

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

GOLDEN GATE RESTAURANT
ASSOCIATION, an incorporated non-
profit trade association,

Plaintiff/Appellee,

vs.

CITY AND COUNTY OF SAN
FRANCISCO and Does 1 through 15,
inclusive,

Defendants/Appellants.

SAN FRANCISCO CENTRAL
LABOR COUNCIL, SERVICE
EMPLOYEES INTERNATIONAL
UNION ("SEIU") LOCAL 2021, SEIU
UNITED HEALTHCARE
WORKERS-WEST, and UNITE-
HERE!., LOCAL 2

Intervenors/Appellants.

No. 07-17370, 07-17372

(U.S. District Court
No. C06-6997 JSW)

**OPPOSITION TO PETITION FOR
REHEARING EN BANC**

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

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INTRODUCTION

In *Retail Indus. Leaders Ass'n v. Fielder*, the Fourth Circuit correctly noted that a law is preempted by ERISA "if it directly regulates or effectively mandates some element of the structure or administration of employers' ERISA plans." 475 F.3d 180, 193 (4th Cir. 2007). The Fourth Circuit applied this rule to hold the Maryland Fair Share Act preempted, because the Act imposed a penalty on employers who did not bring their ERISA plans into compliance with a health care spending requirement. This penalty effectively forced employers "to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold," because no rational employer would pay a penalty to the government rather than providing ERISA benefits to its employees. *Id.*

In contrast, a law avoids preemption if employers can comply without adopting an ERISA plan or amending an existing ERISA plan. *WSB Elec., Inc. v. Curry*, 88 F.3d 788, 793 (9th Cir. 1996). The panel applied this well-established rule to hold that the health care expenditure requirement of San Francisco's Health Care Security Ordinance ("HCSO") is not preempted. Under the HCSO, the many employers who already provide health care to their workers, and whose expenditures exceed the moderate threshold imposed by the ordinance, need not modify their spending at all. The remaining employers must increase their health care spending, but every single one of them may do so without adopting an ERISA plan, changing any existing ERISA plan, or administering an ERISA plan differently in San Francisco than elsewhere. That is because employers in San Francisco have a reasonable, non-ERISA means for complying with the spending requirement: making a payment to the City that will entitle their workers to a deep discount on participation in the City's new universal health care program.

Accordingly, the holdings of the Fourth Circuit in *Fielder* and the panel here are fully compatible: a local government may not impose a penalty on employers for failing to make changes to their ERISA health care plans. But a local government may impose a minimum health care spending requirement if it creates a payment option, like San Francisco's, that provides a reasonable, non-ERISA means to comply. That the city payment option is not a penalty but a rational choice for employers is obvious from the face of the ordinance, and it is confirmed by the fact that almost 1,000 employers had selected it as of July 2008.

GGRA and its allies attempt to escape this reality by claiming that *Fielder* stands for a much broader proposition, namely, that local laws may never impose expenditure requirements in areas, like health care, mentioned in the ERISA statute. However, *Fielder* does not say that. Moreover, this overbroad formulation of ERISA's uniformity principle has been squarely rejected by the Supreme Court. To be sure, ERISA preempts local laws, like the Maryland statute, that prevent employers from administering their ERISA *plans* in a uniform fashion. But laws like San Francisco's that may cause *expenditure* disuniformity, while allowing employers to preserve *plan* uniformity, are permissible, because "cost uniformity was almost certainly not an object of pre-emption . . ." *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 662 (1995). *See also Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987); *Massachusetts v. Morash*, 490 U.S. 107 (1989).

Indeed, local laws subject national employers to disparate spending requirements all the time – with respect to wages, taxes, fees, severance pay, vacation pay, apprenticeship programs, and even health care itself. This is the inevitable consequence of doing business in multiple jurisdictions in the United

States. *Not one* of the numerous cases cited by GGRA or its allies held a law that law provided a reasonable, non-ERISA means for complying preempted.

The other attempts to manufacture a conflict are, as discussed in detail below, even more futile. For example, they contend the panel created an intra-circuit conflict when it rejected the argument that an employer creates an ERISA plan when it makes payments to a government entitlement program. But no other court has even considered such an argument, which in any event is inconsistent with the language of ERISA and the case law interpreting it. They also contend the panel's opinion conflicts with *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), but that case involved a statute that forced employers either to change their ERISA plans or administer those plans differently in one jurisdiction. Overall, there is simply no conflict with any other case. To the contrary, had the panel ruled in favor of GGRA, it would have created a conflict with at least eight cases from this Circuit, the Third Circuit, and the United States Supreme Court. *See pp. 4-15, infra.*

Finally, GGRA argues that en banc review is justified because otherwise more jurisdictions will adopt laws like the HCSO. But that argument is more theoretical than real. It is easy to propose a law, like in Maryland and like so many other "pay or play" proposals, that imposes a penalty on employers for failure to create an ERISA plan or increase spending on an existing ERISA plan. But the establishment of a comprehensive governmental health program to provide care to all residents, and of a system whereby an employer's payments to the program make its workers eligible for participation on highly favorable terms (thereby giving employers a reasonable non-ERISA compliance option) requires a major investment of public money, infrastructure, and personnel. Employer payments cover only a fraction of the costs of the HCSO – it is funded primarily by public

dollars. Presumably that is why no other program like the HCSO has been enacted anywhere in the country.

The panel's opinion simply does not give the green light to laws that interfere with plan uniformity. And, to the extent the ruling might require employers to spend more on health care in San Francisco than elsewhere, *without* interfering with plan uniformity, this is no different from the need for employers to comply with various other laws that affect spending on benefits. Such is the byproduct of federalism. It is not a ground for ERISA preemption.

DISCUSSION

I. **THERE IS NO CONFLICT WITH *EDELHOFF* OR *FIELDER* BECAUSE THE HCSO DOES NOT INTERFERE WITH PLAN UNIFORMITY.**

The argument by GGRA and its allies that the panel's opinion conflicts with *Egelhoff* and *Fielder* is based not only on an inaccurate characterization of those cases, but on a flawed understanding of basic principles of ERISA preemption. Far from creating a conflict with *Egelhoff* and *Fielder*, the panel's decision was compelled by the law of the Supreme Court and of this Circuit.

A. **Although State And Local Governments May Not Dictate Employer Choices About ERISA Plans, They May Enact Laws That Provide Employers With A Reasonable, Non-ERISA Means For Complying.**

Local laws are not preempted if they provide employers a reasonable means for complying that does not require creation or modification of an ERISA plan. For example, in *WSB*, this Court upheld California's prevailing wage statute, which required payment of a minimum amount to workers in a combination of cash and benefits. The Court explained, "nothing in California's scheme requires the establishment of a separate benefit plan in order to comply with the state law. California's statute does not require public works contractors to modify their benefits plans at all." 88 F.3d at 795; *see also S. Cal. IBEW-NECA Trust Funds v.*

Standard Industrial Elec. Co., 247 F.3d 920, 925 (9th Cir. 2001) (state law that "does not require the establishment of a separate benefit plan, and imposes no new reporting, disclosure, funding, or vesting requirements for ERISA plans" is not preempted). As the Third Circuit has put it, "[w]here a legal requirement may be easily satisfied through means unconnected to ERISA plans, and only relates to ERISA plans *at the election of an employer*, it affects employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Keystone Chapter, Associated Builders & Contractors v. Foley*, 37 F.3d 945, 960 (3d Cir. 1994) (emphasis added) (internal quotations, citations and brackets omitted).

This rule is based on the principle – clearly established by the Supreme Court – that even when a law imposes strong incentives on ERISA plans or on employers that administer them, the law still avoids preemption so long as it does not *dictate choices* with respect to ERISA plans. This is the lesson of *Travelers*, which the panel's opinion discusses at length. Panel Op. at 13937-38.

Nor is *Travelers* an isolated decision; the Supreme Court and this Court have applied its central principle time and again. For example, in *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 320 (1997), the Supreme Court considered a portion of California's prevailing wage law that allowed public contractors to pay apprentices less than the minimum prevailing wage if, and only if, the apprentices came from a program approved by the California Apprenticeship Council. The contractor contended that because most apprenticeship programs operate through ERISA plans, a law that requires an employer to pay a higher wage to apprentices from non-approved programs improperly affects the choices of employers and ERISA apprenticeship plans.

The Court rejected this contention. It held that, like the surcharge statute at issue in *Travelers*, "the apprenticeship portion of the prevailing wage statute does not bind ERISA plans to anything." *Id.* at 332. The Court explained that even strong incentives to modify ERISA plans are not preempted:

If a contractor chooses to hire apprentices for a public works project, it need not hire them from an approved program (although if it does not, it must pay these apprentices journeyman wages) The effect of [the statute] on ERISA apprenticeship programs, therefore, is merely to provide some measure of economic incentive to comport with the State's requirements . . . [¶] It cannot be gainsaid that [the statute] has the effect of encouraging apprenticeship programs – including ERISA plans – to meet the standards set out by California, but it has not been demonstrated here that the added inducement created by the wage break available on state public works projects is tantamount to a compulsion upon apprenticeship programs.

Id. at 332-333 (emphasis added, internal citations omitted).

In *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814-15 (1997), the Court affirmed that only when a state law effectively compels choices about ERISA plans is it preempted. In upholding a state tax on health care facilities, including those owned and operated by ERISA plans, the Court acknowledged the law had a direct effect on those ERISA plans, but explained:

As we acknowledged in *Travelers*, there might be a state law whose economic effects, intentionally or otherwise, were so acute "as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers" and such a state law "might indeed be pre-empted under [29 U.S.C. § 1144(a)]." 514 U.S., at 668. That is not the case here.

520 U.S. at 816 fn. 16.¹ *See also WSB*, 88 F.3d at 795-96 (fact that law discourages certain spending on ERISA plans does not render it preempted);

¹ The plaintiff in *De Buono* argued that the health care tax in that case was different from the surcharge at issue in *Travelers* because the health care tax was a (continued on next page)

Hattem v. Schwarzenegger, 449 F.3d 423, 429 (2nd Cir. 2006) (to be preempted, "law must actually dictate which choices *must* be made") (emphasis in original).

B. The HCSO Provides Employers With A Reasonable, Non-ERISA Means For Complying With The Expenditure Requirement.

As the panel concluded, the HCSO easily passes the test discussed above, because it offers a reasonable non-ERISA compliance option. Many employers covered by the ordinance will be required to make no changes to their health care spending whatsoever, because their current expenditures will satisfy the minimum requirement.² And because the HCSO provides a reasonable, non-ERISA means for compliance – the city payment option – employers that *are* required to change their health care spending can do so without adopting an ERISA plan, interfering with an existing ERISA plan, or administering an ERISA plan differently in San Francisco than elsewhere. *See* Panel Op. at 13922-24. Plan uniformity is disturbed only "at the election of an employer." *Keystone*, 37 F.3d at 960.

(footnote continued from previous page)

direct regulation of ERISA plans while the surcharge had only an indirect effect. The Court rejected this distinction, stating "the supposed difference between direct and indirect impact – upon which the Court of Appeals relied in distinguishing this case from *Travelers* – cannot withstand scrutiny." 520 U.S. at 816. This bears noting because GGRA has previously relied on the direct/indirect distinction, although it does not appear to do so in its petition for rehearing en banc.

² Only medium and large employers are covered by the ordinance. Roughly 90 percent of medium and large employers already provide health coverage to their employees. ER 467. And the average cost of health insurance in California is \$379 per month. ER 477. The maximum an employer could be called upon to spend under the ordinance is \$281.60 per month per employee, and that is only for a large employer whose employee works full time. A medium employer whose employee works half time must only pay \$93.60 per month.

One way GGRA and its allies seek to avoid this reality is by arguing that the city payment option is actually an "ERISA means" for complying, because payments by employers to a government entitlement program create ERISA plans. This argument, which even the district court rejected, has apparently neither been made nor adopted in any case in the country. And as discussed further in Section II of this brief, this novel argument makes no sense in light of the terms and purposes of the ERISA statute. *See also* Panel Op. at 13927-37.

GGRA and its allies are thus left with the argument that the city payment option does not provide employers with a *reasonable* means for complying with the HCSO. *See, e.g.*, Brief of the American Benefits Council at 7. This has been the primary argument advanced by GGRA throughout the litigation: that the city payment option is a penalty that effectively forces employers to adopt or change ERISA plans. But the city payment option is not only reasonable; it is quite attractive. By electing to comply with the HCSO by writing checks to the City, employers can ensure that their employees will be eligible for deep discounts on City health care services and avoid the burdens associated with setting up their own health care plans. Furthermore, because the City subsidizes the health care program, employees will often receive extraordinarily generous health care services in relation to the amount paid by the employer. *See, e.g.*, ER 477. In fact, as of July 2008, almost 1,000 employers had already selected the city payment option as a means to comply with the HCSO. Request for Judicial Notice in Opposition to Petition for Rehearing En Banc ("RJN") Exh. 1 at 12.

Far from forcing employers to alter ERISA plans, San Francisco's program is actually structured to *avoid* imposing incentives to alter ERISA plans. A law that imposed a blanket tax on businesses for the purpose of funding the HAP, *without* giving businesses credit for the amount they already spend on health care,

would create a strong incentive for the 90% of medium and large employers that already provide health coverage for their employees to alter their ERISA plans, by dropping existing coverage. After all, they would owe the City the same amount regardless of their private health care expenditures. But nobody could seriously argue that a general tax on businesses to fund a government entitlement program is preempted by ERISA. It would make no sense to conclude that a program like the HCSO, which avoids incenting employers to alter their ERISA plans, would be preempted while a program that created a tremendous incentive to alter ERISA plans would not. *Cf. WSB*, 88 F.3d at 796 ("After all, a cash-only prevailing wage law, which clearly would not be preempted, would more severely discourage benefits contributions than the current scheme").

C. There is no conflict with the Supreme Court's ruling in *Egelhoff*.

Once the ordinance is accurately portrayed, the assertion by GGRA and its allies that the panel's decision conflicts with *Egelhoff* loses all credibility. The Washington statute at issue in *Egelhoff* provided that, in the event a couple divorces, and then one member of the couple dies after the divorce, the survivor is not entitled to the benefits of the dead spouse's ERISA plan, even if the plan's terms did not so provide. The Court held that ERISA preempts such laws because they force plan administrators to change the way they administer their plans in particular jurisdictions. 532 U.S. at 147.

Washington countered that the statute was not preempted because it exempted ERISA plans which explicitly provided that divorced spouses should receive plan benefits. Thus, Washington argued, there were two ways plan administrators could comply with the statute: (1) by administering their plans differently in Washington; or (2) by changing the terms of the plan to include specified language. But the Court held this did not save the statute from

preemption, because both compliance options required plan administrators to change the way they wrote or administered their plans: "Plan administrators must either [disregard the language of their plans and] follow Washington's beneficiary designation scheme or alter the terms of their plan so as to indicate that they will not follow it." *Id.* at 150. Because both options required alteration of an ERISA plan or its administration, the Washington statute is in no way analogous to the HCSO for ERISA preemption purposes.

D. There Is No Conflict With The Fourth Circuit's Ruling In *Fielder*.

The panel's holding that ERISA does not preempt the City's employer spending requirement is also consistent with *Fielder*. In that case, the Fourth Circuit panel held that the Maryland Fair Share Act *did not* include a reasonable government payment option, so that "the only rational choice employers have under the Fair Share Act is to *structure their ERISA healthcare benefit plans* so as to meet the minimum spending threshold." 475 F.3d at 193 (emphasis added). That is because the "government payment option" in Maryland consisted of payments to the state's Medicaid program. The employees on whose behalf payments were made would receive no benefit from the payments. *Id.* That is, they would receive nothing above and beyond what they could receive anyway, assuming they qualified for the Medicaid program in the first place.

The absence of a meaningful government payment option in *Fielder* and the existence of one here means that the two decisions are compatible – together they stand for the proposition that while state and local governments may not impose *penalties* for failure to create or change ERISA plans, they may impose a general health care spending requirement if they create a government program that provides employers with a reasonable non-ERISA means for complying.

GGRA and its *amici* claim there were "two holdings" in *Fielder*, and that the second "holding" conflicts with this panel's decision. Not true. The language they selectively quote as a "holding" is clearly *dicta*, and even that *dicta* bears no relation to this case. Specifically, Maryland argued that Wal-Mart had a different non-ERISA means for complying with the spending requirement, namely, the establishment of Health Savings Accounts ("HSAs"). The court concluded that, even though HSAs themselves are not ERISA plans, they did not present a realistic non-ERISA compliance option because, among other reasons, such accounts must be coordinated with high-deductible health insurance plans, which *are* ERISA plans. *Id.* at 196-97. In that context, in *dicta* the court stated that the requirement that employers coordinate non-ERISA spending (HSAs) with ERISA spending (high deductible health plans) would violate ERISA's preemption provision. None of this is related to whether the city payment option constitutes a reasonable non-ERISA compliance option in this case.

The majority then stated, also in *dicta* (because it had already held that the absence of a reasonable non-ERISA compliance option rendered the law preempted): "Further, the *Fair Share Act* and a proliferation of *similar laws . . .* would force Wal-Mart or any other employer like it to monitor these varying laws and manipulate its healthcare spending to comply with them, whether by increasing contributions to its ERISA plans or navigating the narrow regulatory channel between *the Fair Share Act's definition of healthcare spending* and ERISA's definition of an employee benefit plan." 475 F.3d at 197 (emphasis added). This language makes clear that the majority was (understandably, given the case before it) assuming a world in which *laws like the Fair Share Act* proliferated across jurisdictions. Because the non-ERISA compliance options provided by the Fair Share Act were held not reasonable in virtually all

circumstances, navigation of this "narrow regulatory channel" was impractical and would have disrupted uniformity in *plan* administration. *Id.* (quoting *Egelhoff*). Because the HCSO is nothing like the Fair Share Act, the court's discussion of the consequences of multiple Fair Share Acts cannot be construed as creating a conflict with the panel's opinion.

E. GGRA And Its Allies Attempt To Reinterpret *Fielder* and *Egelhoff* In A Manner That Conflicts With Existing Supreme Court Case Law.

GGRA and its allies ask the Court to interpret the *Fielder dicta* as announcing a rule that employers may not be exposed to different spending requirements in different jurisdictions if the spending happens to deal with a subject, like health care, mentioned by the ERISA statute. Similarly, they make much of the statement in *Egelhoff* that the "tailoring of plans *and employer conduct* to the peculiarities of the law of each jurisdiction is exactly the burden ERISA seeks to eliminate." 532 U.S. at 151 (citation and quotations omitted) (emphasis added). They ask this Court to read the phrase "tailoring of . . . employer conduct" in isolation and to interpret it to preclude *any* local spending requirement with respect to a matter that is mentioned in ERISA. The Supreme Court, however, has squarely rejected such an overbroad formulation of ERISA's uniformity principle. The Court has made clear that although ERISA's preemption provision protects employers' ability to maintain *plan* uniformity, it does not guarantee *expenditure* uniformity for employers. "[C]ost uniformity was almost certainly not an object of pre-emption . . ." *Travelers*, 514 U.S. at (1995).

Specifically, in *Fort Halifax*, the Court held that a state law requiring minimum severance pay expenditures was not preempted because it did not interfere with plan uniformity. The Court made clear that states and localities may

regulate the benefits mentioned in ERISA so long as they do not require alteration of ERISA plans:

Appellant's basic argument is that any state law pertaining to a type of employee benefit listed in ERISA necessarily regulates an employee benefit plan, and therefore must be pre-empted. Because severance benefits are included in ERISA, *see* 29 U.S.C. § 1002(1)(B), appellant argues that ERISA pre-empts the Maine statute. In effect, appellant argues that ERISA forecloses virtually all state legislation regarding employee benefits. This contention fails, however, in light of the plain language of ERISA's pre-emption provision, the underlying purpose of that provision, and the overall objectives of ERISA itself. . . . ERISA's pre-emption provision does not refer to state laws relating to "employee benefits," but to state laws relating to "employee benefit *plans*" . . . The words "benefit" and "plan" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic difference between a "benefit" and a "plan," Congress' choice of language is significant in its pre-emption of only the latter.

482 U.S. at 7-8 (emphasis in original).

Similarly, in *Morash*, the Court considered the preemptive effect of ERISA on state laws requiring the payment of unused vacation benefits to employees upon their discharge. Even though vacation pay is listed in ERISA, the Court concluded that such state laws are not preempted, so long as they do not infringe upon ERISA plans. 490 U.S. at 114-15.

The laws in *Fort Halifax* and *Morash* obviously required the "tailoring of . . . employer conduct" to the peculiarities of different jurisdictions. Indeed, with respect to vacation pay, the *Morash* Court expressly acknowledged that roughly half the states imposed expenditure requirements at the time of its decision. 490 U.S. at 109-10. And with respect to severance pay, several states have, consistent

with *Fort Halifax*, imposed expenditure requirements.³ Another area covered by ERISA in which employers are subjected to an array of different requirements is apprenticeship wages, both in terms of the amount that employers pay apprentices, and the length of the period in which employers may pay them less than the minimum wage.⁴

In the area of health care itself, the very structure of ERISA necessarily contemplates that employers will be subject to disparate costs across jurisdictions. After all, ERISA's savings clause exempts from preemption state laws regulating insurance. 29 U.S.C. § 1144(b)(2)(A). This has resulted in the enactment of more than 1,961 mandates on health insurance, and no two states impose identical sets of coverage mandates. Victoria Craig Brunce et al., *Health Insurance Mandates in the States*, Council for Affordable Health Insurance (2008 ed.) at 1. Accordingly, the cost of employer-provided health insurance varies wildly from state to state. *Id.* at 3-5. Congress never could have included the savings clause if it had viewed ERISA as preserving expenditure uniformity for employers in the area of health care. "Such disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985). And that is why "*cost uniformity was*

³ See, e.g., Haw. Rev. Stat. § 394B-10, 11 (2008); Me. Rev. Stat. Ann. tit. 26, § 625-B (West 2008); 15 PA. Cons. Stat. § 2582 (2008); R.I. Gen. Laws § 28-7-19.2(b),(c) (2008); V.I. Code Ann. tit. 24, § 473 (West 2008).

⁴ See, e.g., Conn. Gen Stat. § 31-58(j) (2008); Del. Code Ann. tit. 19, § 906 (Lexis Nexis 2008); Haw. Rev. Stat. § 387-9 (2008); Kan. Stat. Ann. §§ 44-1207(b), 44-643 (2007); Mo. Rev. Stat. § 290.517 (2008); N.C. Gen. Stat. § 95-25.3(b) (2008); Ohio Rev. Code Ann. § 4111.07 (Lexis Nexis 2008); 43 PA Stat. Ann. § 333.104(b) (Lexis Nexis 2008).

almost certainly not an object of pre-emption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA *plans*." *Travelers*, 514 U.S. at 662.

The upshot is that employers commonly face differing cost requirements in different jurisdictions. They are subject to varying severance pay requirements, minimum wage requirements, vacation pay requirements, apprenticeship and/or training program requirements, taxes, fees, and sick leave requirements, to name just a few. And a requirement in one of these areas may affect the employer's decision about expenditures in another area. Such is the unavoidable (and utterly unremarkable) consequence of doing business in multiple jurisdictions in the United States. Local expenditure requirements are only preempted if they interfere with *plan* uniformity. The attempt by GGRA and its allies to read *Egelhoff* and *Fielder* as mandating a contrary conclusion is unavailing. Indeed, had the panel held that ERISA preempts expenditure requirements even when there is a reasonable non-ERISA means for complying, it would have been at odds with, at a minimum, this Court's rulings in *WSB* and *Standard Industrial*, the Third Circuit's ruling in *Keystone*, and the Supreme Court's rulings in *Travelers*, *Dillingham*, *De Buono*, *Fort Halifax* and *Morash*.

II. THERE IS NO CONFLICT WITH *QUALLS* OR *SCOTT* BECAUSE THE CITY PAYMENT OPTION DOES NOT INVOLVE THE CREATION OF AN ERISA PLAN.

As the litigation has proceeded (and as more employers have chosen the city payment option) GGRA and its allies have placed increasing reliance on an argument formerly relegated to brief mention: that the payment of money to the City *itself* involves the creation of an ERISA plan. This argument, which was rejected even by the district court, is both novel and remarkable. GGRA has

identified no other case in the country in which a party has even argued that payments by an employer to a government entitlement program create an ERISA plan. On that basis alone, this issue does not warrant en banc review.

In any event, employers that choose to make payments to the City are not providing, promising, or administering benefits to their employees. Therefore, there is no basis for concluding that payments to the City involve the creation of an ERISA plan. Certainly the panel's rejection of this argument creates no conflict with *Qualls by & Through Qualls v. Blue Cross of Cal.*, 22 F.3d 839, 843 (9th Cir. 1994) or *Scott v. Gulf Oil Corp.*, 754 F.2d 1499 (9th Cir. 1985).

A. The Definition Of An ERISA Plan.

ERISA specifies that "employee benefit plans" include both "employee welfare benefit plan[s]" and "employee pension benefit plan[s]." 29 U.S.C. § 1002(3). It defines "an employee welfare benefit plan" as "any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise," specified benefits. § 1002(1). Those specified benefits include, among others, vacation, disability, unemployment, severance, and, of course, medical benefits. *Id.*

In *Morash*, the Supreme Court provided a roadmap for determining whether a particular arrangement is the kind of "plan, fund, or program" ERISA was designed to regulate. The Court first concluded that the statutory text was not helpful because it does not answer the question "whether every policy to provide vacation benefits falls within its ambit." 490 U.S. at 114. Thus, the Court directed that, in deciding whether a particular arrangement is an ERISA plan, courts must

"look to the provisions of the whole law, and to its object and policy." *Id.* at 115 (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 51 (1987)).

B. The Object And Policy Of ERISA Is To Ensure That Benefits Promises Made By Private Employers To Their Employees Are Kept.

The central purpose of ERISA is to ensure that the benefits promises made by private employers to their workers are kept. This is demonstrated by ERISA's "declaration of policy":

It is hereby declared to be the policy of this chapter to protect interstate commerce *and the interests of participants in employee benefit plans and their beneficiaries*, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

29 U.S.C. § 1001(b) (emphasis added).

The Supreme Court has confirmed that protection of private employee benefits is indeed ERISA's central purpose:

In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds. To that end, it established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator.

Morash, 490 U.S. at 115 (internal citations omitted). *See also Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510 (1981).⁵

⁵ GGRA and its *amici* paint ERISA as a law whose central purpose is to preserve uniformity for employers. It is true, of course, that the purpose of the *preemption provision* is to ensure uniformity in the administration of ERISA plans. And it is true that Congress viewed plan uniformity as a key component of ERISA. But the fact remains that the preemption provision is but one part of a far more (continued on next page)

C. The City Payment Option Does Not Involve The Establishment Of An ERISA Plan.

- 1. Unlike the provision of health insurance at issue in *Qualls*, an employer that chooses the city payment option is not promising, providing, or administering health benefits.**

The Secretary complains that "the panel failed to address *Qualls* . . . which held that an employer establishes an ERISA plan when it makes payments to a third-party insurer-plan administrator . . ." Secretary's Brief Supporting Rehearing at 2. And she argues that the panel created a conflict with *Qualls* because "no meaningful distinction can be made between a private insurer acting as a third-party administrator and a public agency or its independent contractor acting as a third-party administrator . . ." *Id.* at 13. The Secretary is wrong on both counts: the panel squarely addressed the *Qualls* argument, and there is a huge difference between the relationship employers have with insurance companies and those they have with the HAP – a difference that underscores why the city payment option does not involve the creation of an ERISA plan.

It bears emphasis that an ERISA plan is a plan established by an "employer" for the purpose of "providing . . . benefits . . ." 29 U.S.C. § 1002(1). When an employer contracts with a third party provider such as Blue Cross, and informs its employees that they can receive treatment through Blue Cross, the employer is making a promise to provide benefits. To be sure, the employee looks to Blue Cross for the actual benefits, but it is still the employer "providing . . . benefits" to its employees by contracting with Blue Cross to ensure that the employees will

(footnote continued from previous page)

comprehensive statute. And as discussed above, the definition of an "employee welfare benefit plan" must be construed in light of the purposes of the "whole law." *Morash*, 490 U.S. at 115-16.

receive specified health care services. The employer, when negotiating the contract, can give shape to the plan by deciding, for example, which treatments will be covered or how claims will be processed. And if Blue Cross does not fulfill the contractual obligations it owes to the employer to provide the contemplated benefits, the employer, as an ERISA fiduciary, can sue to ensure that the employer's promise to the employee is kept. *See* 29 U.S.C. §§ 1132(a)(2), (3).

In contrast, with the city payment option, an employer does not "provide" benefits to its employees. And an employer does not – indeed it could not – make any benefits promises to its employees. The employer exercises no influence over the City's decisions about what care to provide or how to operate the HAP. The employer does not enter into a contract with the City to specify which benefits its employees will receive should those employees decide to enroll in the HAP. The employer takes no responsibility for ensuring that a system exists to process employee claims. In short, it is the City, not the employer, that is "providing . . . benefits" to HAP participants, in contrast to the third party insurance situation, where the employer is "providing . . . benefits" through a contractual arrangement with a third party. The panel fully addressed the *Qualls* argument and identified its deficiencies, *see* Panel Op. at 13936, the Secretary's efforts to create a contrary impression notwithstanding.⁶

⁶ Incidentally, the Secretary also contends she "never made" the argument that the HAP is an ERISA plan, and she asserts that the panel mischaracterized her position on this point. Brief of Secretary of Labor Supporting Petition for Rehearing at 13. However, in her merits brief, the Secretary did indeed make this argument: "ERISA . . . applies to government-run employee welfare benefit plans, like the HCSO, that are specifically designed to include private employees of private employers." Brief of Secretary of Labor Requesting Affirmance at 18. The (continued on next page)

Furthermore, because the employer has no control over the HAP, it would be absurd to conclude that the ERISA statute regulates the employer's conduct in making payments to the City. Under ERISA, an employer may be hauled into federal court as a plan administrator for failure to establish claims procedures or to administer those claims properly. 29 U.S.C. § 1133; 29 U.S.C. § 1002(16)(B); 29 C.F.R. § 2560.503-1. When an employer contracts with an insurance company, it typically delegates plan administration responsibilities to the insurer. But with the HAP, there is no such contractual delegation to the City. Accordingly, if the city payment option were held to create an ERISA plan, employers could be sued under ERISA about matters over which they have absolutely no control. Courts must, whenever possible, "interpret statutes so as to preclude absurd results." *Andrieu v. Ashcroft*, 253 F.3d 477, 482 (9th Cir. 2001) (en banc).

2. ERISA is not concerned with the type of employer conduct necessitated by the city payment option.

An ERISA plan typically involves "administrative activity *potentially subject to employer abuse*." *Fort Halifax*, 482 U.S. at 16 (emphasis added). The touchstone is whether the employer exercises significant discretion in administering plan assets and providing benefits. "[W]here benefit obligations are administered by a mechanical formula that contemplates no exercise of discretion, the need for ERISA's protections is diminished. . . . The determination of what constitutes an ERISA plan thus turns most often on the degree of an employer's discretion in administering the plan." *O'Connor v. Commonwealth Gas Co.*, 251

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panel was right to address this argument in its opinion, even if the Secretary has since backed away from it.

F.3d 262, 267 (1st Cir. 2001). As discussed by the panel, the Ninth Circuit has regularly applied this principle. See Panel Op. at 13931 (discussing *Velarde v. Pace Membership Warehouse, Inc.*, 105 F.3d 1313, 1317 (9th Cir. 1997) and *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1323 (9th Cir. 1992)).⁷

An employer that chooses to fulfill its expenditure obligation by making payments to the government is required to do no more than make mechanistic calculations on a quarterly basis, keep records of those calculations, and send a check to the City each quarter. To be sure, the employer must determine which employees are covered by the ordinance, track those employees and their hours worked, and calculate what it owes. However, there is nothing inherently discretionary about this activity – indeed, it is no different from the administrative activity necessitated by any simple tax credit.

The following example proves the point. Obviously, San Francisco could impose a "health care tax" on all businesses and use the payments to fund a health care entitlement program such as the HAP. Similarly, the City could impose such a tax on businesses but give them tax credit in the amount of their private health care expenditures, based on criteria identical to those contained in the HCSO. Nobody would argue that employers' tax payments to the City would create an ERISA plan simply because the employer has calculated the credit to which it is entitled. But there would be no functional difference between an employer calculating such a tax credit and what the employer must do to utilize the city

⁷ The Secretary claims that by focusing on the issue of discretion, the panel "erroneously heightened the test for determining when an 'ongoing administrative scheme' exists." Brief of Secretary of Labor Supporting Rehearing at 11. The panel did not "heighten" anything; it applied well-established case law that the Secretary simply ignores.

payment option. If employer conduct would not create an ERISA plan in the case of a tax credit, it makes no sense that the identical conduct would create an ERISA plan in the case of the city payment option.⁸

3. *Scott* is not relevant to whether the city payment option creates an ERISA plan.

The primary argument advanced by GGRA and its allies as to why the city payment option involves the creation of an ERISA plan is that it satisfies the criteria set forth in *Donovan v. Dillingham*, 688 F.2d 1367, 1370-73 (11th Cir. 1982). The Ninth Circuit has applied this test in several cases, including *Scott*. The test inquires whether "from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits." *Donovan*, 688 F.2d at 1373.

However, *Donovan* describes an *evidentiary test* to determine whether, as a factual matter, an alleged benefits promise by an employer was sufficiently clear to create a *de facto* ERISA plan. That was the issue in *Scott* – whether an alleged oral

⁸ In arguing that the city payment option creates an ERISA plan, GGRA and its amici attempt to blur the distinction between a "plan" in the colloquial sense of the term, and an "ERISA plan." Prior to enactment of the HCSO, an employer's "plan" for how its low-wage workers would receive health care might have been to refer the employees to San Francisco's health care programs for indigent persons. The employer might have evaluated whether the employees qualified for such programs, informed them that they qualified, and instructed them on how to enroll. That arrangement may have met the colloquial definition of a "plan," but it would not have been an ERISA plan because, among other reasons, like the city payment option under the HCSO (and quite unlike the situation where an employer purchases health insurance for its employees), it does not involve any promise by the employer to its employees to provide benefits.

statement by an employer to the employee promising severance pay created an ERISA plan. 754 F.2d at 1503-04.

Courts do not apply that test to the more fundamental, threshold legal question presented here: whether a particular "plan" is the type of "plan" to which Congress intended ERISA to be subjected in the first place. Thus, when the Supreme Court inquired whether compliance with Maine's severance pay statute involved creation of an ERISA plan, it did not apply the *Donovan* test. *Fort Halifax*, 482 U.S. 1 at 11-15. If it had, it would presumably have concluded that severance pay law *did* mandate creation of an ERISA plan, because one could easily "ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits." *Donovan*, 688 F.2d at 1373. Similarly, the Court in *Morash* did not inquire whether employer promises of vacation pay satisfied the *Donovan* test. If it had, it would have deemed the test met, and the case would have come out differently. While the *Donovan* test is useful to adjudicate a factual dispute about whether a *de facto* ERISA plan was created in a particular case, it is not relevant to the threshold legal question whether an arrangement that nobody disputes exists is of the type with which ERISA was concerned in the first place. The *Donovan* test could not be applied to such cases unless *Fort Halifax* and *Morash* were overruled.

GGRA and its allies make much of the panel's observation that "[t]he outcome of *Scott* is almost certainly no longer good law in light of the Supreme Court's subsequent decisions in *Fort Halifax* and *Morash*." Panel Op. at 13932. Given *Scott*'s conclusion that an employer's promise of a lump-sum severance payment created an ERISA plan, and the subsequent conclusion of the Supreme Court in *Fort Halifax* that the promise of a lump-sum severance payment *does not* create an ERISA plan, the panel's observation is unremarkable. But in any event,

for the reasons discussed above, whether *Scott* remains good law in some other regard is not relevant to the question presented here. Moreover, the panel did not overrule *Scott*; it merely observed the conflict between the "outcome" of *Scott* and with subsequent Supreme Court precedent. In any event, *Scott* and *Donovan* are totally inapplicable here, and present no conflict with the panel opinion.

4. The Secretary is not entitled to deference.

The Retail Industry Leaders Association contends the panel should have deferred to the Secretary of Labor's position in this litigation. RILA Brief at 15-16. However, the Secretary did not seek deference from the panel, nor, in her brief supporting rehearing, does she now claim she was entitled to it.

Furthermore, the case relied upon by RILA dealt with the unrelated question whether the Department of Labor's interpretation of its *own regulations* is entitled to deference. *See Auer v. Robbins*, 519 U.S. 452, 461 (1997). In contrast, courts generally "deny deference 'to agency litigating positions that are wholly unsupported by regulations, rulings, or administrative practice' . . . The deliberateness of such positions, if not indeed their authoritativeness, is suspect." *Smiley v. Citibank (S.D.), N.A.*, 517 U.S. 735, 741 (1996) (quoting *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 212 (1988)).

Finally, even if the Secretary *had* sought deference, and even if deference to an agency position first taken in litigation were appropriate in some other circumstance, it would have been unwarranted in this case. When the Secretary of Labor proposes a definition of an ERISA plan that directly contradicts Supreme Court precedent – specifically *Fort Halifax* and *Morash* – her position is highly "suspect," and is not entitled to deference. *Smiley*, 517 U.S. at 741.

III. GGRA'S OTHER ATTEMPTS TO PORTRAY A CONFLICT ARE MERITLESS.

A. There Is No Conflict With *Greater Washington*.

GGRA argues that the panel's opinion conflicts with *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992). In *Greater Washington*, an employer's obligation was triggered *directly by* the benefits it offered through an ERISA plan; whatever ERISA benefits the employer offered, it had to provide those same benefits to injured workers on workers' compensation. *Id.* at 126-27. Here, unlike the law struck down in *Greater Washington*, the HCSO references what an employer *spends* on health care, irrespective of whether that spending operates through an ERISA plan and irrespective of which benefits are offered through such an ERISA plan. As such, the HCSO is just like the law upheld by this Court in *WSB*. See 88 F.3d at 793 ("The references to ERISA plans in the California prevailing wage law have no effect on any ERISA plans, but simply take them into account when calculating the cash wage that must be paid"); cf. *Funkhouser v. Wells Fargo Bank, N.A.*, 289 F.3d 1137, 1143-1144 (9th Cir. 2002).

B. There Is No Conflict With *J.A. Jones*.

GGRA and some *amici* argue that the panel, in distinguishing *Greater Washington* on the ground that an employer's obligation under that statute depended on the ERISA benefits it offered while the HCSO requires a minimum expenditure by all employers regardless of ERISA benefits offered, created a conflict with *Local Union 598, Plumbers & Pipefitters Industry Journeymen & Apprentices Training Fund v. J.A. Jones Constr. Co.*, 846 F.2d 1213 (9th Cir. 1988). They quote out of context the statement in *J.A. Jones* that the "'contribution/benefit' dichotomy, while perhaps superficially appealing, is unsupported by the law." *Id.* at 1219.

When this statement is placed in context, however, it further supports the panel's opinion. The Court in *J.A. Jones* came to the unremarkable conclusion that a forced contribution *into an ERISA plan* was preempted. *See id.* (statute preempted because "it mandates a particular level of contributions by employers *to employee benefit plans* A statute which mandates employer contributions *to benefit plans* and which effectively dictates the level at which those required contributions must be made has a most direct connection with an employee benefit plan") (emphasis added). The HCSO goes out of its way to avoid "mandat[ing] employer contributions to benefit plans." *Id.* There is no basis in law or logic to conclude that an expenditure made separate and apart from an ERISA plan should be considered an "ERISA benefit" for the employee.

C. There Is No Conflict With *Castonguay*.

GGRA next claims a conflict with a case it never cited to the panel: *General Am. Life Ins. Co. v. Castonguay*, 984 F.2d 1518 (9th Cir. 1993). *Castonguay* noted that ERISA regulates "certain relationships: for instance, the relationship between plan and plan member, between plan and employer, between employer and employee (*to the extent an employee benefit plan is involved*), and between plan and trustee." *Id.* at 1521 (emphasis added). Thus, if local laws seek to regulate these relationships, they are "presumptively preempted." *Id.*

But the HCSO does not regulate ERISA relationships. To be sure, the ordinance regulates the relationship between employer and employee, as do countless other laws. And it regulates the relationship between employer and employee with respect to health care expenditures, just as the law in *Fort Halifax* regulated that relationship with respect to severance expenditures, and just as the law in *Morash* regulated that relationship with respect to vacation pay. But like the laws in *Fort Halifax* and *Morash*, the HCSO does not impose any requirements on

the employer-employee relationship with respect to ERISA plans, and therefore it does not run afoul of the "relationship test." *See also Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson*, 201 F.3d 1212, 1222 & n. 12 (9th Cir. 2000) (explaining boundaries of relationship test).

IV. GGRA AND ITS ALLIES GREATLY EXAGGERATE THE CONSEQUENCES OF THE PANEL'S RULING.

Because the panel's decision does not conflict with the Fourth Circuit's holding in *Fielder*, the claims by GGRA and its allies about the national consequences of the ruling are greatly overblown. Indeed, their primary case for en banc review appears to be that the panel's ruling authorizes the "dozens" of "pay or play" laws proposed in various jurisdictions, and that there is an urgent need for the full court to make sure that national employers will not be subjected to such laws. *See, e.g.*, GGRA Petition at 2; Secretary's Brief at 7; RILA Brief at 2. However, many of the proposals they cite are similar to Maryland's Fair Share Act – they impose employer spending requirements and penalties for failure to make the expenditures, but they do not create government health care programs into which employers may pay to comply, where the payments result directly in substantial health care services from that program for the employer's workers.⁹ Indeed, the only two proposals that were *actually enacted* were struck down – the Maryland law in *Fielder* and a virtually identical one in Suffolk County.¹⁰

⁹ *See, e.g.*, Senate Bill No. 1414, 2005-2006 Reg. Sess. (Cal. 2006); House Bill No. 2579, 81st Leg., 2006 Reg. Sess. (Kan. 2006); House Bill No. 2517, 59th Leg., 2006 Reg. Sess. (Wash. 2006).

¹⁰ *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403 (E.D.N.Y. 2007). Incidentally, several of the proposed laws complained of by GGRA and its allies are not "pay or play" laws at all, so it is unclear why they are cited. For example, one is a general tax imposed on employers without regard to (continued on next page)

Thus, it is true, as GGRA points out, that San Francisco's program creates a roadmap for other jurisdictions that may wish to provide universal health care to their citizens. But that roadmap is not so easy to follow. San Francisco has spent significant public dollars to build a universal health care program, only a small portion of which comes from employer payments. The personnel and technical expertise required to build such a program is no small matter either. Particularly in this time of financial hardship for state and local governments, it will be challenging indeed to follow in San Francisco's footsteps. Perhaps that is why no other jurisdiction in the nation has enacted a law like the HCSO since the panel held, in January 2008, that the program was not likely to be preempted.¹¹

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whether they make health care expenditures. Assembly Bill No. 898, 97th Leg., 2005-2006 Reg. Sess. (Wisc. 2006). Another is a basic prevailing wage law. Senate Bill No. 6644, 229th Leg. Sess. (NY 2006).

¹¹ The brief of the American Benefits Council strikes an even more alarmist note by proclaiming that "there are 478 cities and towns in California alone," as if to suggest that 478 different HCSOs are on the verge of sprouting up in California. Brief of American Benefits Council at 14. This ignores the fact that San Francisco is in a unique position compared to all other California municipalities: it is both a city and a county, with boundaries that are coterminous. Under California law, *counties* are responsible for providing health care to the indigent, Cal. Welf. & Inst. Code § 17000, while only *cities* possess the power to impose expenditure requirements on employers. *See, e.g., City of Dublin v. County of Alameda*, 14 Cal. App. 4th 264, 274-75 (1993) (police power of county extends only to unincorporated areas). Accordingly, San Francisco is uniquely situated to enact both a government-run health care program and an employer spending requirement. If other counties in California wished to create universal health care programs that do not create a rush by employers to cancel their employees' health coverage en masse (*see* Section I.B, *supra*), they must first convince every city within the county to impose a health care expenditure requirement on employers.

While the sense of urgency conveyed by GGRA regarding the effect of the panel's ruling on national employers is overblown, a ruling overturning the panel's decision would be tragic for the people of San Francisco. The HCSO has been wildly successful. From the time the HAP was launched in July 2007 through the end of Fiscal Year 2007-2008, more than 27,000 uninsured residents have enrolled in the program. RJN Exh. 1 at 3. Thus, 38 percent of the estimated 73,000 uninsured adults in San Francisco are now receiving health care. *Id.* And it is not the kind of emergency-driven care often provided by counties to indigent residents. These HAP enrollees have "medical homes" where they are assigned a regular health care practitioner who provides preventive and diagnostic care. *Id.* at 8-9. They receive prescription drug benefits, immunizations, and mental health services. *Id.* at 8-11. These services are available in multiple languages, and at 27 locations throughout the City. *Id.* at 2-3.

Moreover, the city payment option has been a popular compliance option for employers: almost 1,000 had chosen it by July 2008. *Id.* at 12. Thus, not only has the City created a reasonable non-ERISA compliance option, but tens of thousands of workers who were previously without health care are now eligible for HAP participation or for medical reimbursement accounts.¹²

As discussed in Section I.B, the employer spending requirement is critical to the HAP's success. If the City were to create a comprehensive, government-run health care program without an employer spending requirement, employers would

¹² Specifically, as of July 2008, roughly 26,000 employees have been made eligible to participate in the City's program as a result of payments to the City by their employers. RJN, Exh. 1 at 12. Roughly half of these people are eligible for participation in the HAP, and the other half are eligible for medical reimbursement accounts. *Id.*

have a strong incentive to drop existing health coverage for their workers, thereby foisting those people onto the City's program. This would not only be unfair, it would likely make universal health care unworkable, and accelerate the deterioration of employer-provided health care – the model of health care provision upon which our society largely depends to ensure that people are covered. The City, in this time of budget shortfalls, cannot realistically be expected to invest the even greater amounts of public dollars that would be necessary to achieve universal health care in the face of widespread cancellation of employer-based health plans. Denying the City the power to provide universal health care would be particularly inappropriate where there is a presumption in favor of local power and against ERISA preemption – a matter GGRA and its allies fail to discuss at all.

In sum, given the absence of a conflict between the panel's ruling and any other case, given the ruling's conformity to existing preemption doctrine, and given the empty sense of urgency conveyed by GGRA and its allies, there is no reason to strike such a devastating blow to the City's effort to achieve universal health care in San Francisco.

CONCLUSION

The Court should deny the petition for rehearing en banc.

Respectfully submitted,

DATED: December 3, 2008

By: _____/s/_____
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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief has been prepared using proportionately double-spaced 14 point Times New Roman typeface. According to the "Word Count" feature in my Microsoft Word for Windows software, this brief contains 9,361 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 December 3, 2008.

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CERTIFICATE OF SERVICE

I hereby certify that on December 3, 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.

Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

I further certify that some of the participants in the case are not registered CM/ECF users. I have mailed the foregoing document by First-Class Mail, postage prepaid, or have dispatched it to a third party commercial carrier for delivery within 3 calendar days, to the following non-CM/ECF participants:

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DATED: December 3, 2008

Respectfully submitted,

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