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 1021, SEIU UNITED HEALTHCARE WORKERS-WEST, and UNITE-HERE! LOCAL 2, Intervenors/Appellants.	Nos. 07-17370, 07-17372 (U.S. District Court No. C06-6997 JSW)

JOINT OPENING BRIEF OF APPELLANTS

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

The Honorable Jeffrey S. White

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JURISDICTIONAL STATEMENT

This is an appeal from a final judgment entered against the Appellants on December 26, 2007, disposing of all parties' claims and holding the San Francisco Health Security Ordinance preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* ER 17. The district court had subject matter jurisdiction under 28 U.S.C. § 1331. The Appellants filed timely notices of appeal on December 27, 2007. This Court has jurisdiction pursuant to 28 U.S.C. § 1291.

ISSUE PRESENTED

Whether the employer spending requirement of the San Francisco Health Care Security Ordinance is preempted by ERISA.

STATEMENT OF THE CASE

As in many cities and states throughout the country, there is a health care crisis in San Francisco. Approximately 82,000 adult residents go without insurance each year – more than one-tenth of the City's population. Although the uninsured obviously suffer most from the crisis, its impact is felt citywide. The taxpayers spend roughly $104 million per year to provide emergency and other health care services to the uninsured population. This figure does not even include the money spent on uninsured people who live outside San Francisco but work in the City and use its health care resources.

To address this crisis, San Francisco adopted the landmark Health Care Security Ordinance ("HCSO" or "Ordinance"), which has two key components. First, it creates a comprehensive governmental health program to provide health care services to uninsured San Francisco residents, as well as qualified nonresidents who work in the City. Second, it imposes a minimum health care spending requirement on businesses with 20 or more employees. Employers can

comply with this spending requirement through private health care spending, or by paying the City so that their employees may participate in the new governmental program.

The district court ruled that the employer spending requirement of the HCSO is preempted by ERISA. However, the courts have uniformly made clear that while ERISA preempts state and local laws that impose mandates with respect to ERISA plans, it does not preempt legal requirements that employers may readily satisfy without altering or adopting ERISA plans. San Francisco's Ordinance falls squarely in this latter category. Employers are free to comply with the spending requirement by setting up ERISA plans if they wish, but they are also free to comply through non-ERISA means, including by making payments to the City. In fact, the law is so clear on this point that this Court has stayed the district court's ruling pending appeal, holding that Appellants have demonstrated "not only a probability," but "a strong likelihood of success on the merits." *Golden Gate Restaurant Association v. City and County of San Francisco*, __ F.3d __, __ (9th Cir. 2008), No. 07-17370 (Slip Op. at 15) ("*GGRA*") (internal quotation marks omitted).

The district court's analysis was tainted by two primary errors. First, the court evidently believed that a law that grants employers a credit against a generally applicable expenditure requirement for their spending on ERISA plans is preempted because such a law makes unlawful "reference to" ERISA plans. ER 11, 13-14. But that notion has been squarely rejected by this Court in several cases, including but not limited to the instant one. *See, e.g., GGRA*, __ F.3d at __ (Slip Op. at 26-28).

Second, the court appeared to assume that *any* local health care spending requirement interferes with the ability of employers to maintain "uniformity,"

thereby running afoul of ERISA's preemption provision. ER 12-13. However, the Supreme Court has already made clear that ERISA's preemption provision is not designed to allow employers to maintain *cost* uniformity; instead, it is designed to allow them to maintain *plan* uniformity. Because the HCSO permits all employers to comply without adopting ERISA plans or amending existing ERISA plans, it "preserves ERISA's uniform regulatory regime," and has "no effect on the administrative practices of a benefit plan . . . unless an employer voluntarily elects to change those practices." GGRA __ F.3d at __ (Slip Op. at 20). The fact that the Ordinance makes the cost of being an employer in San Francisco different from other jurisdictions is wholly unremarkable, and it is not a matter with which ERISA is concerned.

STATEMENT OF FACTS

A. San Francisco's Health Care Crisis

Each year, roughly 82,000 San Francisco adults suffer from a lack of health insurance. ER 476. Aside from the obvious human suffering this causes, the health care crisis imposes a tremendous financial burden on the City and its taxpayers, requiring them to foot the bill for emergency treatment and other health care services. *Id.* The San Francisco Department of Public Health ("DPH") estimates that in Fiscal Year 2005-2006 it spent $104 million to provide health care services to the uninsured. *Id.*

The above figures actually understate the severity of San Francisco's health care crisis, because they do not account for the thousands of uninsured people who live elsewhere but seek health care services from the City. In Fiscal Year 2005-2006, DPH estimates it served approximately 5,300 uninsured individuals who do not live in San Francisco. ER 476-77.

A common misconception about the uninsured is that they are "taken care of" because they qualify for state or federally funded health care programs for the indigent like Medi-Cal (California's Medicaid program). In reality, the large majority of the uninsured do not qualify for care under such programs. For example, an adult is only eligible for Medi-Cal if: (i) her household income falls below the Federal Poverty Level ("FPL"), which is just over $10,000 per year for a single person; and (ii) she is elderly, blind, disabled, pregnant or a single parent.[1] The 82,000 uninsured residents mentioned above do not include the people who are enrolled in San Francisco's indigent health care programs. ER 470.

B. The San Francisco Health Care Security Ordinance

In 2006, to address the City's health care crisis, the San Francisco Board of Supervisors unanimously passed, and the Mayor signed into law, the HCSO.[2] The Ordinance has two key related components – a government health care program and an employer health spending requirement.

1. The government health program

The HCSO establishes a government health care program, operated by DPH. Its primary feature is the Health Access Program ("HAP"), which delivers health care to its participants from a network consisting of San Francisco General

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[1] For a discussion of the programs available to San Francisco's indigent population and an explanation of their limited availability based on FPL and other factors, see DPH, *Health Care Access: A Guide To Health Care Programs in San Francisco*, available at http://www.sfdph.org/Reports/HlthCareAccess042007/HlthCareAccessBody042007.pdf.

[2] The Ordinance is attached hereto as Appendix A, and is also available at http://www.municode.com/Resources/gateway.asp?pid=14131&sid=5.

Hospital, DPH clinics, and participating non-profit and private providers. S.F. Admin. Code § 14.2(a). The Ordinance provides that the HAP shall assign a primary care physician, nurse practitioner or physician assistant to each participant. S.F. Admin. Code § 14.2(e). And it requires that the HAP "provide medical services with an emphasis on wellness, preventive care and innovative service delivery." S.F. Admin. Code § 14.2(f). Among the specific services provided are inpatient and outpatient hospital services, diagnostic and laboratory services, radiological services, mental health services, home health care, and prescription drug benefits. *Id.* The value of this care is substantial – DPH estimates that in 2008 it will cost an average of $261 per participant per month to provide it. ER 477.[3]

The HAP, which is funded in part by the City's general fund, is available to uninsured San Francisco residents, regardless of whether they are employed or unemployed. Enrollees must pay quarterly participation fees, which are set on a sliding scale according to their household income as a percentage of the FPL. The rates are as follows:

FPL:	0-100%	101-200%	201-300%	301-400%	401-500%	501%+
Quarterly Participation Fee:	$0	$60	$150	$300	$450	$675

ER 477.

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[3] Incidentally, DPH changed the name of the HAP program to "Healthy San Francisco" after determining that the name "Health Access Program" would create confusion among San Francisco residents because of its similarity to other programs. See DPH Reg. No. 1(b) (attached as Appendix B). For purposes of this litigation the parties have continued to use the name contained in the Ordinance.

Individual residents who work in San Francisco but live elsewhere do not qualify for HAP participation, but the program contains a feature for those people as well. The Ordinance authorizes DPH to establish and maintain medical reimbursement accounts for qualified nonresident employees who work in the City. S.F. Admin. Code §§ 14.1(b)(7), 14.2(g). Beneficiaries of this aspect of the City's program may draw from their accounts to obtain reimbursement for medical expenses, including payments of health insurance premiums. DPH Reg. 7(g)(i) (Appendix B, attached).[4]

2. The employer spending requirement

The other key component of the HCSO is the employer spending requirement – a mandate that medium and large businesses make minimum health expenditures on behalf of employees who work more than a specified number of hours. Specifically, in 2008 a private employer with 20-99 employees and a nonprofit employer with 50 or more employees must, for any employee who has been employed for 90 days and works more than ten hours per week, make health care expenditures of $1.17 per hour on behalf of that employee. S.F. Admin. Code § 14.1(b)(8); OLSE Reg. No. 5.2(A)(2) (attached as Appendix C).[5] A private employer with 100 or more employees must make health care expenditures of

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[4] In addition to being attached hereto as Appendix B, the DPH regulations are available at http://www.sfhp.org/files/PDF/reports/Attachment_A_Final_Regulations_for_HC_Adoption.pdf.

[5] In addition to being attached hereto as Appendix C, the OLSE regulations are available at http://www.sfgov.org/site/uploadedfiles/olse/hcso/HCSO_Final_Regulations.pdf.

$1.76 per hour on behalf of each covered employee. S.F. Admin. Code. § 14.1(b)(8); OLSE Reg. No. 5.2(A)(1).

It is entirely up to each covered employer to decide how to comply with this spending requirement. The Ordinance defines health care expenditures to mean "any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees," and sets forth the following non-exclusive list of appropriate health care expenditures:

- Contributions to health savings accounts ("HSAs") as defined under Internal Revenue Code section 223 or "any other account having substantially the same purpose or effect";
- Direct reimbursement to employees "for expenses incurred in the purchase of health care services";
- Payments "to a third party for the purpose of providing health care services for covered employees";
- Costs incurred in the "direct delivery of health care services" to covered employees; and
- Payments by the employer to the City "to be used on behalf of covered employees."

S.F. Admin. Code § 14.1(b)(7).[6] Elaborating on the last option – which we will refer to as the government payment option – the Ordinance states: "The City may

[6] Employers receive credit for any amount spent on health care for their employees, regardless of which particular health benefits are provided or offered. The Ordinance defines "health care services" to mean "medical care, services, or goods that may qualify as tax deductible medical care expenses under Section 213 of the Internal Revenue Code, or medical care, services, or goods having substantially the same purpose or effect as such deductible expenses." S.F. Admin. Code § 14.1(b)(9). Section 213 of the Internal Revenue Code defines "medical care" to include any "amounts paid – (A) for the diagnosis, cure, mitigation,

(continued on next page)

use these payments to: (i) fund membership in the Health Access Program for uninsured San Francisco residents; and (ii) establish and maintain reimbursement accounts for covered employees, whether or not those covered employees are San Francisco residents." *Id.*

DPH has structured the program so that, if an employer chooses to satisfy the health care spending requirement by making payments to the City, the employer need only write a check and all employees on whose behalf the payment is made will be eligible to receive health care benefits. When covered employees enroll with DPH, the Department will place HAP-eligible employees into the HAP, and will establish medical reimbursement accounts for those not eligible for the HAP. DPH Reg. Nos. 7(c), 7(f), 7(g).[7] Employers play no role in determining eligibility for HAP participation, no role in establishing benefits to be provided under the HAP, and no role in determining whether a particular individual is eligible for particular treatments or types of care. Instead, such determinations are made solely by the City, which operates the program itself.

Covered employees who qualify for HAP membership will, if their employers choose to satisfy the spending requirement by paying the City, be

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(footnote continued from previous page)
treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body," as well as prescription drugs, insurance, medical-related transportation, long-term care, and other expenses. 26 U.S.C. § 213(d)(1). Regulations implementing the HCSO expressly permit expenses for dental and vision care to qualify. OLSE Reg. No. 4.1(B).

[7] Generally speaking, covered employees who do not qualify for HAP membership will be nonresidents who work in San Francisco. Certain uninsured San Francisco residents (i.e., those who would qualify for Medi-Cal) also do not qualify for HAP participation. DPH Reg. No. 3(a).

entitled to enroll in the program at a 75 percent discount on the quarterly participation fees identified above. DPH Reg. No. 7(f). Furthermore, any covered employee whose fee, after the 75% discount, falls below $50 per quarter will simply be allowed to enroll for free. *Id.* Accordingly, the fees for covered employees are as follows:

Poverty Level:	0-100%	101-200%	201-300%	301-400%	401-500%	501%+
Quarterly Participation Fee:	$0	$0	$0	$75	$113	$169

ER 478.

Employers covered by the Ordinance are required to keep records of their health care expenditures so that San Francisco's Office of Labor Standards Enforcement ("OLSE") may enforce the employer spending requirement. S.F. Admin. Code § 14.3(b). The OLSE regulations describe in more detail the records that employers must maintain: (1) itemized pay statements, which are already mandated by California Labor Code section 226; (2) the address, phone number, and first day of work of each employee; and (3) records of health care expenditures made on behalf of covered employees. OLSE Reg. No. 7.2. The employer must give the OLSE access to these records to facilitate the agency's enforcement duties. S.F. Admin. Code § 14.3(b).

According to the Controller's Office, the large majority – approximately ninety percent – of businesses with 20 or more employees already provide health care benefits to their employees. ER 467. The average monthly health insurance premium in California is $379. ER 477.

C. The Proceedings Below

On November 8, 2006, the Golden Gate Restaurant Association ("GGRA") filed this lawsuit, seeking declaratory and injunctive relief on the theory that the

HCSO's employer spending requirement is preempted by ERISA. A group of San Francisco labor organizations – San Francisco Central Labor Council, Service Employees International Union ("SEIU") Local 1021, SEIU United Healthcare Workers-West, and UNITE-HERE! Local 2 –intervened as defendants.

The parties filed cross-motions for summary judgment, and the district court heard argument on November 2, 2007. On December 26, 2007, the district court held the employer spending requirement preempted and entered judgment for GGRA. The next day, the City and Intervenors filed notices of appeal and an emergency motion for a stay of the district court's judgment pending appeal. The district court denied that motion on December 28, 2007, but on January 9, 2008 this Court granted the emergency stay. In a published opinion, the Court concluded that the City and Intervenors have a "strong likelihood" of success on the merits of their appeal, and that the balance of hardships tipped in favor of allowing the program to go forward while the appeal is pending. *GGRA*, __ F.3d at __ (Slip Op. at 15). The Court also consolidated the appeals by the City and the Intervenors, and ordered expedited briefing. To avoid burdening the Court with duplicative briefing, the City and Intervenors file this Opening Brief jointly.

STANDARD OF REVIEW

The district court's decision regarding preemption is a question of law decided *de novo* by this Court. *See, e.g., WSB Elec., Inc. v. Curry*, 88 F.3d 788, 791 (9th Cir. 1996). The district court resolved the preemption issue on cross-motions for summary judgment, and both its grant of summary judgment to appellees and its denial of summary judgment to appellants are reviewed *do novo*. *See Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 538 (9th Cir. 2004).

SUMMARY OF ARGUMENT

The health care expenditure requirement of the HCSO does not make unlawful "reference to" ERISA plans because it operates on employers "irrespective of . . . the existence of an ERISA plan." *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A.*, 519 U.S. 316, 328 (1997). *See also GGRA*, __ F.3d at __ (Slip Op. at 23-28).

The Ordinance's health care expenditure requirement does not have an improper "connection with" ERISA plans because any employer may readily comply without adopting an ERISA plan or altering an existing plan, and laws that meet this description are not preempted by ERISA. *See, e.g., Dillingham*, 519 U.S. at 333; *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659 (1995); *Southern California IBEW-NECA Trust Funds v. Standard Industrial Electrical Co.*, 247 F.3d 920, 925 (9th Cir. 2001) ("*Standard Industrial*"); *WSB,* 88 F.3d at 795; *Keystone Chapter of Associated Builders & Contractors v. Foley*, 37 F.3d 945, 960 (3rd Cir. 1994) ("*Keystone*"); *GGRA*, __ F.3d at __ (Slip Op. at 17-23).

Nor does the Ordinance run contrary to the purpose of ERISA's preemption provision, which is "to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657. Because the Ordinance permits all employers to comply without adopting ERISA plans or amending existing ERISA plans, it "preserves ERISA's uniform regulatory regime," and has "no effect on the administrative practices of a benefit plan . . . unless an employer voluntarily elects to change those practices." *GGRA*, __ F.3d at __ (Slip Op. at 20). It is true that the HCSO's health care spending requirement might impose different costs on employers in San Francisco as opposed to other jurisdictions, but the Supreme Court has made clear that ERISA's preemption provision does not protect

employers from disparate cost requirements, or from benefit mandates that employers can fulfill without adopting ERISA plans. *Travelers*, 514 U.S. at 662; *Massachusetts v. Morash*, 490 U.S. 107, 109-10 (1989); *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 7-11 (1987).

Finally, the HCSO represents an effort to protect the health and welfare of San Francisco's citizens – an exercise of the traditional police power that cannot be interfered with unless Congressional intent to do so is "clear and manifest." *Travelers*, 514 U.S. at 655 (quotations omitted). ERISA's preemption provision hardly reflects a "clear and manifest" intent to prevent jurisdictions like San Francisco from enacting health care reform programs like the HCSO. To the contrary, as the case law cited above demonstrates, the Ordinance easily avoids preemption.

ARGUMENT

Local laws that "relate to" ERISA plans are preempted. 29 U.S.C. § 1144(a). A local law is deemed to "relate to" ERISA plans if it has an unlawful "reference to" or an improper "connection with" such plans. *Dillingham*, 519 U.S. at 324. Although these phrases seem broad in the abstract, the Supreme Court has made clear that courts are not to apply them with "uncritical literalism." *Travelers*, 514 U.S. at 656. Rather, they are to be interpreted with an eye towards the purpose of ERISA's preemption provision, which is "to permit the nationally uniform administration of employee benefit plans." *Id.* at 657.

Thus, a local law only makes unlawful "reference to" ERISA plans if it "acts immediately and exclusively on ERISA plans," or if "the existence of ERISA plans is essential to the law's operation." *Dillingham*, 519 U.S. at 325. A local law avoids an improper "connection with" ERISA plans if it does not require employers to adopt such plans or to amend any existing plans they may have. *Id.*

at 332-33. *See also, e.g., Travelers*, 514 U.S. at 659-60, 664; *GGRA*, __ F.3d at __; *WSB*, 88 F.3d at 795. For the reasons set forth below, the HCSO neither makes unlawful reference to, nor has an improper connection with, ERISA plans.

I. THE HCSO DOES NOT MAKE UNLAWFUL REFERENCE TO ERISA PLANS.

The district court held that the Ordinances makes unlawful "reference to" ERISA plans. "In order to determine compliance," the court stated, "the Ordinance necessarily refers to whether and how much an employer pays for employee health coverage under its existing plans, assuming such employers maintain them at all." Order at 13. This is a clear misapplication of the "reference to" prong of ERISA preemption.

As the Supreme Court has made clear, a state law is preempted under the "reference to" prong if it "acts immediately and exclusively upon ERISA plans" or if "the existence of ERISA plans is essential to the law's operation . . ." *Dillingham*, 519 U.S. at 325; *accord GGRA*, __ F.3d at __ (Slip Op. at 23). In contrast, if the law "functions irrespective of . . . the existence of an ERISA plan," it is not preempted. *Id.* at 328 (internal quotations and ellipses omitted). *See also Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 831 (1988) (application of general garnishment statute to ERISA plan not preempted because law does not "single out" or give special treatment to ERISA plans); *Oregon Columbia Brick Masons Joint Apprenticeship Training Committee v. Gardener*, 448 F.3d 1082, 1089-90 (9th Cir. 2006) (law that applies to apprenticeship training committees not preempted because it operates without respect to committees' ERISA status).

The HCSO applies to employers in San Francisco regardless of whether they have ERISA plans, and thus functions irrespective of the existence of such plans.

"[T]he Ordinance can have its full force and effect even if no employer in the City has an ERISA plan. If there is no ERISA plan, covered employers can discharge their obligation under the Ordinance simply by making their required health care expenditures to the City." *GGRA*, __ F.3d. at __ (Slip Op. at 24); *see also id.* at 24 ("Here, . . . the Ordinance does not act on ERISA plans at all, let alone immediately and exclusively").[8]

The fact that an employer may, if it wishes, establish compliance with the Ordinance by demonstrating that it spent the required amount of health care dollars on its employees through an ERISA plan does not render the HCSO preempted. Indeed, the Ninth Circuit rejected this very notion in *WSB* when it held that California's prevailing wage statute did not make an impermissible "reference to" ERISA plans even though the cash wage owed to employees was calculated by subtracting the amount paid in the form of ERISA benefits. 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) (state law claims not preempted by ERISA merely because a court would refer to an ERISA plan in calculating damages).

The statute at issue in *WSB* required employers to pay the prevailing wage and permitted employers to fulfill this requirement either by payment of that amount in cash or through a combination of a cash wage and certain specified benefit expenditures (up to a certain cap). 88 F.3d at 791. The district court deemed this Court's ruling upholding the statute inapplicable because it

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[8] Besides the option to make payments to the City, the Ordinance also authorizes a number of other non-ERISA compliance options. *See* note 9, *infra*.

"specifically referred to the calculation of wages, which were to include benefits as part of the total," while the HCSO "would require that private employers calculate not wages but benefits." ER 15. This purported distinction is meaningless from the perspective of ERISA preemption. In *WSB*, as here, the law at issue imposed a general obligation upon employers and credited amounts those employers spent on ERISA plans toward that general obligation. The principle that a law is not preempted simply because it refers to amounts spent on ERISA plans in order to calculate an employer's obligation does not depend upon the particularities of the obligation at issue – a health care spending requirement, here, versus payment of a prevailing wage in *WSB*.

In concluding that the HCSO makes unlawful "reference to" ERISA plans, the district court also relied heavily on *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 126-27 (1992) ("*Greater Washington*"), in which the Supreme Court struck down a local ordinance requiring employers that provided health insurance to their employees under an ERISA plan to provide the same or equivalent coverage for injured employees eligible for workers' compensation. ER (Order at 14). The court's reliance on *Greater Washington* reflects either a misunderstanding of the HCSO or a misunderstanding of the "reference to" prong of ERISA preemption analysis. In *Greater Washington*, an employer's obligation was triggered directly by the benefits it offered through an ERISA plan; whatever benefits the employer offered, it would have to provide those same benefits to injured workers on workers' compensation. Here, 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. The expenditure requirement is a generally applicable mandate that does not depend on the content of any

employer's ERISA plan. For those reasons, *Greater Washington* is simply inapposite. *See GGRA*, __ F.3d at __ (Slip Op. at 25-26).

In short, under the HCSO, an employer's obligations "are measured by reference to payments provided by the employer to an ERISA plan *or* to another entity specified in the Ordinance, including the City." *Id.* at 26 (emphasis added). Thus, the Ordinance "is fully functional even in the absence of a single ERISA plan." *Id.* at 27. This kind of scheme clearly does not run afoul of the "reference to" prong of ERISA preemption.

II. THE HCSO DOES NOT HAVE AN IMPROPER CONNECTION WITH ERISA PLANS.

A. Laws With Which An Employer May Readily Comply Without Adopting Or Altering ERISA Plans Are Not Preempted.

The "'determin[ation] whether a state law has the forbidden connection' with ERISA plans" begins with consideration of "'the objectives of the ERISA statute" and "the nature of the effect of the state law on ERISA plans.'" *GGRA*, __ F.3d __ (Slip Op. at 17) (quoting *Dillingham*, 519 U.S. at 325). Courts have thus identified categories of laws that are and are not preempted based on ERISA's purpose: "to provide a uniform regulatory regime over employee benefit plans." *GGRA*, __ F.3d __ (Slip Op. at 17) (quoting *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 208 (2004)).

State and local governments may not dictate employer choices about which benefits should be included in ERISA plans. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983) (law "which prohibits employers from structuring their employee benefit plans" in certain ways or "which requires employers to pay employees specific benefits" is preempted); *see also Standard Oil v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1980), *summarily aff'd*, 454 U.S. 801 (1981) (striking down Hawaii law that required employers to adopt ERISA plans with specified benefits).

Similarly, state law may not dictate *who* can benefit from ERISA plans. *See Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (state law controlling plan's selection of beneficiary preempted because it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status."). Such laws have an improper "connection with" ERISA plans.

However, this Court and others have uniformly held that a local law does *not* have an improper "connection with" ERISA plans if employers may readily comply with the law without adopting or altering an ERISA plan. For example, this Court upheld California's prevailing wage statute because "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." *WSB*, 88 F.3d at 795. *See also Standard Industrial*, 247 F.3d at 925 (a 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 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*, 37 F.3d at 960 (internal quotations, citations and brackets omitted).

Even when a law gives companies a strong incentive to adopt or amend ERISA plans – indeed, even when a law gives plans *themselves* a strong incentive to make particular choices – the law *still* avoids preemption so long as the non-ERISA option is a real choice. Thus, in *Travelers*, the Supreme Court considered a New York law that imposed surcharges on hospital payments by patients who were covered by commercial insurers, but did not impose those surcharges on payments

by patients covered by a Blue Cross or Blue Shield plan. 514 U.S. at 649. The purpose of this law was, in part, to level the playing field for the Blues, who took on patients that commercial insurers rejected as unacceptable risks. *Id.* at 658. Although the surcharges made the Blues a "more attractive" option for ERISA plans, the Court held:

> An indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself . . . Nor does the indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one. It simply bears on the costs of benefits and the relative costs of competing insurance to provide them.

Id. at 659-60. As such, the surcharge law was distinguishable from laws that mandate a particular benefit structure or dictate the choices of plan administrators: "Although even in the absence of mandated coverage there might be a point at which an exorbitant tax leaving consumers with *a Hobson's choice* would be treated as imposing a substantive mandate, no showing has been made here that the surcharges are so prohibitive as to force all health insurance consumers to contract with the Blues." *Id.* at 664 (emphasis added).

Similarly, in *Dillingham* 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. 519 U.S. at 320. 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, and is therefore preempted.

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 continued:

> 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 Medical and Clinical Services Fund*, 520 U.S. 806, 814-15 (1997), the Court summed up the matter when it reversed a Second Circuit decision holding that a New York tax on the gross receipts of health care facilities was preempted by ERISA because some of the facilities being taxed were owned and operated by ERISA plans. The Court acknowledged that the law had a *direct* economic effect on those ERISA plans but held even this was not enough to establish preemption:

> 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 well 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. Authority from this Circuit and others confirms the same principle. *See, e.g., WSB*, 88 F.3d at 795-96 (fact that law discourages certain spending on ERISA plans does not render it preempted); *Hattem v.*

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

In the proceedings below, GGRA relied heavily on the Fourth Circuit's decision in *Retail Industry Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007). But the majority's opinion in that case (as well as the dissent's) simply confirms the principles described above. *Fielder* involved a preemption challenge to Maryland's Fair Share Act, a law that the majority found had the purpose of forcing Wal-Mart to provide health benefits to its employees through an ERISA plan. *Id.* at 185. The Act provided that any Maryland for-profit employer with more than 10,000 employees that does not spend up to 8% of its payroll on health insurance (i.e., Wal-Mart) must make up the deficiency by paying it to the Secretary of Labor. *Id.* at 184. The Secretary of Labor was authorized to use the proceeds of any payments by Wal-Mart to fund Maryland's Medicaid program. *Id.* Wal-Mart's employees would not receive any additional benefits, services, or cost savings in return for such Medicaid payments. *Id.* at 193.

Recognizing the principle that a law which "effectively mandates some element of the structure or administration of employers' ERISA plans" is preempted while a law that "do[es] not bind the choices of employers or their ERISA plans" is generally permissible, the majority concluded that the Fair Share Act fell within the former category and was thus invalid. *Id.* at 193. The majority reasoned that the Maryland law effectively required Wal-Mart to alter its ERISA plan because no rational employer would choose to pay this money to the State when it could instead increase health care spending in a manner that benefited its employees:

> Healthcare 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 under the Fair Share Act is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold. The Act thus falls squarely under *Shaw*'s prohibition of state mandates on how employers structure their ERISA plans.

Id. at 193-194.

Although the dissent in *Fielder* disputed the majority's factual conclusion that the Fair Share Act left Wal-Mart no real option other than to amend its ERISA plan, *id.* at 202-03, there was no serious disagreement about the fundamental nature of the ERISA preemption inquiry: if an employer can reasonably comply with a state or local law without adopting or altering an ERISA plan, there is no preemption, because such a law does not preclude the uniform administration of ERISA plans. In other words, as long as the choice between the ERISA option and the non-ERISA option is not a Hobson's choice – that is, as long as the non-ERISA compliance option is a real one that a rational employer could choose – the local law is not preempted.

B. The HCSO Provides Employers With A Reasonable Non-ERISA Compliance Option.

In the proceedings below, GGRA contended that by allowing employers to comply with the expenditure mandate either by (i) making payments to the City, or (ii) setting up their own plans, the HCSO creates "precisely the 'Hobson's Choice' disapproved of by the Court in *Travelers*." ER 359. There is no basis, however, for concluding that the government payment option is not a real choice. Not even the district court accepted this argument.

As this Court has already explained, all categories of employers may readily comply with the Ordinance without adopting or altering an ERISA plan. If a

company does not have an ERISA plan, it may avoid adopting one by making payments to the City. If a company has an ERISA plan that covers some workers but not others, it need not fold those additional workers into its ERISA plan; it may instead pay the City on behalf of those workers. If a company has an ERISA plan but does not spend the minimum required amount through that plan, it may comply by paying the difference to the City, and the City will use the money to benefit that company's workers. And if a company already spends the required amount on health care for its employees, it need not do anything. *See generally GGRA*, __ F.3d at __ (Slip Op. at 11-14). Thus, employers may comply with the minimum spending requirement through an ERISA plan *if they wish*, but they obviously do not have to.[9]

Furthermore, the government payment option is an eminently rational choice for employers. The HCSO and its implementing regulations ensure that *every employee* on whose behalf a payment is made to the City can receive substantial health benefits as a result of that payment. Those who qualify for HAP enrollment

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[9] Employers have other non-ERISA compliance options as well. As the Ordinance states, employers may comply by paying into Health Savings Accounts ("HSAs") for their employees, SF Admin. Code § 14.1(b)(7)(a), and such accounts may be structured to avoid being deemed ERISA plans. *See* U.S. Dept. of Labor, Field Assistance Bulletin Nos. 2004-01 & 2006-02. The Ordinance also states that employers may set up accounts similar to HSAs without regard to whether they qualify for preferential tax treatment under the Internal Revenue Code. SF Admin. Code § 14.1(b)(7)(a). And it permits employers to fulfill the expenditure obligation by directly reimbursing employees for health care costs, or by arranging for care to be provided to employees on-site. *Id.* at § 14.1(b)(7)(b), (d). These arrangements may also be structured to avoid ERISA's reach. *See, e.g.*, 29 C.F.R. § 2510.3-1(c)(2). Finally, this list of expenditure options is non-exclusive, allowing employers to devise compliance options that the City may not have contemplated.

receive a 75% discount on their participation fees, which, as discussed at p. 9, *supra*, results in free HAP membership for most covered employees. And any covered employees who do not qualify for HAP enrollment may direct the City to use every dollar paid by their employers to establish and maintain medical reimbursement accounts for them.

Indeed, many employers will presumably find the government payment option quite attractive. After all, it allows them to ensure that their employees will be eligible for health benefits merely by writing a check to the City rather than by undertaking the burden themselves – a burden that may include hiring an employee benefits consultant, learning about and deciding among the many benefit options, contracting with a third party administrator to maintain the plan and process employee claims, preparing the disclosure documentation required by ERISA, complying with ERISA's reporting requirements, and potentially exposing themselves to ERISA-related litigation. Furthermore, the health benefits received by employees from the City will often be extraordinarily generous in relation to the amount paid by the employer. As discussed at p. 9, *supra*, the average insurance premium in California is $379 per month. In contrast, for a medium sized employer with an employee who works 20 hours per week, the employer can satisfy its spending obligation by paying the City $93.60 per month. This allows the employee to obtain a HAP membership that provides comprehensive health services, which cost the City on average $261 per month to provide. In other words, if the employer chooses the government payment option, its employees receive comprehensive health benefits for pennies on the dollar, and the City picks up the rest of the tab.

As such, the HCSO is vastly distinguishable from the law struck down by the Fourth Circuit in *Fielder*, and it passes muster even under the majority's

approach in that case. According to the *Fielder* majority, the government payment option created by Maryland was illusory, because Wal-Mart would confer no direct benefit upon its employees by paying into the state's Medicaid system. 475 F.3d at 193. And the illusory nature of the government payment option meant that the Act "effectively mandate[d] that employers structure their employee healthcare plans to provide a certain level of benefits" because it forced Wal-Mart to comply by amending its plan. *Id.* Here, it is obvious from the face of the ordinance and its implementing regulations that there is nothing illusory about the government payment option. The Ordinance does not force employers into an ERISA-related compliance option – it does not "effectively mandate[] that employers structure their employee healthcare plans to provide a certain level of benefits . . ." *Id.* Accordingly, although it bears noting that the dissenting judge's analysis in *Fielder* is far more consistent with the case law on ERISA preemption, the disagreement between the majority and dissent in that case is irrelevant here. A holding that the HCSO is not preempted on the ground that the government payment option is a real compliance option would create no conflict with the opinion of the *Fielder* majority.

Finally, as discussed earlier, even the existence of an unattractive non-ERISA compliance option may save a local law from preemption, so long as that option is not so unappealing as to be illusory. *Dillingham*, 519 U.S. at 332-33; *Travelers*, 514 U.S. at 659-60. Thus, even if the HCSO's government payment option were not so generous, or even if in some particular situation an employer found it preferable to comply with the spending requirement through an ERISA plan, "such influence is entirely permissible." *GGRA* __ F.3d at __ (Slip Op. at 20). After all, it is entirely the employer's choice, and it is certainly not, as GGRA has contended, a Hobson's choice.

Indeed, imagine if San Francisco were to impose a tax on businesses for the purpose of funding its health care program and *did not* give employers credit for the amount already they spent on health care. Nobody could seriously contend that such a law would be subject to ERISA challenge. But this law would create a tremendous financial incentive for employers to alter their ERISA plans – many companies would very likely drop existing coverage knowing that the City would provide comprehensive health care to their workers and that they would owe the City the same amount regardless of whether they made any private health care expenditures. 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 is not preempted. *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").

In sum, the HCSO exerts no influence on employers to adopt or alter ERISA plans, because the government payment option is quite attractive. And any influence that the Ordinance might be thought to exert "is even more indirect than the influence" upheld by the Supreme Court in *Travelers*. *GGRA*, __ F.3d __ (Slip Op. at 20).

C. The "Uniformity" Argument Adopted By The District Court Reflects A Misunderstanding Of The Purpose Of ERISA's Preemption Provision.

The district court explicitly acknowledged that the existence of the government payment option allows employers comply without creating or modifying ERISA plans. ER 10. And nowhere did it adopt GGRA's argument that the government payment option was not a real choice. Yet it concluded that the Ordinance "interferes with nationally uniform plan administration." ER 12. The

district court was apparently of the view that, because ERISA mentions health benefits, and because San Francisco imposes an expenditure requirement in the area of health care, the Ordinance is automatically preempted because it would interfere with employer decisions about how much to spend on a type of benefit mentioned in ERISA.

The flaw in the district court's reasoning is that it conflated two distinct concepts: regulation of *plans* and regulation of *expenditures*. It is true that local governments may not interfere with the administration of ERISA *plans*, because doing so would violate the purpose of ERISA's preemption provision, which is "to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657. However, if a local government imposes a general *expenditure* requirement, and allows the employer to satisfy that requirement without creating an ERISA plan or disturbing any ERISA plan the employer may already have, this does not implicate national plan uniformity, and therefore does not implicate the concerns underlying ERISA preemption.

The Supreme Court made this clear in *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987). Rejecting the contention that the State of Maine was precluded from requiring minimum severance payments to workers, the Court stated as follows:

> 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.

Id. at 7-8 (emphasis in original). Thus, the mandate at issue in *Fort Halifax* did not conflict with the purpose of ERISA's preemption provision, which was to ensure "that the administrative practices of a benefit *plan* will be governed by only a single set of regulations." *Id.* at 11 (emphasis added). As the Court noted, Congress' concern about uniform plan administration is the reason it "pre-empted state laws relating to *plans* rather than simply to *benefits*." *Id.* (emphasis in original).[10]

Similarly, in *Massachusetts v. Morash*, 490 U.S. 107, 109-10 (1989), the Supreme 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 benefits are listed in ERISA, the Court concluded that such state laws are not preempted, so long as they do not infringe upon ERISA plans. *Id.* at 114-15.

If the district court were correct that the mere regulation of health expenditures violates ERISA's uniformity principle, *Fort Halifax* and *Morash* would have had to come out differently. After all, those decisions permit state and local governments to impose different requirements on employers in the area of severance pay and vacation pay, even though those types of benefits are mentioned

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[10] *See also Delaye v. Agripac, Inc.*, 39 F.3d 235, 237 (9th Cir. 1994) ("In stressing the difference between employee benefits and employee benefit plans, the Court recognized that the purpose of ERISA preemption of state law is to create a single set of regulations to govern benefit *plans*' complex and ongoing administrative activities") (emphasis added).

in ERISA. Indeed, the *Morash* Court acknowledged that roughly half the states had vacation pay requirements at the time of its decision. *Morash*, 490 U.S. at 109-10. Thus, the lesson of those cases is that ERISA's preemption provision is not concerned with expenditure uniformity or uniform regulation of benefits generally; it is concerned with *plan* uniformity. "Cost uniformity was almost certainly not an object of pre-emption . . ." *Travelers*, 514 U.S. at 662.

It is true, then, that San Francisco's program imposes a minimum cost with respect to health care that does not exist in other jurisdictions. But employers face differing cost requirements in different jurisdictions all the time. They are subject to varying severance pay requirements, minimum wage requirements, vacation pay requirements, apprenticeship or training program requirements, taxes, fees, and sick leave requirements, to name just a few. Such is the unavoidable (and utterly unremarkable) consequence of doing business in multiple jurisdictions in the United States. These differing requirements do not implicate the concerns of ERISA's preemption provision, because they do not interfere with *plan* uniformity. Because the HCSO permits all employers to comply without adopting ERISA plans or amending existing ERISA plans, it "preserves ERISA's uniform regulatory regime," and has "no effect on the administrative practices of a benefit plan . . . unless an employer voluntarily elects to change those practices." GGRA __ F.3d at __ (Slip Op. at 20); *see also id.* at 21-22 (HCSO does not dictate plan benefits, eligibility, or other aspects of plan administration).

D. The Recordkeeping Requirements And Enforcement Provisions Of The Ordinance Do Not Create An Improper Connection With ERISA Plans.

1. Recordkeeping

To ensure businesses remain in compliance with the spending requirements, the HCSO provides that, once per quarter, the employer must calculate and keep

records of health care expenditures made on behalf of each covered employee. *See* p 9, *supra*. And the employer must file an annual report with the City to prove its quarterly compliance. S.F. Admin Code § 14.3(b). To make its calculations, the employer must divide the amount spent on health care for an employee by the number of hours worked by that employee during the quarter. This simple exercise in division will determine whether health care expenditures for the quarter exceed the $1.17 or $1.76 per hour required by the Ordinance.

The district court took issue with the these requirements, citing *Aloha Airlines, Inc. v. Ahue*, 12 F.3d 1498, 1505 (9th Cir. 1993), in which the Ninth Circuit struck down a law that imposed reporting requirements on an ERISA plan. ER 10. In relying on this case, the district court failed to recognize the difference between imposing administrative requirements on *a plan* and imposing administrative requirements on *an employer*. This Court has made clear that the difference is a dispositive one. In *WSB*, the plaintiff contended the prevailing wage law was preempted because it required employers to "create a separate administrative scheme in order to: (1) perform ongoing calculations of wages paid and cash equivalents of benefits provided; (2) keep track of the prevailing wage levels in different localities; and (3) maintain detailed payroll records showing hourly wage levels and benefit contributions." 88 F.3d at 795. This Court acknowledged that the law required the employer to do these things, but held such requirements do not raise preemption concerns because they were imposed on *the employer*; the law did not impose "additional administrative requirements for ERISA *plans*." *Id.* (emphasis added). Similarly, under the HCSO, it is the employer that must maintain records of health care expenditures; the Ordinance imposes no requirements on an ERISA plan. *See GGRA*, __ F.3d at __ (Slip Op. at 22-23).

Furthermore, regardless of whether the recordkeeping obligations of the Ordinance fall on the employer or "the plan," they are too minimal to raise preemption concerns. As discussed at p. 9, *supra*, the Ordinance requires employers to maintain payroll records that are already mandated by California law;[11] to keep records of the address, phone number and first day of work of each covered employee, as also required by existing state law;[12] and to track its health care expenditures on behalf of its employees – hardly a monumental task. After all, surely an employer knows how much it is paying an entity like Kaiser or Blue Cross on a monthly or bi-weekly basis for health care.

These administrative obligations are far less onerous than those upheld in *Mackey*. In that case, the Court considered a state law that allowed for garnishment of ERISA plans for the purpose of collecting judgments against plan participants. The Court recognized that, when an ERISA plan is garnished, it will incur "substantial administrative burdens and costs" because "plan trustees are served with a garnishment summons, become parties to a suit, and must respond and deposit the demanded funds due the beneficiary-debtor – funds that otherwise they are required to hold and pay out to those beneficiaries." 486 U.S. at 831. Nonetheless, the statute was not preempted because it did not "single out" ERISA plans. *Id.* The fact that a law might "impose some burdens on the administration of ERISA plans" is not nearly enough to render it invalid. *De Buono*, 520 U.S. at 815.[13]

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[11] *See* Cal. Labor Code § 226.

[12] *See* Cal. Unemp. Ins. Code § 1088.5(d)(4).

[13] *See also Burgio and Campofelice, Inc. v. New York State Department of Labor*, 107 F.3d 1000, 1009 (2nd Cir. 1997) ("[P]reemption does not occur where a (continued on next page)

2. Enforcement

The district court also appeared to take issue with the fact that the Ordinance empowers the City to enforce the employer spending requirement. Order at 10. And GGRA contended below that the HCSO's enforcement provisions conflicted with ERISA's exclusive remedial scheme. ER 361-62. However, in contrast to ERISA's remedial scheme, which focuses specifically on the enforcement of ERISA obligations, *see* 29 U.S.C. § 1132(a),[14] the HCSO's enforcement provisions are not directed at ERISA plans or their administrators. They do not seek to interfere with determinations whether a plan beneficiary is entitled to coverage of a particular medical treatment. Nor do they seek to enforce the duties of plan fiduciaries to protect plan assets and the interests of beneficiaries. Rather, the HCSO's enforcement provisions are directed only at employers, and seek only to ensure that employers are spending a minimum required amount on health care (which, as already discussed, employers can do through ERISA plans or otherwise).

The case relied on by GGRA below for the proposition that the HCSO creates an alternative ERISA enforcement scheme – *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) – is inapposite. In that case, a state law created a cause of action to enforce precisely the same right that ERISA was designed to enforce: the right to receive benefits promised under an ERISA plan. This cause of action

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state law places on ERISA plans administrative requirements so slight that the law 'creates no impediment to an employer's adoption of a uniform benefit administration scheme.'") (quoting *Fort Halifax*, 482 U.S. at 14).

[14] *See also Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (discussing ERISA's enforcement scheme)

involving "denials of coverage promised under the terms of ERISA-regulated employee benefit plans" was preempted because it overlapped with ERISA's enforcement scheme. *Id.* at 211. The HCSO does not, because it is indifferent to whether payments are made through an ERISA plan. *See also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 144 (1990) (cause of action preempted because it remedies right expressly guaranteed and exclusively enforced by ERISA); *Dishman v. UNUM Life Ins. Co. of America*, 269 F.3d 974, 983 (9th Cir. 2001) (plaintiff's tort claim not preempted because it "does not depend on or derive from his claim for benefits in any meaningful way").

It is true that if an employer claimed it complied with the expenditure requirement through payments to an ERISA plan and that claim turned out to be false, the City could penalize the employer for failing to comply with the Ordinance. But the penalty would not be for failure to live up to a promise made in an ERISA plan; it would be for failure to comply with a general expenditure requirement. If the government were precluded from inquiring whether a company made the ERISA payments it has claimed to make to establish compliance with a spending requirement, California's prevailing wage law would be preempted. Under that law, the state may review employer records, as well as investigate and conduct hearings on whether the contractor made the appropriate payments (which can, of course, include ERISA payments). *See* Cal. Labor Code §§ 1771.5, 1771.6. But as *WSB* makes clear, the prevailing wage law avoids preemption because it enforces payment obligations whether made through ERISA plans or not. The same is true here.

III. APPLICATION OF THE NINTH CIRCUIT'S SIMPLIFIED TEST FOR ERISA PREEMPTION CONFIRMS THAT THE ORDINANCE IS NOT PREEMPTED.

In several cases, the Ninth Circuit has applied a "simplified test" for ERISA preemption. This test is perhaps best understood as a reality check – a way for courts to test their application of the somewhat confusing "connection" and "reference" prongs of the ERISA preemption inquiry against basic common sense. The simplified test asks the following questions: "Is the state telling employers how to write their ERISA plans, or conditioning some requirement on how they write their ERISA plans? Or is it telling them that regardless of how they write their ERISA plans, they must do something else outside and independently of the ERISA plans? If the latter . . . there is no preemption." *WSB*, 88 F.3d at 796 (quoting *Employee Staffing Services, Inc. v. Aubry*, 20 F.3d 1038, 1041 (9th Cir. 1994)). *See also Standard Industrial*, 247 F.3d at 925 ("California's statute similarly does not tell employers how to write ERISA benefit plans or how to determine ERISA beneficiary status, and does not condition requirements on how ERISA benefit plans are written"); *Operating Engineers Health & Welfare Trust Fund v. JWJ Contracting Co.*, 135 F.3d 671, 679 (9th Cir. 1998) ("[W]e again find [the] simplified test enlightening").

The HCSO clearly passes the simplified test for the reasons already discussed. And we are aware of no case in which a court has concluded that a local law passes the simplified test, but is nonetheless preempted. Nor has GGRA been able to cite one. Application of this test confirms what is obvious from the preceding sections: the City's Ordinance is not preempted.

IV. A HOLDING THAT THE HCSO IS PREEMPTED WOULD BE CONTRARY TO THE PRESUMPTION THAT CONGRESS DID NOT INTEND TO PREVENT STATE AND LOCAL GOVERNMENTS FROM PROTECTING THE HEALTH AND WELFARE OF THEIR CITIZENS.

That the HCSO is not preempted is clear from the black letter law discussed above. But even if there were some doubt, the Court would still be compelled to uphold the Ordinance against this preemption challenge. That is because where, as here, a local law operates in an area traditionally regulated by state and local governments, all doubts must be resolved against ERISA preemption.

The HCSO is a comprehensive health care reform program that strives to combat a crisis involving the health of the people who live and work in San Francisco – a crisis that not only exacts a steep human toll but also substantially burdens the City's finances. Because the Ordinance is "a measure directly addressed to protection of the public health," it "falls within the most traditional concept of what is compendiously known as the police power." *Head v. New Mexico Board of Examiners in Optometry*, 374 U.S. 424, 428 (1963).[15] The strong presumption that Congress did not intend to preempt such an ordinance "is consistent with both federalism concerns and the historic primacy of state regulation of matters of health and safety." *Medtronic v. Lohr*, 518 U.S. 470, 485 (1996).[16]

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[15] As this Court noted, the provision of health care services to the uninsured population confers benefits not just on the uninsured, but on San Francisco taxpayers and on the City at large. Particularly relevant, given the Appellee in this case, is the fact that "the general public has an interest in the health of San Francisco residents and workers, particularly those workers who handle their food and work in other service industries." *GGRA*, __ F.3d at __ (Slip Op. at 31).

[16] The HCSO is also an exercise of the traditional police power in the sense that it regulates the employment relationship. "States possess broad authority

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Accordingly, the Supreme Court has made very clear that in ERISA preemption cases there should be great reluctance to strike down health care regulations. As the *Travelers* Court advised, courts must presume that ERISA does not preempt laws that operate in this area because "we have worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the *clear and manifest purpose* of Congress.'" 514 U.S. at 655 (quoting *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992)) (emphasis added).[17] As the Court stated in *De Buono*, when a local law operates in the field of health care, the challenger bears "the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law.'" 520 U.S. at 814 (quoting *Travelers*, 514 U.S. at 654). *See also De Buono*, 520 U.S. at 814 fn. 10 ("the Court of Appeals rested its conclusion in no small part on the fact that the [statute] targets only the health care industry . . . . Rather than warranting pre-emption, this point supports the application of the starting presumption against pre-emption") (internal quotations omitted); *GGRA* __ F.3d at __ (Slip Op. at 15-16). Far from meeting its "considerable burden" to overcome the presumption, GGRA has failed to show that the Employee Retirement Income Security Act of 1974 reflects a "clear and manifest" intent by

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under their police powers to regulate the employment relationship to protect workers within the State. Child labor laws, minimum and other wage laws, laws affecting occupational health and safety, and workmen's compensation laws are only a few examples." *De Canas v. Bica*, 424 U.S. 351, 356 (1976).

[17] Incidentally, under California law, the City's police power is coextensive with that of the State (subject of course to preemption by state law). *Birkenfeld v. City of Berkeley*, 17 Cal.3d 129, 140 (1976).

Congress to prevent a locality like San Francisco from enacting a health care reform program like the HCSO.

There is no disputing that San Francisco could have used its police power to enact an ordinance simply requiring all employers to pay a tax to fund a government health program, without regard to whether the employers already provide health care to their employees. This tax could have been fashioned similarly to the HCSO, requiring each employer to pay the City a set amount for each hour worked by each employee. Of course, such an ordinance would be less fair to the estimated 90% of medium and large employers that have already chosen to provide health benefits. And it would create a perverse incentive for those employers to drop the ERISA plans they presently provide for their employees, knowing that care would be available from the City without additional cost to them. So San Francisco has instead used its police power to adopt a health care program that is fairer and more sensible. The program takes into account any existing health care expenditures by employers, and gives them credit for those expenditures. At the same time, the City leaves it to employers to decide for themselves how to make the required health care expenditures, and has created a government health care program that provides employers a way to comply that lets them avoid the burdens associated with setting up their own programs. San Francisco's exercise of its core police power to protect the health of its citizens in this fashion is "no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." *Travelers*, 514 U.S. at 668.

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CONCLUSION

The Court should reverse and remand with instructions to enter judgment in favor of the Appellants.

DATED: January 23, 2008

Respectfully submitted,

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STATEMENT OF RELATED CASES

There are no related cases pending in this Court.

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 10,854 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 January 23, 2008.

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A

CHAPTER 14. SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE

SEC. 14.1. SHORT TITLE; DEFINITIONS.

(a) Short title. This Chapter shall be known and may be cited as the "San Francisco Health Care Security Ordinance."

(b) Definitions. For purposes of this Chapter, the following terms shall have the following meanings:

(1) "City" means the City and County of San Francisco.

(2) "Covered employee" means any person who works in the City where such person qualifies as an employee entitled to payment of a minimum wage from an employer under the Minimum Wage Ordinance as provided under Chapter 12R of the San Francisco Administrative Code and has performed work for compensation for his or her employer for ninety (90) days, provided, however, that:

(a) From the effective date of this Chapter through December 31, 2007, "at least twelve (12) hours" shall be substituted for "at least two (2) hours" where such term appears in Section 12R.3 (a);

(b) From January 1, 2008 through December 31, 2008, "at least ten (10) hours" shall be substituted for "at least two (2) hours" where such term appears in Section 12R.3(a);

(c) Beginning January 1, 2009, "at least eight (8) hours" shall be substituted for "at least two (2) hours" where such term appears in Section 12R.3(a);

(d) The term "employee" shall not include persons who are managerial, supervisorial, or confidential employees, unless such employees earn annually under $72,450.00 or in 2007 and for subsequent years, the figure as set by the administering agency;

(e) The term "employee" shall not include those persons who are eligible to receive benefits under Medicare or TRICARE/CHAMPUS;

(f) The term "covered employees" shall not include those persons who are "covered employees" as defined in Section 12Q.2.9 of the Health Care Accountability Ordinance, Chapter 12Q of the San Francisco Administrative Code, if the employer meets the requirements set forth in Section 12Q.3 for those employees; and

(g) The term "covered employees" shall not include those persons who are employed by a nonprofit corporation for up to one year as trainees in a bona fide training program consistent with Federal law, which training program enables the trainee to advance into a permanent position, provided that the trainee does not replace, displace, or lower the wage or benefits of any existing position or employee.

(h) Nor shall "covered employees" include those persons whose employers verify that they are receiving health care services through another employer, either as an employee or by virtue of being the spouse, domestic partner, or child of another person; provided that the employer obtains from those persons a voluntary written waiver of the health care expenditure requirements of this Chapter and that such waiver is revocable by those persons at any time.

(3) "Covered employer" means any medium-sized or large business as defined below engaging in business within the City that is required to obtain a valid San Francisco business registration certificate from the San Francisco Tax Collector's office or, in the case of a nonprofit corporation. an employer for which an average of fifty (50) or more persons per week perform work for compensation during a quarter.

Small businesses are not "covered employers" and are exempt from the health care spending requirements under Section 14.3.

(4) "Employer" means an employing unit as defined in Section 135 of the California Unemployment Insurance Code or any person defined in Section 18 of the California Labor Code. "Employer" shall include all members of a "controlled group of corporations" as defined in Section 1563(a) of the United States Internal Revenue Code, and the determination shall be made without regard to Sections 1563(a)(4) and 1563(e)(3)(C) of the Internal Revenue Code.

(5) "Health Access Program" means a San Francisco Department of Public Health program to provide health care for uninsured San Francisco residents.

(6) "Health Access Program participant" means any uninsured San Francisco resident, regardless of employment or immigration status or pre-existing condition, who is enrolled by his or her employer or who enrolls as an individual in the Health Access Program under the terms established by the Department of Public Health.

(7) "Health care expenditure" means any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees, including, but not limited to (a) contributions by such employer on behalf of its covered employees to a health savings account as defined under section 223 of the United States Internal Revenue Code or to any other account having substantially the same purpose or effect without regard to whether such contributions qualify for a tax deduction or are excludable from employee income; (b) reimbursement by such covered employer to its covered employees for expenses incurred in the purchase of health care services; (c) payments by a covered employer to a third party for the purpose of providing health care services for covered employees; (d) costs incurred by a covered employer in the direct delivery of health care services to its covered employees; and (e) payments by a covered employer to the City to be used on behalf of covered employees. The City may use these payments to: (i) fund membership in the Health Access Program for uninsured San Francisco residents; and (ii) establish and maintain reimbursement accounts for covered employees, whether or not those covered employees are San Francisco residents. Notwithstanding any other provision of this subsection, "health care expenditure" shall not include any payment made directly or indirectly for workers' compensation or Medicare benefits.

(8) "Health care expenditure rate" means the amount of health care expenditure that a covered employer shall be required to make for each hour paid for each of its covered employees each quarter. The "health care expenditure rate" shall be computed as follows:

(a) From the effective date of this Chapter through June 30, 2007, $1.60 per hour for large businesses and $1.06 per hour for medium-sized businesses;

(b) From July 1, 2007 through December 31, 2007, January 1, 2008 through December 31, 2008, and January 1, 2009 through December 31, 2009, the rates for large and medium-sized businesses shall increase five (5) percent over the expenditure rate calculated for the preceding year;

(c) From January 1, 2010 and each year thereafter, the "health care expenditure rate" shall be determined annually based on the "average contribution" for a full-time employee to the City Health Service System pursuant to Section A8.423 of the San Francisco Charter based on the annual ten county survey amount for the applicable fiscal year, with such average contribution prorated on an hourly basis by dividing the monthly average contribution by one hundred seventy-two (172) (the number of hours worked in a month by a full-time employee). The "health care expenditure rate" shall be seventy-five percent (75%) of the annual ten county survey amount for the applicable fiscal year for large businesses and fifty percent (50%) for medium-sized businesses.

(9) "Health care services" means medical care, services, or goods that may qualify as tax deductible medical care expenses under Section 213 of the Internal Revenue Code, or medical care, services, or goods having substantially the same purpose or effect as such deductible expenses.

(10) "Hour paid" or "hours paid" means a work hour or work hours for which a person is paid wages or is entitled to be paid wages for work performed within the City, including paid vacation hours and paid sick leave hours, but not exceeding 172 hours in a single month. For salaried persons, "hours paid" shall

be calculated based on a 40-hour work week for a full-time employee.

(11) "Large business" means an employer for which an average of one hundred (100) or more persons per week perform work for compensation during a quarter.

(12) "Medium-sized business" means an employer for which an average of between twenty (20) and ninety-nine (99) persons per week perform work for compensation during a quarter.

(13) "Person" means any natural person, corporation, sole proprietorship, partnership, association, joint venture, limited liability company, or other legal entity.

(14) "Required health care expenditure" means the total health care expenditure that a covered employer is required to make every quarter for all its covered employees.

(15) "Small business" means an employer for which an average of fewer than twenty (20) persons per week perform work for compensation during a quarter.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 69-07, File No. 070255, App. 4/2/2007)

SEC. 14.2. SAN FRANCISCO HEALTH ACCESS PROGRAM AND REIMBURSEMENT ACCOUNTS.

(a) The San Francisco Department of Public Health shall administer the Health Access Program. Under the Health Access Program, uninsured San Francisco residents may obtain health care from a network consisting of San Francisco General Hospital and the Department of Public Health's clinics, and other community non-profit and private providers that meet the program's quality and other criteria for participation. The Health Access Program is not an insurance plan for Health Access Program participants.

(b) The Department of Public Health shall coordinate with a third party vendor to administer program operations, including basic customer services, enrollment, tracking service utilization, billing, and communication with the participants.

(c) The Health Access Program shall be open to uninsured San Francisco residents, regardless of employment status. Eligibility criteria shall be established by the Department of Public Health, but no person shall be excluded from the Health Access Program based on a pre-existing condition. Participants may enroll themselves as individuals, with the terms of enrollment to be determined pursuant to Section 14.4(a).

(d) The Health Access Program may be funded from a variety of sources, including payments from covered employers pursuant to Section 14.3, from individuals, and from the City. Funding from the City shall prioritize services for low and moderate income persons, with costs based on the Health Access Program participant's ability to pay.

(e) The Health Access Program shall use the "Medical Home" model in which a primary care physician, nurse practitioner, or physician assistant develop and direct a plan of care for each Health Access Program participant, coordinate referrals for testing and specialty services, and monitor management of chronic conditions and diseases. Health Access Program participants shall be assigned to a primary care physician, nurse practitioner, or physician assistant.

(f) The Health Access Program shall provide medical services with an emphasis on wellness, preventive care and innovative service delivery. The Program shall provide medical services for the prevention, diagnosis, and treatment of medical conditions, excluding vision, dental, infertility, and cosmetic services. The Department of Public Health may further define the services to be provided, except that such services must, at a minimum, include: professional medical services by doctors, nurse practitioners, physician assistants, and other licensed health care providers, including preventive, primary, diagnostic and specialty services; inpatient and outpatient hospital services, including acute inpatient mental health services; diagnostic and laboratory services, including therapeutic radiological services; prescription drugs, excluding drugs for excluded services; home health care; and emergency care provided in San Francisco by contracted providers, including emergency medical transportation if needed.

(g) The Department of Public Health shall also be authorized to use payments made to the City by employers to satisfy their expenditure requirements as set forth in Section 14.3 to establish and maintain reimbursement accounts from which covered employees may obtain reimbursement of health care expenditures.

(h) The City Controller shall ensure any required health care expenditures made by an employer to the City are

kept separate and apart from general funds and shall limit use of the expenditures to the Health Access Program or to the establishment and maintenance of reimbursement accounts from which covered employees may obtain reimbursement of health care expenditures. If any covered employee fails to enroll in the Health Access Program or establish a reimbursement account with the Department of Public Health within a reasonable time, as determined by the Department of Public Health, the City may use the funds paid to the City and County of San Francisco on behalf of that employee for the benefit of the health care programs created by this Ordinance, but the City may not transfer these funds to the City's general fund.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 69-07, File No. 070255, App. 4/2/2007)

SEC. 14.3. REQUIRED HEALTH CARE EXPENDITURES.

(a) Required Expenditures. Covered employers shall make required health care expenditures to or on behalf of their covered employees each quarter. The required health care expenditure for a covered employer shall be calculated by multiplying the total number of hours paid for each of its covered employees during the quarter (including only hours starting on the first day of the calendar month following ninety (90) calendar days after a covered employee's date of hire) by the applicable health care expenditure rate. In determining whether a covered employer has made its required health care expenditures, payments to or on behalf of a covered employee shall not be considered if they exceed the following amount: the number of hours paid for the covered employee during the quarter multiplied by the applicable health care expenditure rate. The City's Office of Labor Standards Enforcement (OLSE) shall enforce the health expenditure requirements under this Section.

(b) Additional Employer Responsibilities. A covered employer shall: (i) maintain accurate records of health care expenditures, required health care expenditures, and proof of such expenditures made each quarter each year, and allow OLSE reasonable access to such records, provided, however, that covered employers shall not be required to maintain such records in any particular form; and (ii) provide information to the OLSE, or the OLSE's designee, on an annual basis containing such other information as OLSE shall require, but OLSE may not require an employer to provide information in violation of State or federal privacy laws. Where an employer does not maintain or retain adequate records documenting the health expenditures made, or does not allow OLSE reasonable access to such records, it shall be presumed that the employer did not make the required health expenditures for the quarter for which records are lacking, absent clear and convincing evidence otherwise. The Office of Treasurer and Tax Collector shall have the authority to provide any and all nonfinancial information to OLSE necessary to fulfill the OLSE's responsibilities as the enforcing agency under this Ordinance. With regard to all such information provided by the Office of Treasurer and Tax Collector, OLSE shall be subject to the confidentiality provisions of Subsection (a) of Section 6.22-1 of the San Francisco Business and Tax Regulations Code.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 69-07, File No. 070255, App. 4/2/2007)

SEC. 14.4. ADMINISTRATION AND ENFORCEMENT.

(a) The City shall develop and promulgate rules to govern the operation of this Chapter. The regulations shall include specific rules by the Department of Public Health on the operation of both the Health Access Program and the reimbursement accounts identified in Section 14.2(g), including but not limited to eligibility for enrollment in the Health Access Program and establishment of reimbursement accounts and rules by the OLSE for enforcement of the obligations of the employers under this Chapter. The rules shall also establish procedures for covered employers to maintain accurate records of health care expenditures and required health care expenditures and provide a report to the City without requiring any disclosures of information that would violate State or Federal privacy laws. The rules shall further establish procedures for providing employers notice that they may have violated this Chapter, a right to respond to the notice, a procedure for notification of the final determination of a violation, and an appeal procedure before a hearing officer appointed by the City Controller. The sole means of review of the hearing officer's decision shall be by filing in the San Francisco Superior Court a petition for a writ of mandate under Section 1094.5 of the California Code of Civil Procedure. No rules shall be adopted finally until after a public hearing.

(b) During implementation of this Chapter and on an ongoing basis thereafter, the City shall maintain an education and advice program to assist employers with meeting the requirements of this Chapter.

(c) Any employer that reduces the number of employees below the number that would have resulted in the

employer being considered a "covered employer," or below the number that would have resulted in the employer being considered a medium-sized or large business, shall demonstrate that such reduction was not done for the purpose of evading the obligations of this Chapter or shall be in violation of the Chapter.

(d) It shall be unlawful for any employer or covered employer to deprive or threaten to deprive any person of employment, take or threaten to take any reprisal or retaliatory action against any person, or directly or indirectly intimidate, threaten, coerce, command or influence or attempt to intimidate, threaten, coerce, command or influence any person because such person has cooperated or otherwise participated in an action to enforce, inquire about, or inform others about the requirements of this Chapter. Taking adverse action against a person within ninety (90) days of the person's exercise of rights protected under this Chapter shall raise a rebuttable presumption of having done so in retaliation for the exercise of such rights.

(e) (1) The City shall enforce the obligations of employers and covered employers under this Chapter, and may impose administrative penalties upon employers and covered employers who fail to make required health care expenditures on behalf of their employees. The amount of the penalty shall be up to one-and-one-half times the total expenditures that a covered employer failed to make plus simple annual interest of up to ten (10) percent from the date payment should have been made, but in any event the totalpenalty for this violation shall not exceed $1,000.00 for each employee for each week that such expenditures are not made.

(2) For other violations of this Chapter by employers and covered employers, the administrative penalties shall be as follows: For refusing to allow access to records, pursuant to Section 14.3(b), $25.00 as to each worker whose records are in issue for each day that the violation occurs; for the failure to maintain or retain accurate and adequate records pursuant to Section 14.3(b) and for the failure to make the annual report of information required by OLSE pursuant to Section 14.3(b). $500.00; for violation of Section 14.4(d) (retaliation), $100.00 as to each person who is the target of the prohibited action for each day that the violation occurs; and for any other violation not specified in this subsection (e)(2), $25.00 per day for each day that the violation occurs.

(3) The City Attorney may bring a civil action to recover civil penalties for the violations set forth in subsections (e)(1) and (e)(2) in the same amounts set forth in those subsections, and to recover the City's enforcement costs, including attorneys' fees.

(4) Amounts recovered under this Section shall be deposited in the City's General Fund.

(f) The City Controller shall coordinate with the Department of Public Health and OLSE to prepare periodic reports on the implementation of this Chapter including participant rates, any effect on services provided by the Department of Public Health, the cost of providing services to the Health Access Program participants and the economic impact of the Chapter's provisions. Reports shall be provided to the Board of Supervisors on a quarterly basis for quarters beginning July 1, 2007 through June 30, 2008, then every six months through June 30, 2010. Reports shall include specific information on any significant event affecting the implementation of this Chapter and also include recommendations for improvement where needed, in which case the Board of Supervisors or a committee thereof shall hold a hearing within thirty (30) days of receiving the report to consider responsive action.

(g) The Director of Public Health shall convene an advisory Health Access Working Group to provide the Department of Public Health and the Health Access Program with expert consultation and direction, with input on members from the Mayor and the Board of Supervisors. The Health Access Working Group shall be advisory in nature and may provide the Health Access Program with input on matters including: setting membership rates; designing the range of benefits and health care services for participants; and researching utilization, actuaries, and costs.

(h) The Department of Public Health and the OLSE shall report to the Board of Supervisors by July 1, 2007, on the development of rules for the Health Access Program and for the enforcement and administration of the employer obligations under this Chapter. The Board of Supervisors or a committee thereof shall hold a hearing on the proposed rules to ensure that participants in the Health Access Program shall have access to high quality and culturally competent services.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 69-07, File No. 070255, App. 4/2/2007)

SEC. 14.5. SEVERABILITY.

If any section, subsection, clause, phrase, or portion of this Chapter is for any reason held invalid or

unconstitutional by any court or Federal or State agency of competent jurisdiction, such portion shall be deemed a separate, distinct and independent provision and such holding shall not affect the validity of the remaining portions thereof. To this end, the provisions of this ordinance shall be deemed severable.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006)

SEC. 14.6. PREEMPTION.

Nothing in this Chapter shall be interpreted or applied so as to create any power, duty or obligation in conflict with, or preempted by, any Federal or State law.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006)

SEC. 14.7. GENERAL WELFARE.

By this Chapter, the City is assuming an undertaking only to promote the general welfare and otherwise satisfy its obligations to provide health care under applicable law. This Chapter should in no way be construed as an expansion the City's existing obligations to provide health care under State and Federal law, and the City shall set all necessary criteria for enrollment consistent with its legal obligations. The City is not assuming, nor is it imposing on its officers and employees, an obligation forbreach of which it is liable in money damages to any person who claims that such breach proximately caused injury. To the fullest extent permitted by law, the City shall assume no liability whatsoever. To the fullest extent permitted by law, any actions taken by a public officer or employee under the provisions of this Chapter shall not become a personal liability of any public officer or employee of the City.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006)

SEC. 14.8. OPERATIVE DATE.

This Chapter shall become operative in three phases. The day this Chapter becomes effective, implementation of the Chapter shall commence. The Health Access Program shall become operative on July 1, 2007. Any requirements on employers for which an average of fifty (50) or more persons per week perform work for compensation during a quarter shall become operative on January 1, 2008. Any requirements on employers for which an average of from twenty (20) to forty-nine (49) persons per week perform work for compensation during a quarter shall become operative on April 1, 2008. This Chapter is intended to have prospective effect only.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 72-07, File No. 070354, App. 4/2/2007)

B

REGULATIONS IMPLEMENTING HEALTHY SAN FRANCISCO AND MEDICAL REIMBURSEMENT ACCOUNT PROVISIONS OF THE SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE

1. Purpose

(a) The purpose of these Regulations is to implement Chapter 14, Sections 14.2 and 14.4 of the San Francisco Administrative Code, the San Francisco Health Care Security Ordinance ("HCSO" or "Ordinance") which authorizes the Department of Public Health ("DPH") to: (i) create and administer a program to provide health care services to San Francisco's uninsured residents; and (ii) establish and maintain Medical Reimbursement Accounts for non-residents who work in San Francisco and other qualified individuals.

(b) The program referenced in subsection (a)(i) above is identified in the Ordinance as the "Health Access Program." However, DPH has determined that the name "Health Access Program" creates confusion among San Francisco residents because of its similarity to other programs. Accordingly, the program shall be named "Healthy San Francisco," and is hereinafter referred to in these regulations as "Healthy San Francisco."

(c) The Healthy San Francisco program will be among those programs offered in satisfaction of the City and County of San Francisco's obligation to provide services to indigent persons under California Welfare and Institutions Code Section 17000. The Regulations in no way shall be construed as an expansion of the City and County of San Francisco's existing obligations to provide health care under any California and/or federal law. Nor shall the regulations limit an individual's entitlement to those services otherwise required under California law.

2. Definitions

(a) Applicant. Any person who applies to participate in the Healthy San Francisco program or the Medical Reimbursement Account program.

(b) Application. The form developed by DPH to determine applicant eligibility for Healthy San Francisco.

(c) City. The City and County of San Francisco.

(d) Clinical Site or Clinical Setting. Any licensed facility that provides health services.

(e) Covered Employee. Any person that meets the definition provided in Section 14.1(b)(2) of the Administrative Code and Regulation 3 of the Office of Labor Standards and Enforcement's Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance.

(f) Covered Employer. An employer that meets the definition as set forth in Section 14.1(b)(3) and its inclusive subparts of the Administrative Code and Regulation 2 of the Office of Labor Standards and Enforcement's Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance.

(g) Federal Poverty Level. Level determined by the "Poverty Guidelines for the 48 Contiguous States and the District of Columbia" as contained in the Annual Update of the HHS Poverty Guidelines developed by the United States Department of Health and Human Services as published in the Federal Register.

(h) Healthy San Francisco Participant. Any uninsured San Francisco resident who fulfills all Healthy San Francisco eligibility provisions and is enrolled in the program.

(i) Health Services. Those services provided through the Healthy San Francisco program which a Participant will receive to treat a health or medical condition, promote health and/or prevent disease.

(j) Household Income. The total annual income of all family members in a household.

(k) Medical Home. The clinical site or clinical setting in which a Participant receives preventive and primary care services.

(l) Medical Reimbursement Account. An account established and maintained by DPH or its vendor from which eligible individuals may receive reimbursement for out-of-pocket medical expenses.

(m) Ordinance. The San Francisco Health Care Security Ordinance adopted by San Francisco Board of Supervisors as Ordinance 218-06, inclusive of any future and subsequent amendments.

(n) Participation Fee: A quarterly amount that Participants in Healthy San Francisco must pay to remain eligible for care under the program.

(o) Point-of-Service Fees: The amount(s) a Participant must pay for specific services at the time services are obtained.

(p) Provider: A California licensed health plan, hospital, clinic, medical group or clinician contracted to deliver health services to program Participants.

(q) Third-Party Administrator. A vendor or other entity that DPH enters into a contract with to perform specified administrative functions on behalf of the program.

3. Healthy San Francisco Program Eligibility

(a) An eligible Participant is any person who:

(i) resides in San Francisco and provides documentation of San Francisco residency based on the guidelines stated in the Healthy San Francisco program brochure provided to applicants;

(ii) is between the ages of 18 and 64 years old, or is an emancipated minor, or a minor not living in the home of a birth or adoptive parent, a legal guardian, caretaker relative, foster parent, or stepparent, and is applying for coverage on his or her own behalf;

(iii) has been without employer-based or individually-purchased health insurance for 90 days from the date of application for Healthy San Francisco eligibility, or has lost employer-based health care coverage within 90 days of date of application due to a change in employment status, or who has lost COBRA coverage within 90 days of date of application; and

(iv) is ineligible for California and/or federally-funded health insurance or assistance programs, provided that the applicant's eligibility for the following programs shall not make the applicant ineligible for Healthy San Francisco:

1) Pregnancy-Related Medi-Cal (Omnibus Budget Reconciliation Act);

2) Pregnancy-Related Medi-Cal (Presumptive Eligibility);

3) AIM Access for Infants and Mothers and

4) Omnibus Budget Reconciliation Act Medi-Cal (non-pregnancy and emergency only).

(b) Neither employment status, immigration status nor the existence of pre-existing health conditions shall be used to exclude a person from eligibility for Healthy San Francisco.

(c) DPH will develop an application for participation in Healthy San Francisco and a process for obtaining a Medical Reimbursement Account for potential participants.

(d) The Healthy San Francisco application will collect information from the applicant necessary to determine program eligibility and eligibility for any subsidies for participation in the program, including, but not limited to name, address, household income, and employment status.

(e) An eligible Participant shall be enrolled for participation into the Healthy San Francisco program if he/she submits a completed application, fulfills the eligibility requirements and pays the required participation fees as established by DPH.

(f) DPH shall, from time to time, require participants to re-establish eligibility for participation in Healthy San Francisco.

4. Healthy San Francisco Program Fees

(a) Healthy San Francisco will have two fee components for its Participants: "participation fees" and "point-of-service fees." These fees shall be based on Participant income which is measured with reference to the Federal Poverty Level.

(i) Participation fees shall be assessed on a quarterly basis for continued participation in the Healthy San Francisco program.

(ii) Point-of-service fees shall be assessed on a sliding scale based on a Participant's Federal Poverty Level when a Participant receives services at a clinical site or clinical setting.

(iii) Any person with an annual household income between 0% and 500% of the Federal Poverty Level shall be eligible for a subsidy for the participation fee, to be determined by DPH.

(b) Non-payment of the participation fee by the program Participant can result in cancellation of enrollment from the Healthy San Francisco program.

5. Healthy San Francisco Services

(a) The program shall provide health services for the treatment of medical conditions with an emphasis on wellness, preventive, and primary care. Services include: professional services by clinicians (i.e., doctors, nurse practitioners, physician assistants, and other licensed health care providers) including preventive, primary, diagnostic, and specialty services; inpatient and outpatient hospital services; diagnostic and laboratory services, including therapeutic radiological services; behavioral health services, including mental health and substance abuse services; prescription drugs, excluding drugs for excluded services; home health care; urgent care; and emergency care provided in San Francisco.

(b) The following is a non-exclusive list of services that shall not be provided by Healthy San Francisco program:

(i) Acupuncture;

(ii) Allergy Testing and Injections;

(iii) Audiology (including hearing aids);

(iv) Chiropractic;

(v) Cosmetic;

(vi) Dental;

(vii) Gastric By-Pass Surgery and Services;

(viii) Genetic Testing and Counseling;

(ix) Infertility;

(x) Long-Term Care;

(xi) Organ Transplants;

(xii) Sexual Reassignment Surgery;

(xiii) Transportation: Non-emergency; and

(xiv) Vision.

(c) Healthy San Francisco does not include any services, including emergency services, provided outside the City and County of San Francisco.

6. Healthy San Francisco Service Provision and Delivery Network

(a) Each Participant shall have a designated clinical site or clinical setting that shall serve as his/her primary care medical home. The primary care medical home shall coordinate a Participant's access to services in the program, monitor management of medical conditions and provide continuity of care.

(i) Upon enrollment into the program, Participants shall select their primary care medical home from a list of participating Healthy San Francisco clinic sites or clinical settings.

(ii) Participants may request a medical home change during their pre-determined program recertification and re-enrollment process.

(iii) Participants may make requests to change their primary care provider (i.e., a physician, nurse practitioner or physician assistant) within their medical home.

(b) The network of providers delivering services to program Participants shall be confined to licensed providers who have a physical location and practice in the City and who have entered into agreements and/or contracts with DPH and/or its Third-Party Administrator to provide services under this program.

(c) Healthy San Francisco shall not include or reimburse payment for services delivered to program Participants by providers that have not entered into agreements and/or contracts with DPH and/or its Third-Party Administrator to provide services to Participants under this program.

7. Covered Employee Participation Rules

(a) Covered Employers who chose to satisfy the Employer Spending Requirement under the Ordinance by making payments to the City shall deliver the payments to DPH's Third Party Administrator. Payments shall be made consistent with the provisions of Section 14.3(a) of the Administrative Code and Regulation 6 of the Office of Labor Standards and Enforcement's Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance.

(b) Along with its payments, the Covered Employer shall provide to DPH's Third-Party Administrator: (i) the name of the Covered Employee, (ii) the amount paid per Covered Employee and (iii) other information as needed by DPH to determine whether the Covered Employee is eligible for participation in Healthy San Francisco or for the establishment of a Medical Reimbursement Account. DPH or its Third-Party Administrator shall provide Covered Employers with a form upon which they may provide this information along with their payments.

(c) DPH's Third-Party Administrator will use the information provided by the Covered Employer pursuant to subsection 7(b) above to determine whether the payment made on behalf of a Covered Employee shall be used to fund the Covered Employee's participation in Healthy San Francisco or to establish a Medical Reimbursement Account for the Covered Employee.

(d) Covered Employees on whose behalf a payment has been made to satisfy the Employer Spending Requirement shall be notified by their Covered Employer that such a payment has been made in accordance with Regulation 7.1 of the Office of Labor Standards and Enforcement's Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance.

(e) DPH or its Third-Party Administrator shall inform Covered Employees where they may go to be screened for enrollment in Healthy San Francisco and/or establishment of Medical Reimbursement Accounts.

(f) A Covered Employee on whose behalf payment has been made to DPH must, in order to participate in Healthy San Francisco, meet program eligibility requirements and enroll in Healthy San Francisco.

(i) A Covered Employee who is determined to be eligible for Healthy San Francisco shall receive a discount of 75% off the participation fee that s/he would otherwise be required to pay to participate in Healthy San Francisco. If as a result of the discount the fee is less than $50 per quarter, the participation fee shall be waived.

(ii) Payments by the Covered Employer shall entitle the Covered Employee to a discounted Participation Fee for six months from the date of enrollment. After six months from the date of enrollment, and every six months thereafter, DPH or its Third-Party Administrator shall determine whether the Participant's Covered Employer has continued payments on the Participant's behalf in the preceding six months. If the Covered Employer has continued to make such payments, the Participant shall remain eligible for a discounted Participation Fee for the following six months. If DPH or its Third-Party Administrator determines that the Covered Employer has not made payments on the Participant's behalf for the preceding six months, the Participant may remain enrolled in Healthy San Francisco by paying a non-discounted Participation Fee.

(g) A Covered Employee that does not meet the program eligibility requirements for participation in Healthy San Francisco but wishes to benefit from the payment made on his/her behalf by a Covered Employer, may sign up for a Medical Reimbursement Account to be established and maintained by DPH's Third Party Administrator. Any funds collected on behalf of a Covered Employee during the calendar year shall be forfeited if the Covered Employee does not sign up for a Medical Reimbursement Account by July 1 of the subsequent calendar year. Any forfeited funds shall be used by DPH to fund the programs described in these regulations.

(i) Covered Employees may obtain reimbursement from the Medical Reimbursement Account for medical care, services or goods that may qualify as tax deductible medical expenses under Section 213 of the Internal Revenue Code including the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body, including the costs of equipment, supplies and diagnostic devices needed for these purposes. Reimbursable medical expenses may also include dental expenses, premiums paid for insurance that covers the expenses of medical care and the amount paid for transportation to receive medical care.

(ii) Any administrative fees charged to the City to establish and maintain the Covered Employee's Medical Reimbursement Account shall be deducted from the balance amount in that Covered Employee's Medical Reimbursement Account.

(iii) A Covered Employee must use the money deposited into the Medical Reimbursement Account within a designated period of time as determined by DPH.

8. Public Information on Healthy San Francisco

(a) DPH shall make available to the public all information necessary to facilitate participation in the programs authorized by the Ordinance.

(b) Written program materials for applicants and participants will be offered, at a minimum in the following languages: Chinese, English and Spanish.

(c) DPH will maintain a program website and ensure that access to program information is available through the 311 System operated by the City.

9. Healthy San Francisco Administration

(a) DPH is responsible for the overall administration of the Healthy San Francisco and Medical Reimbursement Account programs. Its responsibilities include, but are not limited to: overseeing overall program development and implementation; defining program goals, design and policy objectives; ensuring adequate financing and evaluating the program's effectiveness.

(b) DPH may enter into a vendor/contract relationship with a Third-Party Administrator and/or other entities to perform specific administrative or programmatic functions needed to appropriately operate and maintain the program.

10. Reporting

(a) DPH shall make annual reports to the San Francisco Health Commission on the status of the Healthy San Francisco and Medical Reimbursement Account programs.

(b) DPH shall comply with Section 14.4(f) of the Administrative Code with respect to Healthy San Francisco and Medical Reimbursement Account program reports to the San Francisco Board of Supervisors.

C

CITY AND COUNTY OF SAN FRANCISCO
OFFICE OF LABOR STANDARDS ENFORCEMENT

Donna Levitt, Manager

REGULATIONS IMPLEMENTING THE EMPLOYER SPENDING REQUIREMENT OF THE SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE (HCSO)

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Last Revised on 7/12/2007

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INTRODUCTION

The Office of Labor Standards Enforcement ("OLSE") promulgates these Regulations pursuant to Chapter 2A, Article 1, Section 2A.23 and Chapter 14 of the San Francisco Administrative Code. Pursuant to Chapter 14, the San Francisco Health Care Security Ordinance ("HCSO"), the OLSE is mandated to enforce the Employer Spending Requirement of the HCSO.

From February 1 through July 17, 2006, and again on March 7 and May 8, 2007, the Board of Supervisors held 19 hearings at which there were opportunities for public comment on the HCSO and its amendments. In January and June of 2007, the OLSE issued draft Regulations, which were vetted through a public process that included public hearings and the opportunity to provide both oral and written comments and updated several times based upon public input.

In developing these Regulations, the OLSE has been guided by its understanding of the importance of fulfilling the goals of the Ordinance, providing clear direction to employers and employees, and giving weight to considerations of equity and practicality.

Fulfilling the goals of the Ordinance. In developing these Regulations, the OLSE has tried to be faithful to the basic goals of the Ordinance. These goals are well established. The Ordinance and its amendments include extensive statements of legislative findings and purpose, explaining the multiple rationales for the Ordinance and articulating its goals. These statements of legislative findings and purpose is found in Sections 1 of the Ordinance and Amended Ordinance, and, as such, have the full force and effect of law. Particularly in light of the statements of legislative findings and purpose, the Ordinance should be liberally construed to effect its goals.

Providing clear direction to employers and employees. In mandating the OLSE to promulgate regulations on the Employer Spending Requirement of the Ordinance, the Board of Supervisors intended that the OLSE provide clear direction to employers and employees upon which they could rely. (*See* S.F. Admin. Code § 14.4(a).) Accordingly, these Regulations seek to fulfill that mandate.

Giving weight to considerations of equity and practicality. Finally, in adopting the Ordinance, the Board of Supervisors intended that guidelines or regulations take into account considerations of equity and practicality, from both the employee and employer perspective. Accordingly, these Regulations are designed to be both fair and workable for employees and employers alike. One aspect of the Regulations, though not a dominant feature, is to reduce the possibility of abuses by employees and employers.

While these principles have guided the OLSE's judgment in developing these Regulations, it must be acknowledged that general principles do not always automatically yield a single, specific result with respect to a particular Regulation. Multiple and sometimes conflicting considerations come into play in the development of a Regulation. Having been authorized by the Ordinance to promulgate these Regulations, the OLSE ultimately must exercise its judgment in developing Regulations that are reasonable in light of all relevant factors, taking into account both input from the public and its own expertise as a labor standards enforcement office.

REGULATION 1: EMPLOYER SPENDING REQUIREMENT

1.1 Employer Spending Requirement

(A) Each quarter, covered employers are required to make qualifying health care expenditures:

(1) to their covered employees, or

(2) for the benefit of their covered employees.

For the definition of qualifying health care expenditures, see Regulation 4.

1.2 Definition of Quarter

A quarter shall be defined as one of four three-month periods in a calendar year. Thus, the first quarter of the year shall be defined as the period from January 1 through March 31; the second quarter shall be the period from April 1 through June 30; the third quarter, the period from July 1 through September 30; and the fourth quarter, the period from October 1 through December 31.

For timing and manner of payment of the Employer Spending Requirement, see Regulation 6.2.

REGULATION 2: COVERED EMPLOYERS

2.1 Definition of Employer

An employer is an employing unit as defined in Section 135 of the California Unemployment Insurance Code or any person defined in Section 18 of the California Labor Code. An employer includes all members of a "controlled group of corporations" as defined in Section 1563(a) of the United States Internal Revenue Code, and the determination shall be made without regard to Sections 1563(a)(4) and 1563(a)(3)(C) of the Internal Revenue Code.

2.2 Covered Employer

(A) A "covered employer" is:

(1) any Medium-size or Large Business, as defined in subsection C below, that;

(2) engages in business within the City and is required to obtain a valid San Francisco business registration certificate pursuant to Article 12 of the Business and Tax Regulations Code.

(B) Whether an employer is physically located within the geographic boundaries of the City and County of San Francisco has no bearing on whether it meets the definition of a "covered employer." (In contrast, however, only persons who work for a covered employer within the geographic boundaries of the City and County of San Francisco may be considered "covered employees." *See* Regulation 3.)

(C) The law defines three categories of employers:

(1) Large Business: an employer for which an average of 100 or more persons per week perform work for compensation during a quarter. This category shall include nonprofit corporations for which an average of 100 or more persons per week perform work for compensation during a quarter.

(2) Medium-size Business: an employer for which an average of 20 to 99 persons per week perform work for compensation during a quarter. This category shall include only those nonprofit corporations for which an average of 50 to 99 persons per week perform work for compensation during a quarter.

(3) Small Business: an employer for which an average of 19 or fewer persons per week perform work for compensation during a quarter.

(D) For the purposes of determining employer size, the term "persons":

(1) shall include all employees, regardless of their status or classification as seasonal, permanent or temporary, full-time or part-time, contracted (whether employed directly by

the employer or through a temporary staffing agency, leasing company, professional employer organization, or other entity) or commissioned;

(2) shall not be limited to covered employees, as defined in Regulation 3; and

(3) shall include both those who work within San Francisco and those who work outside of San Francisco.

(E) For businesses employing a fluctuating number of employees during a quarter, employer size will be determined based on the average number of persons per week performing work for compensation during the applicable quarter.

(F) Effective Dates of Coverage

(1) This law shall be effective on January 1, 2008 for all employers for which an average of 50 or more persons per week perform work for compensation during a quarter.

(2) This law shall become effective April 1, 2008 for all for-profit businesses for which an average of 20 or more persons per week perform work for compensation during a quarter.

(3) Non-profit Medium-size Businesses for which an average of 49 or fewer persons per week perform work for compensation during a quarter and all Small Businesses are exempt from the requirements of this Ordinance.

REGULATION 3: COVERED EMPLOYEES

3.1 Covered Employees

(A) A covered employee is any person who:

(1) qualifies as an employee entitled to payment of minimum wage pursuant to the Minimum Wage Ordinance, Chapter 12R of the San Francisco Administrative Code;

(2) has been employed by his or her employer for 90 calendar days after his or her first day of work (including any period of leave to which an employee is legally entitled); and,

(3) in a particular week performs at least the number of hours of work specified below:

(a) Beginning January 1, 2008: in a particular week performs at least 10 hours of work for the employer within the geographic boundaries of the City and County of San Francisco.

(b) Beginning January 1, 2009: in a particular week performs at least 8 hours of work for the employer within the geographic boundaries of the City and County of San Francisco.

(c) For employees whose work hours fluctuate from week to week, eligibility will be determined based on the average number of hours worked per week during the applicable quarter.

(B) 90-Calendar-Day Eligibility Period. The 90-calendar-day eligibility period need not be continuous, consecutive, nor completed in the same calendar year.

(1) For an employee who is separated from employment prior to completing the eligibility period, the prior days of employment shall count towards the eligibility period if the employee returns to work within one (1) year of the most recent separation date.

(2) An employee who is separated from employment after completing the eligibility period shall not be required to complete a new eligibility period, if the employee is rehired within one (1) year of the most recent separation date.

(C) Work Performed "Within" the City and County of San Francisco

(1) While employees who travel *through* San Francisco in the performance of their job duties shall not be considered to have performed work in San Francisco, an employee whose work requires stops in San Francisco (for example, to make pick-ups or deliveries) shall be considered to have performed work in San Francisco. For these employees, hours worked shall include travel within the geographic boundaries of the City and County of San Francisco. *See* Regulation 6.1(C)(1)(c).

(2) Work performed on city-owned or city-leased property outside the geographic boundaries of the City and County of San Francisco shall not be considered in meeting the hours requirement in Regulation 3.1(A)(3).

(3) For employees who live in San Francisco, work performed for a covered employer from the employee's own home, including telecommuting, shall qualify as work performed "within" the City and County of San Francisco.

(D) An employee's status or classification as seasonal, permanent or temporary, full-time or part-time, exempt or non-exempt, salaried or hourly, or contracted (whether employed directly by the employer or through a temporary staffing agency, leasing company, professional employer organization, or other entity) or commissioned shall not be considered in determining whether that employee is a covered employee.

(E) Employees made available to work through the services of a temporary staffing agency, leasing agency, professional employer organization, or other entity serving the same or similar function may or may not be considered employees of such entity. Both the client and the temporary staffing, leasing, professional employer, or similar entity may be considered an employer under this Ordinance, and each party shall have an obligation to ensure that the Employer Spending Requirement is met.

(F) Whether an employee is simultaneously employed by more than one employer shall not impact a covered employer's responsibilities under this law.

3.2 Covered Employee Exemptions

(A) The following persons are not covered employees under the HCSO:

(1) Persons who are managerial, supervisory, or confidential employees, unless such employees earn under $74,558 annually (or $35.85 hourly) in 2007. For each year thereafter, this figure shall increase by an amount corresponding to the prior year's increase, if any, in the Consumer Price Index for urban wage earners and clerical workers for the San Francisco-Oakland-San Jose metropolitan statistical area in California. For purposes of this exemption category,

(a) "managerial employee" is defined as an employee who has authority to formulate, determine, or effectuate employer policies by expressing and making operative the decisions of the employer and who has discretion in the performance of his/her job independent of the employer's established policies;

(b) "supervisory employee" is defined as an employee who has authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or the responsibility to direct them, or to adjust their grievances, or effectively to recommend any such action, if the exercise of this authority or responsibility is not of a merely routine or clerical nature, but requires the use of independent judgment;

(c) "confidential employee" is defined as an employee who acts in a confidential capacity to formulate, determine, and effectuate management policies with regard to labor relations, or regularly substitutes for employees having such duties.

(2) Persons who are eligible to receive benefits under Medicare (as distinguished from Medicaid/Medi-Cal) or TRICARE/CHAMPUS (the federal health care and health benefits program for active duty and retired members of the uniformed services, their families, and survivors);

(3) Persons who are "covered employees" as defined in Section 12Q.2.9 of the San Francisco Administrative Code (Health Care Accountability Ordinance), if the employer meets the requirements set forth in Section 12Q.3 of the San Francisco Administrative Code for those employees;

(4) Persons who are employed by a non-profit corporation for up to one year as trainees in a bona fide training program consistent with federal law, which training program enables the trainee to advance into a permanent position, provided that the trainee does not replace, displace, or lower the wage or benefits of any existing position or employee;

(5) Persons who provide verification that they are receiving health care services through another employer, either as an employee or by virtue of being the spouse, domestic partner, or child of another person – provided that the employer obtains from those persons a voluntary written waiver of the health care expenditure requirements of the HCSO as follows. The employer must make its required health care expenditures on behalf of the employee unless all of the following requirements are met:

(a) Employers must use the Employee Voluntary Waiver Form provided in Appendix A.

i. The form must be voluntarily completed by the employee without pressure or coercion from the employee's coworkers or the employer, including, supervisor(s), manager(s), or their agents.

ii. An employee waiver is valid for one year, at which point a new waiver must be signed.

iii. Employees reserve the right to revoke their voluntary waiver at any time; however, the revocation must be submitted in writing.

iv. Employers must provide the employee with a complete copy of the Voluntary Waiver Form.

v. An electronic copy of the Voluntary Waiver Form shall be acceptable, provided that the employee receive a hard copy of any form(s) signed by the employee and the employee is readily able to access copies of such forms.

(b) Employers must maintain in their records a Voluntary Waiver Form signed by each employee for whom the employer seeks to claim an exemption from the requirements of the HCSO, including information regarding the type and source of coverage (e.g., health insurance provided through the employer of the employee's spouse), as specified on the Voluntary Waiver Form, updated annually.

REGULATION 4: HEALTH CARE EXPENDITURES

4.1 Definition of Health Care Expenditure

(A) A health care expenditure is any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees.

(B) Health care services means medical care, services, or goods that may qualify as tax deductible medical care expenses under Section 213 of the Internal Revenue Code, or medical care, services, or goods having substantially the same purpose or effect as such deductible expenses. Qualifying medical expenses include dental treatments and fees paid to dentists for x-rays, fillings, braces, extractions, dentures, and the like; eyeglasses and contact lenses needed for medical reasons; and fees for eye examinations and eye surgery to treat defective vision.

4.2 Examples of Qualifying Health Care Expenditures

(A) Each covered employer has discretion as to the type of health care expenditure it chooses to make for its covered employees. Examples of health care expenditures include, but are not limited to:

(1) Payments to a third party to provide health care services for a covered employee, e.g., health insurance premiums;

(2) Expenditures made by self-insured and/or self-funded insurance programs;

(3) Contributions on behalf of a covered employee to a health benefit flexible spending account, a health savings account, a health reimbursement account, a medical spending account (as defined under sections 125, 223 of the federal Internal Revenue Code and Publication 969 of the Internal Revenue Service), or to any other account having substantially the same purpose or effect without regard to whether such contributions qualify for a tax deduction or are excludable from employee income;

(4) Reimbursement to a covered employee for expenses incurred in the purchase of health care services;

(5) Costs incurred in the direct delivery of health care services for a covered employee; and,

(6) Payments on behalf of a covered employee to the City of San Francisco:

(a) to fund membership in the Health Access Program/*Healthy San Francisco*; or

(b) to establish and maintain medical reimbursement accounts for covered employees.

(B) Health care expenditures shall not include any payment made directly or indirectly to obtain workers' compensation, State Disability Insurance, Social Security, Medicare, or any other coverage required by any other local, state, or federal law.

> **(1) Prevailing Wage/Public Works Contracts.** Payment of the prevailing wage fringe benefit requirement in cash (as part of the covered employee's paycheck or otherwise) shall not satisfy the Employer Spending Requirement of this Ordinance.

(C) Employer health care expenditures shall include administrative costs paid to a third party for the purpose of providing health care services for covered employees, but shall not include administrative costs incurred by the employer, but not paid to a third party. Such costs are properly considered a business expense of the employer.

(D) Health care expenditures made on behalf of a covered employee for the benefit of his or her domestic partner, spouse, family member, or other dependent shall be included in determining whether an employer has met its required expenditure to or on behalf of the covered employee.

4.3 Other Qualifying Health Care Expenditures

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 and Publication 502 of the Internal Revenue Service, but may include medical care, services, or goods having substantially the same purpose or effect. Examples of qualifying expenditures include vision and dental coverage; nonprescription drugs, including, but not limited to, antacids, allergy medicines, pain relievers, and cold medicines; doctor's fees; and necessary hospital services not paid for by insurance.

REGULATION 5: HEALTH CARE EXPENDITURE RATES

5.1 Definition of Health Care Expenditure Rate

The health care expenditure rate is the amount of health care expenditure that a covered employer is required to make for each hour paid for each of its covered employees during a quarter.

5.2 Health Care Expenditure Rates

(A) The health care expenditure rate for a covered employer is determined by that employer's size:

(1) Large Business. Beginning January 1, 2008, Large Businesses for which an average of 100 or more persons per week perform work for compensation during a quarter are required to make a health care expenditure of $1.76 per hour for each hour paid for each of its covered employees.

(2) Medium-Size Business

(a) Beginning January 1, 2008, Medium-size Businesses for which an average of 50-99 persons per week perform work for compensation during a quarter are required to make a health care expenditure of $1.17 per hour for each hour paid for each of its covered employees.

(b) Beginning April 1, 2008, all Medium-size Businesses (including those for which an average of 20-49 persons per week perform work for compensation during a quarter), except nonprofit corporations exempt from the definition of a covered employer, are required to make a health care expenditure of $1.17 per hour for each hour paid for each of its covered employees.

(B) Increases to Health Care Expenditure Rates

(1) For all covered businesses, the health care expenditure rate will be increased by 5% on January 1, 2009. Through 2009, the employer health care expenditure rate is as follows:

Employer Health Care Expenditure Rate Schedule				
Business Size		January 1 2008	April 1 2008	January 1 2009
Large	100+ Employees	$1.76/hour		$1.85/hour
Medium	50-99 Employees	$1.17/hour		$1.23/hour
	20-49 Employees*	Not Applicable	$1.17/hour	
Small	1-19 Employees	Not Applicable		

*Non-profits with less than 50 employees are exempt from the spending requirement.

(2) From January 1, 2010 and each year thereafter, the "health care expenditure rate" shall be determined annually based on the "average contribution" for a full-time employee to the City Health Service System pursuant to Section A8.423 of the San Francisco Charter based on the annual ten-county survey amount for the applicable fiscal year, with such average contribution prorated on an hourly basis by dividing the monthly average contribution by one hundred seventy-two (172) (the number of hours worked in a month by a full-time employee). The "health care expenditure rate" shall be seventy-five percent (75%) of the annual ten-county survey amount for the applicable fiscal year for large businesses and fifty percent (50%) for medium-sized businesses. Beginning in 2009 and in each year thereafter, the OLSE shall publish, by March 1, the adjusted expenditure rates for the upcoming calendar year

REGULATION 6: CALCULATING & MAKING HEALTH CARE EXPENDITURES

6.1 Calculating Health Care Expenditures

(A) A covered employer's required health care expenditure is the sum of the health care expenditure that the covered employer is required to make each quarter for each of its covered employees.

(B) The required health care expenditure is calculated by multiplying the total number of "hours paid," as defined below, to each covered employee during the quarter (starting on the first day of the calendar month following 90 calendar days after a covered employee's first day of work) by the applicable health care expenditure rate specified in Regulation 5.2.

(C) The required health care expenditures are based on hours paid, which may or may not be hours actually worked. "Hours paid" includes both hours for which a person is paid wages for work performed within San Francisco and hours for which a person is entitled to be paid wages, including, but not limited to, paid vacation hours, paid time off, and paid sick leave hours, but not exceeding 172 hours in a single month or 516 hours in a single quarter.

(1) Work Performed and "Hours Paid" within San Francisco

(a) Any work performed by covered employees within San Francisco must be tracked by the employer. Unless there is clear and convincing evidence otherwise, all hours worked by covered employees will be presumed to be for work performed within San Francisco.

(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 hours) will be calculated on a pro rata basis.

(c) Employees whose work requires stops in San Francisco (for example, to make pick-ups or deliveries) shall be considered to be performing work in San Francisco, and their "hours worked" shall include travel within the City and County of San Francisco.

(d) For covered employees who live in San Francisco and perform work for a covered employer from the employee's own home, including telecommuting, "hours worked" shall include all hours worked from home.

6.2 Timing and Manner of Health Care Expenditures

(A) The required health care expenditure must be made regularly, and no later than 30 days after the end of the preceding quarter.

(1) Employers meeting the requirements of the limited exception outlined in Regulation 6.2(B)(2) shall not be required to make expenditures under such plans quarterly.

(2) Nothing in this regulation shall prevent an employer from making regular expenditures prospectively, or before the end of a quarter, in order to obtain health care or health coverage for a covered employee during such quarterly period.

(B) Subject to the following limited exceptions, covered employers must make health care expenditures to or on behalf of each covered employee. Ordinarily, payments to or on behalf of one covered employee that exceed the required health expenditure for that employee will not be included in determining whether an employer has met its total required health care expenditures for all employees. However:

(1) A covered employer that provides uniform health coverage to some or all of its covered employees shall, with respect to those employees, be deemed to comply with the spending requirement of this Ordinance if the average expenditure rate per employee meets or exceeds the applicable expenditure rate (outlined in Regulation 5) for that employer.

(2) A covered employer that provides health coverage to some or all of its covered employees through a self-funded/self-insured plan shall, with respect to those employees, be deemed to comply with the spending requirement of this Ordinance if the preceding year's average expenditure rate per employee meets or exceeds the applicable expenditure rate (outlined in Regulation 5) for that employer.

(3) The average expenditure rate shall be calculated by dividing the total amount of health care expenditures made for such employees by the total number of hours paid to such employees.

(C) An employer may choose more than one option to satisfy its duty to make the required health care expenditures for one or more of its covered employees. An employer may, for example, choose to purchase health insurance for its full-time employees, but make payment to the City to fund part-time employees' membership in the Health Access Program/*Healthy San Francisco.*

(D) The required health care expenditure must be made in full each quarter. Thus, an employer who purchases a health insurance program with premiums that are less than the required expenditure must choose a second option to make the expenditure in full. For example, the employer may choose to pay the remainder to the City to establish and maintain medical reimbursement accounts for such employees.

(E) A covered employer that maintains a health care program that requires contributions by a covered employee shall not have satisfied its obligation to make the required health care expenditures merely by offering a covered employee the opportunity to participate in such a program. Should the employee decline to participate in such a program, the employer shall not have satisfied its obligation to make the required health care expenditures.

REGULATION 7: ADDITIONAL EMPLOYER RESPONSIBILITIES

7.1 Employer Notice to Employee of Payment to the City

A covered employer who satisfies its obligation to make the required health care expenditures by making payment to the City shall provide its covered employees with notice, using the form provided in Appendix B.

7.2 Employer Recordkeeping

(A) Covered employers shall keep, or cause to be kept, for a period of four years from the covered employees' dates of employment:

(1) itemized pay statements, as mandated by California Labor Code Section 226, which requires the following: (a) gross wages earned, (b) total hours worked by the employee (unless salaried), (c) the number of piece-rate units earned and any applicable piece rate if the employee is paid on a piece-rate basis, (d) all deductions, aggregated, (e) net wages earned, (f) the inclusive dates of the period for which the employee is paid, (g) the name of the employee and his or her social security number/the last four digits of his or her social security number or an employee identification number other than a social security number may be shown on the itemized statement, (h) the name and address of the legal entity that is the employer, and (i) all applicable hourly rates in effect during the pay period and the corresponding number of hours worked at each hourly rate by the employee;

(2) the employee's address, telephone number, date of first day of work;

(3) 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;

and, if applicable,

(4) a signed Employee Voluntary Waiver Form (*see* Appendix A) for every employee for whom a covered employer seeks to claim an exemption from the Employer Spending Requirement; and

(5) a copy of the Employer Notice to Employee of Payment to the City (*see* Appendix B).

(B) Employers meeting the requirements of the limited exception outlined in Regulation 6.2(B)(2) shall not be required to demonstrate that expenditures under such plans were made quarterly.

(C) All records necessary to establish compliance with the Employer Spending Requirements of this Ordinance shall be made accessible by covered employers to the OLSE.

(D) Where an employer does not maintain or retain adequate records documenting the health care expenditures made, or does not allow the OLSE reasonable access to such records, it shall be presumed that the employer did not make the required health care expenditures for the quarter for which records are lacking. This presumption shall be rebutted only by clear and convincing evidence.

7.3 Employer Reporting

Covered employers shall provide information to the City regarding its health care expenditures on an annual basis. Such information shall be provided on the HCSO Mandatory Annual Reporting Form, which shall be mailed to all registered businesses and returned with the employer's annual business registration submission to the City, as mandated by Article 12 of the Business and Tax Regulations Code. Additional copies of the HCSO Mandatory Annual Reporting Form may be obtained from the OLSE.

7.4 Employer Cooperation with OLSE Investigation & Enforcement

All covered employers shall cooperate fully with the OLSE in connection with any investigation of an alleged violation of this Ordinance or with any audit or inspection conducted by the OLSE.

7.5 Prohibition against Actions or Attempts to Avoid Employer Coverage

(A) It is unlawful for any employer to reduce the number of employees in order to:

(1) avoid being considered a covered employer, or to

(2) be subject to a lower health care expenditure rate.

(B) In the event of an investigation on a claim based on Section 14.4(c) of the Ordinance, the employer shall be required to demonstrate that such reduction in staffing was for a valid business reason.

7.6 Prohibition against Retaliation

(A) It shall be unlawful for any employer to deprive or threaten to deprive any person of employment, take or threaten to take any reprisal or retaliatory action against any person, or directly or indirectly intimidate, threaten, coerce, command or influence or attempt to intimidate, threaten, coerce, command or influence any person because such person has cooperated or otherwise participated in an action to enforce, inquire about, or inform others about the requirements of this Ordinance.

(B) Taking adverse action against a person within ninety (90) days of the person's exercise of rights protected under this Ordinance shall raise a rebuttable presumption of having done so in retaliation for the exercise of such rights.

7.7 Prohibition against Discrimination

It shall be unlawful for any employer to refuse to hire, employ, or select for a training program leading to employment; to discharge from employment or from a training program leading to employment; or to discriminate against a person in compensation or in terms, conditions, or privileges of employment, based on whether s/he possesses health insurance coverage.

REGULATION 8: OLSE ENFORCEMENT

8.1 OLSE Investigation & Enforcement

(A) The OLSE has the authority to conduct investigation and monitoring and to seek, for violations of this Ordinance, all of the penalties imposed by this Ordinance in order to further its purposes. The Labor Standards Enforcement Officer and other City employees and agents or designees authorized to assist in the administration and enforcement of the requirements of this Ordinance shall have the right to engage in random inspections of employment sites; to have access to workers and other witnesses; and to conduct audits of employer records as reasonably deemed necessary to determine compliance with this Ordinance, including, but not limited to, employee time sheets, payroll records, employee paychecks, and other documents described in Regulation 7.2.

(B) Where prompt compliance is not forthcoming, the OLSE may take any appropriate enforcement action to secure compliance, including initiating a civil action, and/or, except where prohibited by state or federal law, requesting that City agencies or departments revoke or suspend any registration certificates, permits, or licenses held or requested by the employer or person until such time as the violation is remedied.

8.2 Administrative Complaint Procedure

(A) The OLSE shall have sole authority over the administration of the following complaint procedure. This procedure shall include, but need not be limited to, the following:

(1) Any person may file a complaint alleging one or more violations of this Ordinance;

(2) Before beginning to investigate the complaint, the Labor Standards Enforcement Officer shall determine if the allegations of the complaint are sufficient and, based on that assessment, shall determine either to dismiss it or to proceed with an investigation;

(3) If the Labor Standards Enforcement Officer determines at any time that the allegations contained in the complaint are without merit, the Labor Standards Enforcement Officer shall notify the complainant; and

(4) If the Labor Standards Enforcement Officer finds that any allegations in the complaint have merit, the Labor Standards Enforcement Officer shall investigate the matter.

(B) This complaint procedure shall not preclude the Labor Standards Enforcement Officer from initiating or proceeding with an investigation on his or her own authority.

8.3 Notice of Violation

(A) If the OLSE determines that an employer may have violated or is not in compliance with this Ordinance, the OLSE shall issue written notification to the employer mandating compliance within no fewer than ten (10) calendar days from the date of the notification.

(B) The OLSE may, at its discretion, allow the employer additional time beyond the ten (10) calendar days to make the corrections should the OLSE determine that the employer is making a good faith effort to comply.

(C) If, after ten (10) days of the Notice of Violation to the employer by the OLSE, the violation or failure to comply continues and no resolution is imminent, the OLSE may issue a Determination of Violation.

8.4 Determination of Violation

(A) The Determination of Violation shall include:

(1) a description of the violation;

(2) a citation of the provisions of the law violated;

(3) a description of the corrective action required and a timeline within which the action(s) must be completed;

(4) the amount of administrative penalty imposed for the violation(s) and a timeline for payment of such penalty, if applicable;

(5) a description of the process for appealing the Determination of Violation, including the deadline for filing such an appeal; and

(6) the name and signature of the Director of the OLSE or his/her designee.

8.5 Service

(A) Service of a Notice of Violation or Determination of Violation may be accomplished as follows:

(1) The OLSE may obtain the signature of the employer or a representative of the employer responsible for the violation to establish personal service of the document; or

(2) The OLSE may post the document by affixing the document to a surface in a conspicuous place on the employer's place of business or the fixed location within the City from or at which the employer conducts business in the City; or

(3) The OLSE may serve the document by first class mail as follows:

(a) The document shall be mailed to the employer by first class mail, postage prepaid, with a declaration of service under penalty of perjury; and

(b) A declaration of service shall be made by the person mailing the document, show the date and manner of service by mail, and recite the name and address of the employer to whom the Notice of Violation or Determination of Violation is issued.

Service of the document by mail in the manner described above shall be effective on the date of the mailing.

REGULATION 9: CORRECTIVE ACTION AND ADMINISTRATIVE PENALTIES

9.1 Corrective Action

The OLSE may order employers who violate this Ordinance to take appropriate corrective action to address violations of this Ordinance. The OLSE shall not be limited to ordering the actions described below, but may order any other actions it deems necessary to correct the violation(s) committed. Where the OLSE has reason to believe that a violation has occurred, it may order any appropriate temporary or interim relief to mitigate the violation or maintain the status quo, pending completion of a full investigation or hearing.

9.2 Administrative Penalties

(A) If corrective action is not taken, the OLSE may impose administrative penalties upon employers who violate this Ordinance, including, but not limited to, the violations described below. All penalties may be assessed by means of a Determination of Violation issued by the Director of the OLSE or his/her designee.

VIOLATION	CORRECTIVE ACTION	ADMINISTRATIVE PENALTY
Failure to make the required health care expenditures (Admin. Code §§ 14.3(a) & 14.4(e)):	The party shall be ordered to make the required health care expenditure on behalf of each employee or person whose rights under this Ordinance was violated, and/or to reimburse the individual for any and all out-of-pocket medical expenses incurred by that individual for the period during which the employer was in violation of this Ordinance, up to the amount of the required health care expenditure. This payment shall be made retroactively, from the date the expenditure was due, and continuing until the case is resolved to the satisfaction of the OLSE.	The penalty assessed shall be up to one-and-one-half times the total expenditures that a covered employer failed to make, plus interest of up to ten (10) percent on all due and unpaid health care expenditures, from the date payment should have been made. The total penalty for this violation shall not exceed $1,000 for each employee for each week that such expenditures were or are not made.
Failure to cooperate with the OLSE or otherwise impeding the OLSE's ability to conduct an audit or investigation (Admin. Code §§ 14.3(b) & 14.4(e)):	The party shall be ordered to cooperate with the OLSE, effective immediately.	The penalty assessed shall be $25 per day for each day that the violation occurred or occurs.
Failure to allow reasonable access to records of health care expenditures (Admin. Code §§ 14.3(b) & 14.4(e)):	The party shall be ordered to provide the OLSE with reasonable access to records of health care expenditures.	The penalty assessed shall be $25 for each worker whose records are at issue for each day that the violation occurred or occurs.

Failure to maintain or retain accurate and complete records, including destruction of relevant evidence (Admin. Code §§ 14.3(b) & 14.4(e); Regulation 7.2):	The party shall be ordered to produce the records and documents outlined in Regulation 7.2 and to cooperate with the OLSE in reconstructing the records it should have maintained.	The penalty assessed shall be $500.
Failure to satisfy the annual reporting requirement (Admin. Code §§ 14.3(b) & 14.4(e)):	The party shall be ordered to satisfy its annual reporting requirement.	The penalty assessed shall be $500.
Reduction of the number of employees in order to **(1)** avoid being considered a covered employer, or to **(2)** be subject to a lower health care expenditure rate (Admin. Code § 14.4(c); Regulation 7.5):	The party shall demonstrate that such reduction was not done for the purpose of evading the obligations of this Ordinance, but for a valid business reason, or shall be in violation of this Ordinance. If unable to do so, the party shall be ordered to make the required health care expenditure on behalf of each employee or person whose rights under this Ordinance was violated, and/or to reimburse the individual for any and all out-of-pocket medical expenses incurred by that individual for the period during which the employer was in violation of this Ordinance, up to the amount of the required health care expenditure. This payment shall be made retroactively, from the date the expenditure was due, and continuing until the case is resolved to the satisfaction of the OLSE.	The penalty assessed shall be $25 per day for each day that the violation occurred or occurs.
Retaliation, including harassment, and/or discrimination in violation of the Ordinance (Admin. Code § 14.4(d); Regulations 7.6-7.7):	The party shall be ordered to cease, or cause to cease, any and all retaliatory and/or discriminatory actions and, if applicable, to reinstate or otherwise compensate an employee whose rights under this Ordinance was violated.	The penalty assessed shall be $100 for each worker or person whose rights under this Ordinance was violated for each day that the violation occurred or occurs.

(B) Payment of the penalty shall not excuse the failure to correct the violation, nor shall it bar any further enforcement action by the OLSE.

(C) If penalties and/or costs are the subject of administrative appeal or judicial review, then the accrual of such penalties and/or costs shall be stayed until the determination of such appeal or review is final.

9.3 Payment of Penalties and Interest

(A) All administrative penalties shall be made payable to the City and County of San Francisco, be due within thirty (30) days from the date of the Determination of Violation, and be deposited in the City's General Fund when collected.

(B) All interest owing on unpaid health care expenditures shall be made payable to the employee on whose behalf the expenditures should have been made and be due within thirty (30) days from the date of the Determination of Violation.

9.4 Collection of Penalties; Civil Enforcement

(A) The failure of any employer to pay a penalty assessed by Determination of Violation within the time specified on the Determination of Violation constitutes a debt to the City.

(B) The City Attorney may bring a civil action or pursue any other legal remedy to recover civil penalties for the violations set forth in subsections 14.4 (e)(1&2) of this Ordinance in the same amounts set forth in those subsections, and to recover the City's enforcements costs, including attorneys' fees. Enforcement costs shall not count toward any maximum penalty amount set forth in these regulations.

(C) The City may create and impose liens against any property owned or operated by an employer who fails to pay a penalty assessed by the Determination of Violation. The procedures provided for in Article XX of Chapter 10 of the San Francisco Administrative Code shall govern the imposition and collection of such liens.

REGULATION 10: ADMINISTRATIVE APPEALS

10.1 Administrative Appeals

(A) Persons receiving a Determination of Violation may appeal it within fifteen (15) days from the date the document is served. The appeal must:

(1) be in writing and specify the basis for the appeal in detail,

(2) indicate a return address,

(3) be accompanied by the penalty amount,

(4) be filed with the Controller's Office, and

(5) be filed with a copy to the OLSE.

The failure of any person to file an appeal in accordance with the provisions of this Section shall constitute concession to the assessment, and the Determination of Violation shall be deemed final upon expiration of the 15-day period.

(B) Within fifteen (15) days of receiving a proper request for appeal, the Controller or his or her designee shall appoint a hearing officer (who shall not be employed in the Office of Labor Standards Enforcement) to hear and decide the administrative appeal and shall so advise the OLSE and the appellant.

(C) The hearing officer shall promptly set a date, time and place for a hearing on the appeal. Written notice of the time and place for the hearing may be served by first class mail.

(1) Service of the notice must be made at least ten (10) days prior to the date of the hearing to the appellant.

(2) The failure of any person to appear at the hearing shall constitute concession to the assessment,

(3) Except as otherwise provided by law, the failure to receive a properly addressed notice of the hearing shall not affect the validity of any proceedings under this Ordinance.

(D) The hearing must commence no later than thirty (30) days after service of notice of the hearing and conclude within seventy-five (75) days of such notification, unless that time is extended by mutual agreement of all parties.

(E) No later than five (5) days prior to the hearing, the appellant and the OLSE shall submit to the hearing officer, with simultaneous service on the opposing party, written information including, but not limited to, the following: the statement of issues to be determined by the hearing officer and a statement of the evidence to be offered and the witnesses to be presented at the hearing.

(F) The hearing officer appointed by the Controller or the Controller's designee shall conduct all appeal hearings under this Ordinance. The hearing officer may accept evidence on which persons would commonly rely in the conduct of their serious business affairs, including, but not limited to, the following:

(1) A valid Determination of Violation shall be prima facie evidence of the violation;

(2) The hearing officer may accept testimony relating to the violation and/or to the appropriate means of correcting the violation by declaration under penalty of perjury;

(3) The person responsible for the violation, or any other interested person, may present testimony or other evidence concerning the violation and the means and time frame for correction.

10.2 Burden of Proof

The appellant shall have the burden of proving that the basis for the Determination of Violation is incorrect.

10.3 Hearing

(A) Hearing Record. The hearing shall be open to the public and shall be tape-recorded. Any party to the hearing may, at his or her own expense, cause the hearing to be recorded and transcribed by a certified court reporter. The hearing officer may continue the hearing and request additional information from either party prior to issuing a written decision.

(B) Findings and Decision. The hearing officer shall make findings based on the record of the hearing and issue a written decision based on such findings within fifteen (15) days of conclusion of the hearing. The hearing officer's decision may:

(1) uphold the issuance of a Determination of Violation and penalties stated therein,

(2) dismiss a Determination of Violation, or

(3) uphold the issuance of the Determination of Violation but reduce, waive or conditionally reduce or waive the penalties stated in a Determination of Violation or any late fees assessed if mitigating circumstances are shown and the hearing of officer finds specific grounds for reduction or waiver in the evidence presented at the hearing.

The hearing officer may impose conditions and deadlines for the correction of violations or the payment of outstanding civil penalties.

(C) Finality of Hearing Officer's Decision. The decision of the hearing officer shall be final. If the hearing officer concludes that the violation(s) charged did not occur or that the person charged in the Determination of Violation was not the responsible party, the OLSE shall refund or cause to

be refunded the penalty amount to the party that deposited such amount. The hearing officer's decision shall be served on the appellant and the OLSE by certified mail.

(D) Writ of Mandate. The sole means of review of the hearing officer's decision shall be made by filing in the San Francisco Superior Court a petition for a writ of mandate under Section 1094.5 of the California Code of Civil Procedure.

PROOF OF SERVICE

I, DIANA QUAN, declare as follows:

I am a citizen of the United States, over the age of eighteen years and not a party to the above-entitled action. I am employed at the City Attorney's Office of San Francisco, City Hall, Room 234, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102.

On January 23, 2008, I served the following document(s):

JOINT OPENING BRIEF OF APPELLANTS

on the following persons at the locations specified:

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Attorneys for Plaintiff GGRA

BY HAND DELIVERY TO:
CLERK OF THE U.S. DISTRICT COURT
450 Golden Gate Avenue
San Francisco, CA 94102

in the manner indicated below:

☒ **BY UNITED STATES MAIL**: Following ordinary business practices, I sealed true and correct copies of the above documents in addressed envelope(s) and placed them at my workplace for collection and mailing with the United States Postal Service. I am readily familiar with the practices of the San Francisco City Attorney's Office for collecting and processing mail. In the ordinary course of business, the sealed envelope(s) that I placed for collection would be deposited, postage prepaid, with the United States Postal Service that same day.

☐ **BY PERSONAL SERVICE**: I sealed true and correct copies of the above documents in addressed envelope(s) and caused such envelope(s) to be delivered by hand at the above locations by a professional messenger service.

☐ **BY OVERNIGHT DELIVERY**: I sealed true and correct copies of the above documents in addressed envelope(s) and placed them at my workplace for collection and delivery by overnight courier service. I am readily familiar with the practices of the San Francisco City Attorney's Office for sending overnight deliveries. In the ordinary course of business, the sealed envelope(s) that I placed for collection would be collected by a courier the same day.

☐ **BY FACSIMILE**: Based on a written agreement of the parties to accept service by fax, I transmitted true and correct copies of the above document(s) via a facsimile machine at telephone number (415) 554-4747 to the persons and the fax numbers listed above. The fax transmission was reported as complete and without error.

☐ **BY ELECTRONIC MAIL**: I caused a copy of such document to be transmitted via electronic mail in Portable Document Format ("PDF") Adobe Acrobat from the electronic address: *diana.quan@sfgov.org*

I declare under penalty of perjury pursuant to the laws of the State of California that the foregoing is true and correct.

Executed January 23, 2008, at San Francisco, California.

DIANA QUAN