

Nos. 07-17370, 07-17372

Decision: September 30, 2008
Panel Members: Goodwin, Reinhardt, and W. Fletcher

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

GOLDEN GATE RESTAURANT ASSOCIATION,
Plaintiff/Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Defendant/Appellant;

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

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

**REPLY BRIEF IN SUPPORT OF
PETITION FOR REHEARING EN BANC**

Richard C. Rybicki
Patrick B. Sutton
EMPLOYMENT LAW ADVOCATES
A Professional Corporation
975-B First Street
Napa, CA 94559

Jeffrey M. Tanenbaum
David L. Bacon
David S. Foster
Walter T. Johnson
NIXON PEABODY LLP
One Embarcadero Center, 18th Floor
San Francisco, CA 94111

Attorneys for Plaintiff-Appellee, Golden Gate Restaurant Association

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**REPLY BRIEF IN SUPPORT OF
PETITION FOR REHEARING EN BANC**

Plaintiff-Appellee Golden Gate Restaurant Association ("GGRA") respectfully submits this Reply Brief in Support of its *Petition for Rehearing En Banc*. GGRA wishes to reply to several significant points on what constitutes an ERISA-covered plan and the scope of ERISA preemption.

I. APPELLANTS INCORRECTLY DESCRIBE THE UNITED STATES SECRETARY OF LABOR'S POSITION AND APPLY TOO RESTRICTIVE A VIEW OF ERISA'S DEFINITION OF PLAN.

After GGRA filed its *Petition for Rehearing En Banc*, the United States Secretary of Labor filed an *amicus* brief urging rehearing and clarifying that the panel had failed to describe her position accurately. That brief explains that the Secretary had not taken the position that San Francisco's Health Access Program ("HAP", now known as "Healthy San Francisco") is itself an ERISA plan. The panel, and subsequently the appellants, believed that the Secretary had taken this position. But, as explained in her brief, the Secretary's position is that an *employer* establishes its own ERISA-covered health care plan – by electing and implementing the City-payment option – in the same manner that an employer establishes an ERISA plan by purchasing group insurance.

- A. The Secretary aptly analogizes an employer's election to pay into the city program to an employer's election to make payments for group insurance, HMO or PPO coverage.

The Secretary's analogy and position are correct. Merely contributing toward premiums for a group health insurance plan, or enrolling employees in a group plan, is the only employer activity necessary to establish an ERISA-covered "plan, fund or program." See *Kanne v. Connecticut General Life Ins. Co.*, 867 F. 2d 489, 492 (9th Cir. 1988), *cert. denied*, 490 U.S. 1075 (1989); *see also* 29 U.S.C. § 1002(1). The same is true for an employer establishing its ERISA plan through subscription payments to a Health Maintenance Organization ("HMO") or a Preferred Provider Organization ("PPO"). The design of such plans, including the menu of basic benefit and payment options, the discharge of fiduciary duties, and the administrative work in handling claims or providing health care, are handled by the insurance company, HMO, or PPO. The employer's ongoing payments alone, coupled with activity by the insurance company, HMO, or PPO, supply all of the elements necessary to create a program constituting an ERISA employee welfare benefit plan. ERISA does *not* require that plan administration be handled by the employer. To the contrary, the statute expressly authorizes the allocation of all plan administration duties to others *without* affecting ERISA plan status. *See* 29 U.S.C. § 1105(c)(1); *see also* *Brundage-Peterson v. Compcare Health Services Ins. Co.*, 877 F. 2d 509, 511 (7th Cir. 1989) (pointing out that "The contingent feature of a true welfare benefit plan ... is unaffected by the delegation of the administration of the plan to an insurance company - a delegation contemplated by the statute.") The panel's and appellants' basic premise – that regular contributions toward third-party coverage (the HAP) are not sufficient to

create a plan – contradicts the most common plan model used by employers providing health coverage to their employees.

ERISA plans are “affected with a national public interest.” 29 U.S.C. § 1001(a). To serve this interest, ERISA gives an intentionally broad definition to the term “employee welfare benefit plan” in order to sweep as many plans as possible within federal regulation: “*any plan, fund, or program,*” “established ... by an employer,” “for the purpose of providing ... , through the purchase of insurance *or otherwise,*” “medical, surgical, or hospital care or benefits.” 29 U.S.C. § 1002(1) (emphasis added). This is an “or otherwise” case. If an employer contributes towards health care costs or premiums, there is no need for the employer to design a plan, to set up a trust fund, to administer claims and pay benefits, or to provide medical services, in order to establish an ERISA plan. For many employers, these plan design and technical activities are most properly handled by the insurance companies, HMOs, and PPOs that have experience in the design and administration of health care plans. It is the employers’ own program of funding health care coverage that creates an ERISA benefit plan. If the rule were otherwise, very few welfare benefit plans would be ERISA-covered, and few ERISA plans would have proper design or competent, cost-effective administration. Moreover, an employer could easily avoid ERISA’s fiduciary duty, funding, and reporting and disclosure requirements, and the statute’s civil and criminal enforcement provisions, simply by having third parties perform the bundle of plan design and administrative and fiduciary tasks and claims review and payment obligations inherent in any employee welfare benefit plan.

- B. Viewed under the same rules applicable to other health care coverage options, such as group insurance and HMOs, employer payments to the City result in an ERISA plan.

Rather than identifying cases analogous to payments under the San Francisco Health Care Security Ordinance, S.F., Cal., Admin. Code, Chap. 14, §§ 14.1 - 14.8 (2007), appellants and the panel applied a different set of rules drawn from cases addressing situations very different from employer health-care payments. A state requirement that employers make lump-sum severance payments upon plant closing does not require an ERISA plan, for example, because no plan design or administrative scheme – to be handled by anyone, whether employer or third party – is necessary to meet the employer's one-time obligation. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987). Similarly, an ERISA plan is not required to satisfy a state statutory mandate that employers pay discharged employees their full wages, including holiday and vacation pay, upon termination. The statute merely requires the employer, on a one-time basis, to pay the vacation benefits which have already accrued on the employer's books under its own policies and practices. *Massachusetts v. Morash*, 490 U.S. 107, 109 (1989).

Appellants and the panel should have followed the Secretary's lead and looked at relevant case law. Unlike severance or vacation obligations, which concern one-time benefits or deferred payroll obligations, payments to group insurance plans, HMOs and PPOs are close analogs to the City-payment option. In each case, employers establish an ERISA-covered health care plan simply by making contributions towards premiums or subscription payments, *regardless* of whether a third party handles the plan design and the fiduciary duty and administrative tasks as well as claims review and payment obligations. An employer's election of the City-payment option

and ongoing payments should produce an analogous result under ERISA: creation of an ERISA-covered plan.

- C. If adopted, appellants' approach would result in exclusion of the vast majority of insured health plans from ERISA – an absurd result wholly at odds with Congressional intent.

Appellants (and ultimately the panel) have given far too restrictive a reading to ERISA “plan” and set too high a barrier for employee benefit plans to be classified as ERISA plans. Their reasoning “is the classic legal argument that proves too much.” Edward A. Zelinsky, “Golden Gate Restaurant Association: Employer Mandates and ERISA Preemption in the Ninth Circuit,” *Cardozo Legal Studies Research Paper No. 219*, p. 13; *State Tax Notes*, Vol. 47, 2008; available at SSRN: <http://ssrn.com/abstract=1090122>. It fails the most common-sense test for whether a court has adopted the proper standard: whether the standard, as applied to other similar situations, produces an appropriate (or an absurd) result. *See, e.g., Andreiu v. Ashcroft*, 253 F. 3d 477, 482 (9th Cir. 2001) (en banc) (cited by appellants in opposition).

Appellants and the panel adopt a reading of ERISA that would exclude from ERISA's coverage and protections the vast majority of insured health care plans, HMOs and PPOs. The decision, unless corrected, may also encourage promoters of private multi-employer plans to set up low-cost, high-risk plans which mimic aspects of the HAP – such as, for example, a plan designated as a "Greater Metropolitan Health Security Plan" covering both some indigent residents and employees of subscribing employers – in order to be exempt from ERISA's strict fiduciary duty rules, funding rules, reporting and disclosure requirements, and civil and criminal

enforcement provisions. This is an absurd result wholly at odds with the model Congress meant to adopt through ERISA, including the very purposes identified by appellants in their opposition.

II. APPELLANTS FAIL TO ACKNOWLEDGE CONFLICT BETWEEN THE PANEL'S HOLDING AND THE FOURTH CIRCUIT'S ALTERNATIVE HOLDINGS IN *FIELDER*.

Appellants argue that the panel's decision does not create an intercircuit conflict with the Fourth Circuit's opinion in *Retail Industry Leaders Association v. Fielder* ("*Fielder*"), 475 F. 3d 180 (4th Cir. 2007). Appellants focus (as did the panel) on the Fourth Circuit's ruling that "the only rational choice" for employers to comply with the Maryland Act was to increase spending on ERISA plans. See Opposition, p. 10; Panel opn. p. 13948.

Appellants then go even farther, characterizing the balance of the Fourth Circuit's analysis in *Fielder* as "*dicta*." Although they do not define that term, they apparently intend it to mean analysis they consider "not necessary to the court's decision." *U.S. v. Johnson* (9th Cir. 2001) 256 F. 3d 895, 920 (en banc) (Tashima, J., concurring). See Opposition, p. 11, "[the Fourth Circuit] had already held that the absence of a reasonable non-ERISA compliance option rendered the law preempted." This Court has rejected such a narrow reading of what constitutes a court's holding, instead noting that "careful ... treatment of the subject ... [,] not 'made casually [and with] consideration of the alternatives'" was not dictum." *Sanchez v. Mukasey* 521 F. 3d 1106, 1110 (9th Cir. 2008); citing *U.S. v. Johnson, supra*, 256 F. 3d 915 (en banc) (Kozinski, J., concurring).

As discussed in GGRA’s Petition, the Fourth Circuit did not confine its analysis to the question of whether the Maryland Act offered a reasonable non-ERISA option for compliance. See *Petition for Rehearing En Banc* (“Petition”), pp. 16-17. Instead, it discussed several factors supporting preemption including: “*First*,” the “tighter causal link” between the statute and ERISA plans, compared to those addressed in *Travelers* and *Dillingham*; “*Second*” whether “the choices given in the [statute] ... are ... meaningful alternatives by which an employer can increase its healthcare spending;” and “*Further*” whether “a proliferation of similar laws in other jurisdictions would force [employers] ... to manipulate ... health care spending to comply.” *Felder*, pp. 195-97 (emphasis added). The GGRA’s discussion of *Felder* does not attempt to create “two holdings” from the case as Appellants claim. Instead, the *Felder* opinion is an example of a common situation recognized by this Court in which a panel of judges “finds it appropriate to offer alternative rationales for the results they reach.” *U.S. v. Johnson*, *supra*, 256 F. 3d 915.

The panel’s decision in this case results in a direct conflict with *Felder* because it makes no attempt to address the alternative rationales enunciated by the Fourth Circuit. If allowed to stand, it would leave unresolved the question of whether *any* health care spending mandate is preempted – as the Fourth Circuit concluded – or if such a mandate is permissible so long as it includes a “reasonable non-ERISA option” for compliance.¹

¹ Moreover, the panel’s contradictory statements regarding the level of benefit conferred by the City’s public health plan suggest that confusion will remain regarding how much benefit a city or state must offer in return for an employer’s payments to constitute a “reasonable non-ERISA option.” See

In addition, the panel’s application of a “presumption against preemption” in this case also conflicts directly with *Fielder*. The Fourth Circuit considered and squarely rejected arguments identical to those raised by Appellants and amici here. The *Fielder* court contrasted state regulation of “health care providers” and “insurance companies” with “state-imposed regulation of employers’ provision of employee benefits,” and held that the latter was in “conflict with ERISA’s goal of establishing uniform, nationwide regulation of employee benefit plans.” *Fielder*, p. 191, citing *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815-816 (1997); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658-59 (1995) (emphasis in original). The panel’s ruling that local employer health care spending mandates are presumptively valid if they are coupled with a public health care program cannot be reconciled with the Fourth Circuit’s holding on this point.

“It is for this reason that we have adopted a cautionary rule, counseling against creating intercircuit conflicts.” *Taffi v. U.S. (In re Taffi)* 68 F. 3d 306, 308 (9th Cir. 1995). En banc rehearing is the process intended to address such conflicts, and it should be applied here to prevent the confusion that would result from divergent rulings among the circuits.

Petition, p. 16 n. 9. This formulation, which forces courts to assess the degree of return offered by each jurisdiction’s public health program to determine whether it would be attractive to a “rational employer,” is simply unworkable and contrary to ERISA’s goal of streamlining employee benefit programs.

III. APPELLANTS GIVE SHORT-SHRIFT TO THE EXTRAORDINARY IMPACT OF THE PANEL'S DECISION.

Appellants attempt to minimize the importance of the panel's decision by arguing that few other jurisdictions are likely to rely on it to implement their own local spending mandates. Opposition, p. 28. Appellants claim it would be difficult for other state or local governments "to build a universal health care program" as San Francisco has done. *Id.* But while the City's program and its goals are laudable, there is nothing in the panel's decision to indicate such a comprehensive program is necessary to save a local health care spending requirement from preemption. The rule declared by the panel is simply that it must include some "meaningful alternative ... to preserve the existing structure of [employers'] ERISA plans." Panel opn. p. 13948.

With only this vague rule for guidance, it is easy to envision many jurisdictions imposing health care spending requirements like San Francisco's to fund existing public health programs. This seems especially likely "in this time of financial hardship for state and local governments." Opposition, p. 28. With the explosive growth of public health costs, it is hard to believe that other local governments would not impose spending mandates like San Francisco's if the Ordinance is ultimately upheld.

The multiplicity of conflicting employer spending requirements that would result if other cities and states follow San Francisco's model will have an extraordinary impact on administration of employee benefit plans. The Ordinance – and any similar statutes that may be enacted by other jurisdictions – will require employers to comply with health care contribution rules that are unique to each local government. Such health care spending requirements are targeted directly at, and only at, employers.

The panel’s decision permitting interference with employer-provided health care will plainly impair national uniformity in employee benefit plan administration by multistate employers, exactly the result ERISA was enacted to avoid. *Egelhoff v. Egelhoff*, 532 U.S. 141, 149-150 (2001).

This Court en banc should correct the panel decision, a fact already recognized by commentators across the country. “At some point, it will be necessary for the Supreme Court to resolve the conflict presented by Fielder and [the panel decision].” “Golden Gate Restaurant Association: Employer Mandates and ERISA Preemption in the Ninth Circuit,” *supra*, p. 13; *see also* David L. Bacon and Suzanne D’Amato, “The Ninth Circuit Upholds San Francisco Health Care Ordinance Against ERISA Preemption Challenge,” *Benders’ Labor & Employment Bulletin*, Vol. 8, No. 11, p. 511, November 2008: (“‘pay’ or ‘play’ and ‘fair share’ laws, although they may differ in form and substance, raise recurrent issues of central importance to the administration of the nation’s employee benefit plan system.”). “Swift intervention is required ... to restore the carefully-crafted balance between federal and state law struck by Congress in ERISA and to reestablish the preeminence of the federal statute.” *Id.*

December 19, 2008

EMPLOYMENT LAW
ADVOCATES
A Professional Corporation

/s/

Richard C. Rybicki

Counsel for Plaintiff-Appellee,
GOLDEN GATE RESTAURANT
ASSOCIATION

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief has been prepared using proportionately double-spaced 14 point Times New Roman typeface. According the “Word Count” feature in my Microsoft Word for Windows software, this brief contains 3167 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 execute on December 19, 2008.

December 19, 2008

NIXON PEABODY LLP
Jeffrey M. Tanenbaum
David L. Bacon
David S. Foster
Walter T. Johnson

EMPLOYMENT LAW
ADVOCATES
A Professional Corporation

/s/
Richard C. Rybicki

Counsel for Plaintiff-Appellee,
GOLDEN GATE RESTAURANT
ASSOCIATION

CERTIFICATE OF SERVICE
(Fed. R. App. P. 25)

I hereby certify that on December 19, 2008, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

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

Jeffrey A. Berman SIDLEY AUSTIN LLP Suite 4000 55 West Fifth Street Los Angeles, CA 90013	Michael D. Peterson, Esq. Daniel V. Yager, Esq. MCGUINNESS & YAGER 1100 13 th Street NW Suite 850 Washington, DC 20005
Jon W. Breyfogle GROOM LAW GROUP 1701 Pennsylvania Ave N.W. Washington, DC 20006	Thomas M. Christina OGLETREE, DEAKINS, NASH, SMOAK & STEWART 300 North Main Street Greenville, SC 2961
Long X Do CALIFORNIA MEDICAL ASSOCIATION 200 1201 J Street Sacramento, CA 95814	Eugene Scalia, Esq. William J. Kilberg, Esq. Paul Blankenstein, Esq. GIBSON DUNN & CRUTCHER, LLP 1050 Connecticut Avenue, NW Washington, DC 20036-5306

Kathryn Wilber AMERICAN BENEFITS COUNCIL 1212 New York Avenue, NW Washington, DC 20005	
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December 19 2008

NIXON PEABODY LLP
Jeffrey M. Tanenbaum
David L. Bacon
David S. Foster
Walter T. Johnson

EMPLOYMENT LAW
ADVOCATES
A Professional Corporation

/s/
Richard C. Rybicki

Counsel for Plaintiff-Appellee,
GOLDEN GATE RESTAURANT
ASSOCIATION