agency (the Health Choices Administration) that would develop

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[2] United States House of Representatives TriCommittee Health Reform Discussion Draft, June 19, 2009 version, available at http://waysandmeans.house.gov/media/pdf/111/hrdraft1xml.pdf.

sweeping new minimum benefit standards for Qualified Health Benefit Plans (which include *all* ERISA covered health plans) and administer insurance market reforms and consumer protections,

- establish a new federal Health Insurance Exchange through which employers and individuals can obtain federally regulated Qualified Health Benefit Plans,
- provide for tax credits for small employers and premium subsidies for lower income Americans, available only to employers and individuals that purchase insurance though the Health Insurance Exchange, and
- establish a new federal health care plan that competes side by side with private health insurance and is available to anyone obtaining insurance though the Health Insurance Exchange.[3]

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[3] The proposed Senate bills are similarly ambitious and similarly conflict with the Ordinance. For instance, the Committee on Health, Education, Labor, and Pensions' 615 page "Affordable Health Choices Act" would impose broad new insurance market reforms, impose an individual mandate; impose an employer "pay or play" mandate; establish state based Health Benefit Gateways (similar to the Health Insurance Exchange in the House bill); establish a public plan option; provide premium credits on a sliding scale to lower income Americans; establish minimum ("essential") benefits as determined by a Medical Advisory Council, among other initiatives. United States Senate

If the Decision stands, the approach adopted by the City will irreconcilably conflict with a new federal law in literally thousands of ways, big and small. For example, the Ordinance's spending target for employers is different than the House bill's employer spending mandate. The penalties for failing to meet the minimum employer spending level are different under each scheme. Uninsured employees in the City get coverage through the City's Health Access Program ("HAP"), but uninsured employees under the House bill would get insurance through the federal Health Insurance Exchange (including a public plan option). Employees will have access to federal premium subsidies if they are low income in the federal Health Insurance Exchange, but no such federal subsidies would be available to City residents under the City's HAP program. Small employers in San Francisco paying into the City's HAP program could not get tax credits, but such credits would be available to small employers obtaining coverage offered via the new federal Exchange. In short, the tension between the current proposals and the Ordinance is undeniable. In fact, the tension between the current federal proposals and *any* local regulation is indisputable—none of the current proposals contemplate dual federal-state regulation of em-

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Committee on Health, Education, Labor, & Pensions "Affordable Health Choices Act" draft bill, available at http://help.senate.gov/BAI09A84_xml.pdf; Amendment to "Affordable Health Choices Act" draft, available at http://dodd.senate.gov/multimedia/2009/BillText.pdf.

ployer-based health care, and none abandon or amend ERISA's preemption provision.

Clearly, if allowed to stand, the Ordinance will add a level of unwarranted confusion and complexity to the implementation of an otherwise massive federal health care reform measure, a federal-state regulatory conflict that ERISA clearly sought to limit. The Ordinance will needlessly complicate the already intricate and fiercely negotiated proposals being considered by Congress. Further, the costs, complexity and uncertainty will punish the employers that offer health benefits in San Francisco at a time when all employers are struggling to survive in the worst economic crisis since 1929. And the conflict between federal and state requirements will confound state and federal regulators alike. The San Francisco Ordinance is a well-intentioned local effort to address a vexing national problem. Although laudatory, the San Francisco effort will stand in the way of a uniform health care solution.

Even if this Court is unpersuaded that the Ordinance is preempted under ERISA, the Court should nonetheless take this case. Congress must know the legal background against which it is legislating. If San Francisco's Ordinance is not preempted under ERISA currently, as the Council and the Association believe it is, Congress must be informed of ERISA's preemptive scope and adjust its legislation accordingly. For example, as explained above, the Congressional proposals currently do not accommodate state and local regulation and in many cases, directly conflict with current local laws, including the Ordinance. Without a definitive decision from this Court regarding ERISA's preemptive scope, any

Congressional action will likely be incomplete and may require further Congressional action at the time this Court finally and inevitably resolves the preemption issue.

Importantly, this Court does not shy away from resolving deeply important national issues in the face of pending legislation. For example, while the Civil Rights Act of 1968 was pending, this Court granted certiorari and decided *Jones v. Alfred H. Mayer Co.*, 392 U.S. 409 (1968). In its decision, the Court discussed in detail how both Congressional and Court action was necessary. Congress was aware that a favorable decision by the Court might ban the particular discriminatory conduct at issue, but recognized that more comprehensive Congressional action was nonetheless needed. *Id.* at 415-16. For its part, the Court recognized that even in the face of Congressional action, the Court's decision was necessary to address the instant case and to resolve the scope of 42 U.S.C. § 1982's antidiscrimination provisions. *Id.* at 414-17 & n.21. Due to the overriding importance of this issue—and the legal uncertainty caused by the Decision below—this Court should reverse the Ninth Circuit, and reaffirm the correct ERISA preemption standards in this case, providing greater certainty to employers and employees and clarifying the law during this time of Congressional action.

II. THE DECISION ALLOWS STATE REGULATION OF ALL EMPLOYEE BENEFIT PLANS, NOT JUST HEALTH CARE PLANS.

ERISA's preemption provision represents a conscious policy choice by Congress, one 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—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 ... requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *GGRA II*, 558 F.3d at 1007 (quoting *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. Uniformity is a critical part of ensuring that employees understand exactly what benefits to which they are entitled and how to obtain them. *GGRA II*, 558 F.3d at 1009.

The Ninth Circuit's decision rejects any adherence to ERISA's text and this Court's precedent in favor of local and state experimentation. That policy choice was firmly and explicitly rejected by Congress when ERISA was enacted. As the legislative history of ERISA reveals, "the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus

eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 99 (1983) (quoting Senator Williams' statements in the Congressional Record).

More pernicious, however, than the immediate outcome of this Decision is that there is no limiting principle in the Decision that would prevent a state or locality from mandating that employers provide an unlimited array of benefit programs conceived of by state and local governments.

In essence, the Ninth Circuit concluded that a city, county or state could require employers to provide a certain level of benefits to their employees, or pay the locality to do so, without running afoul of ERISA. Logically then, a locality could apply this principle to require that employers must provide life insurance benefits to spouses of all employees and that such coverage must automatically be updated in the event of a divorce and remarriage. Employers that fail to comply by amending their life insurance plans would pay the local government to augment their coverage. This would be permitted under the Decision, but would clearly be at odds with this Court's decision and reasoning in *Egelhoff*. *See* 532 U.S. at 150-51 (concluding that a "statute is not any less of a regulation of the terms of ERISA plans simply because there are two ways of complying with it" and that the statute was preempted because it "'dictate[s] the choice[s] facing ERISA plans'" by leaving plan administrators only the "choice of timing *i.e.*, whether to bear the burden of compliance *ex post*, by paying benefits as the statute dictates (and in con-

travention of the plan documents), or *ex ante*, by amending the plan.").

Given the volatility of the stock market recently, a state might require every employer operating within the state to make matching contributions to all of its employees' 401(k) accounts. If the employer does not offer a 401(k) matching contribution, the state might require the employer to pay the matching amount to a state established defined contribution plan. Or a more aggressive state may decide to address the pressing problem of retirement security by giving employers precisely the same type of options offered under the current San Francisco Ordinance, but require the contributions be used to fund a defined benefit pension plan. Under such a "Pension Plan Ordinance" an employer could fund a defined-benefit pension by a certain dollar amount for every employee. If the employer did not meet the required minimum, it would be required to pay the difference into a state-run pension fund—just as in the current San Francisco Ordinance.

These are the logical results when pressing national problems are addressed in a newly-created regulatory field that had once been occupied explicitly and entirely by the Federal government. Some active localities will rush to the field in myriad different and conflicting ways. Employers may be forced to shift scarce resources to compliance in high cost states, rather than to the provision of uniform benefits to all employees. The result could leave employees in some states with fewer benefits or they may lose their plan altogether.

What cannot be missed is that the policy choices and substantive protections embedded in ERISA will be lost. Under the new state and locally run benefit plans, employees will no longer have the protections of ERISA. Protection of federally mandated fiduciary duties, federally guaranteed pension benefits via the Pension Benefit Guaranty Corporation, federally mandated minimum pension funding requirements, extensive benefit disclosure and claims appeal rights, and access to the federal courts will all be lost to employees. Employers will drown in a morass of overlapping, burdensome and contradictory obligations. *GGRA II*, 558 F.3d at 1009 ("If upheld, *Golden Gate* will undoubtedly serve as a roadmap in jurisdictions across the country on how to design and enact a labyrinth of laws requiring employer compliance on health care expenditures …"). Congress rejected this scenario more than thirty-five years ago in favor of national uniformity through ERISA.

Because the Ninth Circuit's Decision effectively reads ERISA's preemption provision out of the statute, undermining employee benefits ranging from health care to retirement, timely intervention by this Court is imperative.

III. THE DECISION DIRECTLY CONFLICTS WITH SUPREME COURT PRECEDENT.

The Ninth Circuit misgauged the scope of ERISA preemption when it found that the Ordinance was not preempted because employers could comply with the law by simply writing a check to the City. *GGRA,* 546 F.3d at 660. Since compliance could occur without a mandated plan change, the panel con-

cluded that ERISA preemption was not implicated. But this reasoning misreads the scope of ERISA preemption and Supreme Court precedent because the Ordinance impermissibly "structures employers' choices with respect to their existing ERISA plans." *GGRA II*, 558 F.3d at 1007. *See also Egelhoff*, 532 U.S. at 150 (a "statute is not any less of a regulation of the terms of ERISA plans simply because there are two ways of complying with it").

In *Egelhoff*, this Court concluded that a state law automatically revoking spousal beneficiary designations upon divorce was preempted by ERISA. 532 U.S. at 150. This was so even though employers were able to opt out of the state law requirement by simply amending the plan document to state that the state's automatic beneficiary change was not effective. *Id.* at 150-51. Although a one-time plan change (or payment of benefits to the state's default beneficiary) may not have been especially burdensome, the very fact that the statute forced plans and employers to make those choices at all was objectionable, *id.* at 151, given that the statute bound plan administrators to particular state rules, *id.* at 147. Even more troublesome, as the Court recognized, allowing a state to pose such a choice strikes at the very heart of ERISA because plan administrators could be forced potentially to account for provisions in all 50 states. *Id; accord GGRA II*, 558 F.3d at 1007-1008.

The Ordinance places employers in the same box squarely rejected in *Egelhoff*. *See* 532 U.S. at 150-51. The Ninth Circuit below candidly admits that a "covered employer may choose to adopt or to change an ERISA plan in lieu of making the required health

care expenditures to the City." *GGRA*, 546 F.3d at 656. Despite this obvious "connection with" ERISA plans, the Ninth Circuit concluded that the Ordinance was not preempted because it did not *require* an employer to adopt an ERISA plan.[4] *Id.* at 655. Yet neither did the ordinance in *Egelhoff*. That statute was impermissible because under ERISA, plan administrators must follow plan documents and after the statute's passage, plan administrators could not make benefit payments "simply by identifying the beneficiary specified by the plan documents." *Egelhoff*, 532 U.S. at 148. So too, after the passage of the Ordinance, plan administrators cannot provide health benefits simply by identifying the benefits specified by the plan documents. Instead,

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[4] ERISA preemption was clearly 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 are preempted. *Shaw*, 463 U.S. 85, 96 (1983) (New York law mandating pregnancy benefits preempted); *Dist. of Columbia v. Gr. Wash. Bd. of Trade*, 506 U.S. 125, 129-30 (1992) (District of Columbia law requiring employers to provide inactive employees on workers' compensation with the same health benefits as active employees preempted); *Local Union 598, Plumbers & Pipefitters Indus. Journeymen & Appr'ship Train'g Fund v. J.A. Jones*, 846 F.2d 1213, 1221 (9th Cir. 1988) (Washington law mandating minimum apprenticeship training funds preempted); *Agsalud v. Stnd. Oil Co.*, 454 U.S. 801 (1981), *aff'g* 633 F.2d 760 (9th Cir.) (Hawaii law mandating health benefits law preempted). *See also Aloha Airlines v. Ahue*, 12 F.3d 1498, 1505 (9th Cir. 1993) (Hawaii law requiring airlines to pay for certain medical exams preempted).

they "must familiarize themselves with state statutes so that they can determine" the appropriate and required level of benefits to provide. *Id*. at 148-49. In both cases, employers' choices are impermissibly "structure[d] . . . with respect to their existing ERISA plans." *GGRA II*, 558 F.3d at 1007. As a result, this Court should grant certiorari to find that the Ordinance is preempted by ERISA.

IV. THE COURT SHOULD CLARIFY ERISA PREEMPTION PRINCIPLES IN LIGHT OF THE IRRECONCILABLE DECISIONS OF THE FOURTH AND NINTH CIRCUIT.

Although 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), *GGRA,* 546 F.3d at 559, the vigorous dissent to the denial of *en banc* review belies that view. *See GGRA II,* 558 F.3d at 1004. 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 to the state. *Fielder*, 475 F.3d at 184 (citing Md. Code Ann., Lab. & Empl. § 8.5-104(b)). The Fourth Circuit determined that the Maryland Act was preempted by ERISA, holding that the only rational 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 Ninth Circuit placed great weight on its conclusion that 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*, 546 F.3d at 660. But the Ninth Circuit 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 disrupt employers' uniform administration of employee benefit plans on a nationwide basis," *id.* at 194, and "manipulate health care spending to comply with them," directly running afoul of the Supreme Court's *Egelhoff* decision, *id.* at 197. The dissent to the denial of *en banc* rehearing in this case echoed the Fourth Circuit's concern, recognizing that the burden this Decision "places on employers is potentially very great" and risks "the very kind of health care expenditure balkanization ERISA was intended to avoid." *GGRA II*, 558 F.3d at 1009.

In fact, the parallels between the Maryland Act and the Ordinance are too striking to miss. Both laws establish mandated (but different) minimum spending targets for health care benefits. Both laws compel employers to make up any shortfall by mak-

ing their own plans more generous or by making payments to the government. Both laws require employers to keep new records and make myriad new reports to the government. Both laws impose penalties for noncompliance. As the dissent to the denial of *en banc* rehearing in *GGRA* succinctly stated, "[a] currently non-complying employer in San Francisco has the same choice as a non-complying employer in Maryland: Make a payment to the government or change its current ERISA plan." *GGRA II*, 558 F.3d at 1007-08. The differences between *Fielder* and *GGRA* are illusory, the cases are in irreconcilable tension, and this Court should grant certiorari to resolve the conflict.

V. THE DECISION DEPARTS FROM LONG-SETTLED LAW DEFINING ERISA PLANS.

The Decision below concedes that if the payments to the City created an ERISA plan, the Ordinance would be preempted. *GGRA*, 546 F.3d at 653. 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 court held that the Ordinance did not implicate preemption.

As the Department of Labor's amicus brief in the court below definitively and exhaustively explains, 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 insur-

ance 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.

Even if an employer merely purchases insurance and delegates many of the plan's administrative duties (*e.g.*, claims payment) to the insurer, an ERISA welfare plan has been created. *See, e.g., Brundage-Peterson v. Compcare Health Servs. Ins. Corp.*, 877 F.2d 509, 511 (7th Cir. 1989). 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. *Donovan v. Dillingham*, 688 F.2d 1367, 1372-73 (11th Cir. 1982).

This expansive definition of an ERISA plan serves to protect employers and employees alike. As this Court has observed

> Congress enacted ERISA to 'protect ... the interests of participants in employee benefit plans and their beneficiaries' by setting out substantive regulatory requirements for employee benefit plans and to 'provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts.' 29 U.S.C. § 1001(b). The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans.

Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004). In just one recent example, the Seventh Circuit preserved an employee's ERISA claim against

her employer despite the absence of a formal plan document. *Leister v. Dovetail, Inc.*, 546 F.3d 875 (7th Cir. 2008)(Posner, J.). It is difficult to see how a contract with a third-party administrator for 401(k) plan services could meet the definition of an ERISA plan, as it did in *Leister*, under the Ninth Circuit's reasoning. For instance, contrast a typical 401(k) plan with the Ninth Circuit's description of why the HAP program was not an ERISA plan: "[e]mployer payments . . . [routinely] provide only a small portion" of a 401(k) plan's funding (as with the HAP program) and 401(k) plans are administered by entities other than the employer as a matter of course (as with the HAP program). *Id.* Although the nature of HAP enrollment distinguishes it from a typical single employer 401(k) plan, a multi-employer 401(k) plan seems directly analogous to the HAP participation model. In short, it is difficult to reconcile the Seventh Circuit's *Leister* decision that an ERISA plan existed with the Ninth Circuit's cramped plan analysis. And absent an ERISA plan, Leister would have been left without a claim to benefits. *Leister*, 546 F.3d at 879.

ERISA provides participants with substantive protections and access to the federal courts, while employers receive the benefits of uniform regulatory requirements. The Ninth Circuit's unduly narrow definition of an ERISA plan threatens not only to subject employers to a patchwork of possibly conflicting requirements, but may strip employees of important federal protections regarding employer-provided health benefits.

CONCLUSION

For the reasons above, the petition for writ of certiorari should be granted.

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