NO. 08A824

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 2008

GOLDEN GATE RESTAURANT ASSOCIATION, *Applicant*,

v.

CITY AND COUNTY OF SAN FRANCISCO, *Respondent*,

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION ("SEIU"), LOCAL 21; SEIU UNITED HEALTHCARE WORKERS-WEST; and UNITE HERE! LOCAL 2, *Intervenor/Respondents*,

On Application to The Honorable Anthony M. Kennedy, Associate Justice of the United States Supreme Court and Circuit Justice for the Ninth Circuit, for Order Staying Mandate and Vacating Stay of District Court Judgment

JOINT RESPONSE TO APPLICATION FOR ORDER STAYING MANDATE AND VACATING STAY OF DISTRICT COURT JUDGMENT

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Federal Cases

Federal Statutes

State Statutes & Codes

San Francisco Statutes, Codes & Ordinances

Rules

Other References

INTRODUCTION

The fatal flaw in the application filed by the Golden Gate Restaurant Association ("GGRA" or "association") is its failure to provide any reason for emergency intervention. In February 2008, one month after San Francisco's health care spending requirement took effect, the Circuit Justice denied GGRA's first application for a stay. Since that time, the City's program has become fully operational, the medium and large employers covered by the ordinance have been complying with the spending requirement for 15 months, and tens of thousands of previously-uninsured workers now have health coverage under the City's program. There is no basis for disturbing this status quo while the normal certiorari process runs its course.

As a threshold matter, a stay may not issue unless the applicant has demonstrated a likelihood of irreparable harm. Not only has GGRA failed to demonstrate irreparable harm – it has not even *alleged* irreparable harm. The association skips over this prong of the test for a stay entirely, addressing only the three subsequent prongs. This alone requires denial of the stay application.

The closest the association comes to touching upon irreparable harm is its assertion that its members, by continuing to make health care expenditures as they have done for the past 15 months, "may" suffer harm for which there is "no effective remedy." App. at 26. Such a tepid assertion could not establish irreparable harm, even if GGRA had attempted to argue that it did. Indeed, putting aside the general rule that financial loss does not warrant the kind of relief GGRA now seeks, the evidence here suggests there is no financial harm at all. GGRA's members have passed the cost of the health care spending requirement on to their customers in the

form of a health care surcharge, which severely undermines any claim of financial harm. *See* Declaration of Vince Chhabria in Opposition to Application for Order Staying Mandate. In fact, just days after GGRA submitted this application, the association's own director admitted that the health care spending requirement is "working all right now." H. Knight, *Not all restaurants back suit over Healthy S.F.*, San Francisco Chronicle, Mar. 22, 2009 at B-1 (CCSF Appendix, Ex. A).

Nor would a balancing of the equities justify a stay. In addition to the alleged financial harm to its members, GGRA contends that maintenance of the current status quo would inflict harm on businesses nationwide. The association speculates that other state or local governments might emulate San Francisco's program, thereby requiring multi-jurisdictional employers to keep track of more than one local health care spending requirement. This argument primarily goes to the merits of GGRA's preemption challenge. But to the extent GGRA means to argue that laws similar to San Francisco's will crop up before the certiorari process runs its course (and that this somehow would provide a legal basis for emergency intervention), the argument is baseless. Although GGRA makes opaque reference to "similar" measures having been "proposed," it does not, and cannot, point to the actual enactment of a single law similar to San Francisco's since the Court of Appeals allowed the program to take effect 15 months ago. In fact, GGRA does not even cite a *proposal* that was made after San Francisco's program took effect – it cites only a law review article from 2006 that listed laws proposed before the litigation even began.

Pitted against these alleged harms to the association are the very real harms that GGRA's application seeks to inflict upon the City and its

residents. As a result of the employer spending requirement, more than 37,000 San Francisco workers are now covered through the City's program. Staying the lower court decision, and thereby enjoining the health care spending requirement, would cause these workers to lose their coverage and access to critical diagnostic and preventive care and treatment. Moreover, elimination of the spending requirement could outright destroy San Francisco's new health care program, forcing the City to revert to the old, failed model of providing emergency care to uninsured people at public hospitals once it is too late to administer proper preventive and diagnostic care.

Aside from the equities, the case is not worthy of certiorari. Far from creating a split with the Fourth Circuit's ruling in *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007), the decision below operates in harmony with that ruling to stand for the proposition – well established by prior case law – that local governments may impose expenditure requirements on employers so long as those requirements do not interfere with plan uniformity. Moreover, the Court need not rush to decide this legal question, because the likelihood is low that other jurisdictions would quickly adopt similar health care programs. Both the success and legality of San Francisco's program depend on the existence of a comprehensive, government-run health care delivery system that operates at great expense to the City's taxpayers. Particularly given current economic conditions, it is unrealistic to expect that other jurisdictions will rush to follow suit.

In addition, one outcome of the current debate on national health care reform could be to obviate the need for local governments to regulate in this area. Indeed, national health care legislation could moot the legal

question at hand, either by preempting programs like San Francisco's or by expressly authorizing them. This possibility suggests the Court should avoid venturing into the national debate on health care reform by deciding a weighty ERISA preemption question that could be mooted before it ever arises again.

Finally, even if certiorari were granted, it is unlikely the Court would reverse the decision below. GGRA's argument on the merits is that employers have the right not to be required to spend money in areas, like health care, mentioned by the ERISA statute.[1] This fails to recognize the distinction between plan uniformity, which ERISA's preemption provision protects, and expenditure uniformity, which it does not. As the Court has stated, "cost uniformity was almost certainly not an object of pre-emption . . ." *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*, 514 U.S. 645, 662 (1995). And as the Court has explained in cases such as *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987) and *Massachusetts v. Morash*, 490 U.S. 107 (1989), there is a reason ERISA's preemption provision explicitly singles out employee benefit "plans," rather than covering employee benefits generally. *See, e.g., Fort Halifax*, 482 U.S. at 115 ("Given the basic difference between a 'benefit' and a 'plan,' Congress's choice of language is significant in its pre-emption of only the latter"). States and localities may regulate the benefits mentioned in ERISA so long as they do not require alteration of ERISA plans. Because that is precisely what San Francisco's ordinance does, it is not preempted.

[1] 29 U.S.C. § 1002(1).

STATEMENT

A. The Health Care Security Ordinance

Because GGRA's description of the ordinance is incomplete, and because its discussion of the effects of the ordinance on employers and their ERISA plans is inaccurate, we provide a brief description here.

In 2006, roughly 82,000 San Francisco adults suffered from a lack of health insurance – more than one-tenth of the City's population. CCSF Appendix, Ex. B at 3.[2] In response to this health care crisis, the San Francisco Board of Supervisors unanimously passed, and the Mayor signed into law, the Health Care Security Ordinance ("HCSO" or "ordinance"). The ordinance has two key related components – a government health care program and an employer health spending requirement.

The government health care program is operated by the San Francisco Department of Public Health ("DPH"). Its primary feature is the Health Access Program ("HAP"), which delivers health care to its participants from a network consisting of San Francisco General Hospital, DPH clinics, and participating non-profit and private providers. S.F. Admin. Code § 14.2(a).[3] The HAP assigns a primary care physician, nurse practitioner or physician assistant to each participant. And it provides "medical services with an emphasis on wellness, preventive care and

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[2] A common misconception about the uninsured is that they are "taken care of" because they qualify for state or federally funded health care programs for the indigent like Medi-Cal (California's Medicaid program). In reality, most people without health care do not qualify for such programs; rather, they simply go without care or resort to trips to the emergency room when it is too late to receive proper preventive treatment (and then are billed for the high cost of such trips). The 82,000 San Francisco residents who were uninsured do not include the people who were already enrolled in San Francisco's indigent health care programs. CCSF Appendix, Ex. B at 4.

[3] The ordinance, along with the implementing regulations, can be found at CCSF Appendix, Ex. B.

innovative service delivery." S.F. Admin. Code § 14.2(f). Among the specific services provided are inpatient and outpatient hospital services, diagnostic and laboratory services, radiological services, mental health services, home health care, and prescription drug benefits. *Id.* The value of this care is substantial – DPH estimated that in 2008 it cost an average of $261 per participant per month to provide it.[4] CCSF Appendix, Ex. B at 5.

The HAP, which is funded in large part by the City's general fund, is available to uninsured San Francisco residents, regardless of whether they are employed or unemployed. Enrollees must pay quarterly participation fees to receive HAP coverage.[5]

The other key component of the HCSO is the employer spending requirement – a mandate that medium and large businesses make minimum health expenditures on behalf of employees who work more than a specified number of hours. Specifically, in 2008 private employers with 20-99 employees and nonprofit employers with 50 or more employees were required, for any employee who has been employed for 90 days and works more than ten hours per week, to make health care expenditures of $1.17 per hour on behalf of that employee. Private employers with 100 or more employees were required to make health care expenditures of $1.76 per

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

[5] Individual residents who work in San Francisco but live elsewhere do not qualify for HAP participation, but the program contains a feature for those people as well. The ordinance authorizes DPH to establish and maintain medical reimbursement accounts for qualified nonresident employees who work in the City. S.F. Admin. Code §§ 14.1(b)(7), 14.2(g). Beneficiaries of this aspect of the City's program may draw from their accounts to obtain reimbursement for medical expenses, including payments of health insurance premiums. DPH Reg. No. 7(g)(i).

hour on behalf of each covered employee. S.F. Admin. Code. § 14.1(b)(8); OLSE Reg. No. 5.2(A)(1).[6]

It is entirely up to each covered employer to decide how to comply with this spending requirement. The Ordinance defines health care expenditures to mean "any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees." S.F. Admin. Code § 14.1(b)(7). The ordinance makes clear that employers may set up health care plans themselves, or, of they prefer not to do so, they may make payments to the City on behalf of their workers (hereinafter "the city payment option"). *Id.* They may also fulfill the expenditure obligation through a combination of the two. The program is structured so that, if an employer chooses the city payment option, it need only write a check and all employees on whose behalf the payment is made will be eligible to receive health care benefits.

Covered employees who qualify for HAP membership are, if their employers choose to satisfy the spending requirement by paying the City, entitled to enroll in the program at a 75% discount on the quarterly participation fees they would otherwise be required to pay. DPH Reg. No. 7(f). Furthermore, any covered employee whose fee, after the 75% discount, falls below $50 per quarter is simply allowed to enroll for free. *Id.*

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[6] The amount has increased slightly for 2009: $1.85 per hour for large employers and $1.23 per hour for medium employers. OLSE Reg. No. 5.2(B). GGRA has argued that the amount will skyrocket after 2010, CCSF Appendix, Ex. A, but that is false, and in any event, not relevant to whether a stay should be in effect during the certiorari process.

According to studies compiled by the San Francisco Controller's Office, the large majority – approximately ninety percent – of businesses with 20 or more employees already provided health care benefits to their employees at the time the ordinance was enacted. CCSF Appendix, Ex. B at 9. The average monthly health insurance premium in California at that time was $379. *Id.*

The employer health care spending requirement has now been in effect for 15 months. As a result, 37,000 San Francisco workers are covered under the government health program described above. Declaration of Dr. Mitchell H. Katz in Opposition to Application for Order Staying Mandate at ¶11. Thousands of others are enrolled in the program separate and apart from any payment made by an employer. *Id.* Overall, the number of San Francisco residents without health coverage is down to under 23,000, and counting. *Id.* at ¶10.

B. Procedural Background

On December 26, 2007, the district court ruled that the ordinance was preempted by ERISA. The next day, the City and Intervenors filed an emergency application with the United States Court of Appeals for the Ninth Circuit, seeking an order staying the district court's ruling and allowing the employer spending requirement to take effect pending appeal. On January 9, 2008, the Ninth Circuit granted this request, ordered expedited briefing, and set an accelerated date for oral argument on the merits. *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 512 F.3d 1112 (9th Cir. 2008).

After waiting more than one month after the emergency application was granted, GGRA filed an application for a stay of the Ninth Circuit's order with the Circuit Justice. GGRA made arguments that are precursors

to the ones it raises in the present application, namely, that restaurants could suffer financial harm if the spending requirement were allowed to take effect, that the ordinance would require them to keep records, and that businesses could be subject to multiple health care spending obligations as a result of the ordinance. The Circuit Justice denied the stay application. *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, Sup. Ct. Case No. 07A654.

Oral argument on the merits in the Court of Appeals took place on April 17, 2008, and the panel issued its ruling on September 30, 2008, reversing the district court and concluding San Francisco's ordinance is not preempted. *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 546 F.3d 639 (9th Cir. 2008) (*"GGRA II"*). GGRA did not ask the panel for a stay at that time. Instead, it filed a petition for rehearing en banc (but it did not ask the en banc court for a stay either). The en banc petition was denied on March 9, 2009. GGRA Appendix, Ex. F. The mandate issued on March 17, 2009. Meanwhile, San Francisco's health care spending requirement has been in effect, the restaurants and other employers have been complying with it, and 37,000 workers obtained health coverage from the City's program as a result.

STANDARD OF REVIEW

An application for a stay brought pursuant to Supreme Court Rule 23.1 and 28 U.S.C. § 2101(f) may not be granted unless: (1) the applicant demonstrates a likelihood of irreparable harm; (2) the equities favor a stay; (3) there is a reasonable probability that four members of the Court would consider the underlying issue worthy of certiorari; and (4) there is a significant possibility that the Court will reverse the decision below. *See, e.g., Certain Named and Unnamed Non-citizen Children and Their Parents*

v. Texas, 448 U.S. 1327, 1330 (1980) ("*Non-citizen Children*") (Powell, J., in chambers).

It bears emphasis that if an applicant fails to demonstrate a likelihood of irreparable harm, the stay application must be denied for that reason alone, rendering consideration of the other elements of the test unnecessary. *See Whalen v. Roe*, 423 U.S. 1313, 1316 (1975) (Marshall, J., in chambers) (conclusion that applicant has shown no irreparable harm "necessarily decides the application and renders unnecessary" any consideration of the remaining elements). *See also Ruckelshaus v. Monsanto Co.*, 463 U.S. 1315, 1317 (1983) (Blackmun, J., in chambers).

However, if an applicant does demonstrate irreparable harm, this does not obviate the need to inquire whether the equities justify a stay, including whether a stay would be in the public interest. "It is ultimately necessary, in other words, 'to balance the equities – to explore the relative harms to applicant and respondent, as well as the interests of the public at large.'" *Barnes v. E-Systems, Inc.*, 501 U.S. 1301, 1305 (1991) (Scalia, J., in chambers) (quoting *Rostker v. Goldberg*, 448 U.S. 1306, 1308 (1980) (Brennan, J., in chambers)). *See Generally* R. Gressman, K. Geller, S. Shapiro, T. Bishop & E. Hartnett, Supreme Court Practice 873 (9th. ed. 2007).

More generally, in the context of an in-chambers stay application, there is a "presumption that the decisions below – both on the merits and on the proper interim disposition of the case – are correct." *Rostker*, 448 U.S. at 1308. Accordingly, a Circuit Justice "will grant a stay only in extraordinary circumstances." *Bartlett v. Stephenson*, 535 U.S. 1301, 1304 (2002) (Rehnquist, C.J., in chambers) (quoting *Whalen*, 423 U.S. at 1316). *See, e.g., CBS Inc. v. Davis*, 510 U.S. 1315, 1317 (1994) (Blackmun, in

chambers) ("extraordinary circumstances" present where lower court ruling would lead to "indefinite delay" of broadcast that would "cause irreparable harm to the news media that is intolerable under the First Amendment").

ARGUMENT

I. GGRA HAS FAILED TO ALLEGE, MUCH LESS ESTABLISH, IRREPARABLE HARM.

There is a fatal omission in GGRA's application. It argues three of the four requirements for a stay: that there is a reasonable probability the Court will grant certiorari, App. at 8, that there is a significant possibility the Court will reverse the decision below, App. at 12, and that the "balance of equities" favors the association. App. at 24. But the application completely omits any discussion of whether there is a likelihood of irreparable harm. GGRA has submitted no evidence, made no factual assertions, and advanced no legal argument about irreparable harm. Accordingly, no further inquiry is needed – the application must be denied for failure to allege, much less demonstrate, irreparable harm. *See* p. 11, *supra*.

The only portion of the application that could be construed as relating to irreparable harm (even though GGRA does not characterize it as such) is the statement that, absent a stay, restaurants with more than 20 employees will continue making health care expenditures under the ordinance, as they have done for the past 15 months. GGRA asserts that there "may" not be an "effective remedy" for this alleged injury. App. at 26. Putting aside the general rule that monetary injury does not give rise to relief of this kind, *cf. Non-citizen Children*, 448 U.S. at 1332-34, in this case the evidence indicates there has been no financial harm at all – irreparable or otherwise. Shortly after the program took effect, restaurants in San Francisco began passing the cost of the health care spending

requirement on to their customers, in the form of a "Healthy San Francisco" surcharge. *See* Chhabria Decl., Ex. A (receipts and menus reflecting surcharge). Indeed, because restaurants have successfully passed on this cost, and because San Francisco restaurant patrons have been widely supportive of it, GGRA's own director has publicly stated that the health care expenditure requirement is "working all right now." CCSF Appendix, Ex. A. This statement from GGRA's director came just days after GGRA submitted its emergency application to the Circuit Justice. Perhaps that is why GGRA is unwilling to allege its members suffer from irreparable financial harm.

II. THE EQUITIES MILITATE STRONGLY AGAINST A STAY.

Even if one were to assume irreparable harm despite GGRA's failure to allege it, the equities would not justify a stay. In fact, compared to when GGRA sought a stay from the Circuit Justice 13 months ago, the equities in favor of the City and its residents are now much stronger. Back then, the City had only begun implementing its program, the medium and large employers impacted by the spending requirement had not yet developed their systems for making health care expenditures, and workers had not yet obtained health coverage as a result of payments by their employers. Now, the program is fully operational, the medium and large employers have been making their payments, and roughly 37,000 workers enjoy health coverage from the City as a result. A stay would disturb this status quo by stripping people of their health coverage, and could potentially destroy the City's new universal health program in the process.

A. The Harm To GGRA And To Other Businesses Is Minimal.

Aside from GGRA's tepid and unsupportable assertion of financial hardship, the association claims its members are being harmed by the ordinance's recordkeeping requirements. App. at 26. But those requirements are neither onerous nor complex. GGRA's members must maintain itemized pay statements, which is already mandated by California Labor Code section 226. The ordinance requires them to maintain the name, address, phone number and first day of work of each employee, and records of health care expenditures made on behalf of those employees. And they must file annual reports with the City to prove quarterly compliance, which simply involves dividing the amount spent on health care by the hours worked by covered employees. S.F. Admin Code § 14.3. GGRA has not explained how maintaining these records or reporting this information would harm its members. Indeed, GGRA has not explained why such information would not already be maintained in the normal course of business.

Beyond the purported recordkeeping hardship for GGRA's members, the association makes passing reference to alleged financial and recordkeeping hardship that other San Francisco employers covered by the ordinance would suffer if the program continues during the certiorari process. However, no other San Francisco employer has challenged the validity of the program, and accordingly there is no reason to assume that businesses other than some of GGRA's members consider themselves harmed by it. Indeed, the great majority of medium and large employers in San Francisco actually benefit from the health care spending requirement, because they were already providing health insurance to their employees. CCSF Appendix, Ex. B at 9. Any employer that previously spent enough

money on health care to satisfy the ordinance is no longer at a competitive disadvantage vis-a-vis the minority of medium and large employers that had chosen not to spend money on employee health benefits.[7]

GGRA next asserts that the decision below inflicts harm beyond San Francisco, because it could cause multi-jurisdictional employers to be subjected to a flood of different health care spending obligations. To the extent GGRA means to contend that multi-jurisdictional employers will be subjected to different spending obligations *during the certiorari process*, that is without any support. GGRA has not identified a single piece of legislation that has even been proposed, much less enacted, since the Court of Appeals allowed San Francisco's program to take effect 15 months ago. Instead, it cites a law review article from 2006 – before San Francisco's ordinance was even enacted – for the proposition that "over thirty similar statutes *had been* proposed . . ." App. at 9 (emphasis added). The claim of impending nationwide hardship during the certiorari process is illusory.

Even if proposals like the ones listed in GGRA's law review article were pending today, this still would not be a hardship. First, many of those proposals were similar or identical to the Maryland law struck down by the Fourth Circuit, and dramatically different from the ordinance San Francisco has enacted.[8] As discussed in Section III, the Ninth Circuit explained that San Francisco's ordinance was not preempted precisely because of its differences from the Maryland law. Second, the claim of hardship for

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[7] Moreover, even those medium and large employers whose health care spending was affected by the ordinance have received a benefit, because their employees have received health coverage as a result, thereby blunting any claim of harm to those businesses.

[8] *See., e.g.*, Senate Bill No. 1414, 2005-2006 Reg. Sess. (Cal. 2006); House Bill No. 2579, 81st Leg., 2006 Reg. Sess. (Kan. 2006); House Bill No. 2517, 59th Leg., 2006 Reg. Sess. (Wash. 2006).

multi-jurisdictional employers presumes that GGRA is correct on the merits – specifically, that local governments may not impose spending requirements on employers. But as discussed in Section IV, this Court has already made clear that ERISA does not protect employers from local payment requirements merely because they apply to areas mentioned by ERISA.

GGRA's final claim of hardship relates in some fashion to the stimulus package recently passed by Congress and signed into law by the President. App. at 25. The association observes that the ordinance, by allowing San Francisco employers to comply with the health care spending requirement by making payments to the City for their employees' benefit, has given those employers a means to provide health coverage that would not be covered by COBRA. It is difficult to understand what hardship this creates. GGRA seems to be assuming that workers who received no coverage prior to the ordinance, but who now receive comprehensive coverage from the City, are worse off than before because COBRA does not apply to the HAP. This makes no sense. GGRA's invocation of COBRA and the stimulus package appears to be nothing more than an attempt to manufacture one issue not already presented in its unsuccessful stay application from last year.

B. A Stay Would Impose Substantial Hardship On The City And Its Residents.

Since San Francisco's program took effect, the number of residents without health coverage has been reduced from 82,000 to fewer than 23,000. Katz Dec. at ¶10. And as a direct result of the employer spending requirement, more than 37,000 workers now have health coverage from the

City's program. *Id.* at ¶11.[9] A substantial percentage of those enrolled in the program are receiving essential preventive and diagnostic care for chronic conditions such as asthma, heart disease, diabetes, hypertension or cancer. In all, the HAP has so far provided 73,414 health visits, filled 83,200 prescriptions for medication, and performed 2,350 surgical procedures. 41% of those health visits were for conditions that, if left untreated, would lead to heart disease. Another 45% were for conditions that, if left untreated, would lead to hospital-based emergency department overuse. *Id.* at ¶¶12-14. In short, San Francisco is well on its way to resolving its health care crisis.

GGRA's application seeks to force San Francisco back into the old, failed paradigm for health care delivery that the City and its health officials have worked so hard to escape. Most immediately, elimination of the employer spending requirement would deprive these 37,000 workers of their existing health coverage through San Francisco's program. *Id.* at ¶15. This loss of coverage would likely cause substantial numbers of these individuals to cancel planned medical visits and surgeries, forego ongoing medical treatment and prescription medicine, and otherwise take health risks that will result in major declines in health and unnecessary hospitalizations. *Id.* And it has been firmly established that when people lose their health coverage, they receive less care, they are likely to experience major declines in health, and are more likely to be hospitalized. *Id.* Particularly given that many HAP participants have chronic conditions that require regular treatment and monitoring in order to avoid significant

[9] This does not even account for the thousands of workers whose employers chose to provide coverage themselves rather than complying through the city payment option. The City has not yet collected data on this point.

health risks and complications, serious human suffering would result if the stay were granted.

To cite an example the Director of Public Health provides to illustrate the importance of the program, one former restaurant worker with a chronic heart condition, mitral valve prolapse, was unable to obtain health insurance. She needed surgery for her condition, which would have cost her more than $100,000 if performed at a private facility, rendering it unaffordable for her. Because this person was able to join the HAP, she obtained the surgery, and believes she might not still be alive today if she had been unable to obtain this service from the City's new program. *Id.* at ¶16.

GGRA misleadingly suggests none of this matters because San Francisco "already has an obligation," under state law, "to provide health services to its residents." App. at 27. What California law actually states is that counties must provide health services to "indigent" residents. Cal. Welf. & Inst. Code § 17000. Residents who qualify for indigent health care services are deemed "insured" for purposes of this measurement, and therefore the residents who qualify as "indigent" for purposes of this code section were not part of the group of 82,000 uninsured residents that existed before the ordinance became operative. CCSF Appendix B at 4. Accordingly, this state law provision will do nothing to diminish the adverse consequences of a stay for San Francisco and its residents.

The association also suggests that even if the 37,000 workers lost their existing health coverage, the harm they would suffer is speculative because, should they encounter health problems, they might still seek emergency care at San Francisco General Hospital. App. at 28. But reliance on public hospital emergency rooms to provide care to the

uninsured is the very embodiment of the health care crisis the ordinance seeks to address (and that is now a subject of national debate, as discussed *infra*). As the brief of the California Medical Association demonstrated below, a system that relies on use of emergency rooms by the uninsured imposes a tremendous financial strain on local governments, prevents emergency rooms from actually saving lives in true medical emergencies, and deprives the uninsured of the preventive care, diagnostic care, and the monitoring they need to avoid emergencies in the first place. CCSF Appendix, Ex. C at 8-12. Following enactment of the ordinance, emergency room visits to San Francisco General Hospital went down almost *seventy percent* – from 29,976 in the second quarter of 2007 to 8,944 in the second quarter of 2008. *Id.* at 5. GGRA's suggestion that there would be no harm in returning to the old way of dealing with the health care crisis is, to put it charitably, crass.

Even beyond the 37,000 workers who are currently covered, shutting down the health care spending requirement could destroy the City's health care program altogether. If the City were to offer comprehensive health care to its residents without an employer spending requirement, there would be tremendous incentive for employers that currently provide health insurance to their workers to drop that coverage, on the assumption that the workers will simply be absorbed into the HAP. Indeed, workers themselves might prefer that their employer-based coverage be dropped in exchange for a wage increase, given the availability of comprehensive health coverage from the HAP. The impact of this shift could be tremendous – it bears repeating that, prior to enactment of the ordinance, roughly 90% of medium and large employers already provided health insurance to their employees. If even a meaningful portion of those

workers were foisted onto the City's program, the strain on the HAP may be too great to bear. Katz Decl. at ¶18. The City, in this time of budget shortfalls, cannot realistically be expected to invest the even greater amounts of public dollars that would be necessary to achieve universal health care in the face of widespread cancellation of employer-based health plans, not to mention the loss of tens of millions of dollars in annual revenue the HAP receives from employer payments. *Id.* at ¶11.

Finally, the equities tip sharply on the side of the City because it has invested a tremendous amount of money and time to bring the employer spending requirement into operation, all of which would have to be repeated if the requested stay was entered and the law was subsequently upheld. Over the past year, the City has invested hundreds of thousands of dollars on a widespread educational campaign to inform employers of the ordinance and educate them about their compliance options. Katz Decl. at ¶7. And it has spent millions of dollars to create enrollment systems and other tools to ensure that employers and their workers would readily benefit from the coverage under the City's program. *Id.* at ¶9. If the health care spending requirement were to be shut down, only to resume again a year later (after favorable ruling by this Court or, say, an act of Congress that explicitly authorized the program while the case is still pending), much of this time and expenditure would have been wasted, and would have to be repeated. *Id.* at ¶8.

In short, the hardship alleged by GGRA pales in comparison to the harm the City and its residents would suffer should GGRA succeed in its effort to obtain a stay.

III. THE CASE IS NOT WORTHY OF CERTIORARI.

A. The Decision Below Does Not Create A Split With The Fourth Circuit.

The circuits are in agreement that "[w]here a legal requirement may be easily satisfied through means unconnected to ERISA plans, and only relates to ERISA plans at the election of an employer, it affects employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Keystone Chapter, Associated Builders & Contractors v. Foley*, 37 F.3d 945, 960 (3d Cir. 1994) (internal quotations, citations and brackets omitted). *See also Fielder*, 475 F.3d at 193; *Hattem v. Schwarzenegger*, 449 F.3d 423, 429 (2d Cir. 2006); *S. Cal. IBEW-NECA Trust Funds v. Standard Industrial Elec. Co.*, 247 F.3d 920, 925 (9th Cir. 2001); *WSB Elec. Inc. v. Curry*, 88 F.3d 788, 795 (1996).

This agreed-upon rule is based on this Court's authority, which establishes that local laws which *influence choices* relating to ERISA plans are not preempted unless the influence on an employer's choice is so great that it amounts to a *substantive mandate* regarding an ERISA plan. *See Travelers Ins.*, 514 U.S. at 664 ("Although even in the absence of mandated coverage there might be a point at which an exorbitant tax leaving consumers with a Hobson's choice would be treated as imposing a substantive mandate, no showing has been made here that the surcharges are so prohibitive as to force all health insurance consumers to contract with the Blues"); *see also Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 332-33 (1997).

Far from creating a split, the decisions of the Fourth Circuit in *Fielder* and the Ninth Circuit in this case, taken together, do nothing more than apply these well-established principles in the context of health care spending. As the Fourth Circuit explained, the spending requirement at

issue in *Fielder* was preempted because it imposed a penalty that forced the employer to alter its ERISA health care plan, while, as the Ninth Circuit explained, San Francisco's ordinance is not preempted because it creates a comprehensive government health care program into which employers may pay on behalf of their workers, thereby providing them with a reasonable compliance option that does not involve the alteration of an existing ERISA plan or the creation of a new plan.

Specifically, *Fielder* involved a preemption challenge to Maryland's Fair Share Act, which provided that any Maryland for-profit employer with more than 10,000 employees that does not spend up to 8% of its payroll on health insurance (*i.e.*, Wal-Mart) must make up the deficiency by paying it to the Secretary of Labor. *Id.* at 184. The Secretary of Labor was authorized to use the proceeds of any payments by Wal-Mart to fund Maryland's Medicaid program. *Id.* Wal-Mart's employees would not receive any additional benefits, services, or cost savings in return for such payments. *Id.* at 193.

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

> In effect, the only rational choice employers have under the Fair Share Act is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold. The Act thus falls squarely under

> *Shaw*'s prohibition of state mandates on how employers structure their ERISA plans.

Id. at 193-194.

As the Ninth Circuit explained, San Francisco's ordinance, "[i]n stark contrast to the Maryland law, . . . offers employers a meaningful alternative that allows them to preserve the existing structure of their ERISA plans." *GGRA II*, 546 F.3d at 660. Employees whose employers comply through payments to the City, rather than by establishing or altering ERISA plans, receive "tangible benefits" in return. *Id.*

Highlighting the reasonableness of this choice as compared to the penalty in Maryland, 894 employers have selected the city payment option since the health care spending obligation took effect. Katz Decl. at ¶11. That so many employers have selected the city payment option is not surprising, since it allows employers to avoid the inconvenience of setting up their own ERISA plans, while ensuring that their workers will receive comprehensive health coverage from the City at a price far lower than it would cost in the private market.[10]

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[10] Specifically, by simply writing a check to the City, employers avoid a burden that may include hiring an employee benefits consultant, learning about and deciding among the many benefit options, contracting with a third party administrator to maintain the plan and process employee claims, preparing the disclosure documentation required by ERISA, complying with ERISA's reporting requirements, and potentially exposing themselves to ERISA-related litigation. And the health benefits received by employees from the City will often be extraordinarily generous in relation to the amount paid by the employer. As discussed at pp. 7-9, *supra*, the average insurance premium in California $379 per month when the ordinance took effect. In contrast, for a medium sized employer with an employee who works 20 hours per week, the employer could satisfy its spending obligation in 2008 by paying the City $93.60 per month. This allowed the employee to obtain a HAP membership that provides comprehensive health services, which cost the City on average $261 per month to provide. In other words, if the employer chooses the government payment option, its employees receive comprehensive health benefits for pennies on the dollar, and the City picks up the rest of the tab.

Notwithstanding this, GGRA claims an inter-circuit conflict based on the Fourth Circuit's discussion of an issue that was not presented to, or considered by, the Ninth Circuit here. Specifically, after holding that the option of paying the government was nothing more than a penalty that forced Wal-Mart to alter its ERISA plan, the court went on to address Maryland's alternative argument that Wal-Mart had other, private non-ERISA means for complying. These alternatives, according to Maryland, were to satisfy the spending requirement through the creation and administration of on-site medical clinics, or through the establishment of Health Savings Accounts ("HSAs"). The court rejected this argument on the ground that the purported alternatives were unrealistic. 475 F.3d at 196. And *then* the court observed that even if Wal-Mart could avail itself of these options, doing so would necessarily also produce a change in the company's ERISA plan:

> If 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. For example, an individual would be eligible to establish a Health Savings Account only if he is enrolled in a high deductible [ERISA] health plan. *See* 29 U.S.C. § 223(c)(1). In order for Wal-Mart to make widespread contributions to Health Savings Accounts, it would have to alter its package of ERISA health insurance plans to encourage its employees to enroll in one of its high deductible health 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. As Judge William Fletcher pointed out in his opinion concurring in the denial of rehearing en banc, GGRA and the dissenting judges omit the sentences from the above passage which show that the

Fourth Circuit was addressing Maryland's specific argument pertaining to on-site medical clinics and HSAs. GGRA Appendix, Ex. F.

Accordingly, the decisions of the Fourth and Ninth Circuits are not in conflict. Both decisions apply well-established precedent, and their holdings operate in harmony to reaffirm the general ERISA preemption principle – in the specific context of heath care – that while a local government may not effectively force employers to alter or adopt ERISA plans, it may impose spending obligations that allow employers to comply while leaving ERISA plans undisturbed.[11]

B. Other Factors Counsel Against A Grant Of Certiorari.

Particularly given the absence of an inter-circuit conflict, even if the Court believes this ERISA preemption issue may someday be worthy of review, there are substantial reasons to avoid confronting the issue at this time, in the context of this case.

First, there is no serious possibility that other jurisdictions will adopt programs like San Francisco's in the near future. GGRA has cited only measures that were proposed prior to 2006; it does not cite one measure proposed after the Ninth Circuit allowed San Francisco's program to take effect. Furthermore, many of those pre-2006 proposals were similar or identical to the law struck down by the Fourth Circuit. *See* p. 15, supra. Under the Ninth Circuit's reasoning, proposals of this kind have not been given new life.

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[11] GGRA also contends this case is worthy of certiorari because the decision below conflicts with the decisions of this Court. Because, in reality, a ruling striking down San Francisco's program would require the Court to jettison its existing precedent, GGRA's contention in this regard is more appropriately addressed in Section IV, which explains why a majority of the Court would be unlikely to reverse the decision below.

Moreover, it would be extraordinarily difficult for other jurisdictions to establish the type of reasonable non-ERISA compliance option provided by San Francisco's ordinance: payment into a comprehensive, government-run health care program that the City invested significant public dollars to build, and spends significant public dollars (substantially more than that received from employer payments) to maintain. Particularly in this time of financial hardship for state and local governments, it will be challenging indeed to follow in San Francisco's footsteps.

Of course, if that turns out wrong, and if GGRA's dire forecast of multiple health care obligations across jurisdictions bears out, then the Court will have ample opportunity to address the matter in the future. But because there is no reason to credit GGRA's assertion that multiple laws are on the verge of sprouting up, and because GGRA's contention that compliance with multiple spending requirements will be unworkable for employers is presently based on pure speculation, intervention by the Court is not required at this time.

On a related note, the national discussion on President Obama's proposal for health care reform is beginning in earnest, and there are reasons for the Court to avoid venturing into that discussion. Generally speaking, the enactment of national heath care legislation could obviate the need for local governments to act separately to address the health care crisis – indeed, this is presumably another reason other jurisdictions are not rushing to build programs of the HAP's magnitude. And if the federal government enacts legislation that includes an employer spending requirement as the President has proposed, this would presumably preempt local requirements like San Francisco's. Or, national health care reform may take another route, by explicitly authorizing local requirements like

San Francisco's. Either way, the outcome of the health care debate could very well moot the ERISA preemption issue GGRA urges the Court to take up immediately.

IV. THE DECISION BELOW IS CORRECT.

Finally, even if the Court were to grant certiorari, it would likely affirm the decision below. GGRA's argument on the merits is that local governments may not subject employers to health care expenditure requirements. This argument rests on the assumption that when it comes to matters (like health care) that are mentioned in ERISA, local governments simply may not impose expenditure requirements. This Court has rejected that assumption. Indeed, the Court would be required to repudiate the principles expressed in its existing ERISA preemption cases to rule in GGRA's favor.

Although ERISA's preemption provision protects employers' ability to maintain *plan* uniformity, it does not guarantee *expenditure* uniformity for employers. For example, in *Fort Halifax*, the Court held that a state law requiring minimum severance pay expenditures was not preempted because it did not interfere with plan uniformity. The Court made clear that states and localities may regulate the benefits mentioned in ERISA so long as they do not require alteration of ERISA plans:

> Appellant's basic argument is that any state law pertaining to a type of employee benefit listed in ERISA necessarily regulates an employee benefit plan, and therefore must be pre-empted. Because severance benefits are included in ERISA, *see* 29 U.S.C. § 1002(1)(B), appellant argues that ERISA pre-empts the Maine statute. In effect, appellant argues that ERISA forecloses virtually all state legislation regarding employee benefits. This contention fails, however, in light of the plain language of ERISA's pre-emption provision, the underlying purpose of that provision, and the overall objectives of ERISA itself. . . . ERISA's pre-emption provision does not refer to state laws relating to "employee benefits," but to state laws

> relating to "employee benefit *plans*" . . . The words "benefit" and "plan" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic difference between a "benefit" and a "plan," Congress' choice of language is significant in its pre-emption of only the latter.

482 U.S. at 7-8 (emphasis in original).

Similarly, in *Morash*, the Court considered the preemptive effect of ERISA on state laws requiring the payment of unused vacation benefits to employees upon their discharge. Even though vacation pay is listed in ERISA, the Court concluded that such state laws are not preempted, so long as they do not infringe upon ERISA plans. 490 U.S. at 114-15.

In the area of health care itself, the very structure of ERISA necessarily contemplates that employers will be subject to disparate costs across jurisdictions. After all, ERISA's savings clause exempts from preemption state laws regulating insurance. 29 U.S.C. § 1144(b)(2)(A). This has resulted in the enactment of more than 1,961 mandates on health insurance, and no two states impose identical sets of coverage mandates. Victoria Craig Brunce et al., *Health Insurance Mandates in the States*, Council for Affordable Health Insurance (2008 ed.) at 1. Accordingly, the cost of employer-provided health insurance varies wildly from state to state. *Id.* at 3-5.

Congress never could have included the savings clause if it had viewed ERISA as preserving expenditure uniformity for employers in the area of health care. "Such disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985). And that is why "*cost uniformity was almost certainly not an object of pre-emption*, just as laws with only an indirect economic effect on the relative

costs of various health insurance packages in a given State are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA *plans*." *Travelers*, 514 U.S. at 662 (emphasis added).

The upshot is that employers commonly face differing cost (and recordkeeping) requirements in different jurisdictions. They are subject to varying severance pay requirements, minimum wage requirements, vacation pay requirements, apprenticeship and/or training program requirements, taxes, fees, and sick leave requirements, to name just a few. And a requirement in one of these areas may affect the employer's decision about expenditures in another area. Such is the unavoidable (and utterly unremarkable) consequence of doing business in multiple jurisdictions in the United States.

In sum, ERISA does not insulate businesses from being required to spend money. Local requirements are only preempted if they interfere with *plan* uniformity, and as discussed at length herein, San Francisco's ordinance does not do that. To reverse the decision below, the Court would be required to repudiate the principles discussed above, as well as the cases that articulate them, such as *Fort Halifax*, *Morash*, *Travelers*, and *Dillingham*. Accordingly, it is unlikely that five Justices of this Court would rule in GGRA's favor on the merits.

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CONCLUSION

The application for a stay should be denied.

Dated: March 27, 2009

Respectfully submitted,

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