No. 08-1515

IN THE

Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,
Petitioner,
v.
CITY AND COUNTY OF SAN FRANCISCO, *et al.*,
Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR THE RETAIL INDUSTRY LEADERS ASSOCIATION AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

ROBIN S. CONRAD
SHANE B. KAWKA
NATIONAL CHAMBER LITIGATION CENTER, INC.
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

WILLIAM J. KILBERG
Counsel of Record
THOMAS G. HUNGAR
THOMAS M. JOHNSON, JR.
GIBSON, DUNN & CRUTCHER LLP
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

Counsel for Amici Curiae

QUESTION PRESENTED

"The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans. To this end, ERISA includes expansive pre-emption provisions, see ERISA § 514, 29 U.S.C. § 1144, which are intended to ensure that employee benefit plan regulation would be 'exclusively a federal concern.'" *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (internal citation omitted). In the decision below, the Ninth Circuit upheld the San Francisco Health Care Security Ordinance, which requires employers to spend specific minimum amounts on employee health care or else pay an equivalent amount to the City of San Francisco. The Ordinance applies only to employees who work within a discrete geographic area and forces employers to create, maintain, and disclose individualized records on covered employees.

The question presented is whether ERISA § 514, 29 U.S.C. § 1144, which was designed to ensure nationwide, uniform administration of employee benefit plans, preempts state or local laws that mandate minimum employer contributions for employee health care, and dictate recordkeeping, reporting, and disclosure requirements associated with those contributions.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

FEDERAL STATUTES

STATE STATUTES

OTHER AUTHORITIES

BRIEF FOR THE RETAIL INDUSTRY LEADERS ASSOCIATION AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

INTEREST OF *AMICI CURIAE*[1]

The Retail Industry Leaders Association ("RILA") is an international alliance of employers, including retailers, product manufacturers, and service providers, that promotes consumer choice and economic freedom through government advocacy and industry leadership. Its members, which include the largest and fastest-growing retail companies in the industry, account for over $1.5 trillion in annual sales, provide millions of jobs, and operate more than 100,000 stores, manufacturing facilities, and distribution centers both domestically and globally.

The Chamber of Commerce of the United States of America (the "Chamber") is a nonprofit corporation and is the world's largest business federation. The Chamber represents an underlying membership of more than three million companies and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the

[1] Pursuant to this Court's Rule 37.2(a), counsel of record received timely notice of *amici*'s intent to file this brief, and letters of consent from all parties to the filing of this brief have been submitted to the Clerk. Pursuant to this Court's Rule 37.6, *amici* state that this brief was not authored in whole or in part by counsel for any party, and that no person or entity other than *amici* or their counsel made a monetary contribution to the preparation or submission of this brief.

interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files *amicus curiae* briefs in cases raising issues of vital concern to the Nation's business community.

RILA and the Chamber are both committed to protecting their members' ability to establish and administer health plans on a uniform, company-wide basis, and therefore oppose laws such as the San Francisco Health Care Security Ordinance that conflict with the federal policy embodied in ERISA. RILA was the plaintiff in two previous cases involving similar laws that were struck down by the courts. *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007); *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403 (E.D.N.Y. 2007). The Chamber filed *amicus* briefs in the *Fielder* case before both the district court and the court of appeals.

The decision below conflicts with *Fielder* and *Suffolk County* and, therefore, threatens the uniform administration of ERISA plans. RILA and the Chamber filed *amicus* briefs in this case urging the Ninth Circuit to affirm the district court's decision holding the Ordinance preempted, and also in support of *en banc* rehearing.

SUMMARY OF ARGUMENT

I. Certiorari is warranted because the Ninth Circuit's decision directly conflicts with this Court's ERISA jurisprudence. Under this Court's test in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), the San Francisco Ordinance has both an impermissible "reference to" and "connection with" employers' existing ERISA plans.

The Ordinance impermissibly "refer[s] to" ERISA plans under this Court's decision in *District of Co-*

lumbia v. Greater Washington Board of Trade, 506 U.S. 125 (1992), because its health-care spending options specifically include covered plans, and because it requires employers to measure compliance by referring to their current levels of ERISA benefits. The decision below cannot be reconciled with *Greater Washington Board of Trade*. In addition, the Ordinance "refer[s] to" an ERISA plan through the City-payment option, which is itself a covered plan under this Court's decision in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), and not, as the Ninth Circuit concluded, a non-ERISA alternative.

Contrary to the Ninth Circuit's holding, the Ordinance also has an impermissible "connection with" ERISA plans under this Court's precedents because, whether or not it offers non-ERISA means of compliance, it still interferes with uniform plan administration. In enacting ERISA, "Congress intended preemption to afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations." *Fort Halifax*, 482 U.S. at 11. State laws that threaten that goal of uniformity are therefore preempted, because "[r]equiring ERISA administrators to master the relevant laws of 50 states and to contend with litigation would undermine the congressional goal of minimizing the administrative and financial burdens on plan administrators—burdens ultimately borne by the beneficiaries." *Egelhoff v. Egelhoff*, 532 U.S. 141, 149-50 (2001) (internal quotation marks omitted).

The decision below conflicts with this Court's recognition of ERISA preemption's core purpose of uniform plan administration. By sustaining the Ordinance even though it mandates minimum health-care payments and recordkeeping requirements for employers who do business in San Francisco, the

Ninth Circuit's decision fosters the creation of a patchwork regulatory scheme for plan administrators and thereby creates the very burdens foreseen in, and forbidden by, *Fort Halifax* and *Egelhoff*. Certiorari should therefore be granted to correct the Ninth Circuit's erroneous departure from this Court's precedents.

II. Certiorari is also warranted to resolve the conflict between the Fourth and Ninth Circuits over whether ERISA preempts required-contribution laws like the Ordinance that require employers to make locale-specific per-employee expenditures on health care. In *Fielder*, the Fourth Circuit held that ERISA preempted a similar required-contribution law because the law's locale-specific minimum-spending and recordkeeping requirements "would hamper Wal-Mart's ability to administer its employee benefit plans in a uniform manner across the nation." 475 F.3d at 187. In particular, the Fourth Circuit recognized that a "proliferation of similar laws in other jurisdictions would force Wal-Mart or any employer like it to monitor these varying laws and manipulate its healthcare spending to comply with them." *Id.* at 197.

Contrary to the Ninth Circuit's reasoning, *Fielder* cannot be distinguished on the ground that the Maryland law at issue there effectively left employers with no alternative to altering or amending existing ERISA plans. The Fourth Circuit squarely held that, whether or not there were non-ERISA alternatives to compliance, required-contribution laws are preempted because they act directly on ERISA plans by increasing the burdens on plan administrators who must monitor and coordinate all employee health-care costs.

III. Finally, certiorari is warranted because this case presents a recurring issue of substantial importance—whether ERISA preempts laws like the Ordinance that mandate employer-funded health care. Given the current economic constraints on state and local budgets, the temptation to transfer to employers the costs of providing health care to the uninsured is certain to continue. A multiplicity of such state and local laws, however, would eviscerate ERISA's guarantee of uniform plan administration. And the resulting increase in compliance, monitoring, and litigation costs would ultimately result in increased expense to beneficiaries as well.

ARGUMENT

I. CERTIORARI IS WARRANTED BECAUSE THE DECISION BELOW CONFLICTS WITH THIS COURT'S ERISA JURISPRUDENCE.

ERISA broadly preempts all laws that "relate to" a covered employee benefit plan. 29 U.S.C. § 1144(a). Under this Court's precedents, a state or local law "relate[s] to" a plan if it has a forbidden "connection with" or "reference to" a plan. *Shaw*, 463 U.S. at 97. A state or local requirement impermissibly "refers to" a plan if the law on its face concerns ERISA plans, or if the employer must consult its existing benefit plans to measure compliance. *Greater Wash. Bd. of Trade*, 506 U.S. at 130. To determine whether a law has a "connection with" a plan, this Court looks to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *California Div. of Labor Standards Enforcement v. Dillingham Constr., N. A., Inc.*, 519 U.S. 316, 325 (1997) (internal quotation marks omitted).

A. THE DECISION BELOW CONFLICTS WITH THIS COURT'S PRECEDENTS REGARDING "REFERENCE TO" ERISA PLANS.

1. The Ninth Circuit's decision conflicts with longstanding and straightforward precedent from this Court concerning what constitutes a "reference to" an ERISA plan. Under the terms of the Ordinance, an employer's compliance is determined by reference to its "health-care expenditures," which expressly include: "payments by a covered employer to a third party for the purpose of providing health care services for covered employees," and "contributions by such employer on behalf of its covered employees to a health savings account." S.F. Admin. Code § 14.1(b)(7)(a), (c). Employers undoubtedly establish ERISA plans when they make payments to a third-party insurer or to health savings accounts.[2] Therefore, the Ordinance on its face refers to ERISA plans, and assesses compliance by reference to employers' expenditures through such plans. Accordingly, contrary to the Ninth Circuit's holding below, the Ordinance "specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is preempted." *Greater Wash. Bd. Of Trade*, 506 U.S. at 130.

---

[2] As the Department of Labor has noted, health savings accounts are ERISA plans unless "the establishment of the HSAs is completely voluntary on the part of the employees." *See* Employee Benefits Sec. Admin., U.S. Dep't of Labor, Field Assistance Bulletin 2004-1 (Apr. 7, 2004). In addition, an employee can only establish a health savings account if he or she is already enrolled in a "high-deductible health plan," which, if provided by an employer, is itself an ERISA plan. *Id.*; *see also* 26 U.S.C. § 223(c)(1).

In *Greater Washington Board of Trade*, a District of Columbia law required employers to provide health benefits "equivalent to the existing health insurance coverage of [an] employee" while the employee was injured and on workers' compensation. *Id.* at 128 (internal citation omitted). The law was preempted because it referred to ERISA plans on its face, as demonstrated by the fact that employers measured compliance by reference to the benefit levels provided under their existing plans. *See id.* The Ordinance is preempted for the same reason: It refers to ERISA plans, and employers determine their legal obligations by consulting their expenditures made through those plans. If those plan expenditures are (in San Francisco's judgment) insufficient, payments to the City are compulsory. The decision below and *Greater Washington Board of Trade* are in direct conflict.[3]

The Ninth Circuit concluded that *Greater Washington Board of Trade* was inapplicable because the D.C. law at issue there measured compliance by referring to health-care *benefits*, whereas the Ordinance measures compliance by referring to health-care *payments*. Pet. App. 34a-35a. That purported

---

[3] "Reference to" preemption results, as well, from the central role that benefit plans would play in the City's enforcement of the Ordinance. Most employers offer health care through ERISA-regulated plans. Enforcement of the Ordinance therefore will involve the City in examining employers' health plans, and—when non-compliance is alleged—in charging that employer contributions to the plans are insufficient to discharge obligations under the Ordinance. *Cf. Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990) (when a plaintiff must "plead" an ERISA plan as part of a cause of action, the action "relate[s] to" the plan, "[b]ecause the court's inquiry must be directed to the plan").

distinction, however, has no basis in this Court's precedents and collapses under scrutiny. A health-care "benefit" to an employee is a health-care "payment" by the employer, either to a private health insurer or directly to the provider or employee. There can be no health-care "benefit" without a corresponding employer "payment."

Indeed, this Court summarily affirmed a decision rejecting this very distinction, holding that "laws that create funding requirements for employee benefit plans" are laws that "relate to" a plan, and "[s]tatutes regulating contributions to ERISA plans have consistently been held preempted." *Local Union 598, Plumbers & Pipefitters Indus. Journeymen & Apprentices Training Fund v. J.A. Jones Constr. Co.*, 846 F.2d 1213, 1218 (9th Cir. 1988), *summarily aff'd*, 488 U.S. 881 (1988); *see also id.*, 846 F.2d at 1219 ("this 'contribution/benefit' dichotomy, while perhaps superficially appealing, is unsupported by the law"). The judgment below cannot be reconciled with this Court's summary affirmance in *Local Union 598*. Upholding the Ninth Circuit's spurious distinction between benefits and payments would permit states to avoid ERISA preemption by elevating form over function, which this Court has expressly forbidden. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981) ("ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision.").

Moreover, the Ninth Circuit's holding that statutes mandating employer "payments," rather than "benefits," are not preempted, conflicts with this Court's definition of an ERISA plan in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), and with the text of ERISA itself. ERISA defines an employee welfare benefit plan, in relevant part, as

> any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the *purchase of insurance or otherwise* . . . benefits in the event of sickness.

29 U.S.C. § 1002(1) (emphasis added).

In *Fort Halifax*, this Court made clear that, under the statute, an employer establishes or maintains an ERISA plan whenever the employer "assumes . . . responsibility *to pay benefits* on a regular basis," and "faces . . . periodic demands on its assets that create a need for financial coordination and control." 482 U.S. at 12 (emphasis added). In short, the obligation to make regular, periodic payments for employee benefits, plus the duty to monitor those payments, are the quintessential hallmarks of an ERISA-covered plan. *See id.* Therefore, the Ninth Circuit's insistence that a statute must expressly mandate specific "benefits" to have an impermissible "reference to" an ERISA plan conflicts directly with this Court's holding in *Fort Halifax*.

2. The Ninth Circuit's decision also conflicts with *Fort Halifax* in concluding that the Ordinance's creation of a City-run health benefits program, to the extent it is funded by private employers for the benefit of private employees, is not an ERISA plan. Pet. App. 15a. The City-payment option is a "plan" under *Fort Halifax* because it requires employers to make regular payments for employee benefits provided by the City, and to monitor, record, and disclose those payments. Because the City-payment option is an ERISA plan, the Ordinance impermissibly "refer[s] to" a covered plan for that reason as well.

To be sure, the requirement of a "one-time, lump-sum payment triggered by a single event," such as severance pay, neither "establishes, nor requires an employer to maintain," an ERISA plan because it "requires no administrative scheme whatsoever to meet the employer's obligations." *Fort Halifax*, 482 U.S. at 12. But the Ordinance requires employers to make regular quarterly payments to the HAP, not mere one-time, lump-sum payments. *See* S.F. Admin. Code § 14.3(a). In addition, in connection with these payments, an employer must determine each employee's eligibility for the HAP, apply exemptions for "managerial," "supervisory," and "confidential" employees, monitor the total hours that each employee works, calculate the total health-care expenditures required by the HAP for each employee, and maintain records establishing that the required payments were made each quarter. *See* Pet. App. 132a-133a; 143a-144a. That takes planning and an ongoing administrative scheme; it is done "for the purpose of providing for its participants or their beneficiaries . . . benefits in the event of sickness" (29 U.S.C. § 1002(1)); it is, therefore, a covered plan.[4]

In effect, the City has mandated that employers whose voluntary ERISA plans do not meet the City's standards must participate in an ERISA plan that does—namely, the City's plan. If the City had in-

---

[4] This conclusion finds additional support in the Department of Labor's position as *amicus* before the Ninth Circuit that the City-payment option qualifies as a "plan." The Ninth Circuit erred by extending no deference to the Secretary's interpretation of ERISA. *See, e.g.*, *Fed. Express Corp. v. Holowecki*, 128 S. Ct. 1147, 1156 (2008) (extending *Skidmore* deference to position taken by EEOC in policy memorandum issued after this Court granted certiorari).

stead required such employees to participate in a health insurance program provided by a specified private insurer, it would be perfectly clear that the City was mandating participation in an ERISA plan. The result does not change merely because the City itself (rather than a private insurer) operates the mandatory plan.

The court of appeals reasoned that the City-payment option is *not* an ERISA plan because it affords employers no more than a "modicum of discretion" over plan assets, and therefore presents little opportunity for employers to engage in mismanagement. Pet. App. 19a-20a. Nothing in the text of ERISA or in *Fort Halifax*, however, requires an employer to exercise a threshold level of discretion to operate an ERISA plan. On the contrary, employee welfare benefit plans (such as health-care plans) generally do not consist of an employer-managed trust fund and are exempt from ERISA's vesting, minimum-participation, and minimum-funding requirements. *See* 29 U.S.C. § 1051(1). But they are nevertheless covered plans.

It is true, of course, that an employer who elects the City-payment option is not responsible for the ultimate distribution of benefits once it makes payments to the City. This would also be true, however, under a private insurance agreement—once an employer paid the required premiums, the insurer would be responsible for administering the plan according to the terms of the policy. The only difference here is that the Ordinance requires employers to designate the City as the insurer of the plan—a difference that weighs in favor of, not against, a holding of preemption. *Cf. N.Y.S. Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 664 (1995) (suggesting that a law that "re-

quire[s] plans to deal with only one insurer, or to insure against an entire category of illnesses they might otherwise choose to leave without coverage," would violate ERISA); *Egelhoff*, 532 U.S. at 150 (state law dictating choice of beneficiary preempted by ERISA).

B. THE DECISION BELOW CONFLICTS WITH THIS COURT'S PRECEDENTS REGARDING "CONNECTION WITH" ERISA PLANS.

The judgment below also conflicts with this Court's precedents holding that ERISA preempts state and local laws that have a "connection with" ERISA plans. The "connection with" inquiry centers on "the objectives of the ERISA statute" as well as "the nature of the effect of the state law on ERISA plans." *Dillingham*, 519 U.S. at 325. The test, therefore, is whether the law at issue interferes with ERISA's objectives. The court of appeals erroneously overlooked this Court's clear holding that among ERISA's principal objectives is "to provide a uniform regulatory regime over employee benefit plans." *Aetna Health*, 542 U.S. at 208.

Uniform plan administration serves multiple salutary purposes. First, it benefits the employer, or plan sponsor, by "minimiz[ing] the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand*, 498 U.S. at 142. Second, uniformity inures to the benefit of beneficiaries, as higher administrative costs can cause "employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax*, 482 U.S. at 11. Third, elimination of inconsistent state regulation improves federal oversight of the "administrative integrity" of plan operations. *Id.* at 15.

The decision below ignores the reality that the Ordinance violates the objectives of uniform regulation set forth in *Aetna Health* and other precedents of this Court by mandating health-care benefit levels and imposing administrative requirements on San Francisco employers. Contrary to what the Ordinance presumes, employers do not ordinarily allocate health-care costs on a per-employee, per-location basis. Rather, employers generally provide company-wide coverage in order to reduce costs and diversify risk. The premiums that employers pay insurers are based on the overall profile of the insured group, and are not divided up to correspond to hours worked or the place of residence of each insured.[5] Alternatively, in the case of self-insurance, payments reflect the actual cost of health-care services—and again are not fixed according to how many hours an employee worked or where the employee lived.[6] Therefore, the Ordinance's threshold requirement that employers allocate health-care expenditures to specific employees in a specific location will, by itself, require employers to create a special pool of funds for San Francisco employees that is separate from the rest of the employees covered by the company plan. For this reason alone, the law is preempted.

Moreover, the efficiencies that result from a uniform plan—efficiencies that ERISA protects—are defeated when individual localities are permitted to re-

---

[5] *See, e.g.*, *Fielder*, 475 F.3d at 194 (noting that "Wal-Mart does not presently allocate its contributions to ERISA plans or other healthcare spending by State, and so the [Maryland] Fair Share Act would require it to segregate a separate pool of expenditures for Maryland employees").

[6] *See, e.g.*, *Loren v. Blue Cross & Blue Shield*, 505 F.3d 598, 601 (6th Cir. 2007) (describing self-insured plans).

place actuarially-based calculations and market-determined pricing with government-imposed mandates. The need to monitor expenditures in multiple jurisdictions is squarely at odds with ERISA's purpose of establishing a uniform system of plan regulation. And as this Court has held, a crucial purpose of ERISA preemption is to prevent employers from having to deal with the difficulties inherent in complying with the idiosyncratic requirements of 50 states and countless municipalities.

In *Egelhoff*, this Court held preempted a Washington law that revoked a former spouse's status as a plan beneficiary following a divorce, even if the former spouse remained the named beneficiary on ERISA plan documents. *See* 532 U.S. at 144-45. Because this law "interfere[d] with nationally uniform plan administration," it had an impermissible "connection with" an ERISA plan. *Id.* at 148. In particular, if the law were upheld, multiple other jurisdictions might enact similar laws, each with its own peculiar rules for determining beneficiary status—even though ERISA specifically provides that the participant or the plan shall dictate the choice of beneficiary. *See id.* at 147-48. Therefore, this Court held that "[r]equiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Id.* at 149-50 (alterations in original and internal citation omitted).

The Ninth Circuit disregarded this Court's precedents in failing to acknowledge that the same holds true under the Ordinance. ERISA "does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare

benefits," *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995); rather, it leaves the decision whether and when to provide benefits in the hands of employers and clears the way for uniform plan administration. The Ordinance, by contrast, disrupts plan uniformity by requiring employers to subsidize benefits (through health-care payments) in a particular locality that the employer would not otherwise provide. That is true whether the employer satisfies its obligations by purchasing additional benefits for employees through a private insurer, or by purchasing the bundle of benefits provided by San Francisco under the HAP. Under the decision below, employers would need to contend with a multiplicity of similar laws in other states and localities, each with their unique funding mandates and administrative requirements. *Egelhoff* forecloses and directly conflicts with this result.[7]

---

[7] The Ninth Circuit nonetheless asserted that the Ordinance does not have a prohibited "connection with" an employer's ERISA plans because it merely influences *employer* conduct and has no effect on the *plan* itself. *See* Pet. App. 31a, 32a. This scholastic distinction—much like the benefit/payment dichotomy—makes no practical difference and is unsupported by precedent. Employers act as plan sponsors and administrators, and laws that mandate or proscribe an administrator's conduct necessarily have a direct effect on a plan. Indeed, this Court has made clear that Congress intended through ERISA "to ensure that plans *and plan sponsors* would be subject to a uniform body of benefits law[,]" and to eliminate "'the potential for conflict in substantive law . . . requiring the tailoring of plans *and employer conduct* to the peculiarities of the law of each jurisdiction.'" *Travelers*, 514 U.S. at 656-57 (quoting *Ingersoll-Rand*, 498 U.S. at 142) (emphasis added).

C. UNDER THIS COURT'S PRECEDENTS, NON-ERISA ALTERNATIVES DO NOT SAVE A LAW FROM PREEMPTION.

Contrary to the Ninth Circuit's conclusion, the Ordinance is not saved from preemption merely because there are purportedly non-ERISA alternatives for complying with the law. Pet. App. 29a-30a. As an initial matter, as explained above, the City-payment option—the primary alternative offered by the Ordinance to modification of an existing plan—is *not* a non-ERISA alternative, but is instead an ERISA plan in its own right. Even leaving that point aside, the practical effect of the Ordinance and others like it on plan administration would still create the prohibited "connection with" an ERISA plan.

The Washington law in *Egelhoff*, for example, contained a provision that allowed employers to expressly "opt out" of the state-law rule by modifying their plan documents. 532 U.S. at 151. Nevertheless, this Court held that the existence of a statutory "opt out" did not save the law from preemption, because employers were still required to "maintain a familiarity with the laws of all 50 States so that they can update their plans as necessary to satisfy the opt-out requirements of other, similar statutes." *Id.* If the City-payment option were allowed to stand, employers would need to monitor the laws of all 50 states and make ongoing adjustments to ensure that their existing ERISA benefit levels complied with a myriad of state and local minimum-contribution requirements.

Similarly, in *Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *summarily aff'd*, 454 U.S. 801 (1981), the State of Hawaii passed a law requiring employers to include a litany of specific benefits

in their health-care plans. The court of appeals held the law preempted by ERISA, and this Court summarily affirmed. In describing the decision, this Court explained in *Fort Halifax* that the Hawaii law was preempted because an employer's efforts to structure its existing plan to conform with the requirements of a single state would create the "difficulty or impossibility of structuring administrative practices according to a set of uniform guidelines." *Fort Halifax*, 482 U.S. at 13 (explaining *Agsalud*). In addition, "if Hawaii could demand the operation of a particular benefit plan, so could other States, which would require that the employer coordinate perhaps dozens of programs." *Id.* This interference with uniform plan administration is the very essence of a prohibited "connection with" an ERISA plan. Because the Ninth Circuit's decision conflicts with multiple decisions of this Court regarding what constitutes a "connection with" an ERISA plan, certiorari should be granted.

II. CERTIORARI IS WARRANTED BECAUSE THE DECISION BELOW CONFLICTS WITH THE DECISION OF THE FOURTH CIRCUIT IN *FIELDER*.

In *Fielder*, the Fourth Circuit correctly applied this Court's precedents in concluding that required-contribution laws have a prohibited "connection with" covered plans because they violate the core purpose of ERISA preemption: "establishing uniform, nationwide regulation of employee benefit plans." 475 F.3d at 191. By upholding the Ordinance, a local law that mandates particular levels of employee health care and a host of specific recordkeeping requirements, the Ninth Circuit created a direct conflict with *Fielder*.

A. THE ORDINANCE INTERFERES WITH UNIFORM PLAN ADMINISTRATION IN THE SAME MANNER AS THE MARYLAND LAW.

In *Fielder*, the Fourth Circuit held that ERISA preempted the Maryland Fair Share Health Care Fund Act, which like the Ordinance required covered employers (namely, Wal-Mart) to make minimum health-care expenditures for employees or pay the difference to the government, and required covered employers to track expenditures with respect to those employees. *See* 475 F.3d at 183, 186-87.

The Ninth Circuit distinguished *Fielder* on the ground that the Maryland law did not provide employers with any genuine alternative to modifying their benefit plans. Pet. App. 38a-39a. The court of appeals reasoned that employers in Maryland received no benefit from electing to make payments to the State and therefore would be unlikely to choose that option, whereas employers who elect the City-payment option under the Ordinance can enroll eligible employees in the HAP, which provides employees with government-insured health care. *See id.*

The Fourth Circuit's judgment, however, was not dependent on the conclusion that Wal-Mart had no meaningful alternative to altering its ERISA plan. Rather, the court stated that even if there were "a meaningful avenue by which Wal-Mart could incur non-ERISA healthcare spending, we would still conclude that the Fair Share Act had an impermissible 'connection with' ERISA plans." *Fielder*, 475 F.3d at 196. As the Court explained, "[t]he undeniable fact is that the vast majority of any employer's healthcare spending occurs through ERISA plans . . . and any attempt to comply with the Act would have direct effects on the employer's ERISA plans." *Id.* Therefore,

> [i]f Wal-Mart were to attempt to utilize non-ERISA health spending options to satisfy the Fair Share Act, it would need to coordinate those spending efforts with its existing ERISA plans. . . . From the employer's perspective, the categories of ERISA and non-ERISA healthcare spending would not be isolated, unrelated costs. Decisions regarding one would affect the other and thereby violate ERISA's preemption provision.

Id. at 196-97.

In reaching this result, the Fourth Circuit relied on this Court's rejection in *Egelhoff* of Washington State's compelled-beneficiary law. As was true in *Egelhoff*, upholding the Fair Share Act would lead to other jurisdictions enacting similar required-contribution laws, which would "deny Wal-Mart the uniform nationwide administration of its healthcare plans by requiring it to keep an eye on conflicting state and local minimum spending requirements and adjust its healthcare spending accordingly." *Id.* at 197. And as in *Egelhoff*, the existence of an "opt out" provision did not save the Fair Share Act from preemption, because the law still "required plan administrators to 'maintain a familiarity with the laws of all 50 States so that they can update their plans as necessary to satisfy the opt-out requirements of other, similar statutes.'" *Fielder*, 475 F.3d at 197 (quoting *Egelhoff*, 532 U.S. at 151).

The Ordinance has the same impermissible consequences as the Maryland law. As in Maryland, the "undeniable fact" is that most San Francisco employers provide health care through ERISA plans. And as in Maryland, the undeniable effect of the Ordinance will be to increase the costs and burdens of

administering those plans—by requiring employers to: (1) coordinate their existing ERISA spending with additional spending to satisfy the minimum-contribution requirement; (2) maintain and disclose records regarding the spending required by the law; (3) monitor and comply with the laws of other jurisdictions; and (4) segregate and calculate the per-employee and per-location costs of providing health care. *See, e.g.*, *id.* at 194 (noting that Maryland law interfered with plan uniformity by forcing an employer to "segregate a separate pool of expenditures" for a specific location). Given the threat posed by required-contribution laws to uniform plan administration, and their resulting "connection with" ERISA plans, *Fielder* cannot be distinguished on the basis that the Ordinance provides for purportedly non-ERISA alternatives to compliance.

B. THE FOURTH CIRCUIT'S HOLDING DID NOT DEPEND ON AN ABSENCE OF NON-ERISA ALTERNATIVES.

To be sure, the Fourth Circuit in *Fielder* concluded that, under the Maryland law, no rational employer would choose to pay the State rather than alter or amend an existing ERISA plan. *See* 475 F.3d at 193. But this factual finding that the Maryland law was an effective mandate on employers was by no means necessary to the Fourth Circuit's analysis.

On the contrary, the "no rational employer" framework derives from a "trilogy" of Supreme Court decisions involving state laws that lay at the periphery of ERISA preemption because they either regulated third parties (rather than employers themselves) or otherwise had only an indirect economic

effect on ERISA plans.[8] When a law exerts only a "remote," "tenuous," or "indirect" economic influence on a plan—for example, by regulating insurers that do business with ERISA plans—it is not preempted unless the influence is so "prohibitive" that it effectively compels an employer to adopt a particular benefit or select a particular insurer. *Travelers*, 514 U.S. at 645, 661. As the Fourth Circuit recognized in *Fielder*, however, ERISA preemption of the Maryland law did not depend on any such "indirect" effect; rather, a law that mandates employer health-care contributions "*directly* regulates employers' structuring of their employee health benefit plans." *Fielder*, 475 F.3d at 195 (rejecting application of "trilogy" cases) (emphasis in original).

By concluding that the Ordinance survives preemption merely because it provides a supposed non-ERISA alternative, the Ninth Circuit converted one test for preemption—useful in cases of indirect regulation—into the sole criterion for whether a state or local law should be upheld. As the Court in *Fielder* recognized, however, no inquiry into the degree of economic coercion exerted by a state or local law is required when the law acts directly on employers and disrupts uniform plan administration. Rather,

---

[8] *See Travelers*, 514 U.S. at 645 (statute requiring hospitals to collect surcharges from patients not insured by Blue Cross/Blue Shield was not preempted unless the surcharges were so "prohibitive" as to effectively require ERISA plans to provide insurance through the Blues); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 809-10 (1997) (tax on hospitals and other health care providers for gross receipts of patient services not preempted by ERISA); *Dillingham*, 519 U.S. at 332-33 (no preemption of reduced minimum-wage incentive for employers to participate in a state-approved apprenticeship program).

required-contribution laws, by their very nature, dictate choices that ERISA leaves within the hands of employers and plan administrators. As a result, they interfere with uniform plan administration, have a forbidden "connection with" a plan, and therefore are preempted.

In short, the decision below cannot be reconciled with the Fourth Circuit's holding in *Fielder*. This Court should grant certiorari to resolve the conflict.

III. CERTIORARI IS WARRANTED TO RESOLVE AN IMPORTANT, RECURRING QUESTION OF FEDERAL LAW CONCERNING ERISA.

The Ninth Circuit's decision presents an important and recurring issue of federal law: whether ERISA preempts required-contribution laws like the Ordinance that require employers to make minimum health-care payments on behalf of employees. Because the Ninth Circuit's decision will frustrate uniform plan administration—the critical purpose underlying ERISA preemption—certiorari is warranted.

The threat of conflicting state and local regulations is not merely hypothetical. On the contrary, in addition to Maryland and San Francisco, other states and localities have already considered or adopted similar employer-contribution mandates. *See Fielder*, 475 F.3d at 184. For example, Suffolk County, New York, enacted an ordinance that required covered employers to pay health care costs of at least $3.00 per hour for each covered employee. *See Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403, 406 (E.D.N.Y. 2007) (holding ordinance preempted by ERISA). As was true under the Ordinance, the Suffolk County ordinance required employers to track health-care expenditures for Suffolk County employers, record the dates and

hours worked of covered employees, and file annual reports with the county Department of Labor. *See id.*

Massachusetts and Vermont have also enacted similar required-contribution laws, each with their own specific minimum-payment and administrative requirements. *See, e.g.*, 114.5 MASS. CODE REGS. 16.03 (2009); VT. STAT. ANN. tit. 21, § 2003 (2009). In addition, similar proposals have been introduced in most other states. *See* J. Contreras & O. Lobel, *Wal-Martization and the Fair Share Health Care Acts*, 19 St. Thomas L. Rev. 105, 136 (2006) (collecting proposals).

Under the Ninth Circuit's reasoning, such state and local laws would be permitted to stand alongside the Ordinance, and employers would be forced to comply with differing minimum-payment and recordkeeping requirements in numerous states, cities, and counties across the Nation. Each additional jurisdiction that enacts such a law would force employers to segregate and track separate pools of expenditures for each jurisdiction and each covered employee. The resulting aggregate burden on plan uniformity, and the monitoring and compliance burdens on plan administrators, would be enormous. Therefore, this Court should grant certiorari to prevent the pernicious effect that the Ninth Circuit's decision will otherwise have on uniform plan administration.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted.

ROBIN S. CONRAD
SHANE B. KAWKA
NATIONAL CHAMBER
LITIGATION CENTER, INC.
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

WILLIAM J. KILBERG
Counsel of Record
THOMAS G. HUNGAR
THOMAS M. JOHNSON, JR.
GIBSON, DUNN & CRUTCHER LLP
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

Counsel for Amici Curiae

July 10, 2009