

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

GOLDEN GATE RESTAURANT
ASSOCIATION

Plaintiff/Appellee,

vs.

CITY AND COUNTY OF SAN
FRANCISCO

Defendant/Appellant,

SAN FRANCISCO CENTRAL
LABOR COUNCIL, SERVICE
EMPLOYEES INTERNATIONAL
UNION ("SEIU") LOCAL 1021,
SEIU UNITED HEALTHCARE
WORKERS-WEST, and UNITE-
HERE!, LOCAL 2,

Intervenors/Appellants.

No. _____

(U.S. District Court No. C06-6997
JSW)

IMMEDIATE RELIEF REQUESTED
BY DECEMBER 31, 2007

**EMERGENCY MOTION UNDER CIRCUIT RULE
27-3 FOR STAY PENDING APPEAL**

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

The Honorable Jeffrey S. White

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CIRCUIT RULE 27-3 CERTIFICATE

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(ii) Facts showing the existence and nature of the claimed emergency.

The Ordinance enjoined by the district court is scheduled to become operative January 2, 2007. As set forth below, tens of thousands of San Franciscans will be denied health benefits if the Ordinance is prevented from taking effect.

(iii) When and how counsel for the other parties were notified and whether they have been served with the motion; or, if not notified and served, why that was not done.

Counsel for the City first contacted counsel for Appellees prior to the district court's ruling, and informed counsel for Appellees that in the event of a ruling against the City, it would seek a stay pending appeal. This occurred on December 18, 2007. Counsel for the City followed up with an email to counsel for Appellees on December 20, 2007. The City served the papers it filed with the district court seeking a stay concurrently with the filing. The City served the papers it filed with this Court seeking a stay concurrently with the filing, both by email and by overnight mail.

The City is filing an application for a stay from the district court concurrently with this filing. Because relief is requested by December 31, 2007, the City is not waiting for a ruling on the stay application from the district court before filing its emergency motion with this Court. The City does not expect that the district court will rule on the stay application before December 31st because

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Judge White has posted a notice of unavailability on the district court's website for December 27th and 28th and 31st, and the court is closed January 1st.

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INTRODUCTION

This emergency stay application involves San Francisco's groundbreaking universal health care program – a program whose implementation is being watched closely throughout the country and could serve as a model for health care reform across the nation.¹ The district court, in direct contravention of Supreme Court and Ninth Circuit precedent, struck down and permanently enjoined a critical aspect of the program on the ground that it is preempted by the Employee Retirement Income Security Act ("ERISA"). The City, joined by the intervenor-defendants, seeks a stay from this Court so that it may proceed with implementation of the program on January 2, 2008 as scheduled. Without this stay, tens of thousands of San Francisco residents and workers will be deprived of critically necessary health care services – and will suffer the health-related and financial consequences – during the pendency of this appeal. All as the result of flawed reasoning that has already been rejected by this Court and the United States Supreme Court.

The program, titled the San Francisco Health Care Security Ordinance ("HCSO" or "Ordinance") has two key components. First, it creates a comprehensive governmental health program to provide health benefits to uninsured San Francisco residents, as well as qualified nonresidents who work in the City. Second, it imposes a minimum health care spending requirement on businesses with 20 or more employees. The employer can comply with this

¹ See, e.g., Kevin Sack, *San Francisco Takes Unique Approach to Providing Medical Care for All*, N.Y. Times, Sept. 14, 2007 at A1; John M. Glionna, *S.F. offering healthcare to neediest; Trailblazing city plan provides services regardless of residents' immigration status or medical history*, L.A. Times, Oct. 22, 2007, at B1.

spending requirement through its own health care program, or by paying the City so that its employees may participate in the new governmental program.

The Supreme Court and every circuit to address the issue, including this one, have made clear that while ERISA preempts state and local laws that impose mandates on ERISA plans, it does not preempt legal requirements that employers may readily satisfy without altering or adopting ERISA plans, because such requirements do not interfere with uniform plan administration. *See, e.g., New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659 (1995); *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A.*, 519 U.S. 316, 333 (1997); *Southern California IBEW-NECA Trust Funds v. Standard Industrial Electrical Co.*, 247 F.3d 920, 925 (9th Cir. 2001) ("*Standard Industrial*"); *WSB Electric, Inc. v. Curry*, 88 F.3d 788, 795 (9th Cir. 1996). San Francisco's Ordinance falls squarely in this latter category. Employers are free to comply with the spending requirement by setting up ERISA plans if they wish, but they are also free to comply through non-ERISA means, including by making payments to the City.

The district court nonetheless held the employer spending requirement preempted. It did so for two basic reasons. First, it concluded that "[b]y mandating employee health benefit structures and administration, [the employer spending] requirements interfere with preserving employer autonomy over whether and how to provide employee health coverage, and ensuring national regulation of such coverage." Order at 8 (Appendix A, attached). This reasoning is contrary to Supreme Court and Ninth Circuit case law because it conflates the critical distinction between the regulation of health *plans* on the one hand, and health *benefits* on the other hand. A local law may not impose requirements on ERISA plans, but it may impose general requirements relating to the provision of benefits,

even if those types of benefits are mentioned in ERISA and are, as a practical matter, often provided through ERISA plans. *See, e.g., Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 11(1987) (explaining that Congress sought to preempt "state laws relating to *plans* rather than simply to *benefits*") (emphasis in original); *see also Delaye v. Agripac, Inc.*, 39 F.3d 235, 237 (9th Cir. 1994). Because San Francisco's ordinance requires employers to pay for *benefits* but allows them to do so without adopting an ERISA *plan* (or modifying an existing plan) it is not preempted.²

Second, the district court held the requirements of the HCSO preempted because compliance is measured by the amount employers spend on health care, which could occur through an ERISA plan. "In order to determine compliance," the Court stated, "the Ordinance necessarily refers to whether and how much an employer pays for employee health coverage under its existing plans, assuming such employers maintain them at all." Order at 13 (Appx. A, attached). It is true that employers can establish compliance with the spending requirement by demonstrating that they make sufficient health care expenditures through an ERISA plan, but Ninth Circuit precedent makes clear that this is no ground for

² The district court's order expressed concern that local expenditure mandates would require employers to make differing health care expenditures in different jurisdictions. Order at 12-13 (Appx. A, attached). However, "[c]ost 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. So long as a local law permits an employer to maintain *plan* uniformity – as the HCSO clearly does – the possibility of cost disparity does not raise ERISA preemption issues.

preemption: "The references to ERISA plans in the California prevailing wage law have no effect on any ERISA plans, but simply *take them into account* when calculating the cash wage that must be paid The scheme does not force employers to provide any particular employee benefits or plans, to alter their existing plans, or to even provide ERISA plans or employee benefits at all." *WSB*, 88 F.3d at 794 (emphasis added). *See also Dillingham*, 519 U.S. at 324-35, 328; *cf. Funkhouser v. Wells Fargo Bank*, 289 F.3d 1137 (9th Cir. 2002) (state law claims not preempted by ERISA merely because a court would refer to an ERISA plan in calculating damages).

In sum, were the reasoning of the district court correct, *every single one of the cases cited above would have to be wrong*. But they are not wrong – they constitute binding precedent that should have controlled the district court's reasoning.³ Accordingly, the City has a strong likelihood of success on the merits in its upcoming appeal.

Not only does the City have a strong likelihood of success; the balance of hardships tip sharply in favor of allowing the City to implement the program during the appeal. First and foremost, some 20,000 workers who currently lack

³ What's more, the district court's order completely ignored the Ninth Circuit's "simplified test" for determining whether a local law is preempted by ERISA. That test inquires whether the local law: (a) tells employers how to write their ERISA plans or imposes conditions based on how they write their plans; or, alternatively, (b) tells employers that they must fulfill some independent requirement regardless of how they write their ERISA plans. The former type of law is preempted; the latter is not. *WSB*, 88 F.3d at 796. *See also Operating Engineers Health & Welfare Trust Fund v. JWJ Contracting Co.*, 135 F.3d 671, 679 (9th Cir. 1998). The HCSO is clearly the latter type of law, but the district court held it preempted without so much as referencing the simplified test.

coverage will be denied the health care benefits to which they are entitled under the Ordinance. This deprivation will pose serious risks to the health of these workers, because those without benefits are significantly less likely to seek timely treatment or preventive care. And those who do seek treatment – for example, for health care emergencies – will suffer serious financial consequences as a result.

But the harm will not be limited to those workers. If a stay is not granted, tens of thousands of additional uninsured San Franciscans will be denied the ability to participate in the government program created by the Ordinance. While the Ordinance calls for this program to be open to all uninsured residents, without the employer mandate the City will only be able to make the program available to people who fall below 300% of the Federal Poverty Level. Thus, aside from the 20,000 workers discussed above, roughly 39% of San Francisco's uninsured residents will be denied the ability to enroll in the City's program, and, therefore, deprived of access to the comprehensive health care services the City would otherwise provide.

If the employer mandate is blocked, the City and its taxpayers will suffer as well. If 20,000 workers are denied the health expenditures that the Ordinance requires their employers to make, and if 39% of San Francisco's uninsured population becomes ineligible to participate in the new government program, the City would be required to foot the entire bill for any emergency treatment or other health care services those individuals without means to pay seek from San Francisco General Hospital or one of the City's health clinics.

If a stay is not granted, the City and intervenor-defendants respectfully request that the panel expedite the appeal and schedule oral argument in May or June of 2008. The City requests the following briefing schedule:

- Opening Briefs due January 23, 2008

- Amicus Curiae Briefs in Support of Appellants due February 15, 2008
- Appellee's Brief due March 7, 2008
- Amicus Curiae Briefs in Support of Appellee due March 28, 2008
- Reply Briefs due April 18, 2008

BACKGROUND

A. San Francisco's Health Care Crisis

Each year, roughly 82,000 San Francisco adults suffer from a lack of health insurance. Declaration of Dr. Mitchell H. Katz in Support of Emergency Motion Under Circuit Rule 27-3 For Stay Pending Appeal ("Katz Decl. in Support of Stay") at ¶ 3. Aside from the obvious human suffering this causes, the health care crisis imposes a tremendous financial burden on the City and its taxpayers, requiring them to foot the bill for emergency treatment and other health care services. Declaration of Dr. Mitchell H. Katz in Support of San Francisco's Motion for Summary Judgment ("Katz Decl. in Support of SJ") at ¶ 7. The San Francisco Department of Public Health ("DPH") estimates that in Fiscal Year 2005 it spent \$104 million to provide health care services to the uninsured. *Id.*

The above figures actually understate the severity of San Francisco's health care crisis, because they do not account for the thousands of uninsured people who live elsewhere but seek health care services from the City. In Fiscal Year 2006, DPH estimates it served approximately 5,300 uninsured individuals who do not live in San Francisco. Katz Decl. in Support of SJ at ¶ 8.

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, the large majority of the uninsured do not qualify for care under such programs. For

example, an adult is only eligible for Medi-Cal if: (i) her household income falls below the Federal Poverty Level ("FPL"), which is just over \$10,000 per year for a single person; and (ii) she is elderly, blind, disabled, pregnant or a single parent.⁴ The 82,000 uninsured residents mentioned above do not include the people who are enrolled in San Francisco's indigent health care programs. Katz Decl. in Support of SJ at ¶ 6.

B. The San Francisco Health Care Security Ordinance

In 2006, to address the City's health care crisis, the San Francisco Board of Supervisors unanimously passed, and the Mayor signed into law, the San Francisco Health Care Security Ordinance ("HCSO" or "Ordinance"), which is attached hereto as Appendix B.⁵ The Ordinance has two key related components – a government health care program and an employer health spending requirement.

1. The government health program

First, the HCSO establishes a government health care program, operated by DPH, that revolutionizes the manner in which the City protects the health of its people. Its primary feature is the Health Access Program ("HAP"), which will

⁴ For a discussion of the programs available to San Francisco's indigent population and an explanation of their limited availability based on FPL and other factors, see DPH, *Health Care Access: A Guide To Health Care Programs in San Francisco*, available at <http://www.sfdph.org/Reports/HlthCareAccess042007/HlthCareAccessBody042007.pdf>.

⁵ The Ordinance is codified at Chapter 14 of San Francisco's Administrative Code, which, in addition to being attached hereto as Appendix B, is also available at <http://www.municode.com/Resources/gateway.asp?pid=14131&sid=5>. All citations are to the San Francisco Administrative Code except for the Board's declaration of findings and legislative intent, which are not codified.

deliver 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). The Ordinance provides that the HAP shall assign a primary care physician, nurse practitioner or physician assistant to each participant. S.F. Admin. Code § 14.2(e). And it requires that the HAP "provide medical services with an emphasis on wellness, preventive care and 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.*⁶

The value of this care is substantial – DPH estimates that in 2008 it will cost an average of \$261 per participant per month to provide it. Katz Decl. in Support of SJ at ¶ 10. This is in comparison to the \$379 cost of the average monthly insurance premium in California. *Id.* at ¶ 11.

The HAP, which is funded in 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, which are set on a sliding scale according to their household income as a percentage of the FPL. As set forth in the Katz Declaration in Support of Summary Judgment at ¶ 12, the rates are as follows:

⁶ Incidentally, DPH has 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. Appx. C, attached (DPH Reg. No. 1(b)). For purposes of this litigation the City will continue to use the name contained in the Ordinance.

FPL:	<u>0-100%</u>	<u>101-200%</u>	<u>201-300%</u>	<u>301-400%</u>	<u>401-500%</u>	<u>501%+</u>
Quarterly Participation Fee:	\$0	\$60	\$150	\$300	\$450	\$675

Nonresidents who work in the City do not qualify for HAP participation. But the program contains a feature for those people as well: medical reimbursement accounts. The Ordinance authorizes DPH to establish and maintain such 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 the account to obtain reimbursement for medical expenses, including payments of health insurance premiums. Appx. C, attached (DPH Reg. 7(g)(i)).

2. The employer spending requirement

The second key component of the HCSO, which does not become operative until January 2, 2008, 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 a private employer with 20-99 employees and a nonprofit with 50 or more employees must, for any employee who has been employed for 90 days and works more than ten hours per week, make health care expenditures of \$1.17 per hour on behalf of that employee. S.F. Admin. Code § 14.1(b)(8); Appx. D, attached (OLSE Reg. No. 5.2(A)(2)). A private employer with 100 or more employees must make health care expenditures of \$1.76 per hour on behalf of each covered employee. S.F. Admin. Code. § 14.1(b)(8); Appx. D, attached (OLSE Reg. No. 5.2(A)(1)).

It is entirely up to the employer to decide how to comply with this spending requirement. The Ordinance sets forth the following non-exclusive list of appropriate health care expenditures:

- Contributions to health savings accounts ("HSAs") as defined under Internal Revenue Code section 223 or "any other account having substantially the same purpose or effect";
- Direct reimbursement to employees "for expenses incurred in the purchase of health care services";
- Payments "to a third party for the purpose of providing health care services for covered employees";
- Costs incurred in the "direct delivery of health care services" to covered employees; and
- Payments by the employer to the City "to be used on behalf of covered employees."

S.F. Admin. Code § 14.1(b)(7). Elaborating on this last option – which we will refer to as the government payment option – the Ordinance states: "The City may use these payments to: (i) fund membership in the Health Access Program for uninsured San Francisco residents; and (ii) establish and maintain reimbursement accounts for covered employees, whether or not those covered employees are San Francisco residents." *Id.*

DPH has structured the program so that if an employer chooses to satisfy the health care spending requirement by making payments to the City, the employer need only write a check, and all employees on whose behalf the payment is made will be eligible to receive health care benefits. When covered employees enroll with DPH, the Department will place HAP-eligible employees into the HAP, and

will establish medical reimbursement accounts for those not eligible for the HAP. Appx. C, attached (DPH Reg. Nos. 7(c), 7(f), 7(g)).⁷

Covered employees who qualify for HAP membership will, if their employers choose to satisfy the spending requirement by paying the City, be entitled to enroll in the program at a 75 percent discount on the quarterly participation fees identified above. Appx. C, attached (DPH Reg. No. 7(f)). Furthermore, any covered employee whose fee, after the 75% discount, falls below \$50 per quarter will simply be allowed to enroll for free. *Id.* Accordingly, the fees for covered employees are as follows:

Poverty Level:	<u>0-100%</u>	<u>101-200%</u>	<u>201-300%</u>	<u>301-400%</u>	<u>401-500%</u>	<u>501%+</u>
Quarterly Participation Fee:	\$0	\$0	\$0	\$75	\$113	\$169

Katz Decl. in Support of SJ at ¶ 15.

Employers covered by the Ordinance are required to keep records of their health care expenditures so that San Francisco's Office of Labor Standards Enforcement ("OLSE") may enforce the employer spending requirement. S.F. Admin. Code § 14.3(b). The OLSE regulations describe in more detail the records that employers must maintain: (1) itemized pay statements, which are already mandated by California Labor Code section 226; (2) the address, phone number, and first day of work of each employee; and (3) records of health care expenditures made on behalf of covered employees. Appx. D, attached (OLSE Reg. No. 7.2).

⁷ Generally speaking, covered employees who do not qualify for HAP membership will be nonresidents who work in San Francisco. Certain uninsured San Francisco residents (i.e., those who would qualify for Medi-Cal) also do not qualify for HAP participation. Appx. C, attached (DPH Reg. No. 3(a)).

The employer must give the OLSE access to these records to facilitate the agency's enforcement duties. S.F. Admin. Code § 14.3(b).

According to the Controller's Office, the large majority of businesses with 20 or more employees – roughly 90% of them – already provide health care benefits to their employees. RJN Exh. F at 9.

C. The Proceedings Below

On November 8, 2006, plaintiff GGRA filed this lawsuit, seeking declaratory and injunctive relief on the theory that the HCSO's employer spending requirement is preempted by ERISA. A group of San Francisco labor organizations – San Francisco Central Labor Council, Service Employees International Union ("SEIU") Local 1021, SEIU United Healthcare Workers-West, and UNITE-HERE!, Local 2 – successfully intervened as defendants. Litigation was delayed when the Board of Supervisors decided to amend the Ordinance. As part of the amendments, the City pushed back the operative date of the employer spending requirement to January 2, 2008, in part to give the City time to get the program up and running, and in part to give employers sufficient preparation time to comply. Katz Decl. in Support of Stay at ¶ 15. Accordingly, while the City has opened the HAP to a limited portion of the uninsured population with particularly low incomes, the program is not scheduled to be fully operational until 2008.

The parties filed cross-motions for summary judgment, and the district court heard argument on November 2, 2007. In support of its preemption argument, GGRA contended that the employer spending requirement forces employers to alter or amend their ERISA plans, thereby interfering with uniform plan administration. The City and the Intervenors responded that, because the Ordinance allows employers to comply with the spending requirement by paying the City rather than setting up an ERISA plan, it does not require employers to

alter or amend their ERISA plans. Because this "government payment option" creates a meaningful compliance alternative that does not interfere with uniform administration of ERISA plans, Defendants argued, it falls within the category of the numerous state and local laws that the Supreme Court and this Court have upheld in the face of preemption challenges.

The District Court adopted GGRA's reasoning. It concluded that, "[b]y mandating employee health benefit structures and administration, [the employer spending] requirements interfere with preserving employer autonomy over whether and how to provide employee health coverage, and ensuring national regulation of such coverage." Order at 8 (Appendix A, attached). It further concluded that the HCSO is preempted because it makes "unlawful reference" to ERISA plans by potentially measuring compliance with reference to plan expenditures. *Id.* at 13-14. The City intends to file a notice of appeal on the same date as this filing.

STANDARD OF REVIEW

"The standard for evaluating stays pending appeal is similar to that employed by district courts in deciding whether to grant a preliminary injunction." *Lopez v. Heckler*, 713 F.2d 1432, 1435 (9th Cir.), *stay modified on other grounds*, 463 U.S. 1328 (1983). Thus, courts weigh the following factors:

"(1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of a stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies."

Natural Resources Defense Council, Inc. v Winter, 502 F.3d 859, 863 (9th Cir. 2007) (quoting *Hilton v. Braunskill*, 481 U.S. 770, 776 (1987)) (emphasis removed).

The Ninth Circuit has approved of "two interrelated legal tests" for evaluating a request for a stay on appeal, which it has characterized as

"represent[ing] the outer reaches of a single continuum." *Lopez*, 713 F.2d at 1435.

"At one end of the continuum, the moving party is required to show both a probability of success on the merits and the possibility of irreparable injury." *Id.*

"At the other end of the continuum, the moving party must demonstrate that serious legal questions are raised and that the balance of hardships tips sharply in its favor." *Id.*; accord *Natural Resources Defense Council*, 502 F.3d at 862.

When evaluating the parties' respective likelihood of success on the merits, this Court should apply a *de novo* standard to review of a ruling that a state or local law is preempted by ERISA. See *Cleghorn v. Blue Shield of Cal.*, 408 F.3d 1222, 1225 (9th Cir. 2005).

In balancing the respective hardships to the parties, "preventable human suffering," or "deprivation of life's necessities," weighs more heavily than financial loss or administrative inconvenience. *Lopez*, 713 F.2d at 1437. And courts must consider whether retroactive relief can remedy hardships suffered by individuals deprived of an important public benefit. *Id.*

Furthermore, "[t]he public interest" must be considered separately from the hardships that will be suffered by the parties to the case. *Natural Resources Defense Council*, 502 F.3d at 862. This inquiry recognizes that "[o]ur society as a whole suffers when we neglect the poor, the hungry, the disabled, or when we deprive them of their rights or privileges." *Lopez*, 713 F.2d at 1437. That is, "[i]t would be tragic, not only from the standpoint of the individuals involved but also from the standpoint of society, were poor, elderly, disabled people to be wrongfully deprived of essential benefits for any period of time." *Id.*

DISCUSSION

I. THE CITY IS HIGHLY LIKELY TO SUCCEED ON THE MERITS, BECAUSE EMPLOYERS MAY READILY COMPLY WITH THE ORDINANCE WITHOUT ALTERING OR ADOPTING AN ERISA PLAN.

A. ERISA And Its Preemption Provision.

Leading up to ERISA's adoption in 1974, concern in Congress had grown about the mismanagement of pension funds by private companies and private employee organizations. "Senate committee investigations found that the extremely rapid growth of private pension plans had led to all manner of abuses, ranging from ineptness and lack of know-how to outright looting of benefit funds and corrupt administration." M. Gordon, *Overview: Why was ERISA Enacted?*, excerpted in Langbein & Wolk, eds., *Pension and Employee Benefit Law* at 74 (3rd ed. 2000). In taking up ERISA, Congress "wanted to ensure that if a worker has been promised a defined pension benefit upon retirement – and if he has fulfilled whatever conditions are required to obtain a vested benefit – he actually receives it." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510 (1981) (internal quotations and citations omitted).

Accordingly, ERISA imposes a number of requirements and limitations relating to the funding of pension plans and the vesting of pension benefits. 29 U.S.C. §§ 1051-1085. It also imposes fiduciary duties on plan administrators, as well as myriad reporting and disclosure requirements. 29 U.S.C. §§ 1021-1031, 1101-1114. And it creates a federal cause of action that allows plan beneficiaries, fiduciaries, and the Secretary of Labor to sue to enforce the requirements imposed by the statute. 29 U.S.C. § 1132.

Although the legislative history indicates that the Act's sponsors were focused almost exclusively on pension plan regulation,⁸ the language of the statute brings other employee benefit plans within ERISA's regulatory reach. Specifically, ERISA covers two categories of benefit plans: "employee pension benefit plans" and "employee welfare benefit plans." 29 U.S.C. § 1002(3). The latter type of plan, which includes most health care plans, is defined as:

any plan, fund, or program . . . established or maintained by an employer or by an employee organization . . . for the purpose of providing for its participants or their beneficiaries . . . through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs [29 U.S.C. § 1002(1).]

Although the vesting requirements of ERISA do not apply to employee welfare benefit plans, *see* 29 U.S.C. § 1051, the reporting, disclosure and fiduciary duty requirements do apply. 29 U.S.C. §§ 1021-1031, 1101-1114.

ERISA also contains a preemption provision which states: "the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" 29 U.S.C. § 1144(a).⁹

B. State And Local Governments May Regulate The Provision Of The Types Of Benefits Mentioned In ERISA.

The district court's ruling is predicated on the notion that ERISA prevents local governments from enacting *any law at all* relating to employer health care

⁸ *See, e.g.*, Government Printing Office, Legislative History of the Employee Retirement Income Security Act of 1974, Vols. I-III at 487-488, 587-601, 589-590, 1829-1830, 2348, 3295, 4657-4658, 4733, 4748 (1976).

⁹ The preemption provision is sometimes cited as "Section 514" of ERISA. However, for ease of reference, in this litigation the City cites the preemption provision and other parts of ERISA in their codified forms.

expenditures. This conflates two distinct concepts: health care *expenditures* and health care *plans*. ERISA prevents local governments from adopting laws that regulate health plans or dictate plan design. But ERISA says nothing about the regulation of health care or health care expenditures generally.

In *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987), the Supreme Court explained this critical distinction in the context of severance benefits. Rejecting the claim that state and local governments are automatically precluded from regulating severance benefits, the Court stated as follows:

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. [*Id.* at 7-8.]

Thus, the benefit mandate at issue in *Ft. Halifax* did not conflict with the purpose of ERISA's preemption provision, which was to ensure "that the administrative practices of a benefit *plan* will be governed by only a single set of regulations." *Id.* at 11 (emphasis added). As the Court noted, Congress' concern about uniform plan administration is the reason it "pre-empted state laws relating to *plans* rather than simply to *benefits*." *Id.* (emphasis in original). *See also Delaye v. Agripac, Inc.*, 39 F.3d 235, 237 (9th Cir. 1994) ("In stressing the difference between employee benefits and employee benefit plans, the Court

recognized that the purpose of ERISA preemption of state law is to create a single set of regulations to govern benefit plans' complex and ongoing *administrative activities*") (emphasis added).

Accordingly, the fact that the City imposes health care expenditure requirement only begs the question. The true question is whether it does so in a way that runs contrary to the purposes of the preemption provision.

C. Laws That Allow Employers To Comply Without Adopting Or Altering An ERISA Plan Are Not Preempted.

State and local governments may not dictate employer choices about which benefits should be included in ERISA plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983); *see also Standard Oil v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1980) (*summarily aff'd*, 454 U.S. 801 (1981)) (striking down Hawaii law that required employers to adopt ERISA plans with specified benefits). Similarly, state law may not dictate *who* can benefit from ERISA plans. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (state law preempted because it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status."). Such laws have an improper "connection with" ERISA plans.

However, the courts have uniformly held that a local law does *not* have an improper "connection with" ERISA plans, and is *not* preempted, if employers may readily comply with the law without adopting or altering an ERISA plan. As the Third Circuit put it, "[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 of Assoc. of Builders v. Foley*, 37 F.3d 945, 960 (3rd Cir. 1994) (internal quotations, citations and brackets omitted). As the Second Circuit stated,

"it is not sufficient that the law in question has an indirect economic effect on choices; rather, the law must actually dictate which choices *must* be made." *Hattem v. Schwarzenegger*, 449 F.3d 423, 429 (2nd Cir. 2006) (emphasis in original). In the words of this Circuit, a state law that "does not require the establishment of a separate benefit plan, and imposes no new reporting, disclosure, funding, or vesting requirements for ERISA plans" is not preempted. *Southern California IBEW-NECA Trust Funds v. Standard Industrial Electrical Co.*, 247 F.3d 920, 925 (9th Cir. 2001) ("*Standard Industrial*"). See also *WSB Electric, Inc. v. Curry*, 88 F.3d 788, 795 (9th Cir. 1996) ("nothing in California's scheme requires the establishment of a separate benefit plan in order to comply with the state law. California's statute does not require public works contractors to modify their benefits plans at all"). In the words of the Supreme Court, "[a]n indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659 (1995). And as the Court stated in *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A.*, 519 U.S. 316, 333 (1997), "it has not been demonstrated here that the added inducement created by the wage break available on state public works projects is tantamount to a compulsion upon apprenticeship programs." See also *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 816 fn. 16 (1997).

Indeed, even when a law provides a *strong* incentive – an incentive that makes the alteration or establishment of an ERISA plan "quite likely," it is not preempted by ERISA so long as other options remain. *WSB*, 88 F.3d at 795, 796; see also *Dillingham*, 519 U.S. at 333 (law not preempted although it "has the effect of encouraging apprenticeship programs – including ERISA plans – to meet the

standards set out by California"). Moreover, there is no preemption even if the law imposes requirements upon benefit programs that, in *most* cases, will be provided through ERISA plans. *See California Division of Labor Standards Enforcement v. Dillingham Construction, N.A.*, 519 U.S. 316, 327 n.5 (1997) (noting that vast majority of apprenticeship programs operated through ERISA plans but that challengers of law had not shown this to be true of *all* programs). Here, the district court emphasized that most employers' health care expenditures are made through ERISA plans, but failed to give any effect to the fact that the Ordinance permits employers to make and receive full credit for health care expenditures through a non-ERISA mechanism: payments to the City.¹⁰

Even the Fourth Circuit decision relied upon by the district court, *Retail Industry Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007) (hereinafter "*RILA*"), recognized this distinction between laws that interfere with uniform plan administration and laws with which employers may readily comply – a distinction the district court completely ignored. *RILA* involved a preemption challenge to Maryland's Fair Share Act, which the Fourth Circuit found was designed to force Wal-Mart to provide health benefits to its employees. *Id.* at 185. Recognizing the principle 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 majority concluded that the Fair Share Act fell within the former category and was thus invalid. *Id.* at 193. The majority reasoned that the Maryland law

¹⁰ The district court expressly acknowledged that the government payment option creates a non-ERISA means for compliance, *see* Order at 10. It simply failed to give effect to that critical fact.

effectively required Wal-Mart to alter its ERISA plan because neither employers nor their employees would benefit if the employer elected to comply with the law by making payments to the government, and so no rational employer would choose to pay this money to the State when it could instead increase health care spending to the benefit of those employees. *Id.* at 193-194. As discussed below, the HCSO, by contrast, provides a government payment option that a rational employer may choose, for in return for its payments an employer's employees would receive substantial benefits.

D. The HCSO Is Not Preempted Because It Provides Employers With A Reasonable, Non-ERISA Means For Complying.

Among the many options available for complying with the HCSO, the employer may purchase insurance for its covered employees, thereby creating an ERISA plan, or it may make payments to the City on behalf of its covered employees, thereby avoiding the burden of establishing and maintaining an ERISA plan. *See generally* S.F. Admin. Code § 14.1(7).

The employer also may, if it wishes, satisfy the spending requirement by using more than one option. For example, an employer can choose to provide health insurance to its full-time workers but make payments to the City on behalf of its part-time workers. Appx. D, attached (OLSE Reg. No. 6.2(C)). Or, if the employer has an existing ERISA plan but does not spend the required amount per employee through that plan, it can make up the difference by submitting payments to the City on behalf of its covered employees, who will then benefit from those payments. *Id.*¹¹ Thus, even businesses that have pre-existing ERISA plans

¹¹ If these employees are already insured, they would not qualify for HAP participation; but the City would then establish medical reimbursement accounts for them, which they could then use for any medical expenses, including
(continued on next page)

cheaper than the employer spending requirement need not alter those plans if they prefer to maintain uniformity across jurisdictions.

The law struck down by the Fourth Circuit in *RILA* is vastly distinguishable, and the HCSO passes muster even under the majority's approach in that case. According to the *RILA* majority, the government payment option created by Maryland was illusory, because Wal-Mart would confer no direct benefit upon its employees by paying into the state's Medicaid system. *RILA*, 475 F.3d at 193.¹² And because the government payment option was illusory, the Act "effectively mandate[d] that employers structure their employee healthcare plans to provide a certain level of benefits" *Id.* Here, in contrast, the HCSO and its implementing regulations ensure that *every employee* on whose behalf a payment is made to the City can receive health benefits as a result of that payment. Those who qualify for HAP enrollment receive a 75% discount on their participation fees, which, as discussed at p. 11, *supra*, results in free HAP membership for most covered employees. And any covered employee who does not qualify for HAP enrollment may direct the City to use every dollar paid by their employers to establish and maintain medical reimbursement accounts for them.

Indeed, many employers will presumably find the government payment option quite preferable. After all, it allows them to ensure that their employees

(footnote continued from previous page)

copayments, deductibles, monthly employee contributions, or services not covered under their existing plans. Appx. C, attached (DPH Reg. Nos. 3(a)(iii), 7(g)).

¹² As discussed at p. 7, *supra*, the large majority of uninsured adults do not qualify for Medicaid. And people who have jobs (even at such low-paying companies as Wal-Mart) are even less likely to qualify because their income is likely to be too high.

will be eligible for health benefits merely by writing a check to the City rather than by undertaking the burden themselves – 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. Furthermore, the health benefits received by employees from the City will often be extraordinarily generous considering the small amount paid by the employer. As discussed at p. 8, *supra*, the average insurance premium in California is \$379 per month. In contrast, for a medium sized employer with an employee who works 20 hours per week, the employer can satisfy its spending obligation by paying the City \$93.60 per month. This allows the employee to obtain a HAP membership that provides comprehensive health services. These services cost the City on average \$261 per month to provide. In other words, if the employer chooses the government payment option, his employee receives comprehensive health benefits for pennies on the dollar, and the City picks up the rest of the tab. In sum, the government payment option is eminently reasonable; the Ordinance does not present a false choice that actually forces employers to adopt or amend ERISA plans.

The district court acknowledged that, because the HCSO permits compliance by making payments to the City, it does not require employers to establish ERISA plans. Order at 10. For this reason – because employers that do not meet minimum spending requirements through existing private health care spending may comply through payments to the City that will benefit their employees – the district court was simply wrong to conclude that the HCSO regulates the types of

benefits ERISA plans may or must provide. Order at 9. But the district court never even addresses this logical implication of its reasoning.¹³

E. The District Court's Concern With Uniformity In Benefit Levels Was Misplaced.

The district court's order expressed concern that local expenditure mandates could require employers to make differing health care expenditures in different jurisdictions. Order at 12-13 (Appx. A, attached). However, "[c]ost 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. So long as a local law permits an employer to maintain *plan* uniformity – as the HCSO clearly does – the possibility of cost disparity does not raise ERISA preemption issues.

If the district court were correct that employers could not be required to pay different benefit levels in different jurisdictions, just because those benefits happened to be mentioned in ERISA, the Supreme Court's ruling in *Ft. Halifax* would have to be wrong. The fact that employers can be required to make different payments in different jurisdictions was a necessary prerequisite to the

¹³ The district court also relied on the fact that the HCSO imposes minimal record-keeping obligations upon employers in holding the law preempted. Order at 10-11. But in support of this conclusion, the district court cites a Ninth Circuit decision that held preempted a law that imposed obligations upon ERISA *plans*, not upon employers. This Court has previously rejected the argument that requiring an *employer* to maintain certain records (such as those showing its private health care expenditures) is preempted by ERISA. *See WSB Electric*, 88 F.3d at 795. The district court was bound by, and should have followed, that authority.

Court's decision to uphold Maine's severance benefit requirement. The same is true of *Massachusetts v. Morash*, 490 U.S. 107 (1989), where the Court upheld a state law relating to vacation pay – another type of benefit included in ERISA. Indeed, in *Morash* the Court expressly acknowledged that roughly half the states imposed requirements relating to vacation pay. *Id.* at 109-110. Under the district court's reasoning, *Morash* was wrongly decided.

Accordingly, the fact that employers might be required to make differing payments in different jurisdictions does not create an improper "connection with" ERISA plans, so long as the payments can be made through a vehicle that is not an ERISA plan if the employer elects to do so.

F. The Fact That Compliance With The Ordinance May Be Measured With Reference To ERISA Plan Expenditures Does Not Render It Preempted.

In addition to holding that the Ordinance has an improper "connection with" ERISA plans, the district court concluded that the HCSO, by taking into account employer expenditures on ERISA plans to measure compliance, makes an impermissible "reference to" ERISA plans. But the "reference to" prong of ERISA preemption applies only if a law acts exclusively on ERISA plans or the existence of ERISA plans is necessary to its operation. *See Dillingham*, 519 U.S. at 325, 328; *Travelers*, 514 U.S. at 656.¹⁴ Because of the government payment option, neither is the case here. Laws that "are indifferent to the funding, and attendant ERISA coverage" of the programs to which they apply "do[] not [refer to] ERISA plans." *Oregon Columbia Brick Masons Joint Apprenticeship Training Cte. v.*

¹⁴ The Supreme Court has made it clear that a local law does not run afoul of ERISA's preemption provision simply by mentioning such plans. *See WSB*, 88 F.3d at 793.

Gardener, 448 F.3d 1082, 1089-90 (9th Cir. 2006). Or, as this Court put it in *WSB*: "The references to ERISA plans in the California prevailing wage law have no effect on any ERISA plans, but simply *take them into account* when calculating the cash wage that must be paid The scheme does not force employers to provide any particular employee benefits or plans, to alter their existing plans, or to even provide ERISA plans or employee benefits at all." *WSB*, 88 F.3d at 794 (emphasis added); *cf. Funkhouser v. Wells Fargo Bank*, 289 F.3d 1137 (9th Cir. 2002) (state law claims not preempted by ERISA merely because a court would refer to an ERISA plan in calculating damages). The Court's conclusion that the Ordinance has an improper "reference to" ERISA simply cannot be squared with this case law.

G. The District Court's Opinion Ignored This Circuit's Simplified Test For ERISA Preemption.

In addition to the errors described above, the district court's order completely ignored the Ninth Circuit's simplified test for determining whether a local law is preempted by ERISA. That test asks the following questions: "Is the state telling employers how to write their ERISA plans, or conditioning some requirement on how they write their ERISA plans? Or is it telling them that regardless of how they write their ERISA plans, they must do something else outside and independently of the ERISA plans? If the latter . . . there is no preemption." *Id.* at 796 (quoting *Employee Staffing Services, Inc. v. Aubry*, 20 F.3d 1038, 1041 (9th Cir. 1994)). *See also Operating Engineers Health & Welfare Trust Fund v. JWW Contracting Co.*, 135 F.3d 671, 679 (9th Cir. 1998). The HCSO is clearly the latter type of law, but the district court's order concluded that the Ordinance has an improper "connection with" and "reference to" ERISA plans without checking its conclusions against this simplified test.

H. The District Court's Preemption Ruling Did Not Give Adequate Treatment To Federalism Concerns.

The district court's ruling does not merely disregard binding ERISA case law. It also runs afoul of the principle that courts must be very hesitant to assume that Congress, in passing ERISA, meant to disturb the core power of state and local governments to protect the health and welfare of their people. As the Supreme Court has instructed, courts must start from the presumption that the local law is not preempted, and must find preemption only if Congress' intent to preempt is "clear and manifest." *Travelers*, 514 U.S. at 655.

This Ordinance clearly represents an exercise of that core police power. *See, e.g., De Buono*, 520 U.S. at 814 fn. 10 ("the Court of Appeals rested its conclusion in no small part on the fact that the [statute] targets only the health care industry Rather than warranting pre-emption, this point supports the application of the starting presumption against preemption"); *DeCanas v. Bica*, 424 U.S. 351, 356 (1976) ("States possess broad authority under their police powers to regulate the employment relationship to protect workers within the State. Child labor laws, minimum and other wage laws, laws affecting occupational health and safety, and workmen's compensation laws are only a few examples"); *Operating Engineers Health & Welfare Trust Fund v. JWJ Contracting Co.*, 135 F.3d 671 (9th Cir. 1998) ("ERISA pre-emption must have limits when it enters areas traditionally left to state regulation – such as the state's exercise of police powers and its regulation of health, safety, banking, securities, and insurance matters"). Yet, the district court did not resolve doubts about ERISA's preemptive scope in favor of the HCSO.

Nobody would dispute that San Francisco could have used its police power to impose a tax on all employers and use the proceeds to fund its governmental health care program. Of course, that would have made a lot less sense – it would have failed to account for the fact that 90% of businesses with 20 or more

employees have already chosen to provide health benefits to their employees. And it would have created an incentive for employers to drop that coverage. So instead San Francisco adopted a more sensible (and more just) health care reform program that gives employers credit for the health care dollars they may already spend, while allowing employers to comply without creating or modifying ERISA plans. It would be difficult to conclude that Congress intended to block an exercise of the police power that creates *no* incentive to adopt or amend ERISA plans, while allowing local governments to impose taxation schemes that would create a *tremendous* incentive to eliminate ERISA plans. Yet that is what the district court's ruling stands for. It was improper for the district court to frustrate the City's core police power by resolving doubts *in favor* of preemption and adopting an unduly expansive interpretation of ERISA's preemption language.

II. THE BALANCE OF HARDSHIPS AND THE PUBLIC INTEREST WEIGH HEAVILY IN FAVOR OF ALLOWING THE CITY TO IMPLEMENT THE EMPLOYER SPENDING REQUIREMENT WHILE THE APPEAL IS PENDING.

Without a stay, tens of thousands of San Franciscans will be deprived of essential health care services during the pendency of this appeal, because their employers will not be required to make health care expenditures on their behalf and the City will not be able to expand HAP to all uninsured San Francisco residents. The harms that would result if the City were prevented from implementing the employer spending requirement on January 2, 2008 are numerous, serious, and irreparable. First and foremost, DPH estimates that some 20,000 workers who currently lack coverage will be denied the health care benefits to which they are entitled under the Ordinance. Katz Decl. in Support of Stay at ¶ 10. This prospective deprivation poses serious risks to the health of these workers, because those without benefits are significantly less likely to seek timely treatment

or preventive care, and may suffer unnecessary health complications as a result. *Id.* at ¶ 11; Declaration of Martha Hawthorne in Support of Defendants' Emergency Motion for Stay Pending Appeal ("Hawthorne Decl.") at ¶¶3-5, 13-14. Moreover, should these people become injured or seriously ill while lacking health coverage, they could become destitute or be forced into bankruptcy as a result of the medical costs they would be forced to incur. Katz Decl. in Support of Stay at ¶ 11.

The harm caused by preventing San Francisco from implementing the employer spending requirement would not be limited to the estimated 20,000 workers discussed above. To repeat, the HAP is not merely available for workers whose employers make payments to the City. The City also plans to make HAP membership available, for a fee, to all uninsured San Francisco residents, as contemplated by the Ordinance. However, if the employer mandate is prevented from taking effect, the City will be required to limit HAP enrollment to residents who fall below 300% of the Federal Poverty Level. *Id.* at ¶ 12. Accordingly, aside from the 20,000 workers who would be denied payment of health benefits by their employers, roughly 39% of uninsured residents will be denied the ability to enroll in the HAP if the City is prevented from putting the employer spending requirement into effect. *Id.*

The fact that the denial of coverage to these people would impose a significant hardship is demonstrated by the success of the City's program thus far. Although the City has been unable to open the HAP to all uninsured residents prior to the operative date of the employer spending requirement, it has enrolled a subset of uninsured residents with especially low incomes. The benefits incurred by those people have been dramatic. People previously denied health services are now receiving primary care treatment from physicians or nurses. They are receiving

treatment for long-neglected illnesses and injuries, and no longer need to rely unnecessarily on the City's emergency health care system. The financial and emotional burden of going without health coverage has been lifted from them. Indeed, the ability to enroll in the HAP may have saved the lives of people with heart conditions, diabetes, and other ailments, and it is safe to assume that expanded HAP enrollment in 2008 will do the same for more people. Katz Decl. in Support of Stay at ¶ 13; Hawthorne Decl. at ¶¶ 6-15 (discussing positive impact of HAP enrollment on specific individuals); *see also* fn 1, *supra*.

The City and its taxpayers would also suffer significant financial hardship if the spending requirement is blocked. If 20,000 workers are denied the health expenditures that the Ordinance requires their employers to make, the City would be required to foot the entire bill for any emergency treatment or other health care services these people seek from San Francisco General Hospital or one of the City's health clinics. Katz Decl. in Support of Stay at ¶ 14.

The City has gone to great lengths and undertaken great expense to be ready to implement the employer spending requirement on January 2, 2008. It has upgraded and reprogrammed its HAP eligibility and enrollment system to allow it to enroll employees who are participating as a result of the employer spending requirement. It has hired new staff to facilitate communications with employers who wish to comply with the Ordinance through the government payment option. It is in the process of training all enrollment staff to understand the relationship between the employer spending requirement and HAP participation. It has selected a vendor and set up a system to administer health reimbursement accounts for employees who do not qualify for HAP participation. *Id.* at ¶¶ 15-16.

Weighed against these hardships to the workers, the City and the public at large is the fact that employers covered by the Ordinance would be required to pay

for health benefits for their workers during the pendency of the appeal. But as discussed at pp. 13-14, *supra*, the Ninth Circuit has made clear that the deprivation of benefits that would alleviate human suffering imposes a hardship that vastly outweighs financial costs that would be incurred by the opposing party. *See Lopez*, 713 F.2d at 1437. *See also Miller v. Carlson*, 768 F.Supp. 1331, 1339 (N.D. Cal. 1991) (" . . . the balance of hardships strongly favors plaintiffs who will be deprived of essential benefits"); *United States v. Midway Heights County Water Dist.*, 695 F.Supp. 1072, 1077 (E.D. Cal. 1988) (balancing "financial difficulties" against "preventable human suffering" and resolving stay application in favor of the latter). What's more, the companies that are required to make health care expenditures on behalf of their employees will receive a benefit, because those workers will be eligible for comprehensive health benefits as a result. Accordingly, the City, the uninsured, and the public at large would suffer irreparable harm should a stay not issue, and the balance of hardships weighs heavily in favor of allowing the program to move forward on January 2, 2008.

III. IF THE COURT DOES NOT ISSUE A STAY, IT SHOULD EXPEDITE THE APPEAL.

If the Court denies the stay application, the City respectfully requests that the panel expedite this appeal and schedule oral argument for May or June of 2008.

The City requests the following schedule:

- Opening Briefs due January 23, 2008
- Amicus Curiae Briefs in Support of Appellants due February 15, 2008
- Appellee's Brief due March 7, 2008
- Amicus Curiae Briefs in Support of Appellee due March 28, 2008
- Reply Briefs due April 18, 2008

CONCLUSION

The Court should grant the emergency application for a stay of the ruling below so that the City may implement the employer spending requirement beginning January 2, 2008. If the Court does not grant the stay, the panel should expedite the appeal, set oral argument for May or June 2008, and approve the briefing schedule set forth above.

DATED: December 27, 2007

Respectfully submitted,

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By: _____
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STATEMENT OF RELATED CASES

There are no related cases pending in this Court.

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief has been prepared using proportionately double-spaced 14 point Times New Roman typeface. According to the "Word Count" feature in my Microsoft Word for Windows software, this brief contains 9,439 words up to and including the signature lines that follow the brief's conclusion.

I declare under penalty of perjury that this Certificate of Compliance is true and correct and that this declaration was executed on December 27, 2007.

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PROOF OF SERVICE

I, DIANA QUAN, declare as follows:

I am a citizen of the United States, over the age of eighteen years and not a party to the above-entitled action. I am employed at the City Attorney's Office of San Francisco, City Hall, Room 234, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102.

On December 27, 2007, I served the following document(s):

**EMERGENCY MOTION UNDER CIRCUIT RULE
27-3 FOR STAY PENDING APPEAL**

on the following persons at the locations specified:

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in the manner indicated below:

- BY OVERNIGHT DELIVERY:** I sealed true and correct copies of the above documents in addressed envelope(s) and placed them at my workplace for collection and delivery by overnight courier service. I am readily familiar with the practices of the San Francisco City Attorney's Office for sending overnight deliveries. In the ordinary course of business, the sealed envelope(s) that I placed for collection would be collected by a courier the same day.

- BY ELECTRONIC MAIL:** I caused a copy of such document to be transmitted via electronic mail in Portable Document Format ("PDF") Adobe Acrobat from the electronic address: *diana.quan@sfgov.org*

I declare under penalty of perjury pursuant to the laws of the State of California that the foregoing is true and correct.

Executed December 27, 2007, at San Francisco, California.

DIANA QUAN