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 WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE WASHINGTON LEGAL FOUNDATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether ERISA section 514(a), 29 U.S.C. § 1144(a), preempts local "pay-or-play" laws mandating that employers with ERISA-regulated benefit plans: (1) pay specified amounts to obtain health care benefits for employees employed within the locality, and (2) comply with detailed coverage and record-keeping requirements beyond those required by ERISA?

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INTRODUCTION AND INTEREST OF AMICUS CURIAE[1]

The decision below poses a serious threat to the viability of the voluntary employer-provided benefit systems relied upon by an estimated 177 million U.S. residents for, among other things, their health care needs. These plans are generally regulated by the federal Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, which encourages employers to provide health and welfare benefits through an efficient, uniform regulatory structure, backed by a preemption provision that this Court has aptly characterized as "conspicuous for its breadth." *FMC Corp.* v. *Holliday,* 498 U.S. 52, 58 (1990); *see* ERISA section 514(a), 29 U.S.C. § 1144(a).

Notwithstanding ERISA's broad preemption provision, in recent years numerous state and local governments have attempted to mandate benefits or benefit levels for employees at private companies through so-called "pay-or-play" laws. These laws generally require employers to spend specified amounts on health care on behalf of their employees, either by providing those benefits directly through their ERISA-governed plans ("play"), or by paying the state or local government to provide such benefits ("pay"). These attempts generally have failed, in

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[1] Pursuant to Supreme Court Rule 37.6, no counsel for a party authored this brief in whole or in part. No person or entity, other than the Washington Legal Foundation and its counsel, made a monetary contribution intended to fund the preparation and submission of this brief. WLF is filing its brief with the consent of all parties. Letters of consent have been lodged with the Court.

large part because legislators have believed, and courts (including the Fourth Circuit) have found, that such mandated benefit programs are preempted by ERISA.

In the decision below, however, the Ninth Circuit ruled that a typical "pay-or-play" scheme—this one imposed by the San Francisco Health Care Security Ordinance—is *not* preempted by ERISA. That decision will now permit the enactment of similar schemes throughout the Ninth Circuit–which covers some twenty percent of the U.S. population. And the decision, unless reversed, is likely to open the floodgates to massive waves of state and local regulation of ERISA-governed health plans in other circuits as well—regulation that will dramatically increase the cost and administrative burden associated with providing health care benefits. Such a patchwork quilt of regulation – which is precisely what Congress intended to prevent with the enactment of ERISA – will have far-reaching, adverse consequences for the cost of employer-sponsored health care benefits. It will also adversely affect the provision of retirement and other ERISA benefits, which many employers may scale back or eliminate as a result of the increased financial burdens created by "pay-or-play" schemes like the one at issue here.

Such a result would seriously disserve the interests of *amicus curiae,* the Washington Legal Foundation ("WLF"). WLF is a non-profit public interest law and policy center based in Washington, D.C., with supporters in all 50 states. WLF devotes a substantial portion of its resources to defending and promoting free enterprise, individual rights, and a limited, accountable government. WLF regularly appears in

this Court and other federal courts to express its view that government should avoid over-regulation of business. WLF further believes that "pay-or-play" laws like the one at issue here do just that.

STATEMENT

The San Francisco Health Care Security Ordinance (the "Ordinance"), S.F. Cal. Admin. Code, Ch. 14 (2008), has two key components: an employer health spending requirement, and the Health Access Program ("Program"), a city-run health care program funded in part by employer contributions. App. 84a–85a. The Ordinance requires employers to meet minimum health care spending levels for each covered employee—either by making direct payments to the City and County of San Francisco ("City") "to be used on behalf of covered employees" through the Program, or by paying for qualifying health care benefits through other means. *Id.* at 84a. The Ordinance imposes detailed reporting requirements for each covered employee. *Id.* at 85a. The Ordinance creates a new administrative regime to enforce compliance. *Id.* at 85a.

Golden Gate Restaurant Association ("GGRA"), a non-profit association that promotes the interests of the restaurant industry, filed suit in district court seeking an injunction against the enforcement of the Ordinance's employer health spending requirements. *Id.* at 85a–86a. The U.S. District Court for the Northern District of California granted summary judgment in favor of GGRA. *Id.* at 93a. The district court found the Ordinance had "an impermissible connection with employee welfare benefit plans," and therefore was preempted. The court concluded that the Ordinance, *inter alia,* interfered with the nation-

ally uniform administration of ERISA plans, and it imposed recordkeeping, inspection, and other administrative burdens related to employer health care expenditures that went well beyond ERISA's requirements. *Id.*, at 94a, 97a. The district court also found that ERISA preempted the employer spending requirements because they made "unlawful reference to employee benefit plans." *Id.* at 98a.

The Ninth Circuit reversed. It held that the Ordinance did not "relate to" ERISA plans because it did not *require* employers to establish or alter ERISA plans, *i.e.,* they could choose to make payments to the City and leave their plans intact. *Id.* at 11a–12a; 14a. The Ninth Circuit also held that the Ordinance did not make an unlawful "reference to" ERISA plans, in part because "an employer's obligations to the City are measured by reference to the *payments* provided by the employer" rather than the "*benefits* provided by the ERISA plan to the employee." *Id.* at 35a.

The Ninth Circuit denied GGRA's petition for rehearing *en banc* over a dissent by Judge Milan D. Smith, joined by seven judges. GGRA petitioned this Court for a Writ of Certiorari.

REASONS FOR GRANTING THE PETITION

The Petition raises an issue of exceptional importance: whether the administration of the employer-sponsored health care benefits of some 177 million persons can be made subject to separate regulation in potentially 50 states and 30,000 localities, with each state and locality being allowed to impose its own contribution and record-keeping requirements, and its own compliance and enforcement machinery. As the judges who dissented from the denial of the peti-

tion for *en banc* review pointed out, the panel's decision provides every state and local jurisdiction in the Ninth Circuit – and arguably in the entire nation – a "roadmap...on how to design and enact a labyrinth of laws requiring employer compliance on health care expenditures, thereby creating the very kind of health care balkanization ERISA was intended to avoid." Pet. App. 49a (M. Smith, J., *dissenting*).

If allowed to stand, the Ninth Circuit's decision will set off a chain reaction of state and local regulation that will undermine employer-sponsored benefit plans. Mandated contributions in some states and localities will create pressure on employers to alter their plans to make them less costly in states and localities without mandated contributions. That, in turn, will create pressure on states and localities to implement mandates to protect their own citizens. Each new law will create its own standards of coverage, contribution levels, record-keeping and reporting requirements, and enforcement mechanisms.

WLF agrees with the analysis presented in the Petition demonstrating (a) the existence of a circuit conflict on the question presented, and (b) the impossibility of reconciling the Ninth Circuit's decision with ERISA's preemption provision and this Court's decisions interpreting that provision. WLF writes separately to explain how the cumulative burden of state and local laws that will quickly be enacted will have potentially disastrous consequences for the administration of employee health care and other benefit plans, if the Court does not forestall such legislation by granting the petition and reversing the Ninth Circuit's decision. WLF addresses first, how the Ordinance burdens employers, second, how these bur-

dens will only increase as other state and local governments follow San Francisco's example, and finally, why "Pay-or-Play" laws are preempted under ERISA.

I. The San Francisco Ordinance Imposes Substantial Burdens On Employers In The Provision Of Employee Health Care Benefits.

To assess the burden that the Ordinance places on employers, and therefore, on the implementation and administration of employer-sponsored ERISA plans, it is important to understand the Ordinance's structure and administrative requirements. These requirements, which exist separate and apart from ERISA, are detailed below. And they impose enormous burdens on employers, especially small- and medium-sized employers.

A. Covered Employers Must Undergo A Detailed Analysis To Determine The Required Contribution Levels For Each Covered Employee.

For example, the Ordinance requires employers to undertake a detailed analysis to determine their obligation to make benefit contributions to the City on behalf of employees. The City summarizes the process in a four page, multi-step decision tree.[2]

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[2] San Francisco Office of Labor Standards Enforcement, Steps to Determine Whether a Covered Employer Has Met its Spending Requirement under the SF Health Care Security Ordinance (HSCO) 1 http://www.sfgov.org/site/uploadedfiles/olse/hcso/Steps%20to%20Calculate%20HCE%20flowchart(1).pdf (last visited Jul. 8, 2009).

First, an employer must determine whether it is a "covered employer," and if so, whether it is a "large" or "medium" employer. S.F. Admin. Code §§ 14.1(b)(3), (11), (12), (15).

Second, if the employer is "covered," it must ascertain which of its employees are "covered." S.F. Admin. Code § 14.1(b)(2). The definition does not include all San Francisco-based employees, but may include employees located elsewhere. To be covered, an employee must work in the City and be entitled to payment of a minimum wage pursuant to the San Francisco Minimum Wage Ordinance. §§ 14.1(b)(2), 12R. The employee must have been employed for ninety days (though not necessarily continuously or consecutively), and must have worked a number of hours in San Francisco that varies from year to year. §§ 14.1(b)(2)(a)-(c); Office of Labor Standards Enforcement ("OLSE" or "Enforcement Office") Regulations No. 3.1(B).

If these criteria are met as to *any* employee, the employer must then determine whether the employee falls within a number of exclusions from coverage. An otherwise covered employee is excluded if he or she: (1) is "managerial, supervisorial, or confidential, unless such employees earn annually under...[a] figure as set by the administering agency" S.F. Admin. Code § 14.1(b)(2)(d); (2) is eligible for Medicare or TRICARE/CHAMPUS, § 14.1(b)(2)(e); (3) is a "covered employee" as defined by San Francisco's (separate) Health Care Accountability Ordinance. S.F. Admin. Code §§ 14.1(b)(2)(f), 12Q; (4) is employed by a nonprofit corporation for up to one year as a trainee in a bona fide training program consistent with Federal law, which enables the trainee to advance into a

permanent position, provided that the trainee does not replace, displace, or lower the wage or benefits of any existing position or employee, S.F. Admin. Code § 14.1(b)(2)(g); or (5) has benefits through another employer and signs a voluntary written waiver of the Ordinance's requirements that is revocable by the employee at any time. § 14.1(b)(2)(h).

Third, employers must determine how much the Ordinance requires them to spend on health care benefits. To do so, they must determine the applicable hourly rate, which varies depending on the employer's size and the time-period covered. S.F. Admin. Code § 14.1(b)(8). Then, they must multiply the applicable hourly rate by the number of hours for which the employee was paid in the period for work "performed within the City." S.F. Admin. Code § 14(b)(10). Work is done "within the City" if the employee performs the work within the geographic boundaries of the City, including employees who work from their homes within the City limit, and employees whose work requires them to make stops (*e.g.*, for deliveries) in the City (but not who merely drive through the City). OLSE Reg. No. 3.1(C).

Fourth, the employer must determine how much of the money it spends on "health care benefits" can be used as an offset against the spending mandate during the period. Offsets include (but are not limited to): (a) contributions by an employer on behalf of the employee to a health savings account; (b) reimbursement to the employee for expenses incurred in the purchase of health care services; (c) payments to a third party for the purpose of providing health care services for the employee; and (d) costs incurred by the employer in the direct delivery of health care ser-

vices. S.F. Admin. Code § 14.1(b)(7). Expenditures made by self-insured and/or self-funded insurance programs also may be included, but payment of prevailing wage fringe benefit obligations in cash may not. OLSE Reg. No. 2(A)(2), (B)(1).

Finally, the employer must pay the difference between the spending requirement and the amount it spends in recognized health care expenditures for each covered employee. S.F. Admin. Code § 14.3(a).

It is apparent that undertaking this detailed, fact-specific analysis for *each* employee who may be covered under the Ordinance imposes substantial compliance requirements on employers.

B. Covered Employers Must Comply With Detailed Record-Keeping and Reporting Requirements Separate And Apart From Their Obligations Under ERISA.

In addition to the above compliance requirements, covered employers must maintain records "sufficient to establish compliance with Employer Spending Requirements of th[e] Ordinance." OLSE Reg. No. 7.2(A)(3). Employers thus must maintain detailed records that are not required by ERISA (or otherwise). Such documentation includes records of hours or work performed by each employee within the City (regardless of where he or she is regularly employed); records of the time counted toward the employee's initial 90 days of employment (which may be non-consecutive or non-continuous); records justifying an employee's classification as managerial, supervisory or confidential; records of whether the employee is eligible for Medicare or TRICARE/CHAMPUS; and records of the contributions that entitle the employer to an offset.

Where an employer undergoes a reduction in force that would reclassify it to an employer of smaller size, and hence reduce its contribution levels, it must also maintain documentation sufficient to prove that the reduction was not implemented for the purpose of evading its obligations under the Ordinance. S.F. Admin. Code § 14.4(d). That too is highly burdensome.

Finally, employers must provide annual reports to the City. § 14.3(b); OLSE Reg. No. 7.3. If employers satisfy the health care expenditure requirements by making payments to the City, they must also provide quarterly reports to covered employees. OLSE Reg. No. 7.1. These requirements likewise increase an employer's administrative burdens.

C. Covered Employers Are Subject To The Ordinance's Enforcement Scheme Separate And Apart From Their Obligations Under ERISA.

Additional burdens arise from the Ordinance's enforcement scheme. Employers are subject to audit at any time. OLSE Reg. No. 7.4. The Enforcement Office is authorized to issue and adjudicate administrative complaints, remedy violations, and issue penalties ranging from $25 per day to $1000 per employee per week of non-compliance, plus interest. OLSE Reg. No. 9.1-9.3. The determination of the Enforcement Office may be appealed to an administrative hearing officer. OLSE Reg. No. 10.1-10.3. The administrative hearing officer's decision may be reviewed by the San Francisco Superior Court. OLSE Reg. No. 10.3(D).

In sum, the administrative burdens imposed by the Ordinance at issue here represent an enormous

increase in the costs of administering ERISA-regulated employee benefit plans. And they are precisely the kinds of burdens that the ERISA's broad preemption provision was designed to prevent.

II. Unless The Court Acts Now, The Burden On Employers In Providing Health Care Benefits To Employees Will Expand Exponentially As Other State And Local Governments Enact Their Own Health Care Mandates.

If other states and localities are permitted to follow the Ninth Circuit's "roadmap," sponsors of nationwide ERISA plans will confront an array of new requirements affecting contributions and administration. For each jurisdiction implementing its own "pay-or-play" law, the employer will have to determine: (i) whether it is subject to the law; if so (ii) which employees are covered; (iii) what contributions are required; (iv) the extent to which its current plan(s) entitle it to offsets; (v) how to treat employees who may be covered by more than one jurisdiction's mandates; (vi) what records it must keep; and (vii) what reporting is required. Presumably, each jurisdiction will have its own enforcement mechanisms.

Even the most casual analysis of some of the recently proposed "pay-or-play" laws demonstrates, first, that countless additional "pay-or-play" laws will be enacted swiftly by state and local governments if the Ninth Circuit's decision is allowed to stand, and second, that this flood of mandates will place a crushing burden of inconsistent regulation on plan sponsors seeking to provide health care benefits to their employees.

A. States And Localities Already Have Considered Scores Of "Pay-Or-Play" Laws.

The mere number of "pay-or-play" laws that have been proposed attests to the likelihood that such laws will be enacted swiftly if the Ninth Circuit's decision is allowed to stand. As of 2006, more than fifty "pay-or-play" bills had been introduced in twenty-eight state legislatures alone. Julia Contreras and Orly Lobel, *Wal-Martization and the Fair Share Health Care Acts*, 19 St. Thomas L. Rev. 105, 136 (2006). All of these bills sought to impose mandates on employers to pay for employee health care, but beyond this, the bills display a wide range of differences.

B. The Compliance Obligations Of Nationwide Employers Will Expand Dramatically As State And Local "Pay-Or-Play" Laws Are Enacted.

As "pay-or-play" laws take root, employers will be required to constantly assess whether they are subject to such laws in any jurisdiction in which they do business. For example, the Ordinance here covers for-profit employers engaged in business in San Francisco that employ twenty or more persons anywhere in the country. OLSE Reg. No. 2.2(A), (C). Other proposals vary from as few as ten employees to as many as ten thousand. Contreras at 136. Employers below the threshold would, of course, have to monitor all such laws to stay informed of changes in the applicable thresholds, as well as their own employee numbers, to know when coverage may be triggered.

Employers subject to state and local mandates would also have to determine which of their employ-

ees are covered under each jurisdiction's law. As previously explained, determining whether an employee is "covered" in San Francisco involves a detailed, fact-specific inquiry. Various proposals in other states have embraced different definitions, some classifying "employees" as all individuals employed full- or part-time by the covered employer.[3] A Florida proposal cross-referenced other state law definitions of "employee."[4] A Virginia bill did not define "employee" at all.[5] New Jersey's initiative limited "employees" to those working within the State.[6] New York City's definition includes any full-time, part-time, or seasonal employee, but excludes family members and persons "hired to work exclusively for the holiday period from November 1 through December 31."[7] Thus, employers would have to engage in detailed analyses to determine which of their employees might be covered by *every* such law, and monitor *all* of them for changes.

Some of the widest variations in state and local proposals involve a concern central to the provision of ERISA benefits—how to calculate employer health care spending requirements. In contrast to San Francisco's plan, which uses only covered employees

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[3] *See e.g.,* H.R. 1703, 2006 Leg., Reg. Sess. (N.H. 2006); Sen. 2684, 2006 Leg., Reg. Sess. (Miss. 2006).

[4] Sen. 1618, 2006 Leg., Reg. Sess. (Fla. 2006).

[5] H.D. 258, 2006 Leg., Reg. Sess. (Va. 2006).

[6] A. 2513, 212th Leg., 2007-2008 Sess. §2 (N.J. 2006). *See also* A. 1966, 213th Leg., 2008-2009 Sess. (N.J. 2008).

[7] N.Y.C. Admin. Code §22-506(b)(6).

in the expenditure formula, several state proposals would require contribution amounts to be determined as a percentage of the employer's overall payroll, varying from six to eleven percent.[8] A Virginia proposal would require employers to pay "the statewide average of the percent of wages that was spent on employee health insurance costs by all employers with 250 or more employees in the Commonwealth, as determined by the Commissioner."[9] A Wisconsin proposal would require employers to cover all employers and pay at least eighty percent of the cost of that coverage, or else pay "an assessment that is equal to the cost incurred by society as a result of the employer not providing that coverage" – a cost that would be calculated "using the methodology promulgated" by the State.[10] Employers undoubtedly would be subject to a wide variety of contribution mandates applicable to different employees.

Employers wishing to comply with "pay-or-play" laws by "playing"—i.e., paying into their existing ERISA plans—would have to determine for each jurisdiction whether their required health care spending requirements can be offset by benefits they provide through existing ERISA plans. The San Francisco Ordinance counts toward an employer's "Qualifying Health Care Expenditures" any tax deductible medi-

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[8] 19 St. Thom. L. Rev. at 136. *Cf.* H.D. 4024, 2006 Leg., Reg. Sess. (W.Va. 2006), H.R. 1316, 65th Gen. Assem., 2d Reg. Sess. (Colo. 2006).

[9] H.D. 258, 2006 Leg., Reg. Sess. (Va. 2006).

[10] A. 860, 2005-2006 Leg., 2005 Reg. Sess. (Wis. 2005) § 2.3(A)(1).

cal care expenses, "or goods having substantially the same purpose or effect as such deductible expenses." OLSE Reg. Nos. 4.1(A), 4.2, 4.3. A 2007 Michigan proposal had a similar standard, but would not have counted spending with "substantially the same purpose or effect."[11] Florida's proposal contained no limitation on tax deductible spending.[12] Washington's proposal keyed its definition of "health care services expenditures" to state law, rather than the federal Tax Code.[13] Employers would have to determine what portion of the benefits they provide through national ERISA plans (and otherwise) would qualify under *each* jurisdiction's varying definitions.

The advent of state and local "pay-or-play" laws also creates the potential for conflicting obligations as to the same employees. Sponsors of nationally administered ERISA plans will likely employ personnel who fall within the "covered employee" definition of multiple jurisdictions. For example, a delivery driver based in Oakland will be subject to San Francisco's Ordinance if he makes a sufficient number of deliveries in San Francisco. OLSE Reg. No. 3.1(C)(1). But if Oakland enacts its own ordinance, the employer may be subject to the requirements of both jurisdictions with respect to the *same* delivery driver. Under the San Francisco Ordinance, payments made on behalf of the employee to Oakland apparently would not constitute health care expenditures entitling the employer to a setoff against the spending requirements

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[11] Sen. 87, 2007-2008 Leg. Sess., Reg. Sess. (Mich. 2007).

[12] Fla. Sen. 1618 §1.1(e).

[13] H.R. 2517, 59th Leg. 2006 Reg. Sess. (Wash. 2006).

of the San Francisco Ordinance. *See* OLSE Reg. No. 4.2(B) ("health care expenditures shall not include any payment made directly or indirectly to obtain...any other coverage required by any other local, state, or federal law.") Such conflicts likely will riddle a regulatory scheme that consists of scores (or hundreds) of uncoordinated state and local laws.

C. Employers' Record-Keeping And Reporting Obligations Will Also Expand Dramatically.

In addition to complying with the spending mandates of all the applicable local laws, employers will have to comply with a wide array of record-keeping requirements. In the aggregate, these requirements will add to the cost of providing benefits and frustrate plan sponsors' provision of a nationally uniform scheme.

For example, the New York City Ordinance would require plan sponsors to maintain "an accurate work log that includes, for each employee, such employee's name, trade or occupation, and the dates and hours or time periods worked by such employee" and "accurate records of health care expenditures and required health care expenditures." N.Y.C. Admin. Code § 22-506(c)(3).

Employers will also have to comply with the reporting and enforcement provisions of the many new laws. One typical proposal linking spending mandates to the employer's payroll would require annual reporting, *inter alia,* on: (1) how many employees were eligible to receive health care expenditures; (2) how many received them from the employer, (3) how much the employer spent on all health care expenditures; and (4) what percentage of payroll those ex-

penditures represented.[14] Another proposal would require:

> A description of the health care coverage provided by the employer, together with the total cost of that coverage, excluding any deductibles and co-payments that may be required under the employer's group health insurance plan, and a breakdown of the amount of that total cost that is paid by the employer and the amount of that total cost that is paid by the employer's employees.[15]

Any administrative economies of scale that national plan sponsors may be able to exploit would be undermined by the imposition of new statutory and regulatory requirements, as well as varying interpretations of similar record-keeping and reporting requirements, from jurisdiction to jurisdiction.

Finally, failure to comply with reporting requirements, cooperate with auditing agencies, allow reasonable access to records or maintain and retain accurate records could expose an employer to penalties. *See e.g.,* OLSE Reg. No. 9.2(A). Proposed fines vary from San Francisco's penalty of $25 to $500 per violation per day (*id.*), to Wisconsin's sanction of up to $250 per day[16], to Florida's $1000 fine for each day a report goes unfiled.[17] Presumably, each new law will include its own audit and enforcement require-

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[14] Fla. Sen. 1618 §§ 1.4(a)(1)-(5).

[15] Wis. A. 860 § 2.2(a)(2).

[16] Wis. A. 860 § 2.4(a).

[17] Fla Sen. 1618 § 1.7(a).

ments.[18] And these will only add to the crushing, cumulative impact of similar laws enacted in other jurisdictions.

III. "Pay-Or-Play" Laws Are Preempted Because Their Cumulative Impact Will Undermine The Uniform Administration Of Employee Benefits That Is A Hallmark Of Erisa And Will Likely Force Employers To Amend Their Existing Plans.

These burdens powerfully reinforce the district court's conclusion that the Ordinance here—and others like it—is preempted by ERISA. As this Court has observed, "[o]ne of the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits' . . . [u]niformity is impossible, however, if plans are subject to different legal obligations in different states." *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 148 (2001). That is one of the main reasons that ERISA broadly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a). This Court has repeatedly confirmed that ERISA preemption is "expansive." *Egelhoff*, 532 U.S. at 146, *citing New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 655, (1995).

In analyzing whether state or local laws impose a prohibited burden on benefit plans, the Court also takes account of the *cumulative impact* on the ad-

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[18] *Cf.* OLSE Reg. No. 8, N.Y.C. Admin. Code § 22-506(f)(1).

ministration of such plans if a particular type of local regulation were allowed. *Egelhoff*, 532 U.S. at 151. As we now show, "pay-or-play" laws such as the one at issue here are preempted by ERISA, both standing alone, and because of their likely cumulative impact.

1. There can be no doubt that Congress intended ERISA preemption to "eliminate the threat of conflicting [and/or] inconsistent State and local regulation." *Shaw* v. *Delta Air Lines Inc.*, 463 U.S. 85, 99 (1983) (quoting statements by Representative Dent and Senator Williams, ERISA's sponsors in the House and Senate, 120 Cong. Rec. 29197 (1974); 120 Cong. Rec. 29933 (1974)). In *Fort Halifax Packing Co, Inc.* v. *Coyne,* 482 U.S. 1, 9 (1987), the Court recognized that statements on this issue by ERISA's sponsors "reflect recognition of the administrative realities of employee benefit plans." And the Court explained with care *why* Congress sought to minimize the risk of state and local regulations that would vary from ERISA's requirements:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory require-

> ments in differing states. A plan would be required to keep certain records in some states but not in others; to make certain benefits available in some states but not in others; to process claims in a certain way in some states but not in others; and to comply with certain fiduciary standards in some states but not in others.

Id. *See also Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990); *Egelhoff*, 532 U.S. at 148.

The focus on the need for a uniform body of law rather than a "patchwork quilt" of state and local regulations permeates this Court's ERISA jurisprudence. It emphasizes a pragmatic analysis of the actual effect of state and local laws upon ERISA's overarching goal of ensuring uniform administration of covered benefit plans. *See id.*

2. Under any pragmatic analysis, the Ordinance itself subjects a covered employer to substantial regulatory requirements that are different from, and in addition to, ERISA, in the financing and provision of health care benefits to covered employees. The Ordinance requires that benefits be made available to employees working in San Francisco, but not other places. In addition, as explained above, it requires employers to keep records that are not required by ERISA. It has its own enforcement process culminating in state court oversight, but without requiring compliance with ERISA's fiduciary standards.[19] The

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[19] An ERISA fiduciary must discharge his duties solely in the interest of plan participants and beneficiaries. 29 U.S.C. § 1104(a). Yet under the Ordinance, the San Francisco City Controller may appropriate contributions made on behalf of employees to the Program in some circumstances. S.F. Admin. Code § 14.2(h).

Ordinance thus imposes a mandated and self-contained system of employee benefit regulation specific to "San Francisco" employers and employees—*precisely* the type of local regulation of employee benefit plans that ERISA's broad preemption provision was intended to prevent.

The Ninth Circuit attempted to sidestep these concerns by asserting that the Ordinance impacts employers, not plan administrators. Pet. at 32a. But this distinction finds no support in this Court's ERISA preemption jurisprudence. As noted above, this Court has consistently recognized that one purpose of ERISA is to encourage *employers* to make a commitment systematically to provide benefits for their employees. *See, e.g., Coyne,* 482 U.S. at 9. Accordingly, ERISA preemption intentionally makes "plan sponsors"—*i.e.,* employers—as well as plan administrators, subject to a uniform system of laws to minimize the overall administrative and financial burden accompanying the provision of employee benefits. Congress created that regime recognizing that inefficiencies created by uncoordinated and potentially inconsistent state and local laws would ultimately work to the detriment of plan beneficiaries.

Whether these inefficiencies burden employers, plan administrators, or both, their effect is the same. They make it more costly and difficult to provide employee benefits, and therefore, work to the detriment of plan beneficiaries. The Ninth Circuit's attempt to distinguish between employers and plan administrators thus creates a distinction without a difference.[20]

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[20] The Ninth Circuit's reliance upon *Keystone Chapter, Associated Builders & Contractors, Inc.* v. *Foley,* 37 F.3d 945, 960 (3d Cir. 1994), and *WSB Electric, Inc.* v. *Curry,* 88 F.3d 788, 793

3. If San Francisco's ordinance, standing alone, would contravene ERISA's preemption provision – and it does—it is obvious that allowing a wide array of state and local "pay-or-play" laws would impose a very substantial burden on the financing and administration of health care benefit plans. One could hardly imagine a more complex and inefficient way of maintaining "a uniform system of employee benefit laws" aimed at encouraging employers to provide benefits voluntarily than to have scores of uncoordinated state and local "pay-or-play" laws.

In that regard, these laws create a problem even more serious than the one the Court faced in *Egelhoff*. There, the Court invalidated a law that deemed an election of a spouse during marriage to be invalid if the insured and the beneficiary subsequently divorced because such a law, if not preempted, would require plans to monitor the laws of 50 states to determine whether other similar laws might impact a beneficiary determination. 532 U.S. at 148. Here, by contrast, if the San Francisco Ordinance is valid, employers will have to monitor the laws of 50 states and 30,000 localities to determine whether they are subject to complex benefit contribution mandates implemented in countless ways, creating different re-

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(9th Cir. 1996), is misplaced. Both *Keystone* and *Curry* involved "prevailing wage" laws. *Id.* As the district court recognized below, employers subject to the program in *Curry* could satisfy their prevailing wage obligation in whole or in part simply by *paying wages to employees* at the appropriate rate. App. 100a-102a (citing *Curry*, 88 F.3d at 793-96); *see also Keystone*, 37 F.3d at 960. The Ordinance is different. It requires employers to *procure healthcare benefits* for employees. They therefore are not "benefits neutral," as the courts in *Keystone* and *Curry* found the prevailing wage laws to be.

quirements for different employees, if not inconsistent obligations for the same employees. They will be subject to ongoing record-keeping and reporting requirements, audits, and potentially enforcement proceedings. It cannot credibly be disputed that the cumulative burden of such laws would undermine the uniformity of employee benefit law in a far more fundamental and burdensome way than the law at issue in *Egelhoff*.

4. The resulting patchwork of state and local regulations would also likely force employers to amend their existing plans—another basis for finding ERISA preemption. *See Ingersoll-Rand*, 498 U.S. at 142 (ERISA preempts laws that require the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction). To be sure, the Ninth Circuit reasoned that ERISA does not preempt the Ordinance because employers are not "required" to alter their plans. Pet. 29a-30a. Yet it is inevitable that most, if not all, plans *will* be altered as employers become subject to an ever-increasing array of "pay-or-play" laws.

One option will be to decrease health care benefits in places where there are no mandates—which in turn will create pressure to implement mandates in these locations. Another strategy will be to reduce other kinds of benefits, like pension benefits, that states and localities have not (yet) required employers to fund. In either case, plans will be altered.

Even employers who simply absorb the added cost of the new mandates and their associated administrative burdens will alter their plans as they seek to ensure that all their employees receive comparable benefits. That undoubtedly will be a complex task for

large employers who become subject to multiple "pay-or-play" laws. Yet it is highly unlikely that employers will myopically continue to fund their benefit plans without making any alternations to them, as an increasing number of state and local laws may impose countless mandates and regulations.

In short, it is obvious that the Ordinance, and the cumulative sum of the laws it will precipitate if the Ninth Circuit's decision stands, will cause the wholesale alteration of employer-sponsored plans, as employers seek to adjust their benefit packages in the new world of local health care regulation. That was the conclusion of the Fourth Circuit in *Retail Industry Leaders Association* v. *Fielder*, 475 F.3d 180, 196-97 (4th Cir. 2007) ("[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"). And it remains true today.

CONCLUSION

The Ninth Circuit's reasoning fails to account for the cumulative real-world impact that the Ordinance, and others that will follow in its wake, will have on employer sponsored benefit plans.

To be sure, it is impossible to predict *exactly* how the provision of health care benefits and the delivery of health care will change if "pay-or-play" laws are allowed to take root, let alone the impact that such a sea change in health care regulation may have on the national economy. It is clear, however, that allowing the Ninth Circuit's decision to stand will not simply delay the resolution of the problem posed by the San Francisco Ordinance and laws like it. Allowing the

decision to stand, even for a short time, will exacerbate the problem exponentially.

The petition should be granted.

Respectfully submitted,

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