No. 20-35472

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

THE ERISA INDUSTRY COMMITTEE,

Plaintiff/Appellant,

v.

CITY OF SEATTLE,

Defendant/Appellee.

On Appeal from the United States District Court
for the Western District of Washington
No. 2:18-cv-01188-TSZ
The Honorable Thomas S. Zilly

BRIEF OF AMICI CURIAE CITY AND COUNTY OF SAN FRANCISCO, CA; CITY OF AUSTIN, TX; CITY OF CHICAGO, IL; COOK COUNTY, IL; CITY OF LOS ANGELES, CA; CITY OF OAKLAND, CA; CITY OF SACRAMENTO, CA; CITY OF SAINT PAUL, MN; AND WASHINGTON STATE ASSOCIATION OF MUNICIPAL ATTORNEYS IN SUPPORT OF DEFENDANT/APPELLEE CITY OF SEATTLE, AND IN SUPPORT OF AFFIRMANCE

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INTERESTS OF AMICI[1]

Amici are cities and counties committed to ensuring that all of their residents have access to affordable and comprehensive healthcare coverage. *Amicus* City and County of San Francisco ("San Francisco") paved the way for Seattle Municipal Code 14.28 ("SMC 14.28") with San Francisco's Healthcare Security Ordinance ("HCSO"), passed in 2006. In 2008, this Court upheld San Francisco's HCSO against a preemption challenge in *Golden Gate Restaurant Association v. City and County of San Francisco*, 546 F.3d 639 (9th Cir. 2008), *cert. denied*, 561 U.S. 1024 (2010), and the Supreme Court denied certiorari.

Appellant ERISA Industry Committee ("ERIC") seeks to narrow or overturn *Golden Gate*, which remains good law. *Amici* seek to explain why this Court should not abandon that decision. Like the HCSO at issue in *Golden Gate*, SMC 14.28 is intended to improve local health outcomes—a core interest of the "police powers" reserved to states and municipalities. Because this historic reserve of powers belongs to the states under the Tenth Amendment, and such ordinances play an integral role in the well-being of a locality's residents and the management

[1] All parties have consented to this filing. No party's counsel authored the brief in whole or in part, no party or party's counsel contributed money intended to fund preparing or submitting the brief, and no person other than *amici* or their counsel contributed money intended to fund preparing or submitting the brief.

of the healthcare costs these localities bear, the Court should reject ERIC's challenge to *Golden Gate* and affirm the judgment below.

INTRODUCTION AND SUMMARY OF ARGUMENT

ERIC cannot distinguish this case from this Court's controlling precedent in *Golden Gate Restaurant Association v. City and County of San Francisco*, 546 F.3d 639 (9th Cir. 2008). Under *Golden Gate*, ERISA does not preempt Seattle's ordinance. *Amici* submit this brief to emphasize why this Court should decline ERIC's invitation to overrule or limit that important decision.

Golden Gate remains good law in this Circuit, and neither the Supreme Court nor any decisions from this Circuit have cast doubt on its precedential value. *Golden Gate* and the presumption against preemption are vital to preserving state and local autonomy. Its approval of local healthcare ordinances serves important state and local interests, including providing access to and reducing the cost of healthcare in *amici*'s jurisdictions. *Amici* respectfully urge this Court to reject ERIC's invitation to depart from settled precedent, and to uphold Seattle's healthcare ordinance under *Golden Gate*.

I. *Golden Gate* And The Presumption Against Preemption Remain Good Law.

ERIC claims that *Golden Gate* is no longer good law, offering two arguments. First, ERIC argues that the Supreme Court has effectively overturned the presumption against preemption. In the alternative, ERIC argues that *Golden*

Gate is inconsistent with subsequent Supreme Court decisions and thus has been effectively abrogated. Both are wrong.

A. The Supreme Court Continues To Recognize A Presumption Against Preemption In ERISA Cases.

ERIC argues that there is no longer a presumption against preemption. Appellant's Opening Brief ("AOB") at 20–25. But the trio of cases establishing that state and local laws enjoy "a presumption against preemption when they 'clearly operate[ ] in a field that has been traditionally occupied by the states'" remains good law. *Golden Gate*, 546 F.3d at 647 (quoting *De Buono v. NYSA–ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997)); *see also N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995); *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A.*, 519 U.S. 316, 324 (1997). As the Supreme Court has instructed, federal appellate courts must continue to follow any Supreme Court decisions that "directly control[ ]" until such decisions are overruled, and those courts should not parse the case law to assess whether that precedent has been "rejected in some other line of decisions." *Rodriguez de Quijas v. Shearson/Am. Express, Inc.*, 490 U.S. 477, 484 (1989).

ERIC argues that the presumption against preemption, long the law under *Travelers*, *DeBuono*, and *Dillingham*, has effectively been overturned by *Gobeille v. Liberty Mutual Insurance Company*, 136 S. Ct. 936 (2016), and *P.R. v. Franklin California Tax-Free Trust*, 136 S. Ct. 1938, 1946 (2016). But neither of these

decisions overruled *Travelers*, *DeBuono*, or *Dillingham*; neither directly controls here; and neither undermines the reasoning of *Travelers* and its progeny.

Gobeille did not undermine *Travelers* and has no bearing here. *Gobeille* considered a Vermont law requiring disclosure of payments regarding healthcare claims and related information. 136 S. Ct. at 940. The requirements of the Vermont law were extensive. For example, it required "health insurers, health care providers, health care facilities, and governmental agencies" to provide the state with a wide range of "'information relating to health care costs, prices, quality, utilization, or resources required' by the state agency, including data relating to health insurance claims and enrollment." *Id.* at 941. The Supreme Court held that ERISA preempted the Vermont statute because the statute imposed duties inconsistent with ERISA requirements relating to reporting, disclosure, and recordkeeping. *Id.* at 947. But far from overturning *Travelers*, the Supreme Court cited *Travelers* and *Dillingham* approvingly throughout its opinion. *See, e.g.*, *id.* at 943–45. The Court emphasized that it "has noted often" that reporting, disclosure, and recordkeeping requirements, like those central to the Vermont statute in *Gobeille*, are "integral aspects of ERISA." 136 S. Ct. at 945 (collecting cases, including *Dillingham* and *Travelers*). While the Court found that the Vermont statute "cannot be saved by invoking the State's traditional power to regulate in the area of public health" because it had entered such a "fundamental area of ERISA

regulation," the Court did not overrule or limit the presumption established by *Travelers* and its progeny. *Gobeille*, 136 S. Ct. at 946.

Like *Gobeille*, *Franklin* is consistent with *Travelers* and does not undermine the district court's judgment. In considering whether Puerto Rico is a "State" for purposes of the Bankruptcy Code, the Supreme Court in *Franklin* reasoned that the analysis "begins and ends" with the text of the statute because "the statute's language is plain." *Franklin*, 136 S. Ct. at 1946 (quoting *U.S. v. Ron Pair Enters., Inc.*, 489 U.S. 235, 241 (1989)). But ERIC ignores that aspect of the Court's holding, and instead emphasizes (and misconstrues) the sentence that follows: "And because the statute 'contains an express pre-emption clause,' we do not invoke any presumption against pre-emption but instead 'focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' pre-emptive intent.'" *Id*. (citations omitted). This language is arguably dicta since the Court's holding rested primarily on the statutory text. *Franklin*, 136 S. Ct. at 1946. And even if this portion of the Court's decision is in tension with *Travelers* and its progeny (which it is not[2]), *Franklin* is distinguishable because it addressed preemption under the Bankruptcy Code, not ERISA. Any application of *Franklin*

[2] For similar reasons, *Golden Gate*, which relied upon *Travelers* and its progeny, is not "clearly irreconcilable with the reasoning or theory" of *Franklin*. *See*, *infra*, Section I.B.1.

to *Travelers* and its progeny is thus tenuous at best. Therefore, this Court should "follow the case which directly controls," i.e., *Travelers*, "leaving to [the Supreme] Court the prerogative of overruling its own decisions." *Shearson/Am. Express*, 490 U.S. at 484.

B. *Golden Gate* Remains Good Law In the Ninth Circuit.

ERIC argues in the alternative that this Court should find that *Franklin* overturned *Golden Gate* by implication. AOB at 23. Contrary to ERIC's argument, the two decisions do not conflict. But even if ERIC were correct that *Franklin* and *Golden Gate* are in tension, *Golden Gate* is still controlling under this Court's mandate to preserve the consistency of circuit law.

1. *Golden Gate* is, at a minimum, not "clearly irreconcilable" with *Franklin*.

As an intermediate appellate court, "[a] goal of [the] circuit's decisions, including panel and en banc decisions, must be to preserve the consistency of circuit law." *Miller v. Gamie*, 335 F.3d 889, 900 (9th Cir. 2003). A three-judge panel may depart from controlling circuit authority only when that precedent is "clearly irreconcilable with the reasoning or theory of intervening higher authority." *Id.* at 893. A subsequent panel's mere disagreement with a prior Ninth Circuit decision does not satisfy this "high standard." *Aleman Gonzalez v. Barr*, 955 F.3d 762, 775 (9th Cir. 2020). Rather, this Court has admonished that "if we can apply our precedent consistently with that of the higher authority, we must do

so." *FTC v. Consumer Def., LLC*, 926 F.3d 1208, 1213 (9th Cir. 2019). "'[I]t is not enough for there to be some tension between the intervening higher authority and prior circuit precedent.'" *Id.* (quoting *Lair v. Bullock*, 697 F.3d 1200, 1207 (9th Cir. 2012)). *Golden Gate* remains good law because the decision falls far short of being "clearly irreconcilable with the reasoning or theory" of *Franklin*. *Bullock*, 697 F.3d at 1206.

Even assuming *Franklin* overturned the presumption against preemption, *Franklin* is not inconsistent with *Golden Gate*. Although the *Golden Gate* panel's analysis began with the presumption against preemption, it did not end there. The Court proceeded to carefully consider arguments that the HCSO created an ERISA plan under two theories: (1) that the "administrative obligations on employers, in combination with a reasonable person's ability to ascertain 'benefits, beneficiaries, source of financing, and procedures for receiving benefits,'" creates an ERISA plan, and (2) that the Health Access Program ("HAP") created by the HCSO was itself an ERISA plan. 546 F.3d at 648. *Golden Gate* further analyzed whether the requirement under San Francisco's HCSO that employers make payments at a certain level "relates to" the ERISA plans of covered employers. *Id.* *Golden Gate* emphasized that "[a]ny employer covered by the Ordinance may fully discharge its expenditure obligations by making the required level of employee health care

expenditures, whether those expenditures are made in whole or in part to an ERISA plan, or in whole or in part to the City." *Id.* at 655–56.

Franklin is not inconsistent with this Court's detailed analysis in *Golden Gate*. As noted earlier, *Franklin* construed the preemption clause in the Bankruptcy Code, not ERISA's more nebulous preemption clause. Furthermore, *Franklin* did not hold that the Court should abruptly change course and accept the "uncritical literalism" of the ERISA preemption clause it earlier rejected in *Travelers*. *Travelers*, 541 U.S. at 656. Instead, *Franklin* simply reasoned that, when the plain wording of the statute is clear, there is no need to apply the presumption. *Franklin*, 136 S. Ct. at 1946. This analysis does not conflict with the holding of *Golden Gate*, nor does it conflict with the presumption against preemption in ERISA cases because the Supreme Court has repeatedly acknowledged that ERISA's preemption clause is "unhelpful." *Travelers*, 514 U.S. at 656.

Contrary to ERIC's argument, AOB at 23, this Court has not previously held that *Franklin* eliminates the presumption against preemption in ERISA cases. ERIC points to a non-ERISA case, *Atay v. County of Maui*, 842 F.3d 688, 699 (9th Cir. 2016), in support of its argument. AOB at 23. But *Atay* is inapposite. *Atay* analyzed the express preemption clause in another federal statute (this time, the Plant Protection Act) according to the uncontroversial rule that the presumption

against preemption typically plays no role in interpreting a statute with a clear preemption clause. *Atay*, 842 F.3d at 701 (noting that Congress established three conditions in the Plant Protection Act for a local law to be preempted). *Atay*, like *Franklin*, does not come close to upending well-established Supreme Court and Ninth Circuit law concerning ERISA preemption.

Moreover, just last year, the Ninth Circuit re-affirmed that there is a "'starting presumption that Congress d[id] not intend to supplant . . . state laws regulating a subject of traditional state power' unless that power amounts to 'a direct regulation of a fundamental ERISA function.'" *Depot, Inc. v. Caring for Montanans, Inc.*, 915 F.3d 643, 666 (9th Cir. 2019) (quoting *Gobeille*, 136 S. Ct. at 946), *cert. denied*, 140 S. Ct. 223 (2019). Indeed, the petitioner in *Depot* unsuccessfully sought review from the Supreme Court on precisely the theory ERIC adopts here. *See* Petition for Writ of Certiorari, *Caring for Montanans, Inc. v. The Depot, Inc.*, 2019 WL 3216034 (U.S.), *31. Just this year, in the context of construing the preemption clause of the Federal Aviation Administration Authorization Act, the Ninth Circuit again acknowledged the presumption against preemption, "particularly in areas of traditional state regulation." *Miller v. C.H. Robinson Worldwide, Inc.*, 976 F.3d 1016, 1021 (9th Cir. 2020) (citation omitted).

2. Contrary to ERIC's Claim, Other Circuit Courts Have Not "Begun To Reject A Presumption Against Preemption."

In the alternative, ERIC argues that "[a]fter *Franklin*, courts have begun to reject a presumption against preemption when applying ERISA's express preemption provision, determining *Travelers* to have been overtaken on the point." AOB at 23 (citing *Dialysis Newco, Inc. v. Cmty. Health Sys. Grp. Health Plan*, 938 F.3d 246, 259 (5th Cir. 2019)). What other circuits have done does not matter in a case like this, where there is directly applicable Circuit precedent. *See* Section I.B.1, *supra*. And regardless, ERIC's argument fails for two further reasons: there is no "trend" among the circuits, and the Fifth Circuit's reasoning in *Dialysis Newco* is not persuasive.

First, ERIC's argument ignores *Golden Gate,* which remains controlling Ninth Circuit precedent. This Court only looks to other circuits for persuasive authority when no clear in-circuit precedent exists. *See, e.g.*, *Bird v. Glacier Elec. Coop., Inc.*, 255 F.3d 1136, 1145 (9th Cir. 2001) ("Because our precedent is inconclusive, we consider how other federal circuit courts have addressed [the issue].")

Second, contrary to ERIC's suggestion, other circuits are not united regarding the significance of *Franklin*. The Third Circuit has summarily rejected the contention that *Franklin* resulted in any change to the presumption against preemption. *Shuker v. Smith & Nephew, PLC*, 885 F.3d 760, 771 n.9 (3d Cir.

2018) (noting that "[a]s that case does not 'directly control[ ]' here, we 'leav[e] to [the Supreme Court] the prerogative of overruling its own decisions'") (citing *Agostini v. Felton*, 521 U.S. 203, 237 (1997)). The Third Circuit in *Shuker* addressed the presumption against preemption with respect to the Medical Device Amendment. The court distinguished *Franklin*, explaining that the law at issue *Franklin* did not invoke "historic . . . state regulation of matters of health and safety." *Shuker*, 885 F.3d at 771 n.9 (quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996)). Like *Shuker*, and unlike *Franklin*, this case involves the traditional police powers reserved to the states by the Tenth Amendment. *See* Section II.B, *infra*.

Third, the reasoning in *Dialysis Newco* is not persuasive. The Fifth Circuit uncritically observed that, like the bankruptcy provision analyzed in *Franklin*, ERISA "similarly contains an express preemption clause." *Dialysis Newco*, 938 F.3d at 258. This incorrectly assumes that all express preemption clauses are created equal. *Id.* *Travelers* and its progeny allow for the possibility that "the clear and manifest purpose of Congress" regarding the scope of preemption might be evident from the face of the statute, as the Supreme Court found in *Franklin*. *Id*. But *Travelers* and its progeny also recognized that Congress' intended scope of preemption for ERISA was not clear on the face of the statute. *Travelers*, 514 U.S. at 656. ("We simply must go beyond the unhelpful text and the frustrating

difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.")

II. The Presumption Against Preemption Protects Important State And Local Interests.

Courts (including this one) have consistently applied the presumption against preemption, including in ERISA cases—and for good reason. The presumption is critical to our very form of government and enables state and local governments to exercise the full scope of their police powers. These powers are essential to states' and municipalities' ability to protect the health and safety of their residents. ERIC's cavalier—and unfounded—assertion that this Court should discard the presumption against preemption is blind to critical features of our constitutional system and threatens to undermine state and local governments' police power. Here, contrary to ERIC's contention, the presumption applies because Seattle's ordinance is an unambiguous exercise of police power—an area traditionally reserved to state and local governments—and none of the reasons typically supporting the need for preemption are present.

A. The Presumption Against Preemption Is Grounded In Longstanding Assumptions About The Importance Of State Sovereignty.

"States are independent sovereigns in our federal system . . . ." *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996). They "occupy a special and specific position" in our constitutional order, *Garcia v. San Antonio Metro. Transit Auth.*,

469 U.S. 528, 556 (1985), and "[t]he Framers concluded that allocation of powers between the National Government and the States enhances freedom" and "protects the liberty of all persons within a State by ensuring that laws enacted in excess of delegated governmental power cannot direct or control their actions," *Bond v. U.S.*, 564 U.S. 211, 211–22 (2011). This balance is meant to "reduce the risk of tyranny and abuse from either front . . . ." *Gregory v. Ashcroft*, 501 U.S. 452, 458 (1991).

Under this system, "the States possess sovereignty concurrent with that of the Federal Government, subject only to limitations imposed by the Supremacy Clause" of the United States Constitution. *Tafflin v. Levitt*, 493 U.S. 455, 458 (1990). The Supremacy Clause gives the federal government "a decided advantage in [a] delicate balance" between the federal and state sovereigns. *Gregory*, 501 U.S. at 460. "As long as it is acting within the powers granted it under the Constitution, Congress may impose its will on the States." *Id.* Nonetheless, the states retain substantial sovereign authority under the Tenth Amendment. U.S. Const. amend. X.

For these reasons, the Supreme Court "ha[s] long presumed that Congress does not cavalierly pre-empt" state laws.[3] *Medtronic*, 518 U.S. at 485. Of course,

[3] These preemption principles apply equally to state or local laws. *See Golden Gate*, 546 F.3d at 647 ("[S]tate and local laws enjoy a presumption against preemption when they 'clearly operate[ ] in a field that has been traditionally

federal laws may preempt state laws under the Supremacy Clause. But the presumption against preemption recognizes that the aggressive displacement of state and local laws would result in a "serious intrusion into state sovereignty." *Id.* at 488. Accordingly, preemption analysis routinely begins with the presumption that "Congress does not intend to supplant state law." *Travelers*, 514 U.S. at 654–55 (citing *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981)).

B. States' Historic Police Powers Include Ensuring Health and Safety of Their Residents, as Seattle's Ordinance Does.

The presumption against preemption also preserves states' "historic primacy of state regulation of matters of health and safety" pursuant to their police power. *Medtronic*, 518 U.S. at 485. Seattle's law is emblematic of the type of law local governments enact in furtherance of these police powers.

"[T]he regulation of health and safety matters is primarily, and historically, a matter of local concern." *Hillsborough Cty., Fla. v. Automated Med. Labs.*, 471 U.S. 707, 719 (1985). Local governments' prerogatives for ensuring the "health, safety, and welfare of [their] citizens" stem from powers reserved to them under the Tenth Amendment of the United States Constitution. *Erotic Serv. Provider Legal Educ. & Research Project v. Gascon*, 880 F.3d 450, 460 (9th Cir. 2018), *amended*, 881 F.3d 792 (9th Cir. 2018); *see also Paher v. Cegavske*, 457

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occupied by the States'" (citation omitted)). This brief refers to state laws and local laws interchangeably.

F. Supp. 3d 919, 929 (D. Nev. 2020) ("[T]he states' police powers over matters of public health and safety and to act over the general welfare of their inhabitants is entrenched in the rights reserved to the state under the Tenth Amendment to the United States Constitution."). Where, as here, a state or local government acts "in fields of traditional state regulation," the presumption against preemption is "particularly strong." *Gerosa v. Savasta & Co.*, 329 F.3d 317, 323 (2d Cir. 2003) (quoting *Travelers*, 514 U.S. at 654–55), and applies with "particular force," *Altria Grp., Inc. v. Good*, 555 U.S. 70, 77 (2008).

Courts have refused to find state and local laws preempted "in areas of traditional state regulation" beyond the ERISA context as well. *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 151 (2001). These include health- and safety-related subjects as varied as: Medicaid reimbursement procedures, *see, e.g.*, *Gallardo by & through Vassallo v. Dudek*, 963 F.3d 1167, 1182 (11th Cir. 2020); providing a right of action for defective product labeling on herbicide, *see, e.g.*, *Bates v. Dow Agrosciences LLC*, 544 U.S. 431 (2005); food safety, *see, e.g.*, *Sciortino v. Pepsico, Inc.*, 108 F. Supp. 3d 780, 805 (N.D. Cal. 2015); and nutritional labeling requirements, *see, e.g.*, *N.Y. State Rest. Ass'n v. N.Y. City Bd. of Health*, 556 F.3d 114 (2d Cir. 2009).

This Court has recognized that "ERISA pre-emption must have limits when it enters areas traditionally left to state regulation—such as the

state's . . . regulation of health . . . matters." *Operating Eng'rs Health & Welfare Trust Fund v. JWJ Contracting Co.*, 135 F.3d 671, 677 (9th Cir. 1998). Indeed, "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661. The presumption against preemption thus preserves "traditional state regulation[s]" that are "quite remote from the areas with which ERISA is expressly concerned—'reporting, disclosure, fiduciary responsibility, and the like.'" *Dillingham*, 519 U.S. at 330 (quoting *Travelers*, 514 U.S. at 661).

As Seattle amply demonstrates in its brief, the Seattle Ordinance promotes the city's interest in the health and safety of certain employees in its jurisdiction. *See* Appellee's Br. at 16, 25. It improves those employees' access to affordable, high quality healthcare. *Id.* at 5. Like San Francisco's HCSO, Seattle's Ordinance "uses a novel approach to the provision of health services to such persons, but operates in a field that has long been the province of state and local governments, thereby 'implement[ing] policies and values lying within the traditional domain of the States.'" *Golden Gate*, 546 F.3d at 648 (quoting *Boggs v. Boggs*, 520 U.S. 833, 840 (1997)). The presumption against preemption thus applies with "particular force" here. *Altria Grp.*, 555 U.S. at 77.

C. The Policy Behind ERISA Preemption Does Not Conflict With The Presumption Against Preemption And Does Not Support Reversal.

A natural corollary of the presumption against preemption is the "presumption that state and local regulation related to matters of health and safety can normally coexist with federal regulations." *Hillsborough Cty.*, 471 U.S. at 718. Thus, the party raising preemption bears the "*considerable burden* of overcoming 'the starting presumption that Congress does not intend to supplant state law.'" *De Buono*, 520 U.S. at 814 (quoting *Travelers*, 514 U.S. at 654) (emphasis added). ERIC has failed to do so here.

"The purpose of ERISA's preemption provision is to 'ensure [ ] that the administrative practices of a benefit plan will be governed by only a single set of regulations.'" *Golden Gate*, 546 F.3d at 655 (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987) (alteration in original). By including a preemption provision in ERISA, Congress intended

> to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

Ingersoll–Rand Co. v. McClendon, 498 U.S. 133, 142 (1990). "The basic thrust of the pre-emption clause, then, was to avoid a multiplicity of regulation in order to

permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657.

Healthcare regulations like Seattle's ordinance do not implicate these concerns. Seattle's ordinance requires employers to make certain payments for employee healthcare. Appellee's Br. at 5. But, as Seattle explains more fully, it leaves employers significant discretion to decide how to make the required payments. *Id.* at 6. Because it permits, but does not require, payments to be made to ERISA plans, *id.*, and permits, but does not require, employers to comply by making payments to non-ERISA covered entities, *id.* at 46, the ordinance stands on its own without regard to *any* ERISA plan. The ordinance does not require employers to establish or modify an ERISA plan, and nothing about the ordinance implicates the nature of the benefits provided to employees. *Id.* at 8. There is therefore no risk that covered employers would be subject to more than "a single set of regulations." *Golden Gate*, 546 F.3d at 655. The policy behind ERISA's preemption provision is not implicated.

Upholding Seattle's ordinance is consistent with the policy underlying the presumption against preemption. Applying the presumption here strengthens the balance between the federal government's interest in ensuring national uniformity in plan administration while safeguarding the right of state and local governments to promote the general welfare of their residents. As this Court has recognized, the

Supreme Court "has warned not 'to read [ERISA's] pre-emption provision' in such a way as to 'effectively read the limiting language [ ] out of the statute, a conclusion that would violate basic principles of statutory interpretation . . . .'" *Operating Eng'rs*, 135 F.3d at 677 (quoting *Travelers*, 514 U.S. at 661). And there is no need to do so here as ERIC has not carried its "considerable burden" of showing that Congress intended to displace the historic authority of local governments in cases like this one. *De Buono*, 520 U.S. at 814.

III. Local Healthcare Ordinances Like SMC 14.28 Continue To Play An Important Role In Ensuring Access To Healthcare And Health Insurance.

Finally, local healthcare ordinances, like Seattle's, are a critical tool in executing a core local government function: promoting and protecting public health by expanding access to health insurance. This function is within the very core of the traditional domain of *amici*'s police powers. SMC 14.28, like similar programs in localities across the country, ensures that low-income workers receive healthcare, especially those who may be excluded from the Affordable Care Act ("ACA") and other federal and state healthcare laws. ERIC's interpretation of ERISA would eliminate essential care for these communities.

A. Local Healthcare Ordinances Ensure Healthcare for Underserved Populations.

Over 25 million nonelderly adults worked in low-wage jobs in 2018, and 20 percent of these individuals—five million workers in total—lacked health coverage

entirely.[4] Over 50 percent of these workers belonged to a family with a total income below 200 percent of the poverty line ($26,200 for a family of four, in 2020).[5] Accordingly, many low-wage workers—even those who have health coverage—report that they struggle to afford needed healthcare. In 2018, for example, more than one in 10 (12 percent) said that they could not afford needed healthcare within the past year, while 10 percent reported that they forewent that needed care due to affordability concerns.[6] Relatedly, nearly one in five low-wage workers reports that someone in their family struggled to pay medical bills in the past year.[7]

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[4] Rachel Garfield, *et al.*, *Double Jeopardy: Low Wage Workers at Risk for Health and Financial Implications of COVID-19*, KAISER FAM. FOUNDATION (Apr. 29, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/double-jeopardy-low-wage-workers-at-risk-for-health-and-financial-implications-of-covid-19/. The estimated number of low-wage workers in the U.S. varies based upon how it is calculated. *See, e.g.*, Martha Ross & Nicole Bateman, *Meet the Low-Wage Workforce*, 5–8, METROPOLITAN POLICY PROGRAM AT BROOKINGS (Nov. 2019), https://www.brookings.edu/wp-content/uploads/2019/11/201911_Brookings-Metro_low-wage-workforce_Ross-Bateman.pdf (explaining methodology that led to calculation of 53 million low-wage workers in the United States); Marc Doussard, *Chicago's Growing Low-Wage Workforce*, 3, WOMEN EMPLOYED AND ACTION NOW INSTITUTE (2012), https://womenemployed.org/wp-content/uploads/2019/05/Chicagos-Growing-Low-Wage-Workforce-FINAL-1.pdf (using the "Illinois self-sufficiency standard" to define "low-wage work").

[5] Garfield, *supra* note 4; *see also Ross*, *supra* note 4 at 9 ("Indeed, 30% of low-wage workers live below 150% of the federal poverty line (about $36,000 for a family of four), compared to only 3% of mid/high-wage workers.").

[6] Garfield, *supra* note 4.

[7] *Id.*

Largely as a result of the local ordinance upheld in *Golden Gate*, San Francisco is able to provide care through Healthy San Francisco ("HSF") for San Francisco employees who would otherwise be unable to obtain healthcare. Even after the passage of the ACA, HSF remains a major source of care for low-income and underserved San Francisco workers.[8] Undocumented immigrants rely on HSF for access to affordable healthcare because ACA is unavailable to them.[9] However, in addition to undocumented immigrants, "[m]any lawfully present immigrants who are eligible for [healthcare] coverage [under the ACA and federal programs] remain uninsured because immigrant families face a range of enrollment barriers, including fear, confusion about eligibility policies, difficulty navigating the enrollment process, and language and literacy challenges."[10] HSF also covers

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[8] Lisa Aliferis, *How 'Healthy San Francisco' Matters, Doesn't – in Obamacare,"* KQED (October 7, 2013), https://www.kqed.org/stateofhealth/15529/how-healthy-san-francisco-matters-and-doesnt-in-obamacare#:~:text=On%20Jan.,on%20the%20Covered%20California%20marketplace.&text=Individuals%20earning%20from%20%2415%2C500%20to,for%20subsidies%20under%20Covered%20California.

[9] *Id.* Limited scope Medi-Cal coverage is available to some low-income undocumented immigrants, but those immigrants may still enroll in HSF. Denisse Rojas & Miranda Dietz, *Providing Healthcare to Undocumented Residents: Program details and lessons learned from three California County health programs*, University of Berkeley Labor Center, October 4, 2016, at 5.

[10] *Health Coverage of Immigrants*, KAISER FAM. FOUNDATION (Mar. 18, 2020), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/.

individuals in San Francisco with incomes too high to qualify for Medi-Cal but too low to afford premiums under Covered California.[11] Altogether, HSF continues to provide healthcare to approximately 14,000 San Francisco workers.[12] Additionally, HSF plays an important role in helping San Francisco to accommodate its diverse population with tailored offerings and services, like providing information in a variety of languages.[13]

The City of Oakland's Hotel Minimum Wage and Working Conditions Ordinance contains a spending requirement nearly identical to the spending requirements in SMC 14.28 and San Francisco's HCSO. Oakland Municipal Code Chapter 5.93.[14] Oakland's ordinance faced a legal challenge by a hotel industry group on grounds similar to ERIC's arguments here. Holding that Oakland's ordinance requiring compensation that may be directed toward health care is not

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[11] Angela Hart, *Could San Francisco's universal health care model work for all of California?*, SAC. BEE (Mar, 16, 2017), https://www.sacbee.com/news/politics-government/capitol-alert/article138777138.html.

[12] Glenn Daigon, *Cities are Blazing the Trail Toward Healthcare For All*, Salon, (February 10, 2019) https://www.salon.com/2019/02/10/cities-are-blazing-the-trail-toward-healthcare-for-all_partner/.

[13] *See, e.g.*, *Tagalog: Welcome to Health San Francisco*, S.F. DEP'T OF PUB. HEALTH (accessed Nov. 3, 2020), http://healthysanfrancisco.org/wp-content/uploads/HSF_Program_Flyer_TAG.pdf.

[14] OMC 5.93, https://library.municode.com/ca/oakland/codes/code_of_ordinances?nodeId=TIT5BUTAPERE_CH5.93HOMIWAWOCO (last visited November 1, 2020).

preempted by ERISA, the court noted it is "well settled that wages are a subject of traditional state concern." *See Cal. Hotels & Lodging Ass'n v. City of Oakland*, 393 F. Supp. 3d 817, 831 (N.D. Cal. 2019) (quoting *WSB Elec., Inc. v. Curry*, 88 F.3d 788, 791 (9th Cir. 1996)). When Oakland's ordinance was enacted, it was estimated that approximately 1,747 workers would fall within the definition of a covered employee.[15] Extrapolating the amount of additional covered workers affected by this single local ordinance in Oakland to similar ordinances nationwide reveals the potential for enormous benefits.

Cook County, Illinois, operates Cook County Health ("CCH")—one of the nation's largest public hospital systems serving the residents of the second-most populous U.S. county. 45.2 percent of its patients are uninsured, while only 4.4 percent of its patients are commercially insured.[16] To reduce its rate of uncompensated care, CCH operates CountyCare—the largest Medicaid managed

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[15] Annette Bernhardt & Gabriel Sanchez, *Employment Estimates for Hotel Workers in Oakland, CA, 2016*, UC BERKELEY LABOR CENTER (Apr. 9, 2018), https://laborcenter.berkeley.edu/employment-estimates-hotel-workers-oakland-ca-2016/ (estimating the total number of maids or housekeeping cleaners in the Traveler Accommodation Industry within Oakland).

[16] *Cook County Health: Strategic Planning FY2020-2022* at 14 (Mar. 29, 2019), https://cookcountyhealth.org/wp-content/uploads/Item-IXA-SP-discussion-Clinical-Utilization-03-29-19-1.pdf. 35.4 percent of CCH patients were covered by Medicaid, and 15.9 percent were covered by Medicare. *Id*. These numbers are based upon fiscal year 2018.

care plan serving Medicaid beneficiaries living in Cook County.[17] And while CountyCare has allowed CCH to reduce its rate of uncompensated care, like many locally-run health systems, CCH's two hospitals still contribute nearly 55 percent of the total charity care provided by all 68 hospitals in the county—in total, approximately $348 million annually for uninsured and underinsured patients.[18]

If localities could not adopt local laws to promote healthcare access without running afoul of ERISA, these vulnerable communities would immediately lose their vital care. And the consequences would be dire. People without health insurance suffer demonstrably worse health outcomes[19]: they are more likely to

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[17] *Cook County Health: Impact 2023 Strategic Plan 2020-2022* at 15, https://cookcountyhealth.org/wp-content/uploads/Item-VIIB-Strategic-Plan-2020-2022-07-26-19-1.pdf.

[18] *Id*. at 5; *see also* Dr. Jay Shannon, et al., *Cook County Health: FY2020 Proposed Preliminary Budget and Financial Forecast*, at 7 (Aug. 30, 2019), https://cookcountyhealth.org/wp-content/uploads/Item-VIA-Proposed-FY20-Prelim-Budget-Financial-Forecast-2023-R-08-30-19.pdf.

[19] Sameed Ahmed M. Khatana, et al., *Association of Medicaid Expansion With Cardiovascular Mortality*, JAMA CARDIOLOGY (June 5, 2019), doi: 10.1001/jamacardio.2019.1651 (explaining that counties in Medicaid expansion states had fewer deaths per 100,000 residents per year from cardiovascular causes than if they had followed the same trends as counties in non-expansion states); Benjamin D. Sommers, et al., *Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults*, HEALTH AFFAIRS, 1119–128 (June 2017), https://doi.org/10.1377/hlthaff.2017.0293.

suffer from financial strain,[20] and their lives are generally shorter and less healthy.[21]

B. Local Healthcare Systems Cost Less Because of Local Ordinances.

The benefits of local ordinances extend far beyond the individuals receiving healthcare through them. Localities are able to achieve system-wide healthcare goals, efficiencies, and savings. Healthcare costs decrease and outcomes improve when residents receive regular preventative care. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 594 (2012) ("Because those without insurance generally lack access to preventative care, they do not receive treatment for conditions—like hypertension and diabetes—that can be successfully and affordably treated if diagnosed early on.") (Ginsburg, J., concurring in part).[22] For example, HSF "centers on the importance of primary care and routine checkups to help control costs."[23] This design reduces healthcare costs—and most importantly—improves the health of patients. And indeed, increased enrollment in healthcare through

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[20] *E.g.*, Nat'l Academies Inst. of Med., *Hidden Costs, Value Lost: Uninsurance in America*, 67, 69–76 (June 2003).

[21] *Id.* at 3-4; Benjamin D. Sommers, et al., *Mortality and Access to Care Among Adults After State Medicaid Expansions*, 367 New Eng. J. of Med. (2012).

[22] *See also* Blewett, Lynn A., Gestur Davidson, Margaret E. Brown, and Roland Maude-Griffin. "*Hospital provision of uncompensated care and public program enrollment*." Medical care research and review 60, no. 4, 509-527 (2003).

[23] Hart, *supra* note 11.

HSF is correlated with fewer emergency department visits, particularly for newly enrolled or reenrolled individuals.[24] Similarly, when Minnesota increased enrollment as a result of expanded coverage, hospitals saved $58.6 million over a five-year period in uncompensated care.[25]

The COVID-19 pandemic has underscored the compelling local interest in HCSOs. When certain communities do not have access to care because of income and immigration status, disease spreads.[26] Individuals with comprehensive health coverage are nearly three times more likely to get vaccinations compared to those who remain uninsured, thus substantially lowering the risk of communicable

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[24] Marlene Martin, *Providing Comprehensive Health Care for Undocumented People in the United States,* 179 JAMA INTERN MED. 183 (Dec. 21, 2018), https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2719191 ("Fiscal year 2014-2015 analyses showed a decrease in emergency department use per member per year, most prominently among the newly enrolled or reenrolled, who are likely to be undocumented."); Katherine McLaughlin, et al., *Evaluation of Healthy San Francisco: Final Report*, MATHEMATICA POLICY RESEARCH (August 25, 2011), https://healthysanfrancisco.org/wp-content/uploads/Evaluation-of-HSF-Aug-2011.pdf, at 58.

[25] Blewett, *supra* note 22, at 509–27.

[26] *See generally* Miriam Jordan, *'We're Petrified': Immigrants Afraid to Seek Medical Care for Coronavirus*, N.Y. TIMES (May 12, 2020), https://www.nytimes.com/2020/03/18/us/coronavirus-immigrants.html; Ayendy Bonifacio, *For Many Immigrants, an Even Greater Risk*, N.Y. TIMES (Apr. 25, 2020), https://www.nytimes.com/2020/04/25/opinion/immigrants-coronavirus.html.

disease outbreaks in communities.[27] The COVID-19 crisis has also exacerbated the inequities in healthcare coverage,[28] particularly within low-wage occupations deemed "essential."[29] In fact, more than one-third of workers in many frontline industries live in low-income families.[30] For these workers, access to comprehensive, affordable health coverage is thus more vital than ever before.

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[27] Peng-jun Lu, et al., *Impact of health insurance status on vaccination coverage among adult populations,* AM. J. PREVENTATIVE MEDICINE (June 1, 2015), https://doi.org/10.1016/j.amepre.2014.12.008.

[28] Garfield, *supra* note 4 (noting that: (1) 58 percent of low-wage workers are women, compared to 47 percent of all workers; and (2) 23 percent and 16 percent of low-wage workers identify as Hispanic and Black, respectively, compared to 18 percent and 12 percent of all workers, respectively). *See also Ross*, *supra* note 4, at 9.

[29] Hye Jin Rho, et al., *A Basic Demographic Profile of Workers in Frontline Industries*, CENTER FOR ECONOMIC AND POLICY RESEARCH (Apr. 7, 2020), https://cepr.net/a-basic-demographic-profile-of-workers-in-frontline-industries/ (finding that nearly two-thirds of frontline workers are women and that Black, Hispanic, Asian-American/Pacific Islander, and other non-white individuals are overrepresented in many frontline industry occupations). *See also* Jazmyn T. Moore, *et al.*, *Disparities in Incidence of COVID-19 Among Underrepresented Racial/Ethnic Groups in Counties Identified as Hotspots During June 5-18, 2020 – 22 States, February – June 2020*, MMWR MORB MORTAL WKLY REP 2020 (Aug. 21, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6933e1.htm (assessing the "disproportionate incidence of COVID-19 among communities of color.").

[30] *Rho*, *supra* note 6. Immigrants represent one-in-six frontline workers (17.3 percent), yet they face particularly complex health coverage barriers, as well as the fear that accessing that coverage may threaten their legal status. *Id.*; *see also* Hamutal Bernstein, et al., *With Public Charge Rule Looming, One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018*, Urban Institute (May 21, 2019), https://www.urban.org/urban-wire/public-charge-rule-looming-one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018 (reporting that one in seven (13.7 percent) of adults in immigrant families reported avoiding public benefit programs for fear of risking future green

In short, when workers experience gaps in health coverage, local governments step in to make up the difference. Accordingly, they have a vested interest in ensuring that the businesses operating within their communities provide employees with opportunities for comprehensive, affordable care.

C. Local Ordinances Complement the ACA.

The ACA has not reduced the importance of HCSOs—indeed, the two laws work together in a mutually beneficial and complementary way. HCSOs further expand access to healthcare and lower the cost of the healthcare system. Localities that fund public healthcare are motivated to impose local reforms that result in lower general costs.[31] In San Francisco, for example, employer contributions support what is known as "the City Option."[32]

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card status, and more than one in five (20.7 percent) adults in low-income immigrant families reported this fear); Samantha Artiga, et al., *Estimated Impacts of Final Public Charge Inadmissibility Rule on Immigrants and Medicaid Coverage*, KAISER FAM. FOUNDATION (Sept. 18, 2019), https://www.kff.org/report-section/estimated-impacts-of-final-public-charge-inadmissibility-rule-on-immigrants-and-medicaid-coverage-key-findings/.

[31] *Local Government Strategies to Address Rising Health Care Costs*, U. OF TENN. CTR. FOR ST. & LOC. GOV. (Dec. 2014), https://slge.org/assets/uploads/2018/02/2014-Strategies-to-Address-Rising-Health-Care-Costs.pdf.

[32] Jonathan Kauffman, *City's health care initiative shows success, but questions remain*, S.F. CHRON. (Oct. 24, 2017), https://www.sfchronicle.com/restaurants/article/City-s-health-care-initiative-shows-success-12300530.php.

Other large cities, including New York and Los Angeles, are also pursuing local healthcare reforms.[33] Municipalities across the country have studied the San Francisco model, including Denver, Miami, New Orleans, and Pittsburgh.[34] As other cities struggle "with rapid gentrification and growing economic inequality," more will pursue "innovative experiments in social responsibility like [HSF]."[35] Invalidating Seattle's ordinance, as ERIC proposes, would devastate these reform efforts, depressing access to healthcare and increasing costs for healthcare across the board in *amici*'s jurisdictions.

D. The Continuation of HCSOs is Particularly Important with the Uncertainty Surrounding the ACA'S Future.

Uncertainty over the future of the ACA underscores *amici*'s compelling interests in HCSOs. *Amici* support the ACA but are aware of the prospect that the ACA's reach could be curtailed. Commentators have observed that HCSOs remain especially important as a backstop "[i]n the context of continued political efforts to

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[33] Sarah Varney, *Beyond Beltway's 'Medicare-For-All' Talk, Democrats In States Push New Health Laws*, KAISER HEALTH NEWS (Feb. 14, 2019), https://khn.org/news/beyond-beltways-medicare-for-all-talk-democrats-in-states-push-new-health-laws/; Daigon, *supra* note 12.

[34] Daigon, *supra* note 12.

[35] Susan Fang, Meredith Minkler, Susan L. Ivey, Le Tim Ly & Emily Ja-Ming Lee, *Closing the Loophole: A Case Study of Organizing for More Equitable and Affordable Access to Health Care in San Francisco*, 26 J. OF CMTY. PRACTICE 328 (2018).

repeal and replace, or incrementally dismantle, Obamacare."[36] Against the unpredictability of the ACA's future, HCSOs "will likely emerge as the most viable sources of innovation in addressing remaining barriers to coverage in the near term."[37]

CONCLUSION

Amici respectfully request that this Court affirm the district court's judgment in its entirety.

Dated: November 4, 2020

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[ADDITIONAL SIGNATURES ON NEXT PAGE]

[36] *Id.*

[37] Ken Jacobs & Laurel Lucia, *Universal Health Care: Lessons From San Francisco*, 37 HEALTH AFFAIRS 1375 (Sept. 2018), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.0432.

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Dated: November 4, 2020

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/s/ Martina Hassett
MARTINA HASSETT