IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Nos. 07-17370, 07-17372

GOLDEN GATE RESTAURANT ASSOCIATION,
Plaintiff-Appellee,
v.
CITY AND COUNTY OF SAN FRANCISCO,
Defendants-Appellants
and
SAN FRANCISCO CENTRAL LABOR COUNCIL,
SERVICE EMPLOYEES INTERNATIONAL UNION
LOCAL 1021, SEIU UNITED HEALTHCARE
WORKERS-WEST, and UNITE-HERE! LOCAL 2,
Intervenors-Appellants.

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

BRIEF FOR THE SECRETARY OF LABOR AS AMICUS CURIAE SUPPORTING APPELLEE AND REQUESTING AFFIRMANCE

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STATEMENT OF IDENTITY, INTEREST, AND AUTHORITY TO FILE

This case raises an important question whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 et seq., as amended, preempts the employer health care spending requirements in San Francisco's Health Care Security Ordinance, S.F. Cal. Admin. Code, Ch. 14 (2006 & 2007). The Secretary of Labor has primary authority for enforcing and administering Title I of ERISA, 29 U.S.C. §§ 1002(13), 1136(b). Accordingly, she has participated as amicus curiae in many ERISA preemption cases. She has authority to file this brief under Fed. R. App. P. 29(a).

STATEMENT OF THE ISSUE

Whether the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001 et seq., preempts the employer healthcare spending requirements in San Francisco's Health Care Security Ordinance, S.F. Cal. Admin Code, Ch. 14 (2006 & 2007).

STATEMENT OF THE CASE

1. In July 2006, the City and County of San Francisco enacted the Health Care Security Ordinance (HCSO) to provide health care for uninsured residents. ER 403 (Declaration of Legislative Findings and Intent). To reduce the burden on taxpayers of paying for such care, the HCSO establishes a City-run program that emphasizes preventive care and requires covered employers "to make

reasonable health care expenditures on behalf of their employees." Id. The employer-spending requirement is "[e]ssential to the successful operation of this system." Id.

To comply with the employer-spending requirement, a covered medium-sized employer (20-99 employees) must currently make "health care expenditures" of $1.17 for each hour paid for each of its covered employees, and a large-sized employer (100 or more employees) must currently pay $1.76 per hour. S.F. Admin. Code § 14.1(b)(8), (11), (12).[1] "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.

Id. § 14.1(b)(7). Authorized expenditures include:

> (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 [City-run] 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.

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[1] This payment will increase by 5% in 2009 and by a rate linked to a 10-county health expenditure rate for following years. S.F. Admin. Code § 14.1(b)(8)(b), (c).

Id. (paragraphing added).[2] The City-run program provides health care for eligible uninsured San Francisco residents through a network of hospitals and clinics. Id. § 14.2(a). A medical reimbursement account is an account from which covered employees may obtain reimbursement of health care expenditures. Id. § 14.2(g).

In addition to making required health care expenditures, a covered employer must keep records to show that required expenditures have been made every calendar quarter and to provide information to the City's Office of Labor Standards Enforcement (OLSE). S.F. Admin. Code § 14.3(b). An employer may also have to determine whether it is covered as part of a controlled group of

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[2] A "[h]ealth care expenditure" also includes, but is 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.

S.F. Admin. Code § 14.1(b)(7).

corporations, id. § 14.1(b)(4), and whether employees are excluded from coverage under a number of exceptions. See id. § 14.1(b)(2)(d)-(h). An employer may also have to differentiate hours worked by employees inside and outside the City, calculate the percentage of paid time off attributable to work inside and outside the City, and determine the hours worked by and location of telecommuters. See id. § 14.3(b); OLSE Reg. § 6.1(C).

A covered employer cannot reduce the number of its employees below the number that would have resulted in the employer's being covered or in being considered a medium- or large-sized business unless the employer demonstrates that the reduction was not done to evade the HCSO. S.F. Admin. Code § 14.4(c). An employer may not engage in various kinds of retaliatory or threatening activities against any person because that person has cooperated or participated in an action to enforce, inquire about, or inform others about the HCSO requirements. Id. § 14.4(d). The City enforces the HCSO's employer requirements and may impose substantial penalties for employer noncompliance. Id. § 14.4(e).

2. In November 2006, Golden Gate Restaurant Association filed a complaint against the City in district court, arguing that ERISA preempts the HCSO. ER 559. The district court agreed and in December 2007 granted summary judgment to the Association and enjoined the City from enforcing the

HCSO. ER 4. In January 2008, this Court stayed the district court's judgment pending appeal. Golden Gate Restaurant Ass'n v. City and County of San Francisco, 512 F.3d 1112 (9th Cir. 2008).

SUMMARY OF ARGUMENT

The employer spending requirements in San Francisco's Health Care Security Ordinance (HCSO) have a prohibited connection with ERISA plans and are therefore preempted under 29 U.S.C. § 1144(a) for two independent reasons. First, they mandate employee benefit structures or their administration because employers can comply with the law's requirements only by establishing or maintaining ERISA plans. Second, the spending requirements interfere with uniform plan administration.

ERISA broadly defines employee welfare benefit plans to include any plan, fund, or program through which a private employer provides health benefits to its employees, and the Act broadly preempts any state laws that "relate to" such plans. The HCSO purports to directly regulate the provision of health benefits by private employers to their employees and, in this manner, governs precisely the same relationships that Congress subjected to exclusive federal regulation under ERISA.

Although the City and intervenors attempt to avoid preemption by contending that the City-payment option creates a realistic "non-ERISA" way for

employers to comply with the HCSO, the City-payment option in fact requires an employer to establish and maintain an ERISA plan. As this and other Courts have held, an employer creates an ERISA plan whenever it provides benefits of the type provided by an ERISA plan for its employees through an ongoing administrative program, and a reasonable person can identify the benefits, beneficiaries, source of financing, and procedures for receiving benefits. A private employer's provision of benefits through the City-payment option meets all of these criteria and, therefore, constitutes an ERISA-covered plan.

The fact that the HCSO is a City-run program does not place it, or its City-payment option, outside ERISA or its preemption provision. There can be no question that if the City-payment option required an employer to make payments to a private entity to operate and administer a health program for its workforce, the City would thereby require establishment of an ERISA plan and the ordinance would be preempted. Nothing in the analysis changes simply because the mandated health benefit payments are required to be made to the City, rather than a private entity. There is no carve-out in ERISA's text for such arrangements, nor is there any applicable exemption from the broad sweep of ERISA preemption. ERISA exempts government-run plans only when their coverage is limited to the government's own employees. Because ERISA provides no general exemption for state laws mandating employer health-care

payments, there is no basis for implying an exemption for an ordinance that mandates the creation of a financial arrangement that otherwise meets all the criteria for an ERISA plan.[3]

Even if the HCSO did not mandate that employers meet its spending requirements through ERISA plans, the spending requirements are nonetheless preempted because they interfere with uniform plan administration. The Ordinance's interference is substantially greater than the interference that led to preemption of a state law in Egelhoff v. Egelhoff, 532 U.S. 141 (2001). A decision that would allow States, cities, counties, townships, and municipalities to mandate the health benefit levels that private employers within their jurisdictions must pay would open plan sponsors up to a potentially bewildering and conflicting array of mandates. It is impossible to square the imposition of such a burden of compliance and coordination on plan sponsors with ERISA's goal of permitting the uniform administration of plans on a nationwide basis. Accordingly, this Court should follow the Fourth Circuit's analysis in Retail

[3] After this Court held in Standard Oil v. Agsalud, 633 F.2d 760 (9th Cir. 1980), aff'd, 454 U.S. 801 (1981), that ERISA preempted a Hawaii health care law, Congress amended ERISA to permit a limited exemption from ERISA preemption for that law. 29 U.S.C. § 1144(b)(5). This narrow exemption underlines Congress' intent not to exempt other health care laws. See Pub. L. No. 97-473, § 301(b), 96 Stat. 2605, 2612 (1983) (exemption for Hawaii "shall not be considered a precedent with respect to extending such amendment to any other State law").

Industry Leaders Association v. Fielder, 475 F.3d 180 (4th Cir. 2007) and hold that ERISA preempts the HCSO's employer spending requirements.

ARGUMENT

ERISA PREEMPTS THE HCSO'S EMPLOYER SPENDING REQUIREMENTS BECAUSE THEY HAVE A PROHIBITED CONNECTION TO EMPLOYEE BENEFIT PLANS

After carefully reviewing the HCSO, the Department of Labor has concluded that the Ordinance's employer spending requirements are preempted by ERISA. While the Department does not denigrate the seriousness of the problems the HCSO attempts to address, ERISA does not permit a state or local government to address health care problems the way the HCSO does, i.e., by imposing ongoing obligations on employers to make prescribed minimum levels of health care expenditures for their employees.[4] First, we discuss the relevant ERISA preemption principles. Next, we explain why the HCSO's employer spending requirements – both the City-payment option and all of the other options – are preempted for two independent reasons: they "mandate employee benefit structures or their administration," New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 658 (1995), and

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[4] The Department expresses no opinion on whether other parts of the HCSO can be severed from the employer spending requirements or whether other legislative approaches could accomplish the HCSO's ends without running up against ERISA preemption.

they "interfere[] with nationally uniform plan administration." Egelhoff v. Egelhoff, 532 U.S. 141, 148 (2001).

A. ERISA preempts state laws that mandate employee benefit structures or their administration or that interfere with uniform plan administration

Section 514(a) of 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). "State law" includes "laws, decisions, rules, regulations, or other State action having the effect of law," and "State" is defined to include subdivisions and agencies of a state. 29 U.S.C. § 1144(c)(1), (2).

A law relates to an employee benefit plan "if it has a connection with or reference to such a plan." Travelers, 514 U.S. at 656 (citation omitted); accord Egelhoff, 532 U.S. at 146-47. To determine whether a law has a prohibited connection, the Court goes "beyond the unhelpful text," and looks to ERISA's objectives as a guide to the scope of state law that would survive preemption. Travelers, 514 U.S. at 656. The Court also examines the purpose and effect of the challenged state law. Id. at 658. If the challenged state law intrudes upon an area of core ERISA concern, it has a connection with ERISA plans and is preempted, regardless of the state law's intended or stated purpose and effect.

Congress's purpose in enacting 29 U.S.C. § 1144(a) was "to establish the regulation of employee welfare benefit plans as exclusively a federal concern." Travelers, 514 U.S. at 656 (citation and internal quotations omitted); see also

Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2003) ("The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans."). To that end, a state law has a prohibited connection with ERISA plans if it "mandate[s] employee benefit structures or their administration." Travelers, 514 U.S. at 658. Such laws include not only laws requiring plans to provide specific benefits, as in Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 97 (1983), but also laws that require plans "to calculate benefit levels" differently than in other states. Travelers, 514 U.S. at 657-58 (citations omitted).

A state law is also independently preempted if "it interferes with nationally uniform plan administration." Egelhoff, 532 U.S. at 148. This is so because Congress wanted "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." Travelers, 514 U.S. at 656 (quotations and indentation omitted).

Accordingly, ERISA preempts state laws directed at plans or plan sponsors that mandate plans as well as benefits. Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 16 (1987). Such laws put employers "to the choice of operating separate ongoing benefit plans or a single plan subject to different regulatory

requirements, and [employers] would face the prospect that numerous other States would impose their own distinct requirements - a result squarely inconsistent with the goal of ERISA preemption." Id. Permitting such laws would also "afford employers a readily available means of evading ERISA's regulatory scope, thereby depriving employees of [ERISA's] protections." Id.[5]

B. The HCSO provisions mandate employee benefit structures

The HCSO's employer spending requirements are preempted because they have a prohibited connection with ERISA plans. Specifically, all of the options for compliance require an employer to create or alter an ERISA plan.[6] The City-payment option that this Court assumed did not require the creation of alteration of an ERISA plan, see Golden Gate Restaurant Ass'n v. City and County of San Francisco, 512 F.3d 1112, 1118-19 (9th Cir. 2008), in fact constitutes a "state-

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[5] A state law has a prohibited reference to an ERISA plan if the law "acts immediately and exclusively upon ERISA plans . . . or the existence of ERISA plans is essential to the law's operation." California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 325 (1997). Because, as set forth below, the HCSO's healthcare spending requirements have an impermissible connection with ERISA plans, it is unnecessary to address whether they also have an impermissible reference.

[6] The test for preemption is not whether a state law mandates the creation of an ERISA plan but rather whether it relates to or has a connection with such a plan. For example, a statute saying "create a plan or pay a $1,000 fine" would be preempted, even if many or most employers would rationally choose to pay the fine. In this case, however, the forbidden connection with ERISA plans is particularly clear because the ordinance actually mandates the creation or alteration of a plan as set forth above.

mandated benefit plan[]" that is preempted by ERISA. See Fort Halifax, 482 U.S. at 16. The other payment options permitted by the HCSO also require the establishment or maintenance of ERISA plans. Moreover, even if one or more of the options did not require the creation or alteration of an ERISA plan, the HCSO's employer spending requirements would still be preempted because they demonstrably "interfere[] with nationally uniform plan administration." Egelhoff, 532 U.S. at 148.

1. To comply by paying the City, an employer must establish and maintain an ERISA plan

The HCSO requires employers "to make reasonable health care expenditures on behalf of their employees," ER 403, and thereby intrudes upon a core aspect of ERISA's regulatory framework. ERISA specifically regulates employee welfare benefit plans and defines such plans to include "any plan, fund, or program [that is] established or maintained by an employer" to the extent it is "established or maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness." 29 U.S.C. § 1002(1) (emphasis added). The HCSO regulates in this same area by requiring payments 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." S.F. Admin. Code § 14.1(b)(7).

a. To comply with the City-payment option, an employer must establish a plan as defined in 29 U.S.C. § 1002(1). An employer creates a plan whenever it establishes "an ongoing administrative program," and a reasonable person can "ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits." Winterrowd v. Am. Gen. Annuity Ins. Co., 321 F.3d 933, 939 (9th Cir. 2003) (citations and internal quotations omitted). A private employer's provision of benefits through the City-payment option meets all of these criteria and, therefore, constitutes an ERISA-covered plan.

Ongoing administrative program: The courts have identified several types of administrative schemes that constitute ERISA-covered plans. This Court has recognized that an ongoing administrative program may be created based solely on the actions of an employer, such as when an employer pays severance benefits through an arrangement that requires ongoing, particularized, administrative, discretionary analysis and applies to multiple employees. Compare Bogue v. Ampex Corp., 976 F.2d 1319, 1321-23 (9th Cir. 1992) (severance pay plan was ERISA plan), with Delaye v. Agripac, Inc., 39 F.3d 235, 238 (9th Cir. 1994) (distinguishing Bogue and finding no plan). This Court has held that an ongoing administrative scheme also exists when an employer's purchase of group

insurance creates "a complex ongoing relationship between the insureds and the insurer which require[s] constant administrative attention by the insurer." Qualls v. Blue Cross of Cal., 22 F.3d 839, 843 (9th Cir. 1994). Although the payments made by an employer to a third-party insurer may be quite simple and mechanical from the employer's perspective, yet a plan including an ongoing administrative scheme, and consequently an ERISA plan, unquestionably exists.

Even if only the employer's actions were taken into account, the City-payment option clearly requires the creation of an ongoing administrative program. Among other things, an employer must calculate for each calendar quarter employees' hours worked inside and outside San Francisco and percentages of paid leave attributable to work in San Francisco. See S.F. Admin. Code § 14.3; OLSE Reg. §§ 6.1, 7.2. In making these calculations, the employer may have to make discretionary decisions, without clear guidance from the HCSO, on which of its employees can be excluded from coverage as managerial, supervisory or confidential employees under S.F. Admin. Code § 14.1(d); how to treat employees from a temporary help agency, see OLSE Reg. § 3.1(E); how to track the hours worked and location of work by telecommuters and employees whose work requires stops in San Francisco (for example, to make pick ups and deliveries), see id. § 6.1(C)(1)(c), (d); how to track hours of part-time or temporary employees to see if they worked in San Francisco for at least 10 hours

a week, see S.F. Admin. Code § 14.1(b)(2); and how to prove that a layoff or firing was not prohibited, see id. § 14.4(c), (d). These ongoing administrative obligations clearly constitute an ongoing administrative program. Cf. Simas v. Quaker Fabric Corp., 6 F.3d 849, 854 (1st Cir. 1993) (finding Bogue "closely in point" and holding that ERISA preempts a state law requiring employers to pay employees when a company changes control because "the time period is prolonged, individualized decisions are required, and at least one of the criteria is far from mechanical").

In addition to the direct administrative obligations the City-payment option imposes directly on employers, the City-payment option also involves an ongoing administrative program of the sort this Court recognized in Qualls. Specifically, the City-payment option necessarily entails the creation of an administrative arrangement analogous to the "complex ongoing relationship between insureds and the insurer" involved in Qualls, which this Court held was an ongoing administrative program that "required constant administrative attention by the insurer." Qualls, 22 F.3d at 843. Under the City-payment option, the employer and its employees are in the same position analytically as the employer and the insured employees in Qualls, and the City agencies that administer the HCSO and the third-party administrator hired to provide benefit administration services for the program are in the same position as the insurer. See

http://www.prweb/com/releases/2007/8prweb550142.htm (announcing selection of Plexis Healthcare Systems to provide benefits administration services for the City program). Under the City-payment option, the ordinance requires city agencies, a benefits administrator, and employers to make particularized, discretionary decisions for multiple employees over an extended period of time. These ongoing responsibilities show that, as in Bogue, 976 F.2d at 1323, there is "no way to administer the program without an administrative scheme." Thus, when an employer chooses to provide health benefits through the City-payment option it establishes or maintains an ERISA-covered plan in the same manner, and for the same reasons, as when it provides health benefits through the purchase of an insurance policy administered entirely by an insurance company.

Identifiable benefits, beneficiaries, source of financing, and procedures for receiving benefits: The requirement that a reasonable person be able to ascertain benefits, beneficiaries, source of financing and procedures for receiving benefits "requires neither formalities nor elaborate details," so "[v]ery few offers to extend benefits will fail [that] test." Winterrowd, 321 F.3d at 939. Here, the benefits are the services provided through the City's health program or the funds in the reimbursement account. See 29 U.S.C. § 1002(1) (under ERISA's definition of a welfare benefit plan, the provision of medical care "through the purchase of insurance or otherwise" is an ERISA benefit) (emphasis added). The

beneficiaries are the employer's enrolled employees. The source of financing is the employer, although the employee also pays participation fees to enroll in the City's program and the City may pay some costs of the program. The procedures for receiving benefits are set out in the Department of Public Health's (DPH's) regulations, ER 415.

These factors demonstrate that the City-payment option requires an employer to establish a plan. Cf. Randol v. Mid-West Nat'l Life Ins. Co., 987 F.2d 1547, 1550 (11th Cir. 1993) (employer's purchase of health insurance policy with co-payments establish plan). An employer's compliance with the HCSO through the City-payment option thus has all the hallmarks of an ERISA plan.[7]

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[7] Fort Halifax and Massachusetts v. Morash, 490 U.S. 107 (1989), are consistent with this analysis. See Jt. Opening Br. 27. In Fort Halifax, the Supreme Court held that ERISA did not preempt a state law requiring employers to pay severance benefits when a plant closed because the law did not require an employer to establish or maintain an employee benefit plan. 482 U.S. at 12. The "onetime, lump sum payment triggered by a single event [that] requires no administrative scheme," in Fort Halifax, id., is far different from the ongoing administrative scheme required by the HCSO. In Morash, the Supreme Court held that an employer's payment of vacation benefits out of its general assets was not an ERISA plan because the payments were "typically fixed, due at known times, [did] not depend on contingencies outside the employee's control," and presented no risks to employees different from the risk of non-payment of wages. 490 U.S. at 115. The Court recognized that plans to pay medical benefits are covered by ERISA because those benefits "accumulate over a period of time and are payable only upon the occurrence of a contingency outside of the control of the employee." Id. at 116. The Court further recognized that ERISA could cover "a separate fund created by a group of employers." Id. at 120.

b. The City and intervenors wrongly assume that a government-run program for private employers is different from a program run by private entities. While ERISA exempts governmental plans from its coverage, 29 U.S.C. § 1003(b)(1), it defines a governmental plan as a plan a government establishes or maintains "for its employees." 29 U.S.C. § 1002(32). Accordingly, when a government allows private employees to participate in more than a de minimis number even in an employee benefit plan that the government establishes or maintains for its own employees, the result is a plan that is subject to ERISA. See, e.g., Pension & Welfare Benefit Admin. Opinion No. 95-27A, 1995 WL 670760 (DOL Nov. 8, 1995); South Cent. Ind. School Trust v. Poyner, No. 1:06-cv-1053-RLY-WTL, 2007 WL 3102149, *5 (S.D. Ind. 2007); Nord Cmty. Mental Health Ctr. v. County of Lorain, 638 N.E.2d 623, 625-26 (Ohio App. 1994). The narrowness of the exemption for government plans that cover the government's own employees shows that ERISA otherwise applies to government-run employee welfare benefit plans, like the HCSO, that are specifically designed to include private employees of private employers.

c. Treating the City-payment option as requiring employers to establish ERISA plans also furthers Congress' purpose in enacting ERISA of providing employees with protections to ensure that they received promised benefits. See 29 U.S.C. § 1001(b). The Supreme Court recognized in Fort Halifax the danger

of allowing state-mandated plans to circumvent these protections. As the Court observed, such laws would "afford employers a readily available means of evading ERISA's regulatory scope, thereby depriving employees of [ERISA's] protections." Fort Halifax, 482 U.S. at 16. That concern is present here. The City-payment option provides no fiduciary standards to ensure that the money employers pay to employees' reimbursement accounts is used properly, but allows funds to be forfeited if an employee does not sign up for an account within a specified time period, allows deductions from employee accounts for administrative expenses, and may set time limits for employees to use account money. See ER 421-22 (DPH Reg. § 7(g)). The HCSO also provides none of the comprehensive protections in the Department of Labor's claims procedure regulation, 29 C.F.R. § 2560.503-1, for employees to challenge coverage decisions by DPH or its third party administrator See Healthy San Francisco, Participant Handbook 9, available, through links, at http://www.healthysanfrancisco.org. Thus, if the City-payment option were a non-ERISA non-preempted option, employers could choose it as the way to provide health care to their employees without benefit of ERISA's important protections.[8]

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[8] The City and intervenors argue that because the City could have required all employers to pay a tax to fund a government health program without regard to whether employers provided health care to their employees, it can enact a

2. To comply without paying the City, an employer that is not meeting the HCSO spending requirement must establish or alter an ERISA plan

The City and intervenors additionally argue that three of the non-City payment options also allow non-ERISA compliance options. Jt. Opening Br. 22 & n.9. This Court should reject that argument for substantially the same reasons that the Fourth Circuit rejected a similar argument in Retail Ind. Leaders Ass'n v. Fielder, 475 F.3d 180 (2007).

In Retail Industry, a state law required certain employers to spend 8% of their total wages on healthcare for their employees or pay the shortfall to the state. The state argued that employers could meet the spending requirement outside of ERISA through health savings accounts and on-site medical clinics. 475 F.3d at 196. The City and intervenors make essentially the same argument here. Jt. Opening Br. 22 n.9.

The Fourth Circuit correctly held that an employer cannot rely on health savings accounts to satisfy the mandated spending requirement. Although the Department of Labor has stated that a health savings account is not necessarily an ERISA plan, an individual is eligible for a health savings account only if the

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program that gives employers credit for their health care expenditures as a means of avoiding the incentive a general tax would give to employers who provide coverage to drop it. Jt. Opening Br. 36. Whether or not a health care tax targeted at employers would be preempted, the HCSO is preempted because it does substantially more than give employers a credit for existing health care expenditures; it mandates the provision of ERISA benefits and structures.

individual is covered under a high deductible health plan (generally an ERISA plan) and no other more comprehensive plan. Retail Indus., 475 F.3d at 196; see also 26 U.S.C.A. § 223(c)(1) (2007). The health savings account option therefore requires employers who do not have high deductible health plans to alter their existing ERISA plans or establish a new plan to allow the high deductible plan. Id. Moreover, even after that change in plan structure, health savings accounts have contribution limits that may not meet HCSO expenditure requirements.[9] Health savings accounts are therefore not a realistic way to comply with the HCSO's per-employee spending requirements under threat of substantial penalties.

The Fourth Circuit also correctly concluded that on-site clinics are not realistic compliance options. Retail Indus., 475 F.3d at 196. The Department allows an employer to establish a non-ERISA on-site clinic only for minor injuries. 29 C.F.R. § 2510.3-1(c)(2). An employer's payments for some employees' minor injuries cannot possibly satisfy its obligation to pay for all employees regardless of whether they have clinic-qualifying injuries.

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[9] The current annual contribution limit for such an account is not more than $2,900 for self-only coverage. See Revenue Procedure 2007-36, 2007 WL 1378095. That is less than a large employer's required HCSO payments of $1.76 per hour for an employee who works 172 hours a month for a full year ($3632.64). See S.F. Admin. Code § 14.1(b)(8), (10).

The HCSO also allows an employer to contribute to accounts having "substantially the same purpose or effect" as a health savings account or directly reimburse employees for health care costs. S.F. Admin. Code § 14.1(b)(7)(a), (b). The City and intervenors do not explain how any such arrangement can exist apart from ERISA, however, and the arrangements listed in OLSE Reg. § 4.2(A)(3) all involve ERISA plans. In particular, a "medical savings account" (like a health savings account) requires a high deductible health plan and generally no other health coverage and has contribution limits that may not meet HCSO expenditure requirements. 26 U.S.C. § 220(c); see also Internal Revenue Service, Publication 969, at 9-10 (2006). An employer-sponsored "flexible spending arrangement (FSA)" is an ERISA plan, although certain health FSAs may be exempt from the group health plan requirements in Part 7 of ERISA. See 69 Fed. Reg. 78,720, 78,734 (Dec. 30, 2004). A Health Reimbursement Arrangement is a group health plan generally subject to ERISA requirements. See Internal Revenue Service Notice 2002-45, 2002 WL 1378617, p. 5 (July 15, 2002); 29 U.S.C. § 1167(1). In short, these compliance options, like the health savings account and on-site clinics, are not realistic ways for an employer to meet the HCSO's continuing, per-employee spending requirements.

C. The HCSO interferes with uniform plan administration

In staying the district court's decision, this Court recognized that the HCSO imposes administrative burdens on covered employers, but concluded that the burdens are permissible because they exist whether or not a covered employer has an ERISA plan and are thus "burdens on the employer rather than on the ERISA plan." Golden Gate, 512 F.3d at 1123. In discussing the "reference to" aspect of ERISA preemption, the Court concluded that the HCSO was not preempted because it measures an employer's obligations "by reference to the payments provided by the employer to an ERISA plan or to another entity specified in the Ordinance," rather than by "the level of benefits provided by the ERISA plan to the employee." Id. at 1124 (Court's emphasis). This analysis, however, is incompatible with controlling precedents, record evidence, the realities of employee benefit plan administration, and the Fourth Circuit's decision in Retail Industry.

As discussed above, the Supreme Court has repeatedly stated that ERISA's goal is "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law." Travelers, 514 U.S. at 656 (emphasis added; quotations omitted). In assessing the impact of the HCSO, this Court is required to consider how it affects employers in their capacity as plan sponsors, and cannot dismiss as irrelevant burdens that fall on employers rather than on plans.

The Supreme Court has repeatedly stated that ERISA preempts state laws that require plans "to calculate benefit levels" in one state based on conditions that differ from those in other states, without suggesting that it makes any difference whether the state does so directly by mandating a minimum level of plan benefits or indirectly by mandating a minimum level of payments to the plan. See Travelers, 514 U.S. at 657-58. Indeed, this Court has specifically held that a contribution/benefit dichotomy "is unsupported by the law," and that a law mandating specified levels of employer contributions to benefit plans "has a most direct connection with an employee benefit plan." Local Union 598, Plumbers & Pipefitters Indus. Journeymen & Apprentices Training Fund v. J.A. Jones Constr. Co., 846 F.2d 1213, 1219 (9th Cir.), aff'd, 488 U.S. 881 (1988); see also Retail Indus., 475 F.3d at 192 (agreeing with Local Union 598 on this point).

Furthermore, the Supreme Court has held that a state law is preempted when it imposes burdens on plan administration that are much slighter than those imposed by the HCSO. In Egelhoff, the Court held that ERISA preempted a state law that operated to revoke the designation of a divorced spouse as a plan beneficiary, even though the state law specifically permitted plan sponsors to opt out of its application. Egelhoff, 532 U.S. at 151. Although an employer could negate the law's impact through a simple election, the Court held that the law impermissibly interfered with plan administration because it required a plan

administrator "to maintain a familiarity with the law of all 50 States so that they can update their plans as necessary." Id. In contrast, there is no means for San Francisco employers to avoid the much greater impact that the HCSO necessarily has on plan design and administration. Relying on Egelhoff, the Fourth Circuit correctly held that ERISA preempts a state law requiring employers to spend a minimum amount on health care even if the employer had a non-ERISA means of doing so because (1) any attempt to use a non-ERISA option would require an employer to coordinate its spending efforts with existing ERISA plans, and (2) a proliferation of similar laws in other jurisdictions would force employers to monitor those varying laws and manipulate their healthcare spending to comply with them. Retail Indus., 475 F.3d at 196-97.

The HCSO exemplifies that court's justifiable concerns. In light of the sheer number of city, county, and municipal regulatory authorities in the United States, the potential for conflicting and inconsistent laws is obvious. Accordingly, if this Court permitted the City to enforce the HCSO's health care spending requirements, the burden on plan sponsors and administrators to monitor, coordinate, and comply with the obligations imposed by such a patchwork regulatory structure would be exponentially greater than with the laws at issue in Egelhoff and Retail Industry.

The potentially adverse effect on existing ERISA plans is illustrated by the Boro Declaration in Support of the Association's Motion for Summary Judgment, Supplemental Excerpts of Record (SER) 234; see Appellee's Br. 30 n.11. Mr. Boro works for Max's World, Inc., a company that employs more than 100 employees in San Francisco and more than 500 employees outside San Francisco. SER 235 ¶ 2. Max's has different requirements for its health plan than the HCSO imposes and does not track hours worked inside as opposed to outside San Francisco. Id. at 235-236 ¶¶ 3-8.

Even assuming that no other state or local government passes a similar law, the HCSO seriously interferes with the ability of such an employer to maintain a uniform plan for its employees. After enactment of the ordinance, such an employer can maintain uniformity only by changing the benefits under its existing ERISA plan so that all of its employees receive benefits in the manner dictated by San Francisco. Alternatively, the employer could give San Francisco employees different or additional benefits, but the employer would then lose the benefit of uniform company-wide plan administration. No matter how it proceeds, the employer would have to adjust its administrative practices to reflect the unique administrative requirements, terms, and prohibitions of the San Francisco law, such as special rules for calculating hours worked inside and outside of San Francisco, restrictions on a plan's ability to require employee

contributions as part of a health insurance program, detailed recordkeeping mandates, and the Ordinance's provisions on the quarterly timing for determining an employer's compliance with the contribution mandates. See S.F. Admin. Code § 14.3(b); OLSE Reg. § 6.1(C)(1), 6.2.

These problems would be magnified by the effect on plans if other cities or states adopt a law like (but not identical to) the HCSO. For example, an employer could face inconsistent requirements if another local government or state decides not to follow the HCSO's approach of calculating spending based on hours an employee works, subject to annual adjustments measured by health care spending in the San Francisco area. See S.F. Admin. Code § 14.1(b)(8). A state or local government could require employers to calculate health care spending based on a percentage of wages, or could have different coverage exceptions, different annual increases, different recordkeeping requirements, and different treatment of paid leave, telecommuters, temporary employees, and employers hired from a staffing agency. The possibility of such conflicting laws is real and serious, given the varying laws introduced in state legislatures, see SER 49-52; Amicus Curiae Br. of the Attorney General of California in Support of Appellants 10, and local governments' interest in the subject. See Retail Indus. Leaders Ass'n v. Suffolk County, 497 F. Supp.2d 403 (E.D. N.Y. 2007).

Exposing plans and plan sponsors to such potentially conflicting requirements is exactly what 29 U.S.C. § 1144(a) prohibits. See, e.g., Travelers, 514 U.S. at 656. Moreover, even if the various laws managed to avoid the imposition of inconsistent spending mandates, compliance dates, benefit requirements, and reporting standards, an employer would still have the onerous obligation "to monitor these varying laws and manipulate its healthcare spending to comply with them." Retail Indus., 475 F.3d at 197. Under Egelhoff and Retail Industry this required monitoring of laws and manipulation of healthcare spending leads to preemption.

The City's arguments give short shrift to the importance of uniform plan administration and to the primacy of federal regulation of employee benefits under ERISA. If this Court were to uphold the city ordinance, it would expose plan sponsors to the potentially contradictory regimes of numerous states, cities, and other localities, and it would require plan sponsors to design and administer ERISA-covered plans in accordance with the dictates of local officials. Such a result would directly contravene ERISA's express preemption of any laws that "relate to any employee benefit plan," and wholly undermine Congress' evident intent to permit the uniform nationwide administration of employee benefit plans. Accordingly, the ordinance is preempted.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted.

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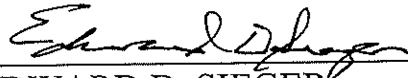

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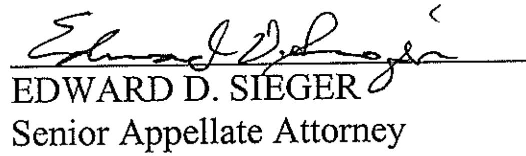
MARCH 2008

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7), I hereby certify that the Brief for the Secretary of Labor is proportionally spaced in 14-point type and contains 6,635 words as determined by the Microsoft Word software program used to prepare the brief.



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I hereby certify that on this 27th day of March 2008, two copies of the Brief for the Secretary of Labor were served by Federal Express, postage prepaid, and a courier service, on the following counsel of record:

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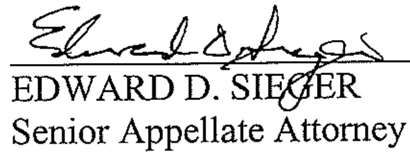

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