Case Nos. 07-17370, 07-17372

Oral Argument scheduled for April 17, 2008

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)

BRIEF AMICUS CURIAE OF AMERICAN BENEFITS COUNCIL IN SUPPORT OF GOLDEN GATE RESTAURANT ASSOCIATION AND IN SUPPORT OF AFFIRMING THE DISTRICT COURT DECISION

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

The Honorable Jeffrey S. White

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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: ____________, 2008

Respectfully submitted,

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STATEMENT REGARDING CONSENT OF ALL PARTIES FOR AMERICAN BENEFITS COUNCIL TO FILE BRIEF AMICUS CURIAE

The American Benefits Council ("Council") requested consent 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 brief to assist the Court in its review of the decision of the United States District Court for the Northern District of California in *Golden Gate Restaurant Association v. City and County of San Francisco, et al.,* No. C 06-06997 JSW, 2007 WL 4570521 (N.D. Cal. Dec. 26, 2007). The decision held that the San Francisco Health Care Security Ordinance ("Ordinance") is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA").

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 include 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 importance to the Council. Its 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 and the Ordinance, and other similar "pay-or-play" laws, if allowed, would 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 all 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 and may force employers to reduce their health coverage or drop it altogether.

ARGUMENT

I. Introduction and Summary

The District Court was correct that the Ordinance is preempted by ERISA because it forces employers operating in the City or County of San Francisco

("City") to treat a subset of their work force differently in order to meet the City's mandated spending requirement for health care benefits. Regardless of how an employer chooses to meet the City's requirements, it forces an employer to make choices in benefit structures and administration that Congress thought were better left to employers and not to state and local governments. The District Court's decision is consistent with the decisions of other courts that have addressed similar pay-or-play laws. *See Retail Ind. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007) (addressing the Maryland Fair Share Health Care Fund Act); *Retail Ind. Leaders Ass'n v. Suffolk Co.*, 497 F. Supp. 2d 403 (E.D.N.Y. 2007) (addressing the Suffolk County Fair Share for Health Care Act).

A panel in this Circuit stayed the District Court's injunction, signaling its own view that on the merits the Ordinance was not preempted by ERISA. *Golden Gate Restaurant Ass'n v. City and County of San Francisco,* 512 F.3d 1112 (9th Cir. 2008) ("Stay Decision"). The panel reached that conclusion based largely on the reasoning that compliance with the Ordinance did not require an employer to modify an ERISA-covered employee benefit plan. Specifically, the panel thought that employers that did not meet the Ordinance's health care spending mandates could otherwise comply with the Ordinance without implicating ERISA by simply

making a payment to the City to fund membership in the Health Access Program/*Healthy San Francisco* ("Program").[1]

The Council believes that the Stay Decision misreads the scope of ERISA preemption and the Supreme Court's rulings by not fully considering the legal significance of a law compelling employers to make a choice about their existing plans, or the practical consequences of the particular "choices" thrust upon employers by the Ordinance.

As we discuss in more detail below, for the many employers that do not already meet its requirements, the Ordinance compels an employer to make one of two choices. An employer could choose to amend or establish an ERISA-covered health plan that creates a separate benefits and administrative structure for its San Francisco employees. This option would saddle the employer with the burdensome and conflicting local standards for health plans of the sort that Congress attempted to prevent through preemption. This would create a problem that would grow exponentially if thousands of state and local governmental

[1] The Ordinance provides that the funds paid to the City under the Ordinance will be used to fund membership into the Program *or* establish and maintain medical reimbursement accounts ("MRAs"). The Program provides health services to uninsured residents of the City. *See* Regulations Implementing Healthy San Francisco and Medical Reimbursement Account Provisions of the San Francisco Health Care Security Ordinance ("Healthy S.F. Reg.") § 5(a). To participate in the Program, an individual must meet certain eligibility requirements, including residency in the City and a lack of health insurance coverage. Healthy S.F. Reg. § 3(a). Individuals that do not meet all of the eligibility requirements for the Program (*e.g.*, nonresidents and individuals with some health care coverage) may sign up for an MRA. Individuals may obtain reimbursements from the MRAs for medical care, services and goods that qualify as tax deductible medical expenses under Internal Revenue Code § 213.

jurisdictions were to follow the City's lead and impose their own unique standards. Alternatively, an employer could choose to carve "covered employees" out of their health plans and simply pay the City.

This "choice" stratagem to avoid preemption cannot be squared with the Supreme Court's holding in *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 & n.1 (2001). *Egelhoff* rejected the view that states can avoid preemption by offering employers a theoretical means to avoid changing their ERISA plans, especially one that few of the Council's members would make for a host of reasons.

Perhaps more importantly, the notion that an employer can comply with the Ordinance without creating or amending an ERISA plan—and thereby implicating ERISA preemption—is simply not correct as a matter of law. Under one choice, an employer that is not already in compliance with the Ordinance must create or amend an ERISA plan to meet the Ordinance's spending targets. And, as the statute and the case law demonstrate, if such an employer instead chooses to pay amounts to the City to fund the Program, the fact that the employer must design and execute an ongoing administrative scheme means that the employer has created a separate "employee welfare plan" subject to ERISA. It is that act of coercion—the forced establishment or amendment of an ERISA plan to comply with the Ordinance—that implicates ERISA. As the Supreme Court has repeatedly

emphasized, Congress, through ERISA, intended for employers to have the option of creating plans or not.

In short, under all of the pathways to compliance with the Ordinance, a complying employer must establish or modify an ERISA plan that is dictated not by the needs of its business and workforce but by the City's view of what benefits should be afforded their residents. And that is precisely what ERISA preemption is designed to prevent.

II. Congress Intended to Prohibit States and Local Governments from Dictating Choices to Employers with Respect to Their Health Plans.

A. The Ordinance Dictates that San Francisco Employers Make Certain Choices.

In the past several years, the Supreme Court has refined its interpretation of ERISA preemption to allow for the fact that employee benefit plans are a significant part of our economy and some state regulation is bound to affect them at least indirectly. For example, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995), the Court found that New York's indirect economic regulation of plans through a general tax on hospital charges did not trigger preemption since it did not preclude uniform administrative practices or benefit packages. 514 U.S. at 659-661. But, the Court recognized that while an indirect economic regulation of a product or service purchased by a plan generally does not force a particular choice on an employer

that implicates ERISA preemption, "there might be a point at which an exorbitant tax leaving consumers with a Hobson's choice would be treated as imposing a substantive mandate." *Id.* at 664. *See also Employee Staff'g Servs., Inc. v. Aubry*, 20 F.3d 1038, 1041 (9th Cir. 1994) (holding that state laws that dictate how employers must write their ERISA plans, or attempt to condition a requirement on the existence of an ERISA plan, are subject to preemption).

Six years later, in *Egelhoff*, the Court emphasized the importance of looking at the choices a state law imposes on employers with respect to their plans. 532 U.S. at 147-51. In *Egelhoff*, the Supreme Court held that a state law automatically revoking spousal beneficiary designations upon divorce was preempted as it applied to ERISA plans. *Id.* at 150. The Court made this determination even though employers were able to opt out of the state law 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 to make choices at all, the Court held, was objectionable. "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.* Letting any state pose that choice, according to the Court, strikes at the heart of ERISA, for then plan administrators potentially could be forced to account for the opt-out provisions in all 50 states. *Id*. 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. For that reason alone—the fact that the employers must respond to the Ordinance's requirements—ERISA preempts the Ordinance.

Accordingly, we believe that the key to the legal issue presented here is understanding what kinds of choices the Ordinance will impose on employers as a practical matter. One of the reasons the Council believes it is important to present its views is that no one knows more about the choices employers must make in designing and running a health plan than the Council's members.

All of the Council's members that are subject to the Ordinance already sponsor an ERISA-covered group health plan, and most of them are extremely generous under any standard. Many of these plans apply nationwide to employees in every state. Thus, it is telling that many, if not most, Council members have established plans that are probably not in compliance with every aspect of the Ordinance. For example, an employer may use different waiting periods for new employees, or decide to direct its limited health care dollars towards full time employees instead of part time, temporary or seasonal workers.

The Council's members thus have the following options for compliance. Some Council members could amend their ERISA plans to either change the allocation they have made among classes of employees, or they could redirect

money from other benefit programs to meet the City's minimum health care spending requirement for each of these "covered employees." Though unlikely, some Council members could terminate coverage for all their "covered employees" and leave them to make their own way in the City's new and untested program. Other Council members might choose to protect their employees within their existing ERISA plans and pay the City the difference between the minimum health care spending requirement and the actual amount spent on their ERISA plans for each of these "covered employees."

As noted, under *Egelhoff,* the fact that the City forces employers to make choices with respect to essential features (*i.e.*, participation and benefit amounts) of a core ERISA benefit (*i.e.*, health care coverage) is sufficient to trigger preemption. *Egelhoff*, 532 U.S. at 147-48. But, as we now show, it is equally significant that each of the pay-or-play choices compelled by the City, *as a practical matter,* implicates at least one of the central concerns behind Congress' decision to provide for comprehensive preemption of state law in ERISA.

B. Multi-state Health Plans are Complex Undertakings that Require Preemption of State Law for their Efficient Operation

The Council assumes that, if the Ordinance is allowed to stand, initially most employers will choose not to abandon their employees to the City's new and untested Program and will first try to amend their health plans to comply. As a

practical matter, this will entail precisely the type of harm that ERISA preemption was enacted to prevent.

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 Pack'g Co. v. Coyne*, 482 U.S. 1, 9 (1987). *See also Travelers Ins.*, 514 U.S. at 656. Indeed, "[u]niformity is impossible . . . if plans are subject to different legal obligations in different states." *Egelhoff*, 532 U.S. at 148. Preemption can be express or implied and "is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose." *Shaw v. Delta Airlines,* 463 U.S. 85, 95 (1983).

The need for a uniform administrative scheme is highlighted by the complex set of decisions employers make in designing and administering their plans.

Plan design decisions start with a determination of what resources an employer has available for benefits and then a consideration of what portion of those resources should be allocated to health care. That difficult allocation process continues within the specific context of the health plan as the employer determines

who will be eligible, when they will become eligible, how they can elect coverage, and what benefits can be provided with the available funds. After decades of health care cost inflation, every employer is faced with making distinctions in a plan's eligibility provisions that take into account an employee's status as a full-time, part-time, temporary, seasonal, salaried, hourly or collectively bargained employee. The employer must then choose who can obtain coverage through the employee—spouse, dependents only, domestic partners, etc. Similarly, in determining the benefit package, numerous decisions must be made, including cost-sharing requirements, what benefits are covered, pre-authorization requirements, and whether coverage is offered on an indemnity, preferred provider network, or HMO basis (or some combination of the three). Trade-offs are inevitable as employers seek to attract and retain employees in a competitive labor market while keeping their costs low enough that they can be competitive in the marketplace and provide affordable coverage for plan participants.

Even if viewed in isolation, each of the decisions made by employers in designing a health plan is complex on its own. Determining a plan's cost-sharing provisions is a good example. Most large employers may offer employees a number of plan choices that have different employee cost sharing provisions. A single plan may offer options that include different deductible levels, coinsurance, start and end dates for coinsurance, out-of-pocket maximums, limits on services,

and monthly employee contributions (*e.g.*, an employer may cover a greater percent of the cost if the employee enrolls in a less expensive plan option).

Once plans are designed, plan administration activities are similarly complex. Plan specific enrollment materials are prepared and distributed, often with the assistance of consulting firms. An annual enrollment is conducted, generally using a combination of written and electronic (both intranet and internet) media. Many large employers perform enrollment fairs or workshops, or produce DVDs to explain their offerings. Council members spend significant sums to train their human resources personnel in these multi-state plans, and on the procedures and systems infrastructure necessary to administer them. For example, most plans engage third party administrators ("TPA"), who provide the plan with access to a network of health care providers (*e.g.,* doctors, hospitals), process claims for benefits filed by employees, negotiate discounts with providers, make payments to providers, assist in plan enrollment and eligibility, and prepare and distribute information on plan benefits. Sometimes more than one TPA is hired to administer different plan options or different geographic regions. Plan fiduciaries sometimes separately contract with a pharmacy benefit administrator ("PBA"), to assist in putting together the plan's prescription drug formulary, offering the plan a network of retail and mail-order pharmacies that sell covered prescriptions to plan participants at discounted rates, and processing claims for prescription drug

benefits. Plan fiduciaries may engage a myriad of other health plan specialists, including specialists to help coordinate care for chronically sick patients, audit firms to review whether TPAs and PBAs have processed claims consistent with their agreements with providers and the terms of the benefit plan, and consultants to evaluate the overall performance of plan service providers and conduct requests for proposals.

The Ordinance adds another level of complexity to this already highly detailed administrative scheme used for multi-state plans. 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."

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 benefits 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 enacted pay-or-play laws, there could be hundreds of different reporting and filing requirements, eligibility rules, effective dates of coverage, and benefit provisions, all enforced through hundreds of different compliance and penalty regimes. Plan administrators would be forced to constantly stay informed about all of these laws and run duplicative payroll and other administrative systems while they attempt to run their own complicated plans in a parallel universe. Questions will be manifold, answers few, as both employers and jurisdictions struggle to figure out what rule applies, for example, to an employee who works from home and then moves to San Francisco, or who works two days a week in a San Francisco office and three days at home in San Jose.

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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=§ion=allabout&zone=locc&sub_sec=allabout_facts.

This is not a far-fetched scenario. Three jurisdictions have passed pay-or-play laws (including the City), and many more state and local governments are poised to adopt similar laws depending on the disposition of this case. *See* J. Contreras & O. Lobel, *Wal-Martization and Fair Share Health Care Acts*, 19 St. Thomas L. Rev. 105, 136 (2006) (indicating that about 30 states were considering similar pay-or-play laws). Unfortunately, there is no uniformity between the detailed requirements of the Ordinance and any other similar law or pending law, nor would one expect thousands of state and local governments to act in lockstep to produce such uniformity.[4]

If laws like the Ordinance are permitted to stand, employers with multi-state ERISA plans will be forced to discard their previously uniform administrative practices and benefit packages, thereby frustrating ERISA's objective of providing for national uniform administration. *Fort Halifax*, 482 U.S. at 10-11. The connection between laws like the Ordinance and an employer's health plans is inescapable and will lead to the "regulatory balkanization" rightly envisioned by the Fourth Circuit when it addressed the Maryland Fair Share Health Care Fund

[4] Compare, for example, flow charts posted by the enforcement agencies of San Francisco and Vermont, which set out the analysis employers must apply to determine their compliance obligations under the jurisdictions' respective pay-or-play laws and regulations. *Compare* Steps to Determine Whether a Covered Employer Has Met its Spending Requirement under the San Francisco Health Care Security Ordinance (HCSO), *available at* http://www.sfgov.org/site/uploadedfiles/olse/hcso/FlowChrtSteps.pdf, *with* Vermont Dep't of Labor's How to determine if an employee should be included in the calculation for "Full Time Equivalent" (FTE), *available at* http://labor.vermont.gov/Portals/0/UI/Covered-Uncovered%20Tree%20-%20June%202007.pdf.

Act. *Fielder* 475 F.3d at 193 (finding the only rational choice for an employer in a pay-or-play regulatory situation is to amend its ERISA plan). Further, if the Ordinance is passed and other jurisdictions follow with similar laws, multi-state employers will no longer be able to uniformly administer their welfare plans. This loss will cause an increase in costs to plan sponsors and plan participants, and may ultimately result in private employers reducing or completely dropping health care coverage for employees, as well as possibly curtailing or eliminating wellness programs and other employer initiatives for improving the quality of life for employees—all areas where private sector employers have been leaders.

C. The Choice to Provide Coverage Through the City Implicates ERISA Preemption.

In issuing the Stay Decision, the motions panel reasoned that the Ordinance was not preempted, in part, because employers with existing welfare plans theoretically could maintain a plan that does not meet the Ordinance's health care spending requirement and elect to make a payment to the City for the difference between the amount they have paid under their plan and the Ordinance's mandated amount (so-called "Selective High Coverage," "Full Low Coverage," and "Selective Low Coverage" Employers) rather than amend their existing welfare plan. *Stay Decision*, 512 F.3d at 1118. According to the panel, having the option of not modifying or terminating its own plan in order to comply with the Ordinance's mandate allows an employer the opportunity to avoid the real world

consequences on its plan discussed above. Of course, as noted above, this reasoning ignores *Egelhoff*, which made it clear that forcing an employer to make choices with regard to plan administration alone triggers preemption. *Egelhoff*, 532 U.S. at 147-48.

However, this line of reasoning appears to be aimed at distinguishing the Ordinance from the Maryland Fair Share Health Care Fund Act that the Fourth Circuit held was preempted in *Fielder*. In *Fielder*, the court found that the only real option for an employer was to modify its existing plan since the payments to the state would in no way benefit the employer's workforce. *Fielder,* 475 F.3d at 193. But the Council's members cannot disagree more with the idea that paying amounts to the City is a viable choice. Few of the Council's members would seriously consider making payments to the City to provide their employees coverage in its untested Program. Benefits uniformity is more than an administrative necessity. Uniformity ensures that a multi-state employer can offer all of its similarly situated employees the same benefits, ensuring continuity in benefit programs when employees move from one location to another location. Uniformity is also a critical part of ensuring that employees understand exactly what benefits they are entitled to and how to obtain them.

But even if the Council's members were to choose to make payments to the City consistent with the Ordinance, that would not mean that ERISA no longer

applies to those employees. The option of making payments to the City to fund the Program for some employees still implicates ERISA preemption because that choice also requires an employer to create a plan subject to ERISA. Indeed, such an employer would actually be maintaining two ERISA plans—one through its participation in the Program plus the employer's previously established plan for the rest of its employees.

This is a function of the breadth of ERISA. In general, 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). This means any plan that a private employer develops to provide health care coverage for its employees is necessarily an ERISA-covered plan.

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 (April 6, 1990). An employer's plan does not even need to be established through a formal plan document; the employer's actions may be sufficient to constitute "establishing" a plan within the meaning of section 3(1) of ERISA. *Dillingham*, 688 F.2d at 1372 (establishing test for determining if a plan exists); *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1503 (9th Cir. 1985) (following *Dillingham* test).

Of course, it is possible that an obligation that is forced on an employer could create a plan that is covered by ERISA. The Supreme Court has indicated that if an employer is required by a state law to systematically undertake a host of administrative obligations, such as determining eligibility, determining benefit levels, monitoring the availability of funds, and keeping records, an employer's compliance with such state law establishes an ERISA plan. *Fort Halifax,* 482 U.S. at 12-14.

For the reasons set forth above, an employer's payment to the City to fund the Program in lieu of providing compliant coverage through a new or existing ERISA plan results in the establishment of an ERISA plan. Employers making this choice are required to keep records of their workforce and evaluate the generosity and terms of their existing welfare plan so that they can make initial and ongoing

eligibility determinations based on statutory criteria. They are compelled to determine appropriate contribution levels for each of their employees and make regular quarterly payments to the City for it to use on behalf of those employees if the employers' own health care spending (re: ERISA plan expenditures) is deemed insufficient. They must maintain ongoing recordkeeping systems to track eligibility, enrollment and fee payments. They 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, the functions an employer is compelled to carry out if it pays the City are the same functions that an employer must carry out if it elected to satisfy the requirements of the Ordinance simply by purchasing an insurance policy to provide health coverage to its employees. *Cf. Brundage-Peterson,* 877 F.2d at 511. Thus, when an employer decides to pay the City instead of making additional compliant 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. *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. *Shaw*, 463 U.S. at 96 (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'p 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)

This reasoning was not considered by the motions panel when it granted the stay of the district court's order and ruled that the City and the Intervenors were likely to succeed on appeal. Moreover, the panel did not address the Fourth Circuit's ruling in *Fielder*, where that court found that no reasonable employer would choose to pay a general tax to Maryland that would not directly benefit its employees. The Council believes that the option of paying amounts to the City,

while maintaining an existing plan, is just as unattractive and coercive as the Maryland payroll tax struck down in *Fielder*.

As discussed above, the "choice" to pay into the Program is not a practical alternative for most of the Council's members. It does not avoid administrative complexity; but instead adds a whole new layer of complexity. It does not foster equity among the Council's members' employees; it discriminates among them in a way that has no reference to the realities of their jobs or their employers' businesses. It does not foster understanding about the need for employees to take some control over their own health care decisions; it requires them and the Council's members to forfeit control to the City and the vagaries of the political process. It does not help employees understand exactly what they are entitled to; it deprives them of the benefit of the sophisticated communications materials the Council's members work so hard to create. It does not give employees access to the Council's members' employee benefits professionals who have been trained to help employees navigate through the Nation's complex health care system; it leaves them to government agencies who have no stake in their success as employees, and are too often underfunded and understaffed.

As a practical matter, the "option" of making payments to the City is no choice at all.

CONCLUSION

ERISA does not preclude state and local governments from taking steps 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 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 the focus of the next Administration and the 111th Congress.

The issue at stake in this appeal is of vital importance to all Americans, particularly the more than 132 million individuals who are covered under employer-sponsored ERISA plans.[5] The Council urges this Court 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. To do so will provide a strong incentive and a roadmap to other cities, counties, and states (literally thousands of jurisdictions) to similarly regulate employee welfare plans. Such an outcome would ultimately lead to a complete dissolution of the ERISA framework for uniform plan administration.

Dated: _____________, 2008

Respectfully submitted,

American Benefits Council

By: __________________

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[5] *See* William Pierron, ERISA Pre-emption: Implications for Health Reform and Coverage, EBRI Issue Brief No. 314 (Feb. 2008) (132.8 million individuals are covered by ERISA plans).

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 5,640 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 March 27, 2008.

Dated: _____________, 2008 American Benefits Council

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on the ___ day of March, 2008, a true and correct copy of the foregoing Brief of Amicus Curiae on behalf of the American Benefits Council was sent via facsimile and certified mail, postage prepaid to:

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