Nos. 07-17370, 07-17372

In the United States Court of Appeals
for the Ninth Circuit

GOLDEN GATE RESTAURANT ASSOCIATION,
Plaintiff-Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Defendant-Appellant,

and

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

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

Brief of The ERISA Industry Committee and The National Business Group on Health as *Amici Curiae* in Support of Appellee's Petition for Rehearing En Banc

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Fed. R. App. P. 26.1 Disclosure Statement

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

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

Dated: October 31, 2008

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STATEMENT OF INTEREST OF THE *AMICI CURIAE*

With the consent of all parties, in accordance with Federal Rule of Appellate Procedure 29(a) and Circuit Rule 29-2(a), The ERISA Industry Committee ("ERIC") and The National Business Group on Health ("NBGH") respectfully submit this brief as *amici curiae* in support of Appellee's Petition for Rehearing En Banc.

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

ERIC participates as *amicus curiae* in cases with the potential for far-reaching effects on employee benefit plan design or administration. The decision to file an *amicus* brief is made by ERIC's Legal Committee based on established criteria that limit ERIC's participation to significant cases in which the Legal Committee believes that ERIC will present views that will not be presented by the

parties or other potential *amici*. ERIC believes that this challenge to the San Francisco Health Care Security Ordinance (the "Ordinance") is such a case.[1]

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

DISCUSSION

I. The Panel Opinion Disregards the Strong Congressional Interest in Uniformity of Employee Benefit Plans Reflected by ERISA's Preemption Provision

In Section 514, ERISA contains one of the most expansive preemption provisions of any federal statute. Although the panel opinion refers to the creation of a uniform regulatory regime as one of the primary purposes of ERISA, slip op. at 13924-25, it fails to acknowledge the strength of Congress's intent to achieve that goal and also fails to give effect to that intent.

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

When enacting ERISA, Congress was not content to provide the basis for implicit preemption by occupying the regulatory field for employer-provided retirement and welfare plan benefits. Nor did Congress merely provide that any state regulation that was inconsistent with federal requirements would be preempted. Section 514(a) provides that ERISA preempts "any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan." 29 U.S.C. § 1144(a) (emphasis added).[2]

As Professor James Wooten accurately recognized, "preemption issues played a pivotal role in Congress's decision to pass ERISA." James A. Wooten, *A Legislative and Political History of ERISA Preemption, Part 2*, J. Pension Benefits, Spring 2007, at 5. Although protection of retirement plan assets was a primary concern, a coalition reflecting both employer and labor perspectives also sought the establishment of a uniform regulatory regime nationwide for both retirement and welfare benefit plans. *See id.* at 10.

Before ERISA was enacted, employee benefit plans were regulated by a patchwork of state statutes, local ordinances, and court-made rules. An employer that provided benefits to a multistate work force encountered severe administrative

[2] This broad preemption provision is subject only to limited exceptions, including an exception for laws regulating insurance, a traditional subject of state regulation. *See* 29 U.S.C. § 1144(b)(2)(A) (state laws regulating insurance, banking, or securities are not preempted).

difficulties and wasteful expense as it attempted to comply with rules that differed from state to state, and sometimes from city to city. It was difficult or even impossible for a large multi-jurisdiction employer to tailor its benefit programs to the needs of its workforce.

The bills passed by the House and Senate as precursors to ERISA included a preemption provision that was much narrower than the preemption provision that was ultimately included in Section 514(a) of ERISA. The precursor bills would have superseded state law only in areas specifically regulated by the federal statute.[3] In conference, however, the conferees recognized that such a system would be unworkable. Senator Javits, one of the chief architects of ERISA, explained that the narrow preemption provision "open[ed] the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme." He concluded that, "on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain [specified] exceptions—the displacement of State action in the field of private employee benefit programs." 120 Cong. Rec. 29942 (Aug. 22, 1974) (remarks of Sen. Javits).

[3] H.R. 2, 93d Cong., 2d Sess., § 514(a) (1974) (House bill); H.R. 2, 93d Cong., 2d Sess., § 699(a) (Senate bill).

The principal House sponsor of ERISA, Representative John Dent, was equally emphatic in describing the central importance of a broad preemption provision. Representative Dent stated:

> I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.

120 Cong. Rec. 29197 (Aug. 20, 1974) (remarks of Rep. Dent).

Senator Williams also emphasized the need to relieve employers of inconsistent state regulation:

> It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in the broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

120 Cong. Rec. 29933 (Aug. 22, 1974) (remarks of Sen. Williams).

The conferees understood that the broad preemption provision included in ERISA would prevent state and local governments from experimenting with employment-related health reform. In fact, one of the main reasons that the conferees expanded the preemption provision was to preclude such state-by-state

health reform efforts.[4] When the conferees debated ERISA, they knew that Hawaii already had enacted a health reform measure, and that California was considering similar legislation. The conferees feared that inconsistent state laws regulating health care would undermine employment-based health plans, and they recognized that the narrow preemption provision included in the precursor bills was not sufficient to protect plans from this threat.

Since its enactment with the expansive preemption provision in 1974, ERISA has provided a powerful incentive to employers to provide employee benefit plans, including health care plans, by allowing employers to sponsor voluntary plans, giving those employers considerable flexibility in deciding what benefits to offer and how to fund their plans, and by exempting employers from the patchwork quilt of state and local regulation that they otherwise would face. Broad ERISA preemption has allowed employers to become the largest source of health care coverage in the United States and to provide coverage to tens of millions of employees and their families.

The panel opinion largely disregards ERISA's preemption goals by emphasizing another objective: to protect against misuse of benefit plan funds.

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[4] Michael S. Gordon, minority counsel to Senator Javits during the consideration and passage of ERISA, described the history of ERISA's preemption provision in *Health Care Reform: Managed Competition and Beyond*, Employee Benefits Research Institute, Issue Brief No. 135 (March 1993).

See, *e.g.*, slip op. at 13928. That purpose, however, is neither inconsistent with nor of greater importance than Congress's intent to broadly preempt patchwork state regulation of employer-provided benefit plans, including health care and other welfare benefit plans.

The panel opinion circumvents congressional intent regarding preemption by relying, in part, on the assertion that ERISA was not intended to preempt either state regulation of heath care providers or governmental provision of health care services to persons with low or moderate incomes. *Id.* at 13925-26. In doing so, the opinion relies on a sleight-of-hand that leaps from state regulation or state delivery of health care *services* (permitted by ERISA) to state-imposed mandates that employers provide health care benefits (preempted by ERISA).

II. The Balkanization That Would be Encouraged by the Panel Opinion Would Be Detrimental to the Maintenance of Uniform Benefit Plans by Multi-Jurisdiction Employers

Large businesses are substantially more likely than smaller firms to offer health benefits to their employees. According to a 2007 survey by the U.S. Department of Labor, among firms employing at least one hundred workers, 93% of employers offered health care benefits. By contrast, only 59% of smaller firms, with less than one hundred employees, offered some form of health care coverage to their employees. *See* U.S. Dep't of Labor ("DoL"), Bureau of Labor Statistics,

National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2007, at 15 tbl.7.

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

Large firms also are more likely than small firms to sponsor self-insured health plans. William Pierron & Paul Fronstin, Employer Benefit Research Institute, *Issue Brief No. 314: ERISA Pre-emption: Implications for Health Reform and Coverage*, at 11 (2008). While only 55% of all employees are covered by self-insured plans, 89% of workers in firms with more than 5,000 employees are covered by self-insured plans. *Id.* The difference is significant because ERISA's preemption provision exempts self-insured plans from state regulation. As a result, employers that sponsor self-insured health plans can tailor their plans to address their employees' needs and avoid the cost of complying with the varied requirements of state insurance laws. *See* 29 U.S.C. § 1144(b)(2)(B); Pierron &

Fronstin, *supra*, at 11; *see also* Victoria Craig Bunce & JP Wieske, *Health Insurance Mandates in the States 2008* (Council for Affordable Health Ins., Alexandria, Va.), Jan. 2008 (listing health insurance mandates and estimating costs of compliance).

Giving employers the flexibility to choose the benefit plans they will establish and flexibility in the design of the plans that they do establish are fundamental features of ERISA. If health care coverage is legally mandated, some employers might lack the resources to provide the mandated coverage and might be required to terminate employees, reduce employee compensation or other benefits, or cease operations. At the same time, employers that offer health care coverage can use their health care plans to attract and retain employees.

For multi-jurisdictional employers, like the members of ERIC and NBGH, ERISA preemption is essential. Under ERISA, multi-jurisdictional employers can offer a single, coordinated package of employee health care benefits to all eligible employees, regardless of where they live or work. This permits plans to provide health care benefits at costs that are significantly lower than they would be under a regime requiring a multi-jurisdictional employer to meet the varying mandates of each state or locality in which one or more of its employees works. In addition, an employee who transfers or relocates to a workplace in a different jurisdiction can continue to participate in the same nationwide benefit plan and can retain the same

benefits that are important to him, particularly if the employee or a family member suffers from a disease or condition that is currently undergoing treatment. The retention of those benefits is also important in avoiding the confusion that, in the absence of a uniform plan, would inevitably arise as a result of a transfer.

The alternative to ERISA preemption is a patchwork regime that requires multi-jurisdictional employers to adapt their policies to the disparate mandates of every locality and state that regulates health care coverage. Moreover, employers would face the certainty of conflicting or disparate mandates and other conflicting requirements. *See PM Group Life Ins. Co. v. W. Growers Assurance Trust*, 953 F.2d 543, 547 (9th Cir. 1992) ("ERISA is designed to relieve employers from the difficulties of complying with diverse state laws"). Multi-jurisdictional employers would not be able to "round up" to whatever jurisdiction requires the *most* benefits. Indeed, "most benefits" is not likely to be meaningful since the benefits mandated by one jurisdiction might conflict with the benefits mandated by another, and some employees will assign values to certain benefits that differ from the values assigned to the same benefits by other employees, because of differences in their circumstances. Reporting and recordkeeping requirements would vary substantially among jurisdictions, and multi-jurisdictional employers would be functionally unable to offer a uniform array of benefits, much less administer them.

Furthermore, under the Ordinance's mandate for workers in San Francisco, employers must be able to *prove* to the City that they have met the minimum expenditure requirement on the basis of expenditures that the local rules define as legitimate health care expenditures. Nothing guarantees that other jurisdictions—*e.g.*, Oakland or Los Angeles or New York—would define eligible expenditures in the same way. As a result, employers would constantly need to monitor amendments to state and local laws to determine whether the benefits provided in one jurisdiction count toward the spending requirement of another. This problem is inevitable once state and local regulation of employee benefits is permitted. Large employers will have no choice but to establish separate accounting systems that are capable of responding to and keeping track of the wide variety in the substantive mandates of the jurisdictions that follow the City's approach.

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

that these various ordinances would create. Few, if any, employers would find that maintaining a health plan was worth the effort even if it were possible.

Such concerns are not speculative. Large businesses have already faced the threat of conflicting spending and recordkeeping requirements under health care laws enacted in Maryland and New York, which sought to impose spending and recordkeeping requirements markedly different from those imposed by the Ordinance. *See Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 184 (4th Cir. 2007) (Maryland legislature enacted statute requirement certain employers to spend 8% of total wages on "health insurance costs" and to make annual reports regarding numbers of employees, "health insurance costs," and the percentage of compensation spent on "health insurance costs"); *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403, 406-07 (E.D.N.Y. 2007) (county in New York enacted legislation requiring certain employers to make expenditures equivalent to the approximate cost to the public health care system of providing health care to each employee, as determined by an administrative agency). Even the small sample of laws described in published judicial decisions makes it evident that states and municipalities could take a wide variety of approaches and impose, in the aggregate, enormous recordkeeping burdens on employers.

As employers spend increasing amounts on such administrative expenses, the increased cost of care will be borne by employees in the form of higher

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

III. The Panel Opinion Is Not Consistent with the Fourth Circuit's Decision in *Fielder*

In 2007, a similar law was considered and held to be preempted by the United States Court of Appeals for the Fourth Circuit. In *Fielder*, the challenged Maryland law required certain large employers to spend 8% of their total payroll on employee health benefits or to pay the difference between the mandated amount and their actual expenditures to the state. 475 F.3d at 183. Any funds paid to the state could be used only to fund Maryland's health programs for children. *Id.* at 185. Although the Ordinance requires San Francisco to earmark the funds paid by an employer to provide health care to the employer's particular employees, the two laws take the same basic approach: they require the employer to choose either to spend a specified amount to provide health care directly to its employees or to pay the same amount to the state or local government.

The Fourth Circuit held that ERISA preempted the Maryland law because it left an affected employer with no rational choice other than to provide its

employees with health care and thereby required the employer to alter (or create) an ERISA plan. The employer who responds to a mandate by providing the required health care benefits to its workforce can hope to receive "improved retention and performance of present employees and the ability to attract more and better new employees." *Id.* at 193. Conversely, an employer that possessed the resources to provide mandated benefits but chose to pay the State instead would gain nothing and "might suffer from lower employee morale and increased public condemnation." *Id.* Consequently, "the only rational choice employers have is to structure their ERISA health care benefit plans so as to meet the minimum spending threshold." *Id.*

The San Francisco Ordinance puts employers in the same position. When economically feasible,[5] the employer's purported choice between paying for its own employees' health care coverage and paying an equivalent amount to the City is really no choice at all.[6] *See Suffolk County*, 497 F. Supp. 2d at 417 (evaluating a similar law enacted by Suffolk County, N.Y., and holding that "it is unreasonable

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

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

to expect employers to contribute to the community or directly to the state, rather than to their own employees"). By far the most—and perhaps only—rational decision for an employer that could shoulder the administrative burden would be to meet the Ordinance's spending mandate by establishing an ERISA plan.

CONCLUSION

Amici urge this Court to grant the Appellee's petition for rehearing en banc.

Dated: October 31, 2008

Respectfully submitted,

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Certificate of Service

I certify that on October 31, 2008, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

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

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

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Certificate of Compliance

I certify that pursuant to Circuit Rule 29-2(c)(2), the attached Brief of *Amici Curiae* in Support of Appellee's Petition for Rehearing En Banc has a typeface of 14 point Times New Roman font and, according to the "Word Count" feature in my Microsoft Office® Word 2003 software, contains 3,388 words up to and including the signature lines that follow the brief's conclusion but excluding the cover and tables of contents and authorities.

I declare under penalty of perjury that this Certificate of Compliance is true and correct and that this declaration was executed on October 31, 2008.

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