Nos. 07-17370 and 07-17372
SCHEDULED FOR ORAL ARGUMENT APRIL 17, 2008
U.S.D.C. Case No. C06-6997-JSW ((N.D. Cal.)

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,

and

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 1021, SEIU UNITED HEALTHCARE WORKERS-WEST; AND UNITE HERE! LOCAL 2,
Defendants-Intervenors/Appellants.

BRIEF OF THE INTERNATIONAL FRANCHISE ASSOCIATION, THE SOCIETY FOR HUMAN RESOURCE MANAGEMENT, AND THE NATIONAL ASSOCIATION OF MANUFACTURERS, AS *AMICI CURIAE*, IN SUPPORT OF APPELLEE AND URGING AFFIRMANCE

On Appeal From the United States District Court
For the Northern District of California
The Honorable Jeffrey S. White, U.S.D.J.

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CORPORATE DISCLOSURE STATEMENTS

Amicus the International Franchise Association ("IFA") is a non-profit organization organized under Section 501(c)(6) of the Internal Revenue Code. IFA has no parent corporation. There is no publicly held corporation that owns 10% or more of IFA's stock.

Amicus the Society for Human Resource Management ("SHRM") is a non-profit corporation organized under Section 501(c)(6) of the Internal Revenue Code. SHRM has no parent corporation. There is no publicly held corporation that owns 10% or more of SHRM's stock.

Amicus the National Association of Manufacturers ("NAM") is a non-profit corporation organized under Section 501(c)(6) of the Internal Revenue Code. NAM has no parent corporation. There is no publicly held corporation that owns 10% or more of NAM's stock.

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Statements of Interests of the Amici[1]

The International Franchise Association ("IFA") is an international membership organization whose domestic members include over 10,000 franchisees, over 1,300 franchisors, and over 500 supplier members in the United States. As the only trade association that represents the common interests of franchisors and franchisees, the IFA's mission is to safeguard the business environment for franchising worldwide. To further this purpose, the IFA has filed amicus briefs in scores of cases such as this, where the outcome of an appeal might pose a significant threat to the legal and regulatory environment in which franchises operate.

The Society for Human Resource Management ("SHRM") is the world's largest association of human resource professionals, currently with more than 575 affiliated chapters and members in more than 125 countries. SHRM represents more than 225,000 individual members, including many professional benefits specialists in the United States. SHRM's mission includes advancing human resources' role in developing and executing employers' business and organizational strategies. Thus, SHRM's members have a professional interest in safeguarding one of the most important objectives of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"): ensuring that the adoption and design of employee benefit

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[1] Counsel for all parties have consented to the filing of the Amici's joint *amicus curiae* brief.

plans will not be subject to a patchwork of potentially conflicting regulations under state laws.

The National Association of Manufacturers ("NAM") is the nation's largest industrial trade association, representing small and large manufacturers in every industrial sector and in all 50 states. The NAM's mission is to enhance the competitiveness of manufacturers by shaping a legislative and regulatory environment conducive to U.S. economic growth and to increase understanding among policymakers, the media and the general public about the vital role of manufacturing to America's economic future and living standards.

Preliminary Statement

ERISA was designed in part "to protect employers from conflicting and inconsistent state and local regulation of [pension and welfare benefit] plans," and this Court correctly has recognized that ERISA's express preemption provision is a means of achieving this purpose. *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1501 (9th Cir. 1985), *citing Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 (1983). Protecting employers from state laws purporting to regulate employee benefit plans, in turn, promotes a related congressional goal: "[creating] a zone of employer autonomy in the design and operation of employers' welfare plans." *See* E.A. Zelinsky, *Maryland's "Wal-Mart" Act: Policy and Preemption*, 28 Cardozo, L.Rev. 847, 869 (2006). Congress intended Section 514(a) to be construed broadly to eliminate threats to employer autonomy and regulatory uniformity. *See* 120 Cong. Rec. 29,933 (1974).

The San Francisco Health Care Security Ordinance, as amended, San Francisco Administrative Code §§ 14.1 *et seq.* (2007) ("the

Ordinance"), stands as an obstacle to the realization of these statutory goals and completely unravels the legislative compromises reached at the national level in 1974 that allowed Congress to pass ERISA. *Cf.* Michael S. Gordon, *Introduction: The Social Policy Origins of ERISA,* in Employee Benefits Law (S.J. Sacher and J.I. Singer, eds., ABA, 2d ed. 2000) at xc–cii (ERISA would not have been adopted if it had not been premised on preserving employer autonomy over plan adoption and plan design). As the leading historian of ERISA has noted, giving the act broad preemptive effect was essential to its adoption. "The desire for federal preemption was a key factor – perhaps, the key factor – in creating the coalition that pushed ERISA through Congress." J.A. Wooten, *A Legislative and Political History of ERISA Preemption, Part I,* 14 J. of Pension Benefits 10 (2006).

The District Court correctly ruled that "By mandating employee health benefit structures and administration, [the Ordinance] interfere[s] with preserving employer autonomy over whether and how to provide employee health coverage, and ensuring uniform national regulation of such coverage." Dkt. 74, p. 8. The judgment in this case must be affirmed to assure that the national consensus on which ERISA was passed remains a cornerstone of the law.

Argument

According to Appellants, the Ordinance merely establishes a "health care spending requirement" for covered employers, leaving them free to satisfy the requirement through "non-ERISA means, including by making payments to the City." Joint Opening Brief of Appellants ("App. Br."), 1, 2. Based on this characterization of the Ordinance,

Appellants urge that the Ordinance is not preempted because it regulates only expenditures, not plans. *See* App. Br., 26-27, *citing and quoting Fort Halifax Co. Packing v. Coyne*, 482 U.S. 1, 7-8 (1987).

Appellants' argument artificially divorces the spending requirement from the circumstances that trigger it, the limited type of spending that will satisfy it, and the ongoing administrative steps an employer must take to comply with it, *i.e.*, the very factors establishing the existence of an ERISA-governed plan. *See* Section I, *infra.* It also incorrectly suggests that the Ordinance permits compliance by "non-ERISA means," but compliance by non-ERISA means is impossible. *See* Section II, *infra.* When the spending requirement is considered in the context of the Ordinance as a whole, it is clear that ERISA preempts it. *See* Section III, *infra.*

I. The Ordinance Requires a Covered Employer to Maintain an ERISA-Governed Health Plan.

Compliance with the spending requirement necessarily requires a covered employer to maintain an ERISA-governed plan. When the Ordinance applies, it establishes an obligation on the part of a covered employer to arrange payment for health care for one or more of its employees. This is clear from the two most elementary facts about the Ordinance's spending requirement: (1) a covered employer's spending requirement is triggered if and only if an employer-employee relationship exists between itself and an employee meeting the Ordinance's coverage criteria; and (2) a covered employer's spending obligation can be discharged only by payments to or for the benefit of each of its own covered employees. *See* Ordinance, § 14.1(b)(2) (defining

"covered employee") and (7) (defining "health care expenditure" as an amount paid by a covered employer to or for the benefit of "its covered employees").

Furthermore, the Ordinance requires the covered employer to maintain records proving that it has made regular and systematic payments to or on behalf of each of its covered employees for the purpose of providing health coverage, a type of employee benefit explicitly referred to in ERISA's definition of an employee welfare benefit plan. Ordinance, §§ 14.1(b)(7) and 14.3(b); *cf.* ERISA § 3(1), 29 U.S.C. § 1002(1). Thus, covered employer's obligation can be satisfied only by programmatic spending designed to provide health care to its employees. *See* App. Br. at 7 & n.6. These facts alone are sufficient to show that *any* mode of compliance with the spending requirement necessarily involves actions by the employer that satisfy ERISA's definition of an employee welfare benefit plan:

> . . . *any* plan, fund, or *program* . . . established or maintained *by an employer* . . . to the extent that such plan, fund, or program was established or is maintained *for the purpose of providing* for its participants or their beneficiaries, through the purchase of insurance *or otherwise*, (A) medical, surgical, or hospital care or benefits . . .

ERISA § 3(1), 29 U.S.C. § 1002(1) (emphases added).

Significantly, Appellants do not argue to the contrary. Instead, they claim that a covered employer can comply with the Ordinance "merely by writing a check," as if to suggest that, like compliance with the Maine statute at issue in *Fort Halifax*, compliance with the Ordinance need not involve "an ongoing administrative program" and

therefore does not involve a "plan." *See* App. Br. at 23 and *cf. Fort Halifax, supra,* 482 U.S. at 12 ("The requirement of a one-time, lump-sum payment triggered by a single event requires no administrative scheme whatsoever . . . To do little more than write a check hardly constitutes the operation of a benefit plan.").

Appellants' assertion fails to meet the substance of the legal issue involved. The Ordinance requires an employer to adopt ongoing administrative duties to determine the scope of its quarterly obligation of providing its covered employees with health benefits, whether that process culminates in "merely writing a check" or in the adoption of any other compliance method. Appellants cannot deny this, and it would not matter if they did because the law is clear and the facts are uncontested.

This Court has held that the dividing line between cases involving ERISA plans and cases like *Fort Halifax* is whether an "administrative scheme" is required because circumstances related to individual employees must be analyzed in light of certain criteria to determine benefit entitlement. *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1323 (9th Cir. 1992). Examples abound of instances in which the Ordinance requires the employer to apply criteria spelled out in the Ordinance to individual circumstances, but a few examples related to eligibility for benefits and payment amounts should suffice.

The first example is the provision of the Ordinance that vests the employer with discretion to seek a waiver of covered employee status from an employee each year. To exercise its ability to seek a waiver, the employer first must determine (with sufficient certainty to "verify" the

fact) that the employee has other employer-provided coverage, either in his or her capacity as an employee or as the domestic partner, spouse or child of another person. Ordinance § 14.1(b)(2)(h). As a second example, to determine whether spending is required on behalf of certain employees earning less than a specified amount, the employer must determine whether the employee is a managerial, supervisory or confidential employee. Ordinance, § 14.1(b)(2)(d). These determinations are far more complex and nuanced than the determinations on which this Court relied in *Bogue* to find that a severance plan was covered by ERISA.

The need for an ongoing administrative process also is hard-wired into the variables that determine the amount of an employer's spending requirement from quarter to quarter. For example, the minimum amount of the required expenditure with respect to a given covered employee for a given quarter is a function of "hours paid," defined in the Ordinance to include hours worked by the covered employee in San Francisco during that quarter plus hours treated as "hours paid" (under criteria established by the Ordinance and applied by the employer) even if no work is performed. Ordinance, §§ 14.1(b)(8) and (10) and 14.3(a). Thus, to demonstrate compliance with the spending requirement, employer must have a process in place to monitor this variable and to adjust its spending accordingly on an ongoing basis.

In short, there is no serious argument to be made that this case falls on the "no plan" side of the *Fort Halifax* line. Regardless of the particular compliance alternative a given employer might choose, the spending requirement compels a covered employer to maintain an

ERISA-governed plan. *Cf. Fort Halifax, supra*, 482 U.S. at 14 n.9 (what "makes a plan a plan" is the employer's foreseeable "need to make regular payments . . . on an ongoing basis").

II. The Ordinance's Specific Compliance Alternatives Effectively Require a Covered Employer to Maintain an ERISA-Governed Plan.

The other essential premise of Appellants' argument—that the Ordinance specifies five alternatives that permit compliance but do not involve maintaining an employee benefit plan—is also wrong. *See* App. Br. 16, 21-22 and n.9. What Appellants call the "payments to the City" option ("City payment") necessarily involves the adoption of a group health plan described in Section 3(1) of ERISA, 29 U.S.C. § 1002(1). *See* Section II.A, *infra*. None of the four remaining "non-ERISA" compliance options (some of which actually involve ERISA-governed plans) affords a covered employer a realistic means to comply with the Ordinance's spending requirement. *See* Section II.B, *infra*.

A. By Choosing the "City Payment" Option, an Employer Adopts a Group Health Plan.

The centerpiece of the City's argument in the Court below and in this Court is that the "City payment" option is a "non-ERISA compliance option." App. Br. 14 n.8 and 21-22; *see also id.*, at 2. The leading academic authority on ERISA preemption has pointed out the fallacy in that argument by showing that if a covered employer adopts the "City payment" option, the employer will have adopted a multiple employer group health plan. *See* E.A. Zelinsky, *'Golden Gate Restaurant Association' Employer Mandates and ERISA Preemption in*

the Ninth Circuit," Cardozo Legal Studies Research Paper No. 219, 23-28 (2008), available at http://ssrn.com/abstract=1090122.

The contrary conclusion is simply not possible under applicable law. If a covered employer chooses the "City payment" option, the payment automatically results in health care program eligibility for those of the employer's own covered employees on whose behalf the payment was made, and for no one else. Regulations Implementing Healthy San Francisco and Medical Reimbursement Account Provisions of the San Francisco Health Care Security Ordinance ("Group Plan Regulations"), § 7(c) ("DPH's Third-Party Administrator will . . . determine whether the payment made on behalf of a Covered Employee shall be used to fund *the* Covered Employee's participation in Healthy San Francisco or to establish a Medical Reimbursement Account for *the* Covered Employee.") (emphasis added). As a result of the employer's payment, the covered employee may enroll in the Healthy San Francisco plan ("HSF") at a discounted rate (if the employee resides in the City and meets other eligibility criteria for HSF), or to participate in the Medical Expense Reimbursement Plan (if she does not reside in the City or is ineligible for HSF). Thus, when an employer makes its employees eligible for coverage under the City's plan by paying its required health care expenditure to the City, the employer necessarily establishes an ERISA-governed plan vis-a-vis its own employees. *See Patelco Credit Union v. Sahni*, 262 F.3d 897, 907-08 (9th Cir. 2001). Whether or not the City's health plan is itself governed by ERISA is irrelevant to this issue. *Credit Managers Ass'n v. Kennesaw Life & Accident Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987).

The conclusion that a covered employer establishes an ERISA-governed plan by choosing the "City payment" option for compliance follows from *Scott, supra*, 754 F.2d at 1504, in which this Court adopted the test for plan establishment first articulated by the Eleventh Circuit in *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) (en banc).[2] Under the *Donovan v. Dillingham* test, an employer has "established" a plan for purposes of ERISA § 3(1) if "from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits." *Id.* at 1373. *See Scott, supra,* at 1504 (allegation of facts from which a reasonable person can ascertain the four *Donovan v. Dillingham* factors "is clearly a sufficient allegation of the establishment of a plan"). All four of the *Donovan v. Dillingham* factors are readily ascertainable when a covered employer chooses the "City payment" compliance option. *See* Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance (HCSO) ("Spending Regulations"), § 4.2(A)(6) (defining "health care expenditures" to include "[p]ayments on behalf of a covered employee to the City of San Francisco: (a) to fund membership in the Health Access Program/*Healthy San Francisco*; or (b) to establish and maintain medical reimbursement accounts for covered employees.")

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[2] The continued vitality of the *Donovan v. Dillingham* test in the Ninth Circuit was confirmed in *Winterrowd v. Am. Gen. Annuity Ins. Co.,* 321 F.3d 933, 939 (9th Cir. 2003).

As this Court has held, the criteria of ERISA § 3(1) are met where an employer purchases coverage for its employees from a third party, and by doing so simply delegates to the third party a task the employer otherwise would have undertaken itself if it had chosen to establish a self-funded plan. *Silvera v. Mutual Life Ins. Co.*, 884 F.2d 423, 427 (9th Cir. 1989). Thus, a covered employer that chooses to comply with the Ordinance by availing itself of the "City payment" option thereby establishes a welfare benefit plan just as surely as if the same employer had chosen to comply by contracting with an HMO to provide medical care to its covered employees. The City tacitly acknowledged this fact in the District Court, where it depicted Healthy San Francisco as a lower-cost competitor of private sector insurers and other financial intermediaries. Defendant San Francisco's Motion and Memorandum In Support of Summary Judgment, Dkt. 51 at 20.

B. None of the Remaining Compliance Options Referred to in the Ordinance Allows an Employer to Comply With the Spending Requirement by a "Non-ERISA Means."

Appellants invoke four other so-called "non-ERISA means" of compliance in addition to the "City payment" option: tax-favored health savings accounts described in Section 223 of the Internal Revenue Code ("HSAs"); taxable health savings accounts ("quasi-HSAs"); direct reimbursement of medical expenses that are not made under an employer sponsored plan ("random reimbursements"); and providing medical care at clinics maintained by the covered employer ("on-site clinics"). *See* App. Br., 11, 13-14, 16, 21-22 and n.9. None of these four

options, alone or in combination, affords covered employers a "non-ERISA means" of compliance with the spending requirement. In fact, two of them (the random reimbursement option and the on-site clinic option) would not result in compliance at all. *See* Section II.B.1, *infra.* The quasi-HSA option, the on-site clinic option, and (under all but the most improbable of circumstances) the HSA option all require a covered employer to maintain a group health plan covered by ERISA. *See* Section II.B.2.i - iii, *infra.* In addition, the HSA option can be adopted only if the covered employer conforms the terms of its ERISA-governed group health plans to a requirement incorporated into the Ordinance by reference to Section 223 of the Internal Revenue Code. *See* Section II.B.2.ii, *infra.* Furthermore, even if the quasi-HSA option did not involve adopting an ERISA-governed plan and even if the random reimbursement option genuinely could result in full compliance, no employer would choose either of them because they would impose adverse tax consequences on covered employees. *See* Section II.B.3, *infra.*

1. An Employer Cannot Comply With the Spending Requirement Using Random Reimbursements and/or On-Site Clinics.

The Ordinance's spending requirement includes an "employee-by-employee" and a "quarter-by-quarter" rule that prohibit an employer from demonstrating compliance based on either (a) its average health care expenditures per hour worked; and/or (b) its expenditures for any covered employee over a period of more than three months. *See* Ordinance, § 14.3, and Spending Regulations, § 6.2(A) (establishing

quarterly payment requirement). The Ordinance explicitly provides that in determining compliance for a quarter, "payments to or on behalf of a covered employee shall not be considered if they exceed . . . the number of hours paid for the covered employee during the quarter multiplied by the applicable health care expenditure rate." Ordinance, § 14.3. *See also* Spending Regulations, § 6.1 ("A covered employer's required health care expenditure is the sum of the health care expenditure that the covered employer is required to make each quarter for each of its covered employees.") and § 6.2(B) (restating the general rule that excess payments for a given employee "will not be included in determining whether an employer has met its total required health care expenditures for all employees."). [3]

The "employee-by-employee" rule and the "quarter-by-quarter" rule make it statistically impossible for an employer to comply with the spending requirement by any *ad hoc* approach to reimbursing the medical expenses of covered employees or diagnosing and treating their medical conditions at on-site facilities. Under either of these approaches, the employer's spending pattern for a given covered employee would go up and down in tandem with the employee's need for medical care. As a result, a covered employer cannot comply with the spending requirement by relying on random reimbursements or on-site

[3] If a covered employer folds its covered employees into one of two specific categories of ERISA-governed group health plans, regulations promulgated under the Ordinance permit the employer to be deemed in compliance with the spending requirement based on average expenditures for the covered group of employees as a whole. Spending Regulations § 6.2(B)(1)-(2). As discussed in Section IX, *infra*, this fact is an independent basis for affirming the judgment.

clinics unless, against astronomical odds, each of an employer's covered employees undergoes medical treatment every quarter in an amount that equals or exceeds the employee's individual entitlement under the Ordinance.

2. The On-Site Clinic Option, the HSA Option, and the Quasi HSA Option Require That an Employer Maintain an ERISA-Governed Plan With Particular Terms Dictated by the Ordinance.

i. On-Site Clinics.

Complying with the Ordinance by establishing medical care centers on employer premises is not realistic. *Cf. Retail Indus. Leaders Ass'n. v. Fielder,* 435 F. Supp. 2d 481 (D. Md. 2006) at 497 (establishing a first aid station program that can meet the spending requirements of the Maryland Fair Share Health Care Act solely by treating minor injuries and illness and/or providing first aid for accidents during working hours is simply not a practical alternative).

Moreover, the operation of on-site clinics of the sort contemplated by the Ordinance necessarily would be employee benefit plans. ERISA § 3(1), 29 U.S.C. § 1002(1). Appellants' suggestion to the contrary evidently springs from misplaced reliance on a Department of Labor regulation exempting certain limited-purpose on-site clinics such as first aid stations from regulation as employee welfare plans. *See* 29 C.F.R. § 2510.3-1(c)(2).

The regulatory exemption for on-premises first aid stations in 29 C.F.R. § 2510.3-1(c)(2) was never intended to apply to a program that spends a defined amount per hour worked on first aid and medical care

for minor illnesses and injuries. Section 2510.3-1(c)(2) was promulgated to relieve employers of the regulatory burdens of Title I compliance, *not* to strip employers of the protection of ERISA preemption. During the rulemaking process, the Department of Labor specifically found that "first aid stations . . . arguably might fall within [the scope of] section 3(1)." Office of Employee Benefits Security, U.S. Dep't of Labor, Notice of Proposed Rulemaking, 40 Fed. Reg. 24642 (June 9, 1975). DOL's reason for administratively excluding on-site first aid facilities from the regulatory definition of "welfare benefit plan" was its conclusion that such facilities confer only "incidental benefits" on employees, *i.e.*, that the employer maintains such facilities to promote its interest in allowing employees to report for or remain at work or its interest in minimizing the harm from on-the-job sickness and accidents. *Id.* Thus, the Department of Labor concluded that "[t]he protection which would be afforded to employees if such facilities were treated as employee benefit plans would not justify the costs of Title I compliance." Notice of Proposed Rulemaking, *supra*, 40 Fed. Reg. at 24642. The same certainly cannot be said of clinics that could provide medical care complying with the Ordinance, given that the annual per-employee cost could be as high as $3,623.64. *Cf.* Ordinance § 14.1(b)(10) (capping hours paid at 172/month) and Spending Regulations, § 5.2(B)(1) (establishing $1.76/hour rate for 2007).

ii HSAs.

Appellants suggest that a covered employer can meet the Ordinance's spending requirements by paying the required amounts

into health savings accounts ("HSAs") maintained for covered employees under Code § 223. *See* App. Br., 22 n.9, citing Employees Benefits Security Admin., U.S. Dep't of Labor Field Assistance Bulletin 2004-1 (April 17, 2004) ("FAB 2004-1"); *see also* I.R.C. § 223.

Appellants' belief that this approach represents a "non-ERISA means" of compliance is unfounded, and it certainly does not follow from FAB 2004-1. While FAB 2004-1 may represent an Executive Branch decision to exempt HSAs from regulation under ERISA, it does not purport to exempt state laws relating to HSAs from the preemptive effect of ERISA § 514(a).

In any event, an employer cannot comply with the Ordinance by contributing to an HSA under I.R.C. § 223 for each of its covered employees without also abiding by a limitation flowing from Section 223 on its ability to include those employees under its other ERISA-governed plans. Section 223 specifies that contributions to an HSA are excludable from gross income only if made on behalf of an "eligible individual." An individual is an "eligible individual" for any month only if he or she is covered by a "high deductible health plan" as of the first day of the month *and* if he or she is not covered by any health plan which is not a high deductible health plan. I.R.C. § 223(c)(1)(A)-(B)(i). While it is conceivable in theory that all an employer's covered employees might have individual "high deductible health plans," as a practical matter, an employer that wanted to comply with the Ordinance through HSA contributions also would need to establish this specific kind of insured group health plan for its covered employees. Furthermore, as Appellants concede, "state law may not dictate *who*

can benefit from an ERISA Plan." App. Br. 17, citing *Egelhoff v. Egelhoff,* 532 U.S. 141, 147 (2001) (emphasis in original). The "HSA contribution" compliance option is therefore preempted because it necessarily dictates to covered employers that they may not allow covered employees to participate in any other employer sponsored health plan that is not a "high deductible health plan." *Retail Indus. Leaders Ass'n v. Fielder,* 475 F.3d 180 (4th Cir. 2007) at 196, 197. ("RILA")

iii. Quasi HSAs.

Any medical expense reimbursement account that satisfies the Ordinance's spending requirement also necessarily satisfies ERISA's definition of a welfare plan, for the same reasons that the "City payment" option would when the payment is used by the City's Third Party Administrator to set up a medical reimbursement account. *See* Section II.A, *supra.*

3. The Random Reimbursement and Quasi-HSA Options Would Impose Adverse Tax Consequences on Covered Employees.

Even if an employer could overcome the practical difficulties associated with the random reimbursement option, and even if each covered employee required at least 100% of her or his Ordinance-worth of medical care per quarter, the income tax consequences of these compliance methods would be unacceptable to employers and employees

alike. If an employee is reimbursed for medical expenses, and the reimbursement is derived from employer contributions, the amount of the reimbursement is includible in the employee's gross income for federal tax purposes unless (1) the reimbursement is (a) paid under a policy of insurance, or (b) paid under a plan in discharge of the employee's legally enforceable right to the reimbursement; or (2) if "on the date the employee became sick or injured, the employee was covered by a plan (or a program, policy, or custom having the effect of a plan) providing for the payment of amounts to the employee in the event of personal injuries or sickness, and notice or knowledge of such plan was reasonably available to the employee." Treas. Reg. § 1.105-5(a).

By hypothesis, the random reimbursement method cannot satisfy any of the three alternative criteria for excluding the reimbursement from the employee's gross income, since if any of those alternative standards were met, the "random reimbursement method" would be an ERISA-governed plan. ERISA § 3(1), 29 U.S.C. § 1002(1); *Donovan v. Dillingham*, *supra*, 688 F.2d at 1371. One or more *ad hoc* reimbursements do not constitute a plan under Treas. Reg. § 1.105-5. *Estate of Kaufman v. Com'r*, 33 T.C. 660, 666 (1961), *aff'd* 300 F.2d 128 (6th Cir. 1962). *See also American Foundry v. Commissioner*, 59 T.C. 231, 239 (1972). Thus, because of the very same factors that would make random reimbursements fail to fall within ERISA's definition of a plan, random reimbursements would burden employers with reporting and withholding duties, and employees with income taxation on the reimbursed amounts. Treas. Reg. § 1.105-5(a). *See, e.g., Larkin v. Commissioner,* 48 T.C. 629, 633 (1967) (the existence of a plan is a

prerequisite to excluding medical reimbursements from an employee's income under I.R.C. § 105(b)).

Similar unfavorable tax consequences would follow if an employer funded an account from which an employee could draw to pay for medical expenses. Unless such an arrangement is an HSA or entitled to tax treatment as a plan under I.R.C. § 105, the employee will be required to include the amount in her or his gross income when the account is funded, even if many years pass before the employee incurs any medical expenses. *Cf. Minor v. United States*, 772 F.2d 1472, 1474 (9th Cir. 1985) (under the economic benefit doctrine, an employee's gross income includes an employer contribution to a deferred compensation plan for the employee where the contribution is nonforfeitable, fully vested, and secured from the claims of the employer's creditors by being held in trust). *See also* Rev. Rul. 2002-80, 2002-2 CB 925 (2002) (advance "reimbursements" of medical expenses not excludable under Code § 105(b)).

III. The Ordinance's Spending Requirement Is Preempted By ERISA.

A. The Ordinance's Spending Requirement Is Preempted Under ERISA's Express Preemption Provision, Section 514(a).

It is undisputed that a state or local law "relate[s] to" an employee benefit plan within the meaning of ERISA's general preemption provision, ERISA § 514(a), 29 U.S.C. § 1144(a), if it requires a covered employer to maintain an ERISA-governed plan or if it dictates specific terms of a covered employer's plans. *See Shaw v. Delta Air Lines, Inc.*,

463 U.S. 85, 96-97 (1983); *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001); *Standard Oil Co. v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981). *Cf. N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995) ("state laws that mandate[] employee benefit structures or their administration" are preempted).

Moreover, state-mandated adoption of an employee benefit plan is prohibited by Section 514(a) whether the mandate results from an outright command or from leaving the covered employer with no other reasonable option for compliance. *RILA, 475 F.3d at* 192-93 ("a state law has an impermissible 'connection with' [footnote omitted] an ERISA plan if it directly regulates *or effectively mandates* some element of the structure or administration of employers' ERISA plans.") (emphasis added). *Cf. Keystone Chapter, Associated Builders & Contractors v. Folely*, 37 F.3d 945, 960 (3d Cir. 1994).

It therefore follows from the considerations discussed in Sections I and II, *supra*, that the Ordinance is preempted under Section 514(a).

B. The Ordinance Is Preempted Under the "Simplified Test" Proposed by Appellants.

Appellants describe this Court's reasoning in *WSB Elec. v. Curry*, 88 F.3d 788, 796 (9th Cir. 1996), as a "'simplified test' for ERISA preemption." App. Br., 33. Whether or not this description is apt, it is certainly true that if a requirement imposed under state law is

conditioned on "how [employers] write their ERISA plans," the state law is preempted. App. Br., 33.[4]

As noted above, the Ordinance's "employee-by-employee rule" and the "quarter-by-quarter" rule erect a virtually insurmountable obstacle to compliance with the spending requirement for any employer that does not adopt the "City payment" compliance option. *See* Section II.B.1, *supra.* To be sure, the City's Spending Regulations provide that an employer will be deemed to have complied with the spending requirement, even if it cannot show compliance with the "employee-by-employee" and the "quarter-by-quarter" rules, but only if the employer adopted a self-insured group health plan and folds its covered employees into it on a uniform basis with other employees covered under the self-insured plan. Spending Regulations, § 6.2(A)-(B).

The Spending Regulations describe the precise terms of the ERISA-governed plan the employer must have in order not to be subject to the "employee-by-employee" and "quarter-by-quarter" rules:

> (1) A covered employer that provides uniform health coverage to some or all of its covered employees shall, with respect to those employees, be deemed to comply with the spending requirement of this Ordinance if the average expenditure rate per employee meets or exceeds the applicable expenditure rate . . . for that employer.

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[4] *Amici* submit that this rule is better understood as a specific application of ordinary "conflict" preemption analysis. *See* Section III.C, *infra*,

> (2) A covered employer that provides health coverage to some or all of its covered employees through a self-funded/self-insured plan shall, with respect to those employees, be deemed to comply with the spending requirement of this Ordinance if the preceding year's average expenditure rate per employee meets or exceeds the applicable expenditure rate . . . for that employer.

Spending Regulations, § 6.2(B)(1)-(2). Moreover, a covered employer that has adopted a self-insured group health plan is not required to satisfy the general rule that expenditures must be made quarterly. Spending Regulations, § 6.2(A)(1). Thus, a covered employer is effectively compelled to include covered employees in an ERISA-governed plan in order to come within Sections 6.2(A)-(B) of the Spending Regulations, or to become a participating employer in the City's plan. Either way, the covered employer is required to maintain an ERISA plan, the terms of which are dictated at least in part by the Ordinance.

C. The Ordinance Is Preempted Because It Is an Obstacle to Full Achievement of ERISA's Fundamental Purposes.

The District Court held that "[the Ordinance] interfere[s] with preserving employer autonomy over whether and how to provide employee health coverage." Dkt. 74, p. 8. While the District Court did not explicitly rely on traditional conflict preemption doctrines to strike down the Ordinance, given that holding, it certainly could have. The Ordinance denies a covered employer the ability to allocate its benefits budget according to its own view of how to maximize the overall welfare of its employees – *i.e.*, the Ordinance forbids what ERISA permits, and

therefore it is preempted on that basis alone. *See Bank of Am. v. City & County of S. F.*, 309 F.3d 551, 561-64 (9th Cir. 2002) (local ordinance prohibiting ATM fees preempted where the National Bank Act permits such fees to be charged); *Broad v. Sealaska Corp.*, 85 F.3d 422, 426-429 (9th Cir. 1995) (state law prohibiting certain discriminatory distributions to shareholder preempted where federal statute implicitly permitted such distributions). On this record, conflict preemption, and specifically "obstacle preemption," is a particularly appropriate basis for an affirmance.

Under the conflict preemption doctrine as applied by the Supreme Court, a state law is preempted "where 'compliance with both federal and state regulations is a physical impossibility,' . . . *or where state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'*" *Gade v. National Solid Wastes Management Ass'n.*, 505 U.S. 88, 98 (1992) (emphasis added) (internal citations omitted). Although ERISA contains an express preemption rule, the conflicts preemption doctrine also is fully applicable where a state law conflicts with or operates to frustrate the objectives of ERISA's provisions. *See Boggs v. Boggs*, 520 U.S. 833, 841 (1997). State and local laws are preempted if an analysis of their effects shows that they would conflict with a basic federal objective embodied in ERISA. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).

A state law is an obstacle to the accomplishment and execution of the full purposes and objectives of Congress where the state law significantly impairs the exercise of a federally secured right. *See Capital Cities Cable, Inc. v. Crisp*, 467 U.S. 691, 709-11 (1984)

(Oklahoma statute that required cable broadcaster to delete wine commercials from pay channels preempted under "conflict preemption" analysis because compliance with the Oklahoma law would result in broadcaster's inability to comply with a condition for availing itself of the benefits of compulsory licensing conferred by the Copyright Revision Act of 1976). Furthermore, a state law is preempted if it "burdens the exercise of [a] federal right" established by a federal statute and "[t]he burden . . . is inconsistent in both design and effect with the . . . aims" of the federal statute. *Felder v. Casey*, 487 U.S. 131, 141 (1988). Where federal law provides that a party has a choice between two alternatives, a state law is preempted as being an obstacle to the federal law if the state law penalizes the party's choice of one of those alternatives. *Livadas v. Bradshaw*, 512 U.S. 107, 117 (1994) (state labor commissioner's policy of not enforcing the state's wage payment act in cases involving collectively bargained employees where contract provided for arbitration held preempted by the National Labor Relations Act).

The District Court's "interference" holding implicitly recognized the unassailable proposition that ERISA was intended to preserve employer autonomy over the adoption and design of employee benefit plans.

ERISA is premised on the voluntary adoption of employee benefit plans by employers. *Nachman Corp. v. Pension Ben. Guaranty Corp.*, 446 U.S. 359, 384-85 & n.35 (1980). *See also Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983); *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) ("Nothing in ERISA . . . mandate[s] what kind of benefits

employers must provide if they choose to have such a plan."); and *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans."). ERISA affirmatively commits plan design decisions to employers. *See, e.g.*, E.A. Zelinsky, *'Travelers,' Reasoned Textualism, and the New Jurisprudence of ERISA Preemption*, 21 Cardozo L. Rev. 807, 812 (1999) (footnotes omitted).

In fact, the congressional decision to commit plan design issues to employers is embedded in the language of the Act that defines the term "employee benefit plan," and suffuses the legislative history of ERISA's explicit preemption provision. ERISA defines the term "employee welfare benefit plan" to include any "plan, fund, or program . . . *established or maintained by an employer*" that provides specified types of benefits. ERISA § 3(1), 29 U.S.C. § 1002(1) (emphasis added). Section 402(a)(1) of ERISA provides that "Every employee benefit plan shall be *established and maintained* pursuant to a written instrument." *See* 29 U.S.C. § 1102(a)(1) (emphasis added).[5] ERISA explicitly makes the written instrument determinative of how the plan is administered and funded, including who is eligible for coverage and what benefits are available under the plan. *See* ERISA § 402(b)(4), 29 U.S.C. § 1102 (b)(4) and § 404(a)(1)(D), 29 U.S.C. § 1104 (a)(1)(D) (requiring a plan fiduciary

[5] An "instrument" has been defined as "A document or writing which gives formal expression to a legal act or agreement, for the purpose of creating, securing, modifying, or terminating a right." *Black's Law Dictionary* 801 (6th ed. 1991).

to discharge his duties with respect to a plan "in accordance with the documents and instruments governing the plan" to the extent not inconsistent with ERISA). Thus, one and the same action by the employer—the adoption of a written instrument—both causes an employee benefit plan to be "established or maintained" and defines its terms. Since the decision to execute the instrument is clearly left to the employer under ERISA, the statutory text establishes that the terms of any given plan are left to the employer as well. *Cf.* Zelinsky, *Maryland's 'Wal-Mart' Act, supra,* at 867 ("[the Fair Share Act] intrudes upon employers' autonomy as to medical plan participation and funding, topics ERISA reserves for employer discretion.").

Preemption of inconsistent state law relating to employee benefit plans is an essential manifestation of and safeguard for Congress's policy favoring voluntarily adopted benefit plans exclusively. See *Travelers*, *supra*, 514 U.S. at 656-57 (Section 514(a) was adopted to prevent the need to tailor both plans and "employer conduct" to state laws). The conclusion that "Section 514 and the structure of ERISA [create] a zone of employer autonomy in the design and operation of employers' welfare plans," *see* Zelinsky, *Maryland's 'Wal-Mart' Act*, supra, 869, is fully supported by ERISA's legislative history. ERISA's explicit preemption provision was regarded as essential to encouraging employers to adopt and maintain welfare benefit plans because Congress knew that uniformity reduces the cost and administrative burdens associated with employer-sponsored benefit plans. *See*, M. S. Gordon, *The History of ERISA's Preemption Provision and Its Bearing on the Current Debate over Health Care Reform* (1992),

reprinted in EBRI Issue Brief (Mar. 1993), p. 28, 29 (noting that House-Senate conferees strengthened the language of ERISA's preemption provision in part because Hawaii's Prepaid Healthcare Act and California's expressed intention to adopt a similar measure convinced the AFL-CIO and the business community "that a series of state laws with varying health plan requirements would impose impossible compliance burdens on large multistate plans."). *See also* 29 U.S.C. § 1001a(c)(2), as added by § 3 of the Multiemployer Pension Plan Amendments Act of 1980, and 29 U.S.C. § 1001b(c)(2), as added by Title XI, § 11002 of the Single Employer Pension Plan Amendments Act of 1986.

The Ordinance not only forbids what ERISA permits; it also interferes with the method Congress provided for governing employment-related health coverage, and therefore is preempted because it is an obstacle to ERISA's goals. *See Public Util. Dist. No. 1 v. IDACORP, Inc.*, 379 F.3d 641, 649 (9th Cir. 2004). As Appellee's Answering Brief has demonstrated, the Ordinance interferes with and significantly impairs a covered employer's statutory right under ERISA to design its employee benefit plans as it sees fit, subject only to the constraints of a single body of federal law. Appellee's Answering Brief, 22-23 and 28-31. In particular, the Ordinance imposes financial and record-keeping burdens on employers based solely on their choice of one plan design permissible under federal law versus another. Thus, the Act is preempted under the "conflict preemption" doctrine.

Conclusion

For the reasons set forth above, the judgment should be affirmed.

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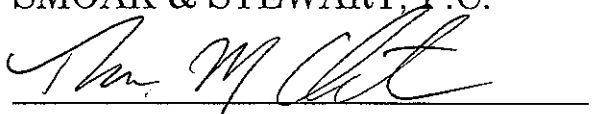

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CERTIFICATE OF COMPLIANCE

I certify that pursuant to Fed. R. App. P. 32 (a)(7)(C) the attached Brief of the International Franchise Association, the Society for Human Resource Management, and the National Association of Manufacturers as *Amici Curiae* in Support of Appellee and urging Affirmance has been prepared in a proportionally spaced typeface of 14 points in Century using Microsoft Word 2002 and contains 6,871 words, according to the word count feature of Microsoft Word 2002 for Windows XP, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

I declare under penalty of perjury that this Certificate of Compliance is true and correct and that this declaration was executed on the Date of Execution.

Dated: March 28, 2008

Respectfully submitted:

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PROOF OF SERVICE BY OVERNIGHT DELIVERY COURIER

I, ROBERT E. COGGINS, 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 Ogletree Deakins, Nash, Smoak & Stewart, P.C., 300 North Main Street, Greenville, SC 29601.

On March 28, 2008, I served the following document:

BRIEF OF THE INTERNATIONAL FRANCHISE ASSOCIATION, THE SOCIETY FOR HUMAN RESOURCE MANAGEMENT, AND THE NATIONAL ASSOCIATION OF MANUFACTURERS, AS *AMICI CURIAE*, IN SUPPORT OF APPELLEE AND URGING AFFIRMANCE

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