Nos. 07-17370, 07-17372

In the United States Court of Appeals
for the Ninth Circuit

GOLDEN GATE RESTAURANT ASSOCIATION,
Plaintiff-Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Defendant-Appellant,

and

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION, HEALTHCARE WORKERS-WEST; SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1021; UNITE HERE!, LOCAL 2,
Defendants-Intervenors-Appellants.

On Appeal from the United States District Court for the Northern District of California (Jeffrey S. White, *Judge*), No. CV-06-06997-JSW

Brief of The ERISA Industry Committee and The National Business Group on Health as *Amici Curiae* in Support of Plaintiff-Appellee and Affirmance

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Fed. R. App. P. 26.1 Disclosure Statement

The undersigned counsel of record for *Amici Curiae* The ERISA Industry Committee and The National Business Group on Health hereby furnish the following information in accordance with Rule 26.1 of the Federal Rules of Appellate Procedure:

The ERISA Industry Committee and The National Business Group on Health are non-stock, non-profit corporations. They have no parent corporations, and no individual owns 10% or more of their stock.

Dated: March 28, 2008

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Attorney of Record for The ERISA Industry Committee and The National Business Group on Health

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STATEMENT OF INTEREST OF THE *AMICI CURIAE*

With the consent of all parties, in accordance with Federal Rule of Appellate Procedure 29(a), The ERISA Industry Committee ("ERIC") and The National Business Group on Health ("NBGH") respectfully submit this brief as *amici curiae* in support of Appellee.

ERIC is a non-profit corporation representing America's largest private-sector employers. ERIC's members maintain, administer, and provide services to health care plans and other employee benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. § 1001 *et seq.* Millions of active and retired workers and their families receive health care benefits through employee benefit plans sponsored by ERIC's members.

ERIC participates as *amicus curiae* in cases with the potential for far-reaching effects on employee benefit plan design or administration. The decision to file an *amicus* brief is made by ERIC's Legal Committee based on established criteria that limit ERIC's participation to significant cases in which the Legal

Committee believes that ERIC will present views that will not be presented by the parties or other potential *amici*. ERIC believes that this is such a case.[1]

NBGH, formerly known as the Washington Business Group on Health, is a non-profit organization devoted to representing large employers' perspectives on national health policy issues. With some 300 members, NBGH is the national voice of large employers dedicated to finding innovative and forward-thinking solutions to the nation's most important health care issues. NBGH facilitates communications between large employers and national policymakers on key health care issues and participates actively in national health policy debates.

SUMMARY OF THE ARGUMENT

Private-sector employers are the primary source of health care coverage in the United States. More Americans receive health care coverage from employer-sponsored plans than from any other source. A substantial percentage of those who have health care coverage receive their coverage through ERISA-governed plans sponsored by large employers that do business in numerous states and local jurisdictions throughout the country.

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[1] *See, e.g.*, *LaRue v. DeWolff, Boberg & Assocs.*, 128 S. Ct. 1020, 1027 (2008) (Roberts, C.J., concurring in part and in judgment); *Gen. Dynamics Land Sys. v. Cline*, 540 U.S. 581 (2004); *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003); *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Cooper v. IBM Personal Pension Plan*, 457 F.3d 636 (7th Cir. 2006).

Large employers typically provide health care benefits on a uniform basis to similarly situated participants, regardless of the state or local jurisdiction in which the participants work. Nationwide uniformity allows health care plans to operate efficiently and to provide participating employees and their families with health care coverage at a lower cost than would be possible if their plans were required to comply with the varying requirements of each jurisdiction in which the employer conducts business. Moreover, because employees of large employers often transfer from a position in one jurisdiction to a position in a different jurisdiction, a health care plan that provides uniform coverage nationwide allows employees to make such transfers without disrupting or losing their health care coverage.

ERISA does not require employers to sponsor health care plans or any other employee benefit plans. By preempting state and local laws, ERISA encourages employers to provide benefits that address their employees' needs cost-effectively, on a uniform nationwide basis, and without being saddled with the cost and complexity of varying and sometimes conflicting state and local laws.

If the San Francisco Health Care Security Ordinance ("the Ordinance") is allowed to circumvent ERISA's preemption provision, the Ordinance would subvert fundamental policies that Congress sought to advance when it enacted ERISA. Directly contrary to the voluntary employee benefit plan regime established by ERISA, the Ordinance would (1) require covered employers to

provide health care coverage, (2) specify how much a covered employer must spend on health care coverage, and (3) prevent covered employers with operations in San Francisco (the "City"), and in any other jurisdiction that adopts similar legislation, from maintaining health care plans that operate uniformly nationwide. The cost of complying with the resulting patchwork quilt of state and local health care laws will be borne by both employers and employees.[2]

If local jurisdictions throughout the country are permitted to adopt health care legislation that avoids ERISA preemption, plans sponsored by employers that have employees in multiple jurisdictions ("multi-jurisdictional employers") will be subject to a wide variety of mandates and reporting requirements that will significantly increase plan costs. The higher administrative costs imposed on multi-jurisdictional plans will inevitably reduce the health care benefits that such plans provide and/or increase the costs borne by employees (and by the government programs that provide access to other health care services).

ERIC and NBGH submit that the Ordinance is preempted by ERISA. As a practical matter, the Ordinance requires employers to maintain employee benefit plans and regulates the expenditures and administration of such plans. The

[2] The cost of health care coverage under the vast majority of employer-sponsored plans is borne by not only by the sponsoring employer, but also by the participating employees who pay for coverage by making contributions to the plan and as a result of plan features such as deductibles, co-payments, and the like.

Ordinance's "opt out" provision—which offers employers the option of making payments to the San Francisco health fund—fails to save the Ordinance from ERISA preemption for two reasons: (1) no rational employer with the resources to accept the administrative burden would make such payments rather than spend the same amount to provide health care coverage for its own employees; and (2) the alternative that the Ordinance offers to employers that "opt out" —to make contributions to the San Francisco health fund—will itself create an ERISA-governed plan. Because the Ordinance requires an employer to maintain an ERISA-governed employee benefit plan even if the employer "opts out," the Ordinance is preempted by ERISA.

DISCUSSION

I. Millions of Americans Receive Health Coverage under ERISA-Governed Plans

Employment-based group health plans provide health care coverage to more than 161 million Americans, representing 62.2% of all health coverage in the United States. William Pierron & Paul Fronstin, *Issue Brief No. 314: ERISA Pre-emption: Implications for Health Reform and Coverage* (Employer Benefit Research Inst., Wash., D.C.), Feb. 2008, at 10 fig.1. The most recent National Compensation Survey determined that over 70% of the persons employed by firms in the private sector had access to some form of health care coverage. U.S. Dep't of Labor ("DoL"), Bureau of Labor Statistics, *National Compensation Survey:*

Employee Benefits in Private Industry in the United States, March 2007, at 12 tbl.5 (2007). By contrast, individually-purchased health care accounted for only 6.8% of all coverage, and public health programs, like Medicare and Medicaid, accounted for only 17.5%. Pierron & Fronstin, *supra*, at 10 fig.1. Clearly, employers are the predominant providers of health care in the United States.

Private-sector employers on average pay more than 80% of the premium for each employee. For employees with single-person coverage, employers contribute almost $300 a month toward the premium for each employee. For employees with family medical coverage, that figure jumps to slightly more than $660 a month. DoL, *supra*, at 19-20 tbls.11 & 12.

The vast majority of employer-provided health care coverage is provided through plans governed by ERISA. Of the 161 million Americans receiving coverage through their employers, more than 132 million (82%) receive their coverage through an ERISA-governed plan. Pierron & Fronstin, *supra*, at 11. Thus, any change in the law governing ERISA-governed plans could substantially alter the employee-benefits landscape for tens of millions of Americans who rely on ERISA-governed plans for their health care needs.

II. Multi-Jurisdictional Employers Are Responsible For a Major Share of the Employer-Based Health Coverage Provided To Employees and Their Families

Large businesses are substantially more likely than smaller firms to offer health benefits to their employees. According to a 2007 survey by the DoL, among firms employing at least one hundred workers, 93% of employees were offered health care. By contrast, only 59% of smaller firms, with less than one hundred employees, offered some form of health care coverage to their employees. DoL, *supra*, at 15 tbl.7.

Because of their size, large firms typically have employees in numerous jurisdictions. These multi-jurisdictional employers provide a substantial percentage of all of the private health care coverage offered in the United States. On average, firms with at least one hundred employees pay 82% of the cost of providing health care coverage to each covered employee, *id.* at 18 tbl.10, and spend more than $290 per month to provide an employee with single-person coverage and more than $700 per month to provide an employee with family coverage. *Id.* at 19-20 tbls.11 & 12.

Large firms also are more likely than small firms to sponsor self-insured health plans. Pierron & Fronstin, *supra*, at 11. While only 55% of all employees are covered by self-insured plans, 89% of workers in firms with more than 5,000 employees are covered by self-insured plans. *Id.* The difference is significant

because ERISA's preemption provision exempts self-insured plans from state insurance laws. As a result, employers that sponsor self-insured health plans can tailor their plans to address their employees' needs and avoid the cost of complying with the varied requirements of state insurance laws. *See* 29 U.S.C. § 1144(b)(2)(B); Pierron & Fronstin, *supra*, at 11; *see also* Victoria Craig Bunce & JP Wieske, *Health Insurance Mandates in the States 2008* (Council for Affordable Health Ins., Alexandria, Va.), Jan. 2008 (listing health insurance mandates and estimating costs of compliance).

III. ERISA Encourages Employers to Offer Health Plans By Allowing Employers to Determine the Benefits They Provide and By Preempting State and Local Laws

Since its enactment in 1974, ERISA has provided a powerful incentive to employers to provide employee benefit plans, including health care plans, by allowing employers to sponsor voluntary plans, giving those employers considerable flexibility in deciding what benefits to offer and how to fund their plans, and by exempting employers from the patchwork quilt of state and local regulation that they otherwise would face. The central statutory provision expressing each of these policies is ERISA's preemption provision, set forth in Section 514, 29 U.S.C. § 1144. ERISA's preemption provision has allowed employers to become the largest source of health care coverage in the United States and to provide coverage to tens of millions of employees.

A. ERISA Does Not Require Employers to Maintain Health Plans

As the Supreme Court has explained,

> "[N]othing in ERISA requires employers to establish benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). Rather, employers have large leeway to design disability and other welfare plans as they see fit.

Black & Decker Disability Plan v. Nord, 538 U.S. 882, 833 (2003). Giving employers the flexibility to choose the benefit plans they will establish and flexibility in the design of the plans they do establish are fundamental features of ERISA. Some employers might lack the resources to provide legally-mandated health care coverage and might be required to terminate employees or cease operations if health care coverage were mandated by law. At the same time, employers that offer health care coverage can use their health care plans to attract and retain employees.

Congress's decision to allow employers to decide whether to offer health care coverage to their employees was a considered policy decision that coverage mandates—at the federal, state, or local level—were inappropriate and potentially excessively burdensome for some employers, especially small businesses.[3] In

[3] Small Business Admin., *The Small Business Economy for Data Year 2006: A Report to the President* 305 tbl.A.7. (2007). Firms with less than twenty employees account for more than 18% of employment. *Id.*

order to prohibit benefit mandates by state and local governments, Congress included in ERISA a broad preemption provision that was subject only to limited exceptions for laws regulating insurance, a traditional subject of state regulation. *See* 29 U.S.C. § 1144(b)(2)(A) (state laws regulating insurance, banking, or securities are not preempted); James A. Wooten, *A Legislative and Political History of ERISA Preemption, Part 1*, 14 J. Pension Benefits 31, 34 (2006) (business and union opposition to patchwork state regulation was largely responsible for the broad preemption provision).

B. ERISA Allows Employers to Tailor Their Health Plans to Address Their Needs and the Needs of Their Employees

ERISA also allows employers to decide what coverage will be provided under an ERISA plan. *See Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985) (ERISA "does not regulate the substantive content of welfare-benefit plans"). This, too, reflects Congress's judgment that the marketplace, rather than legislative mandates, should determine the benefits that health plans provide.

> The flexibility an employer enjoys to amend or eliminate its welfare plan is not an accident …. Giving employers this flexibility also encourages them to offer more generous benefits at the outset, since they are free to reduce benefits should economic conditions sour. If employers were locked into the plans they initially offered, they would err initially on the side of omission.

Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co., 520 U.S. 510, 515 (1997) (internal quotations omitted). ERISA's lack of coverage

mandates and its broad preemption provision therefore embody a robust federal policy favoring private decisionmaking.

This policy is enhanced by ERISA's "deemer clause," which exempts employer-sponsored self-insured benefit plans from state insurance regulations. *See* 29 U.S.C. § 1144(b)(2)(B). As a result, large companies are permitted to operate health care programs that are exempt from state insurance mandates. As the Supreme Court stated in *Inter-Modal*, such freedom is no "accident": it allows employers and employees to elect particular coverages and reflects the reality that market forces profoundly influence the willingness and scope of private-sector employers' provision of health care benefits.

C. ERISA Allows Employers to Offer Uniform Health Benefits on a Nationwide Basis

For multi-jurisdictional employers, like the members of ERIC and NBGH, ERISA preemption is essential. Under ERISA, multi-jurisdictional employers can offer a single, coordinated package of employee health care benefits to all eligible employees, regardless of where they live or work. This permits plans to provide health care benefits at costs that are significantly lower than they would be under a regime requiring multi-jurisdictional employers to meet the various mandates of each state or locality in which one or more of its employees happen to work. Indeed, the threat of conflicting state and local regulation was one of the prime reasons for the enactment of ERISA in the first place.

> As we have said before, [the ERISA preemption provision] indicates Congress's intent to establish the regulation of employee welfare benefit plans "as exclusively a federal concern." *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). We have found that in passing [the preemption provision], Congress 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 … requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656-57 (1995) (internal quotations omitted and ellipses and last alteration in original).

The alternative to ERISA preemption is a regime that requires multi-jurisdictional employers to adapt their policies to the disparate mandates of every state and locality that wishes to regulate health care. Moreover, employers would face the real possibility of conflicting mandates or other conflicting requirements. *See PM Group Life Ins. Co. v. W. Growers Assurance Trust*, 953 F.2d 543, 547 (9th Cir. 1992) ("ERISA is designed to relieve employers from the difficulties of complying with diverse state laws"). Multi-jurisdictional employers may not simply be able to "round up" to whatever jurisdiction requires the *most* benefits. Reporting and recordkeeping requirements might vary substantially among

jurisdictions, and multi-jurisdictional employers would be functionally unable to offer a uniform array of benefits. At best, they would be subject to the expensive and time-consuming task of tailoring their benefits packages, data compilation, and reporting practices to the requirements of each jurisdiction.

IV. The Ordinance Conflicts With Important Federal Policies That Are Central to ERISA

Despite the motions panel's suggestion that the Ordinance operates only obliquely on ERISA-governed plans, the Ordinance undermines important federal policies that are central to ERISA.

A. The Ordinance Requires Employers to Maintain Health Plans and to Meet Minimum Expenditure Requirements

The Ordinance requires every covered employer to certify that it has made the required "health care expenditure" either directly or indirectly on behalf of every covered employee.[4] Direct expenditures include amounts spent to provide health care coverage via health savings accounts, reimbursement of employee expenditures, payments to third parties, and costs incurred in the direct delivery of health care to employees. The employer's only alternative is to make payments to the City to be used to provide health care for the employer's employees. S.F., Cal.,

[4] For large employers, the current spending mandate (before upward adjustment in later years) requires an expenditure of $1.60 per hour per employee, for up to 172 hours per month. Thus, a large employer must spend $275.20 per full-time employee per month. *See* S.F., Cal., Admin. Code §§ 14.1(b)(8), (10); 14.3.

Admin. Code §§ 14.1(b)(7); 14.3. Thus, by requiring the employer to fund health care coverage for its employees, the Ordinance directly conflicts with ERISA's policy favoring voluntary employee benefit plans.

There is little question that health care is an increasingly important part of an employer's benefits package. Indeed, as of 2005, health care spending totaled almost two trillion dollars, or 16% of the gross domestic product. *See* Aaron Catlin et al., *National Health Care Spending in 2005: The Slowdown Continues*, 26 Health Affairs 142, 142 (2007). Access to health care and the quality of that care are some of the most important political issues of our day, and federal, state, and local governments have all offered solutions that must be seriously considered by policymakers at every level.

Nonetheless, in enacting ERISA, Congress chose to support a voluntary regime. Nothing in ERISA requires employers to establish health care plans, and ERISA leaves the design of those plans largely up to the employer (and to collective bargaining where the plan is negotiated). Congress's decision recognizes the economic reality that health benefits are expensive and that not all businesses can bear the substantial costs that mandatory health benefit plans would impose.

Thus, the Ordinance is completely inconsistent with this important federal policy: rather than relying on the voluntary regime established by ERISA, the

Ordinance requires employers to provide health care coverage, either directly or indirectly, and to provide a mandated level of support to such coverage.

If the Court were to hold that the Ordinance is not preempted by ERISA, the ultimate economic consequences are unclear. While the health care expenditures of many ERIC and NBGH members exceed the level mandated by the Ordinance, the same cannot be said for the large number of smaller businesses that employ a substantial number of San Franciscans. *See supra* note 3 (businesses with less than twenty employees account for 18% of employment nationally). Rather than increasing health care coverage, the Ordinance might have the opposite effect, if the Ordinance causes employers either to curtail their operations in the City or to leave the City altogether.

B. The Ordinance Will Burden Employers that Already Meet the Ordinance's Coverage and Spending Requirements

On average, a large employer in the United States spends approximately $290 a month per employee for single-person health care coverage, *see supra* Part II, which exceeds the amount initially required by the Ordinance, *see supra* note 4 (Ordinance requires spending approximately $275 per full-time employee per month, subject to future upward adjustment). Nevertheless, even employers that already satisfy the Ordinance's spending mandate would be substantially burdened by the Ordinance. The Ordinance, and the legislation that other jurisdictions are

likely to adopt if the Ordinance is held not to be preempted by ERISA, would overwhelm employers with accounting and recordkeeping requirements.

First, the Ordinance requires the employer to identify the employees who qualify as "covered employees" under the Ordinance. *See* S.F. Admin. Code § 14.1(b)(2); S.F., Cal., Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance (HCSO) § 3.1 [hereinafter HCSO Regs.]. The rules governing this process are hardly straightforward. The physical presence of the employer (and in certain cases, that of the employee) is irrelevant. *See* HCSO Regs. § 2.2(B). A "covered employee" is defined as one who performs at least ten hours of work per week within the City. While the time that employees spend merely traveling through San Francisco does not count toward the ten-hour minimum, an employer must count the time a transient employee spends in the City performing substantive duties—e.g., making pick-ups or deliveries—including travel time within the City. *Id.* §§ 3.1(A)(3), (C)(1); 6.1(C)(1)(d). Any time that a resident of San Francisco spends working from home must also be counted. *Id.* §§ 3.1(C)(3); 6.1(C)(1)(d).

In addition, the Regulations' definition of "work performed" is not based on a common-sense understanding of that term. Paid vacation, time off, and paid sick leave are all counted toward the ten-hour requirement, and the Regulations offer only cryptic guidance on how an employer is to account for non-working time for

those employees who work both within and without San Francisco. *Id.* § 6.1(C)(1)(b) ("For covered employees who perform some work outside of San Francisco, 'hours paid' that are not hours actually worked (e.g., paid vacation hours, paid time off, and paid sick leave) will be calculated on a pro rata basis.").

For businesses with only salaried employees and that now have no reason to track their employees' hours of work, the Ordinance requires an entirely new recordkeeping system. Far from having only an incidental effect on existing ERISA plans, the Ordinance would require employers to develop new systems to record the information the Ordinance requires.

Second, employers are also required to track their health care expenditures. *Id.* § 6. What constitutes a legitimate expenditure under the Ordinance is itself a matter of extensive regulation. *See id.* § 4. Although the Regulations specify that medical expenses currently deductible under Section 213 of the Internal Revenue Code count toward the mandatory expenditure requirement, *id.* § 4.1(B), the Regulations otherwise offer merely non-exclusive examples, with very little guidance as to what might (or might not) count toward the mandatory expenditure requirement, *see id.* §§ 4.2(A) ("Examples of health care expenditures include, but are not limited to …"); 4.3 ("Qualifying health care expenditures shall not be limited to those that qualify as tax deductible medical care expenses under Section 213 of the Internal Revenue Code … but may include medical care, services, or

goods having substantially the same purpose or effect."). Moreover, the Regulations exclude *administrative* expenses associated with third-party provision of health care, *id.* § 4.2(C), a distinction that many employers may not be able to make. At the same time, the Regulations provide that qualifying expenditures include items that are usually treated as personal expenses, such as non-prescription allergy medications, cold medicines, and pain relievers. *Id.* § 4.3.

An employer with an existing health care plan—not to mention employers that currently have no health care plan—would face a substantial burden in complying with the Regulations. For example, the employer would have to account for premiums paid on behalf of each employee, any services that the employer offers outside of its ERISA plan that have "substantially the same purpose or effect," reallocate its known expenditures to take account of the Ordinance's exclusion of administrative costs, and establish a system to track any reimbursement of its employees' incidental purchases of over-the-counter drugs or other medical services.

The text of the Regulations does not reveal the complexity of the recordkeeping that the Regulations require. While the Regulations require the employer to provide a detailed account of each employee's personal information and work history, *id.* § 7.2(A)(1)-(2), the Regulations regarding expenditure records state only that "records sufficient to establish compliance with the

Employer Spending Requirements of this Ordinance, including, as applicable, records of health care expenditures made, calculations of health care expenditures required under this Ordinance for each covered employee, and proof documenting that such expenditures were made at least quarterly each year." *Id.* § 7.2(A)(3). However, compiling such "proof" is no small feat. The Regulations go well beyond what ERISA requires and could require many employers to overhaul their existing recordkeeping systems.

Complying with the Ordinance's recordkeeping requirements will be burdensome for even the most sophisticated employers. Although many major employers maintain health care plans that satisfy the Ordinance's spending requirements, the expense and burden of complying with the Ordinance's recordkeeping requirements could determine how some employers choose to provide health care benefits to their employees in the future. In this respect, the Ordinance's broad definition of "expenditure" might even motivate some employers—especially small employers—to transfer responsibility for health care coverage to San Francisco and thereby avoid the need to comply with some of the recordkeeping requirements. This approach might be especially attractive to smaller businesses that comply with the Ordinance's spending requirement but lack the resources to develop systems to demonstrate they do so. For such

employers, the most economical and simplest way to demonstrate compliance would be to make a direct contribution to the City.

C. The Ordinance Will Prevent Employers from Offering Uniform Health Benefits

Unless it is preempted by ERISA, the Ordinance will prevent employers from providing uniform health benefits to their employees nationwide and could, as a result, cause employers to reduce or eliminate benefits for employees and their families.

Although an employer might elect to preserve a uniform nationwide plan by "rounding up"—*i.e.*, by meeting the highest spending requirement imposed by any jurisdiction in which it does business—this strategy will be very wasteful. Because health care costs vary considerably throughout the United States, an employer that provides one uniform level of spending might be driven to an excessive level of spending in one jurisdiction simply to match the minimum spending requirement in another.

Beyond this, however, employers must be able to *prove* that they have met the minimum expenditure requirement on the basis of expenditures that the local rules define as a legitimate health care expenditure. Nothing guarantees that jurisdictions will define eligible expenditures in the same way, and employers will constantly need to monitor amendments to state and local laws to determine whether the benefits provided in one place count toward the spending requirement

of another. This problem is endemic once state and local regulation of employee benefits is permitted. Large employers will have no choice but to establish separate accounting systems that are capable of responding to and keeping track of the wide variety in the substantive mandates of the jurisdictions that follow the City's lead.

This leads to the problem of recordkeeping. The data that the Ordinance requires may differ substantially from the data required by other jurisdictions, and employers will be forced to attempt to meet each jurisdiction's particular requirements. The problems employers face in meeting San Francisco's recordkeeping requirements will be exponentially increased. Employers would face a maze of requirements that would divert time and resources from providing care and toward compliance with the huge administrative burden that these various ordinances would create.

Such concerns are not speculative. Large businesses have already faced the threat of conflicting spending and recordkeeping requirements under health care laws in Maryland and New York, which imposed spending and recordkeeping requirements markedly different from those imposed by the Ordinance. *See Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 184 (4th Cir. 2007) (certain employers required to spend 8% of total wages on "health insurance costs" and to make annual reports of numbers of employees, such "costs," and the percentage of

compensation spent on "health insurance costs"); *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403, 406-07 (E.D.N.Y. 2007) (certain employers required to make expenditures equivalent to the approximate cost to the public health care system of providing health care to each employee, as determined by an administrative agency). Even this small sample of published judicial decisions makes it evident that states and municipalities could take a wide variety of approaches and impose, in the aggregate, enormous recordkeeping burdens on employers.

As employers spend increasing amounts on such administrative expenses, increased costs of care will be borne by employees in the form of higher contribution requirements (or higher co-payments or deductibles), lesser benefits, or eliminated benefits, precisely the outcome that Congress sought to avoid when it passed ERISA. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987) ("A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them.").

V. ERISA Preempts The Ordinance

The Supreme Court has explained that a state law "relates to an ERISA plan," *see* 29 U.S.C. § 1144(a), and is therefore preempted "if [1] it has a connection with or [2] reference to such a plan." *Egelhoff v. Egelhoff*, 532 U.S.

141, 147 (2001) (internal quotation omitted). "[T]o determine whether a state law has the forbidden connection, [a court should] look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive as well as to the nature of the effect of the state law on ERISA plans." *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc.*, 519 U.S. 316, 325 (1997). A law references an ERISA plan if it "acts immediately and exclusively upon ERISA plans … or … the existence of ERISA plans is essential to the law's operation." *Id.*

For the reasons set forth in Part IV, *supra*, the Ordinance has a "connection with" an ERISA plan and is therefore preempted on that ground alone. The Ordinance's recordkeeping and administrative requirements would subvert many of ERISA's fundamental policy goals, including the goals of voluntary plan sponsorship and nationally uniform recordkeeping and administration.

The lynchpin of the motions panel's decision to vacate the District Court's injunction was its conclusion that the Ordinance "does not require any employer to adopt an ERISA plan or other health plan. Nor does it require any employer to provide specific benefits through an already existing ERISA or other health plan." *Golden Gate Rest. Ass'n v. City & County of San Francisco*, 512 F.3d 1112, 1121 (9th Cir. 2008). In the panel's view, an employer could fully discharge its

obligations under the Ordinance by paying the required amount to the City and make no change in its existing ERISA-governed health plan. *See id.* at 1121-22.

Although an employer can comply with the Ordinance by making payments to the City, this option fails to save the Ordinance from preemption for two independent reasons: (1) when faced with the choice the Ordinance offers, no rational employer with the resources to accept the requisite administrative burden would choose to make payments to the City rather than provide its employees with health care; and (2) even if an employer chose to make payments to the City, an arrangement under which an employer makes regular payments to the City would itself constitute an employee benefit plan for purposes of ERISA. As a result, an employer cannot comply with the Ordinance without participating in an ERISA-governed employee benefit plan.

A. Under the Ordinance, Any Rational Employer With the Resources to Accept the Requisite Administrative Burden Would Have No Alternative But to Establish an ERISA Plan

A similar law was considered and held to be preempted by the United States Court of Appeals for the Fourth Circuit in *Retail Industry Leaders Ass'n v. Fielder*. In *Fielder*, the challenged Maryland law required certain large employers to spend 8% of their total payrolls on employee health benefits or to pay the difference between that mandated amount and their actual expenditures to the state. 475 F.3d at 183. Any funds paid to the state could be used only to fund Maryland's health

programs for children. *Id.* at 185. Although the Ordinance here requires San Francisco to earmark the funds paid by an employer to provide health care to the employer's particular employees, the two laws are otherwise substantially identical: they require the employer to choose either to spend a specified amount to provide health care directly to its employees or pay the same amount to the government.

The Fourth Circuit held that ERISA preempted the Maryland law because it left an affected employer with no rational choice other than to provide its employees with health care and thereby required the employer to alter (or create) an ERISA plan.

> As Wal-Mart noted by way of affidavit, it would not pay the State a sum of money that it could instead spend on its employees' health care. *This would be the decision of any reasonable employer.* Health care benefits are a part of the total package of employee compensation an employer gives in consideration for an employee's services. An employer would gain from increasing the compensation it offers employees through improved retention and performance of present employees and the ability to attract more and better new employees. In contrast, an employer would gain nothing in consideration of paying a greater sum of money to the State. Indeed, it might suffer from lower employee morale and increased public condemnation.
>
> In effect, *the only rational choice employers have … is to structure their ERISA health care benefit plans so as to meet the minimum spending threshold.*

Id. at 193 (footnote omitted and emphases added).

The Ordinance puts employers here in the same position. When economically feasible,[5] the employer's purported choice between paying for its own employees' health care coverage and paying an equivalent amount to the City is really no choice at all.[6] *See Suffolk County*, 497 F. Supp. 2d at 417 (evaluating a similar law enacted by Suffolk County, N.Y., and holding that "it is unreasonable to expect employers to contribute to the community or directly to the state, rather than to their own employees"). By far the most—and perhaps only—rational decision for an employer that could shoulder the administrative burden would be to meet the Ordinance's spending mandate by establishing an ERISA plan, as the motions panel acknowledged:

> A covered employer may choose to adopt or to change an ERISA plan in lieu of paying the required health care expenditures to the City. An employer may be influenced by the Ordinance to do so because, when faced with an unavoidable obligation to make the required health care expenditure, it may prefer to make that expenditure to an ERISA plan.

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[5] As noted above, some small employers may lack the resources both to spend the mandated amount on health care for employees and to undertake the recordkeeping burden required by the Ordinance. *See* Part IV.B, *supra*.

[6] The fact that funds paid to the City under the Ordinance are earmarked for each employer's employees does not change this conclusion. Unless it is certain that employees will receive identical benefits from either San Francisco or their employer, an employer "might suffer from lower employee morale and increased public condemnation" if it were to make the payments to the City rather than spend the funds on its employees directly. *Fielder*, 475 F.3d at 193.

Golden Gate, 512 F.3d at 1122. Thus, the practical effect of the Ordinance is to compel the employer to establish an ERISA plan, and ERISA clearly preempts any state or local law that requires an employer to establish an employee benefit plan. *See Travelers*, 514 U.S. at 658 ("ERISA pre-empt[s] state laws that mandate[] employee benefit structures or their administration"); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("Employers or other plan sponsors are generally free under ERISA, for any reason at any time to adopt, modify, or terminate welfare plans."); *see also Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (ERISA preempted New York's mandated pregnancy benefit).

B. An Arrangement Under Which an Employer Regularly Contributes Funds to a Program That Uses the Funds to Provide Health Care Benefits to the Employer's Employees Is an Employee Benefit Plan under ERISA

An employer's payments to the City are earmarked and used to fund an employee's participation in the City's own health care program or reimbursement accounts administered by the City. S.F. Admin. Code § 14.2. The funds that an employer pays to San Francisco will be used to provide health care coverage to the employer's employees, as opposed to being treated as part of the City's general revenue or funding related programs, like Maryland's, to provide children's health care.

Under ERISA, any "plan, fund, or program … established or maintained by an employer … for the purpose of providing … medical, surgical, or hospital care

or benefits" is an employer sponsored plan regulated by ERISA. 29 U.S.C. § 1002(1). This standard is not difficult to meet: any arrangement under which an employer regularly contributes funds to provide health or other welfare benefits is a "plan" governed by ERISA. As the Supreme Court has explained, where the employer "assumes … responsibility to pay benefits on a regular basis, and thus faces … periodic demands on its assets that create a need for financial coordination and control," it has established a "plan" under ERISA. *Fort Halifax*, 482 U.S. at 12; *see also Fielder*, 475 F.3d at 190 ("a grant of a benefit that occurs periodically and requires an employer to maintain some ongoing administrative support generally constitutes a 'plan'"). Based on this standard, there can be no question that the elaborate recordkeeping and accounting requirements imposed by the Ordinance, all in aid of linking expenditures to the provision of health care for particular employees, cause an employer to maintain an ERISA-governed welfare plan.

Thus, the motions panel was mistaken in concluding that an employer can avoid altering or establishing ERISA plans by making regular contributions to San Francisco. *See Golden Gate*, 512 F.3d at 1121. The arrangement mandated by the Ordinance constitutes an ERISA-governed plan. Plainly, there is no way an

employer to comply with the Ordinance without establishing or maintaining an ERISA-governed plan.[7]

CONCLUSION

Amici urge this Court to affirm the judgment of the District Court and to hold that the San Francisco Ordinance is preempted by ERISA. The Ordinance conflicts with several important federal policies reflected in ERISA and would create an administrative nightmare for large multi-jurisdictional employers, like ERIC and NBGH's members, who would have no choice but to create separate accounting systems for the various jurisdictions in which their employees work. Furthermore, because the Ordinance does in fact require such employers to establish ERISA plans, either on their own or as administered by San Francisco, the Ordinance clearly "relates to" or has a "connection with" an employee benefit plan and is therefore preempted by ERISA.

[7] Although benefit plans provided by governments for their own employees are not subject to ERISA and its preemption provision, *see* 29 U.S.C. §§ 1002(32), 1003(b)(1), that exemption does not apply to an arrangement under which non-governmental employers fund a plan that a city administers for the contributing employer's employees, as opposed to the city's employees.

Dated: March 28, 2008

Respectfully submitted,

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Certificate of Service

The undersigned attorney hereby certifies that on March 28, 2008, I caused the required originals of the foregoing brief of The ERISA Industry Committee and The National Business Group on Health As *Amici Curiae* in Support of the Appellee to be served on the Clerk of Court via Federal Express.

On that same day, I also caused two copies of the foregoing brief to be served via Federal Express on each of the following:

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