

Maintaining Healthy Laboratories of Experimentation: Federalism, Health Care Reform, and ERISA

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In this Comment, we demonstrate the ingenuity of San Francisco’s Health Care Security Ordinance and explain why local experimentation with health care solutions is an invaluable component of America’s ongoing efforts to solve the national health care crisis. We then analyze the Golden Gate Restaurant Association’s legal challenge to the Ordinance, which argues that the Ordinance’s employer pay-or-play provision is preempted by the Employee Retirement Income Security Act (“ERISA”). After demonstrating that the jurisprudence surrounding ERISA’s preemption clause is a model of uncertainty and ambiguity, we argue that state and local governments deserve clarity on whether ERISA preempts their pay-or-play laws, and that the political branches are best suited to resolve this issue. We conclude by proposing both legislative and administrative approaches to ERISA reform.

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INTRODUCTION

In 2006, the City and County of San Francisco (“San Francisco” or “City”) was in the midst of a citywide health care crisis. An estimated 82,000 of its residents lacked basic health insurance.¹ This lack of coverage posed a serious threat to the health and well-being of the City’s uninsured residents, and it also placed a substantial economic burden on the City’s taxpayers.² Without access to basic health care services, the City’s uninsured population was forced to use costly emergency rooms at public hospitals, paid for by the City’s taxpayers, to treat otherwise preventable illnesses and injuries.³

To remedy this problem, the City enacted the San Francisco Health Care Security Ordinance⁴ (“Ordinance”) to provide its uninsured residents with universal access to health care.⁵ The Ordinance has two primary components: it creates Healthy San Francisco (“Healthy SF”), which is a City-administered health care program focusing on preventative care,⁶ and it contains an employer-spending requirement, which helps fund the Healthy SF program.⁷ The Ordinance is considered a “pay-or-play” law, in that employers must either provide ERISA health benefit plans to their employees or pay into a City fund that helps finance Healthy SF.

The Ordinance has had a substantial impact on providing quality health services to those who need it most. As of April 2010, 52,477 uninsured City residents, or an estimated 82 percent of uninsured adults, had enrolled in Healthy SF, and that number continues to grow.⁸ The Ordinance has enjoyed significant success; approximately 94 percent of its participants express satisfaction with Healthy SF,⁹ emergency room visits at San Francisco General Hospital have decreased by almost 70 percent,¹⁰ and the program has received national attention. Indeed, President Barack Obama has praised Healthy SF,

1. UNIVERSAL HEALTHCARE COUNCIL, FINAL REPORT TO MAYOR GAVIN NEWSOM: SAN FRANCISCO HEALTH ACCESS PROGRAM: SERVING UNINSURED ADULTS 3 (2006), *available at* http://www.sfhp.org/files/PDF/about_us/UHC_Report_to_Mayor_06-23-06.pdf.

2. *Id.*

3. *Id.*

4. San Francisco Health Care Security Ordinance, S.F. ADMIN. CODE § 14 (2007).

5. As will be explained below, the Ordinance does not provide actual health insurance.

6. § 14.2.

7. § 14.3.

8. *Program Stats*, HEALTHY SAN FRANCISCO, <http://www.healthysanfrancisco.org/files/Charts/index.html?DataDate=04272010&PCount=52477> (last visited May 3, 2010) [hereinafter *Program Stats*].

9. DEP’T OF PUB. HEALTH, OFFICE OF LABOR STANDARDS ENFORCEMENT & CITY CONTROLLER’S OFFICE, STATUS REPORT ON THE IMPLEMENTATION OF THE SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE 10 (2010), *available at* http://www.healthysanfrancisco.org/files/PDF/January_2010_BoS_Report.pdf [hereinafter DPH STATUS REPORT].

10. Brief for Respondent in Opposition to Petition for Writ of Certiorari at 6, *Golden Gate Rest. Ass’n v. City & Cnty. of San Francisco*, 546 F.3d 639 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010) (No. 08-1515) [hereinafter Brief for Respondents].

stating that “[i]nstead of talking about health care, mayors like Gavin Newsom in San Francisco have been ensuring that those in need receive it.”¹¹

However, the future of Healthy SF and programs like it is uncertain. Some have questioned the continuing need for Healthy SF and other local health care reform initiatives due to the recent passage of federal health care reform (“federal reform”). Moreover, after the City passed the Ordinance, the Golden Gate Restaurant Association (“Association”) filed a lawsuit alleging that section 514(a) of the federal Employee Retirement Income Security Act of 1974¹² (“ERISA”) preempts the Ordinance’s employer-spending requirement.¹³ The District Court for the Northern District of California struck down the Ordinance, holding that ERISA does in fact preempt the employer-spending requirement.¹⁴ However, the U.S. Court of Appeals for the Ninth Circuit reversed the district court and found that ERISA does not preempt it, subsequently denying the Association’s petition for rehearing en banc over the objection of seven judges.¹⁵ In fall 2009, the Association filed a petition for certiorari before the Supreme Court, and in response, the Court asked the Office of the Solicitor General for its view on whether the Court should grant the petition.¹⁶ The solicitor general responded by urging the court to deny the petition,¹⁷ and the Court followed suit.¹⁸

The Association’s lawsuit is a case study in the uncertainty that the jurisprudence interpreting ERISA’s preemption provision can create for state and local governments seeking to enact their own version of health care reform through employer pay-or-play provisions.¹⁹ Confusingly, although preemption cases turn on congressional intent, the legislative history regarding ERISA’s preemption clause as it relates to welfare benefit plans is surprisingly sparse. Furthermore, the ambiguity of ERISA’s preemption language has only “mushroomed with the Supreme Court’s failure to consistently apply well-settled rules of statutory construction to interpret that ambiguous language in

11. Bob Egelko, *U.S. Silent on Newsom’s Health Plan*, S.F. CHRON., July 20, 2009, at C1.

12. Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 5 U.S.C., 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

13. *Golden Gate Rest. Ass’n v. City and Cnty. of San Francisco*, 535 F. Supp. 2d 968, 970–71 (N.D. Cal. 2007), *rev’d*, 546 F.3d 639 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010).

14. *Id.* at 979.

15. *Golden Gate Rest. Ass’n v. City and Cnty. of San Francisco*, 546 F.3d 639, 642 (9th Cir. 2008), *reh’g denied*, 558 F.3d 1000 (9th Cir. 2009), *cert. denied*, 130 S. Ct. 3497 (2010).

16. *Golden Gate Rest. Ass’n v. City and Cnty. of San Francisco*, 130 S. Ct. 357 (2009).

17. Brief for the United States as Amicus Curiae, *Golden Gate Rest. Ass’n v. City & Cnty. of San Francisco*, 546 F.3d 639 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010) (No. 08-1515).

18. *Golden Gate Rest. Ass’n v. City and Cnty. of San Francisco*, 130 S. Ct. 3497 (2010).

19. ERISA, which is the federal statute governing employee benefit plans, contains the following preemption provision: “the provisions of [ERISA] 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) (2006).

harmony with the statute's overall purposes."²⁰ As a result, the Court's ERISA preemption jurisprudence has produced a series of complex, interrelated inquiries that require state and local legislative bodies to determine whether a pay-or-play law "relates to," has a "connection with," makes impermissible "reference to," or acts "immediately and exclusively upon" ERISA plans, and additionally, whether the "existence of ERISA plans is essential to" a state law's operation.²¹

Unsurprisingly, this uncertainty discourages many state and local governments from experimenting with novel solutions to their own health care crises.²² San Francisco took the plunge and, as a result, has experienced the uncertain path typical of preemption analyses. The Ordinance was struck down by a district court and upheld by the Ninth Circuit, which nearly reheard its decision en banc, only to languish on the Supreme Court's docket for nearly a year before the Court denied the Association's certiorari petition. But even though the Supreme Court allowed the Ninth Circuit's opinion to stand, the Court in no way delivered any certainty that would prevent future pay-or-play health care regimes from being placed in jeopardy.²³

As a result, if successful pay-or-play laws such as the Ordinance are to become prevalent solutions to state and local health care problems, state legislatures and city councils require clear and unambiguous guidance on how to institute those laws while avoiding ERISA preemption. The success of Healthy SF and the minimal economic impact it has had on employers deserve to be lauded, not mired down in legal challenges based on more than thirty years of confusing jurisprudence. Accomplishing this demands a clear and unambiguous solution from our political branches.

Accordingly, this Comment discusses the legal issues underlying ERISA and San Francisco's Ordinance as they relate to both the Association's unsuccessful lawsuit and the future of state regulation of employee benefits, and then proposes a policy-based solution. In Part I, we provide a brief synopsis of the impact of the national health care crisis, and then discuss San Francisco's groundbreaking response of passing the Ordinance. We conclude that the Ordinance is not only a novel and unique approach to dealing with one of the City's most pressing problems, but it has also shifted what was originally a costly and episodic system of emergency care into a workable universal health care access model.

20. Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?*, 74 TUL. L. REV. 951, 953 (2000).

21. *See id.* at 996 n.216. *See infra* Part II for a more in-depth examination of the intricacies of ERISA jurisprudence.

22. *See infra* note 311.

23. *See, e.g., infra* notes 250–266 and accompanying text (discussing a similar pay-or-play health care regime that the U.S. Court of Appeals for the Fourth Circuit struck down).

In Part II, we discuss the implications that federal healthcare reform is likely to have on the Ordinance. After analyzing the Healthy SF program in light of federal reform, we conclude that even after the major federal provisions go into effect in 2014, Healthy SF will remain necessary for many of the City's residents because they will continue to lack access to regular health insurance. Thus, until 2014, the demand for Healthy SF is likely to grow.

In Part III, we analyze the Association's lawsuit, which alleged that ERISA preempts the Ordinance's employer-spending requirement. We provide a brief introduction to the ERISA statute, with a particular emphasis on its preemption provisions and the congressional intent underlying its creation. In Part IV, we then present the Ninth Circuit's opinion in *Golden Gate Restaurant Association v. City and County of San Francisco* ("GGRA"), which upheld the statute as permissible under ERISA's preemption clause, and discuss how the ambiguity and uncertainty inherent in the Court's preemption jurisprudence led seven circuit judges to dissent from the court's denial of an en banc rehearing.

After analyzing the GGRA opinion in light of the Court's struggle with ERISA's preemption clause, we conclude that the judiciary is neither likely nor best suited to provide a solution to lawsuits like GGRA that will create a safe environment for state and local experimentation. Thus, in Part V, we argue that the most effective solution to the ERISA-Ordinance conflict is a joint response from the political branches that would clarify the interaction between ERISA and state and local health care reform initiatives in a way that provides greater certainty going forward.

I.

THE HEALTH CARE CRISIS AND THE CREATION OF HEALTHY SF

A. The National Problem

The lack of access to affordable health services is an increasingly pervasive problem in cities across the United States.²⁴ Nearly fifty million Americans do not have basic health insurance coverage,²⁵ including 10 percent of all children and nearly 30 percent of young adults age eighteen to twenty-four.²⁶ Furthermore, one in three Americans under sixty-five—87 million people—went without health insurance for some period of time between 2007

24. INST. OF MED. OF THE NAT'L ACADS., AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE 2 (2009); Samuel C. Salganik, Note, *What the Unconstitutional Conditions Doctrine Can Teach Us About ERISA Preemption: Is It Possible to Consistently Identify "Coercive" Pay-Or-Play Schemes?*, 109 COLUM. L. REV. 1482, 1486–88 (2009).

25. FAMILIES USA, LIVES ON THE LINE: THE DEADLY CONSEQUENCES OF DELAYING HEALTH REFORM 1 (2010), <http://www.familiesusa.org/assets/pdfs/delaying-reform.pdf>.

26. CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA C. SMITH, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS P60-236, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008, at 21 (2009).

and 2008.²⁷ In 2006 alone, the absence of health coverage cost the U.S. economy an estimated \$102 to \$204 billion.²⁸ That translates to a yearly cost of \$1,100 per family, or 8 percent of health care premiums.²⁹

In addition to its economic impact, this lack of coverage has significant consequences for the health and well-being of these uninsured individuals. Adults without health insurance are more likely to be diagnosed with a disease in an advanced stage, and are more likely to die prematurely than adults who have health insurance.³⁰ For example, studies on uninsured women have found that they are substantially more likely to be diagnosed with advanced-stage breast cancer than women with health insurance.³¹ Additionally, lack of health insurance is the third leading cause of death for the elderly, following heart disease and cancer.³² Finally, people with limited access to routine preventative care are likely to “delay seeking treatment when ill, suffer from poorer health outcomes and ultimately rely on more costly episodic or emergency care for health conditions that could have been treated in primary care settings.”³³ From 2000 to 2006, at least 137,000 Americans died prematurely because they did not have health coverage.³⁴ In fact, one study found that there are nearly 45,000 excess deaths annually associated with lack of insurance.³⁵

The lack of access to health care is destructive not only to the health of the uninsured but also to their financial well-being. For example, one Harvard study found that medical bills contributed to a shocking 62 percent of all bankruptcies filed in 2007.³⁶ Another study conducted by the Kaiser

27. FAMILIES USA, AMERICANS AT RISK: ONE IN THREE UNINSURED 2 (2009), <http://www.familiesusa.org/assets/pdfs/americans-at-risk.pdf>.

28. SARAH AXEEN & ELIZABETH CARPENTER, NEW AM. FOUND., COST OF FAILURE: THE ECONOMIC LOSSES OF THE UNINSURED 1 (March 2008), http://www.newamerica.net/files/nafmigration/Cost_Of_Failure.pdf.

29. BEN FURNAS & PETER HARBAGE, CENTER FOR AM. PROGRESS ACTION FUND, THE COST SHIFT FROM THE UNINSURED 1 (2009), http://www.americanprogressaction.org/issues/2009/03/pdf/cost_shift.pdf.

30. FAMILIES USA, *supra* note 27, at 12–13.

31. Cathy J. Bradley et al., *Differences in Breast Cancer Diagnosis and Treatment: Experiences of Insurance and Uninsured Patients in a Safety Net Setting*, 45 INQUIRY 323, 325 (2008); Michael T. Halpern et al., *Insurance Status and Stage of Cancer at Diagnosis among Women with Breast Cancer*, 110 CANCER 403, 403–11 (2007).

32. J. Michael McWilliams et al., *Health Insurance Coverage and Mortality Among the Near-Elderly*, 23 HEALTH AFFAIRS 223, 229 (2004).

33. DPH STATUS REPORT, *supra* note 9, at 4.

34. STAN DORN, URBAN INST., UNINSURED AND DYING BECAUSE OF IT: UPDATING THE INSTITUTE OF MEDICINE ANALYSIS ON THE IMPACT OF UNINSURANCE ON MORTALITY 3 tbl.2 (2008), http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf.

35. Andrew P. Wilper et al., *Health Insurance and Mortality in US Adults*, 99 AM. J. PUB. HEALTH 2289, 2294 (2009).

36. David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. OF MED. 741, 741 (2009), available at http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf. While the study notes that less than 25 percent of those filing for bankruptcy did not have health insurance, the percentage of people uninsured in 2007 was approximately 15 percent. *Id.* at 743; Ian Urbina, *A Decline in Uninsured is Reported*

Commission on Medicaid and the Uninsured found that in 2009, 22 percent of uninsured Americans between the ages of eighteen and sixty-four reported that they had been contacted by a collection agency about medical bills.³⁷ That same year, 14 percent of Americans in that age group were unable to pay for basic necessities due to medical bills, and 20 percent had exhausted all or most of their savings paying for medical expenses.³⁸ Furthermore, because uninsured patients are unable to negotiate discounts on hospital and doctors' fees like insurance companies do, uninsured patients often pay more than two and a half times the amount that insured patients pay for hospital services.³⁹ In sum, lack of access to basic health care has a major detrimental impact on Americans' health and financial well-being.

B. San Francisco's Solution: Healthy SF

1. San Francisco's Health Care Crisis

In 2006, San Francisco was one of many American cities feeling the economic burden of caring for a large uninsured population; it had approximately 82,000 uninsured adult residents.⁴⁰ Notably, the San Francisco Department of Public Health found that the City's uninsured residents were not necessarily unemployed.⁴¹ Instead, prior to the Ordinance's enactment, over half of San Francisco's uninsured adult population had employment but lacked health care coverage because it was either not available from their employers or, when it was available, it was unaffordable.⁴²

After studying the impact those residents' lack of health coverage had on the City, San Francisco realized that the uninsured were forced to use episodic emergency care, which was "inefficient, costly and counter to the larger goal of improving health status."⁴³ Even when the uninsured were not seeking care in emergency rooms, they still had to "navigate a cumbersome and fragmented delivery system comprised of safety net and traditional providers within the public and non-profit sectors" to receive any care at all.⁴⁴

for 2007, N.Y. TIMES, Aug. 27, 2008, at A14. Therefore, it is clear that not having health insurance significantly increased the chances of filing for bankruptcy.

37. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE UNINSURED: A PRIMER 9 (2009), <http://www.kff.org/uninsured/upload/7451-06.pdf>.

38. *Id.*

39. Gerard Anderson, *From "Soak the Rich" to "Soak the Poor": Recent Trends in Hospital Pricing*, 26 HEALTH AFFAIRS 780, 781 (2007).

40. UNIVERSAL HEALTHCARE COUNCIL, SAN FRANCISCO HEALTH ACCESS PROGRAM: SERVING UNINSURED ADULTS 3 (2006) [hereinafter UHC Report], http://www.sfhpc.org/files/PDF/about_us/UHC_Report_to_Mayor_06-23-06.pdf.

41. *Id.*

42. *Id.*

43. *Id.*

44. *Id.* at 6.

Prior to the creation of Healthy SF, community clinics, hospitals, nonprofit hospitals, and private providers attempted to provide the City's uninsured population with health care access.⁴⁵ But this system was “an inefficient and under-resourced patchwork . . . leav[ing] providers confused and patients with less than optimal care.”⁴⁶ In 2004, as many as 57,000 of San Francisco's uninsured residents—69 percent of them—received some form of health care services from either public or nonprofit providers.⁴⁷ Of these 57,000 residents, 20 percent of them received one of the most costly forms of care by utilizing emergency services.⁴⁸

2. *The Health Access Plan*

With the foregoing concerns in mind, San Francisco passed the Ordinance. The first component of the Ordinance is a City-run health care program, called Healthy SF, that “prioritize[s] services for low and moderate income persons.”⁴⁹ It is operated by the San Francisco Department of Public Health and has been in effect since 2007.⁵⁰ The City describes Healthy SF as “an innovative health care program designed to expand access to health services and deliver appropriate care to uninsured adult residents.”⁵¹ However, Healthy SF is not health insurance.⁵² Rather, it restructured the preexisting public and nonprofit health care safety net systems into a single integrated system.⁵³ As a result, Healthy SF does not offer services outside of the City or outside of its provider network of care.⁵⁴

3. *The Employer-Spending Requirement: Pay-or-Play*

The Ordinance's second component—the component that presents the legal issue—is the employer-spending requirement, which requires employers to make “health care expenditures to or on behalf of” qualifying employees.⁵⁵ An employer calculates its health care expenditure for a covered employee “by multiplying the total number of hours paid for each of its covered employees during the quarter . . . by the applicable health care expenditure rate.”⁵⁶ In 2010, private employers with twenty to ninety-nine employees and nonprofit

45. *Id.* at 7.

46. *Id.*

47. *Id.*

48. *Id.*

49. S.F. ADMIN. CODE § 14.2(a), (d) (2007).

50. § 14.2(a).

51. SAN FRANCISCO DEP'T OF PUB. HEALTH, HEALTHY SAN FRANCISCO PROGRAM IN-DEPTH 7 (2007) [hereinafter HEALTHY SF IN-DEPTH], http://www.healthysanfrancisco.org/files/PDF/HSF_Program_In-Depth.pdf.

52. *Id.*

53. *Id.*

54. *Id.* at 9.

55. § 14.3(a).

56. § 14.3(a).

employers with fifty or more employees were required to spend \$1.37 per hour for any employee employed for ninety days who worked more than eight hours per week.⁵⁷ Private employers with one hundred or more employees were required to spend \$1.96 per hour for each employee.⁵⁸ The employer-spending requirement is capped at forty hours per week for both groups.⁵⁹

The Ordinance leaves a covered employer the discretion to choose what type of health care expenditure it wants to make for its qualified employees.⁶⁰ This provision is a “pay-or-play” measure, wherein an employer “must either spend a certain amount on employee health care” or pay the City a defined amount per employee.⁶¹ The choices include contributions to a health-savings account, reimbursement for purchased health care services, payment to a third party to provide health care services, costs of direct delivery of health care services, and payments to the City for use in Healthy SF.⁶² Under the City-payment option, employers make payments to the City, which allows uninsured, covered employees who are City residents to enroll in the program.⁶³ Other covered employees become eligible for medical reimbursement accounts with the City.⁶⁴

The Ordinance also requires covered employers to “maintain accurate records of health care expenditures, required health care expenditures, and proof of such expenditures made each quarter each year.”⁶⁵ These records are not required to be in any particular form,⁶⁶ and employers only need to file a one-page report with the City once per year to identify the total amount paid for health care and how the money was spent.⁶⁷

Finally, the Ordinance contains two additional provisions to make compliance easier for large employers that operate both inside and outside of San Francisco. Under the first regulation, employers that provide traditional health insurance to their workers can establish compliance without tracking the health care dollars spent on each individual employee, and without making any

57. § 14.1(b)(8), (10); OFFICE OF LABOR STANDARDS ENFORCEMENT, CITY & CNTY. OF SAN FRANCISCO, REGULATIONS IMPLEMENTING THE EMPLOYER SPENDING REQUIREMENT OF THE SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE (HCSO) § 5.2(A)(2) (2008) [hereinafter OLSE Reg. 2008]; *see also* OFFICE OF LABOR STANDARDS ENFORCEMENT, CITY & CNTY. OF SAN FRANCISCO, REGULATIONS IMPLEMENTING THE EMPLOYER SPENDING REQUIREMENT OF THE SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE (HCSO) § 5.2(B)(2) (2007).

58. S.F. ADMIN. CODE § 14.1(b)(8).

59. § 14.1(b)(10).

60. *Id.*

61. Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J.L. MED. & ETHICS 88, 94 (2009) [hereinafter Jacobson, *Opportunities and Limits*].

62. § 14.1(b)(7); OLSE REG. 2008, *supra* note 57, § 4.2(A).

63. § 14.2(d); Brief for Respondents, *supra* note 10, at 3.

64. § 14.2(h).

65. § 14.3(b)(i).

66. *Id.*

67. OLSE REG. 2008, *supra* note 57, § 7.3.

separate calculations for their San Francisco-based employees.⁶⁸ Any employer that purchases insurance for its employees in both San Francisco and other parts of the country must only divide its total insurance costs by the total number of employees.⁶⁹ As long as the amount spent per employee is greater than the spending obligation, then employers are in compliance.⁷⁰

The second regulation allows employers that operate “self-insured”⁷¹ plans to establish compliance in the same way as those that provide traditional health insurance.⁷² Under this regulation, these types of employers comply “if the preceding year’s average expenditure rate per employee meets or exceeds the applicable expenditure rate . . . for that employer.”⁷³ Employers covered by the regulation can establish compliance by showing that they have spent a certain amount per employee on a plan-wide basis.⁷⁴

4. *The Employer-Spending Requirement’s Impact on ERISA Plans*

The Ordinance’s employer-spending requirement provides substantial flexibility to employers that already make health care expenditures as well as those that do not.⁷⁵ The spending requirement can impact San Francisco employers’ yearly health care expenditures in three ways. First, if an employer makes a contribution to an ERISA plan that already meets the employer-spending requirement, the employer does not need to do anything except maintain records to fulfill the reporting requirement.⁷⁶ Second, if an employer does not have an ERISA plan and previously made no health care contributions for its employees, it may fulfill the employer-spending requirement by creating its own ERISA plan, making a contribution to the City, or doing some combination of the two.⁷⁷ Third, if an employer has a preexisting ERISA plan but does not contribute enough to meet the employer-spending requirement, either because an employer’s ERISA plan covers all of its employees but does not spend enough on each, or because an employer only provides a full ERISA plan for some of its employees, these employers may fulfill the rest of their mandated spending through increased ERISA contributions or by contributing the difference to the City’s plan.⁷⁸

68. § 6.2(B)(1).

69. Brief for Respondents, *supra* note 10, at 4–5.

70. *Id.* at 5.

71. These are plans where “the employer bears the risk of employee health care costs on its own rather than paying an insurance company a set rate to bear that risk.” *Id.*

72. OLSE REG. 2008, *supra* note 57, § 6.2(B)(2).

73. *Id.*

74. Brief for Respondents, *supra* note 10, at 5.

75. *Golden Gate Rest. Ass’n v. City & Cnty. of San Francisco*, 546 F.3d 639, 661 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010).

76. *Id.*

77. *Id.*

78. *Id.*

Two points are worth noting with regard to ERISA plans and the employer-spending requirement. First, under no circumstances is an employer *required* to establish or modify a preexisting ERISA plan.⁷⁹

The City-payment option allows employers to make payments directly to the City, if they so choose, without requiring them to establish, or to alter existing, ERISA plans. If employers choose to pay the City, the employees for whom those payments are made are entitled to receive either discounted enrollment in [Healthy SF] or medical reimbursement accounts with the City.⁸⁰

Second, the Ordinance is concerned with the level of employer-spending rather than the nature of the health care benefits the employer provides.⁸¹ An employer can make its contribution however it chooses, as long as it meets its per-employee required expenditure.⁸² Therefore, the Ordinance provides ample flexibility for employers to structure their benefits in a way that works best for them and their employees.

C. Healthy SF's Policy Implications: State and Local Governments as Effective Laboratories of Health Care Experimentation

State and local experimentation with health care is normatively desirable because it enables each locality to adopt laws that fit local conditions and preferences regarding the services provided.⁸³ Different states have different needs and view their relationships with health care in different ways. For example, the uninsured population in New Hampshire is far different from the uninsured population in Texas, both in raw numbers and in its proportion to the total state population.⁸⁴ During 2007 and 2008, nearly half of all Texans under the age of sixty-five had been uninsured for at least a month,⁸⁵ while in New Hampshire, one-quarter of those under age sixty-five had been uninsured.⁸⁶ The number of uninsured in New Hampshire was in the hundreds of thousands,⁸⁷ while Texas had millions of uninsured residents.⁸⁸ With such significant

79. *Id.* at 646.

80. *Id.*

81. *Id.* at 647.

82. *Id.*

83. Edward Zelinsky, *The New Massachusetts Health Law: Preemption and Experimentation*, 49 WM. & MARY L. REV. 229, 280–81 (2007) [hereinafter *Zelinsky, Massachusetts*].

84. Compare FAMILIES USA, HEALTH COVERAGE IN TEXAS: HOW WILL REFORM HELP? 2 (2010), <http://www.familiesusa.org/assets/pdfs/health-reform/state-gains-2010/texas.pdf> [hereinafter *FAMILIES USA TEXAS*], with FAMILIES USA, HEALTH COVERAGE IN NEW HAMPSHIRE: HOW WILL REFORM HELP? 2 (2010), <http://www.familiesusa.org/assets/pdfs/health-reform/state-gains-2010/new-hampshire.pdf> [hereinafter *FAMILIES USA NEW HAMPSHIRE*].

85. FAMILIES USA TEXAS, *supra* note 84, at 2.

86. FAMILIES USA NEW HAMPSHIRE, *supra* note 84, at 2.

87. *Id.*

88. FAMILIES USA TEXAS, *supra* note 84, at 2.

differences, it makes sense for states and localities to tailor their programs to their own specific needs.

Moreover, as a philosophical matter, different cities may support different approaches to health care. Places like San Francisco may wish to experiment with single-payer systems, while other cities may prefer a more libertarian, consumer-driven approach to health care.⁸⁹ Allowing states to experiment with different ways to provide health care to their residents allows those programs to take into account local conditions and preferences.⁹⁰ It also allows states to generate information on programs that other states can emulate or adapt.⁹¹ Indeed, Healthy SF, which is attuned to San Francisco's ethos, resources, and population, is a case study in voter-driven local experimentation.

1. The Ingenuity of Healthy SF

The Ordinance has been increasingly successful since it went into effect in 2006, improving the health of over 50,000 City residents and lessening the burden on hospitals and taxpayers.⁹² Healthy SF has many of the main ingredients necessary to create a successful health care program. First, it offers coverage and choice by providing a comprehensive set of services to the uninsured without excluding people with preexisting conditions.⁹³ Second, it makes coverage affordable by matching out-of-pocket costs with income levels—that is, the lower the individual's income, the less that individual pays for services.⁹⁴ Third, Healthy SF establishes shared responsibility between City residents and businesses through a funding mechanism that utilizes tax dollars, employer contributions, and participant funding.⁹⁵ Fourth, the program simultaneously promotes prevention and wellness by “focusing on the delivery of primary and preventative care and ensuring that all participants select a primary care medical home that can provide and coordinate these services for individuals.”⁹⁶ Finally, Healthy SF controls costs; the program is less expensive than providing health insurance, and expensive emergency room visits decreased among the uninsured after the program began.⁹⁷ All of these factors have combined to create an innovative and effective program that is receptive to the needs of the City's uninsured population.

89. See Zelinsky, *Massachusetts*, *supra* note 83, at 281.

90. *Id.*

91. *Id.*

92. *Program Stats*, *supra* note 8.

93. SAN FRANCISCO DEP'T OF PUB. HEALTH, ANNUAL REPORT TO THE SAN FRANCISCO HEALTH COMMISSION (FOR FISCAL YEAR 2008–09) 50 (2009) [hereinafter 2009 ANNUAL REPORT], http://www.healthysanfrancisco.org/files/PDF/2008-09_HSF_Annual_Report_SF_Health_Commission.pdf.

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

2. Positive Reviews

Recent evaluations of the quality of care provided by Healthy SF and the impact that care has had on San Francisco have been overwhelmingly positive. In 2009, a Healthy SF participant survey conducted by the Kaiser Family Foundation found that Healthy SF is improving the health and well-being of its participants, and that Healthy SF participants give the program a positive evaluation.⁹⁸ Of those participating in the Kaiser survey, 94 percent were satisfied with the program, 92 percent stated that they would recommend the program to a friend, and 92 percent thought other cities should create similar programs.⁹⁹

In 2010, the San Francisco Department of Public Health presented its Healthy San Francisco Annual Report for 2009–2010 (“Report”).¹⁰⁰ The Report reflects what the Kaiser participant survey suggests: Healthy SF is enjoying substantial success.¹⁰¹ The Report found that 76 percent of Healthy SF participants are utilizing primary care services, and that participants’ emergency room visits are well below California’s average.¹⁰² In fact, only 9 percent of emergency room visits by Healthy SF participants were avoidable—that is, the visit could have occurred in a primary care setting¹⁰³—and Healthy SF participants use emergency rooms at a much lower rate than City residents on Medi-Cal.¹⁰⁴ Additionally, a Department of Public Health analysis of quality and access measures for Healthy SF, benchmarked to the National Medicaid Average (“NMA”), found that Healthy SF was better than average in many quality measures¹⁰⁵ and that it was near average in measuring adult access to care.¹⁰⁶ Measured by participant satisfaction and access to care, Healthy SF has already had a positive impact on the City.

3. Steady Employment Numbers

Prior to the Ordinance’s passage, many of its opponents feared that the employer-spending requirement would create job loss by increasing employers’ costs for each employee, thereby diverting employer resources from paying salaries to providing health care.¹⁰⁷ However, the employer-spending

98. DPH STATUS REPORT, *supra* note 9, at 10.

99. *Id.*

100. *See* SAN FRANCISCO DEP’T OF PUB. HEALTH, ANNUAL REPORT TO THE SAN FRANCISCO HEALTH COMMISSION (FOR FISCAL YEAR 2009–10) (2010) [hereinafter 2010 ANNUAL REPORT], http://www.healthysanfrancisco.org/files/PDF/2009-10_HSF_Annual_Report.pdf.

101. *Id.* at 3.

102. *Id.*

103. *Id.* This rate is lower than that of a San Francisco public HMO serving adult Medi-Cal recipients (18 percent). *Id.*

104. 2010 ANNUAL REPORT, *supra* note 100, at 3.

105. *Id.* at 3, 26.

106. *Id.* at 41.

107. *See* Robb Mandelbaum, *Is the Employer Mandate a Job Killer? Not in San Francisco*, N.Y. TIMES BUS. DAY, YOU’RE THE BOSS BLOG (Sept. 18, 2009, 12:01 PM),

requirement has not created job loss.¹⁰⁸ As one health economist states, “There’s no evidence at all that Healthy San Francisco’s pay-or-play employer mandate is adversely affecting employment.”¹⁰⁹ As of December 2008, there was no indication that the City’s employment grew more slowly after the Ordinance’s enactment than did employment in surrounding counties.¹¹⁰ Instead, employment trends were slightly better in the City.¹¹¹ A 2009 research brief produced by the Institute for Research on Labor and Employment found that “the substantial job losses that some worried would be generated by the employer requirement have not materialized. This remains true even when we focus our attention on two of the sectors most impacted by the employer requirement—retail and restaurants.”¹¹²

Many employers in San Francisco have adjusted to the higher operating costs by passing them along to consumers in the form of higher prices.¹¹³ About one out of every four restaurants has instituted a surcharge, averaging 4 percent of the bill, to pay for the additional costs.¹¹⁴ These price increases have not been detrimental to the economy, however, because they do not undermine businesses’ competitive edge:

Local service businesses can add this surcharge (or raise prices) without risking their competitive position, since their competitors will be required to take similar measures. Furthermore, some of the costs may be passed on to employees in the form of smaller pay raises, which could help ward off the possibility of job losses. Over the longer term, if more widespread coverage allows people to choose jobs based on their skills and not out of fear of losing health insurance from one specific employer, increased productivity will help pay for some of the costs of the mandate.¹¹⁵

In fact, some San Francisco restaurants strongly support the Ordinance, including members of the Golden Gate Restaurant Association. Two of the Association’s members, restaurants Zazie and Medjool, filed an amicus brief on behalf of San Francisco that urged the Supreme Court to uphold the

<http://boss.blogs.nytimes.com/2009/09/18/is-the-employer-mandate-a-job-killer-not-in-san-francisco>.

108. *Id.*

109. *Id.*

110. William H. Dow et al., Op-Ed., *A Public Option That Works*, N.Y. TIMES, Aug. 22, 2009, at A17, available at <http://www.nytimes.com/2009/08/22/opinion/22dow.html> [hereinafter Dow Op-Ed.].

111. *Id.*

112. ARINDRAJIT DUBE ET AL., INST. FOR RESEARCH ON LABOR AND EMP’T, THE IMPACT OF SAN FRANCISCO’S EMPLOYER HEALTH SPENDING REQUIREMENT: INITIAL FINDINGS FROM THE LABOR AND PRODUCT MARKETS 3 (2009), http://www.irlle.berkeley.edu/cwed/wp/sfhealth_09.pdf.

113. *Id.* at 4.

114. *Id.*

115. Dow Op-Ed., *supra* note 110, at A17.

Ordinance.¹¹⁶ Zazie and Medjool argue that the Association's claim is not representative of the views of all San Francisco restaurants, their employees, the City's taxpayers, and the restaurant-going public.¹¹⁷ They further argue that the employer-spending requirement allows restaurants that want to provide health care to do so without suffering significant economic losses because it "levels the economic playing field for businesses" that might otherwise "be driven out of business because of the difficulty in competing with other restaurants that do not spend money on health care."¹¹⁸

In sum, Healthy SF provides the City's uninsured population with meaningful and affordable health care access without substantially burdening employers. Without the program, thousands of City residents would lose their health care and would likely flood emergency rooms or otherwise neglect medical services until they required more costly procedures.¹¹⁹ The ingenuity and success of Healthy SF is commendable, leading one commentator to note that:

As a matter of policy, there is a compelling argument for letting states and localities experiment in the health care arena Just as we cannot know the impact of the San Francisco ordinance on employers, workers, consumers and potential [immigrants] to the city unless the ordinance is given a chance, we won't know whether these cost-saving devices can protect the solvency of an innovative municipal program like [Healthy SF] without letting San Francisco try. The great strength of our system of federalism is that San Francisco's experiment will generate data from which other communities will learn.¹²⁰

With this in mind, we now examine the impact that federal health care reform will have on Healthy SF.

II.

THE IMPLICATIONS OF FEDERAL HEALTH CARE REFORM ON HEALTHY SF

In March 2010, after many decades of federal government inaction, President Barack Obama signed the Patient Protection and Affordable Care Act¹²¹ and the Health Care and Education Reconciliation Act of 2010¹²² into law. Together, the two bills constitute the largest overhaul of the nation's health

116. Brief for Zazie and Medjool Restaurants as Amici Curiae in Support of Respondents, *Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 546 F.3d 639 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010) (No. 08-1515).

117. *Id.* at 2.

118. *Id.* at 1.

119. *See id.* at 16–17.

120. Edward Zelinsky, *Golden Gate Restaurant Association: Employer Mandates and ERISA Preemption in the Ninth Circuit* 5–6, 44 (Cardozo Sch. of Law, Jacob Burns Inst. for Advanced Legal Studies, Working Paper No. 219, 2008) [hereinafter *Employer Mandates*], available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1090122.

121. Pub. L. No. 111-148, 124 Stat. 119 (2010).

122. Pub. L. No. 111-152, 124 Stat. 1029 (2010).

care system since Medicare's passage in 1965.¹²³ By 2019, federal reform will provide health insurance to 92 percent of all U.S. residents, or approximately 32 million people.¹²⁴ However, even after the full implementation of federal reform, millions of Americans will be left uninsured, including tens of thousands of San Francisco residents. Accordingly, the City and its taxpayers, who pay for the uninsured's costly and otherwise preventable emergency care, still have a strong interest in maintaining the Healthy SF program.

A. The Basics of Federal Health Care Reform

1. Increased Access, Lower Cost, Improved Public Health

Federal reform includes an array of sweeping changes to the federal health care system, taking substantial steps toward making health insurance more accessible and affordable.¹²⁵ The most significant coverage provisions include an expansion of Medicaid eligibility,¹²⁶ the creation of subsidized health insurance exchanges for individuals and small businesses,¹²⁷ and an employer mandate.¹²⁸ Federal reform also makes a number of tax changes,¹²⁹ including substantial cost-containment measures, and contains requirements aimed at increasing accessibility and affordability, such as preventing private health insurance providers from denying applicants based upon preexisting conditions.¹³⁰ Further, federal reform makes significant investments in public health, establishing prevention and wellness programs and strengthening the health care workforce.¹³¹ All of these reforms will be implemented incrementally over the next ten years.¹³²

123. Pat Wechsler, *States Sue Over Overhaul That Will Bust State Budgets*, BLOOMBERG (Mar. 23, 2010, 4:30 PM), <http://www.bloomberg.com/apps/news?pid=20601087&sid=ajwSWE6H1kHM>.

124. *Reform Summary: Hospital-Specific Provisions*, AM. HOSP. ASS'N (Mar. 22, 2010), available at <http://www.oahhs.org/news/press-releases/2010/summary-hospital-specific.html>.

125. See Pub. L. No. 111-148, 124 Stat. 119 (2010); Pub. L. No. 111-152, 124 Stat. 1029 (2010).

126. Pub. L. No. 111-148, §§ 2001–07, 124 Stat. 119, 271–85 (2010).

127. Pub. L. No. 111-148, §§ 1201–55, 124 Stat. 119, 154–896 (2010) (modified by Pub. L. No. 111-148, § 10103, 124 Stat. 892).

128. Pub. L. No. 111-148, §§ 1501–02, 124 Stat. 119, 242–50 (2010) (modified by Pub. L. No. 111-148, § 10106, 124 Stat. 907).

129. Pub. L. No. 111-148, §§ 1401–02, 124 Stat. 119, 213–24 (2010) (modified by Pub. L. No. 111-148, § 10105, 124 Stat. 906).

130. Pub. L. No. 111-148, §§ 1101–05, 124 Stat. 119, 141–54 (2010) (modified by Pub. L. No. 111-148, § 10102, 124 Stat. 892).

131. Pub. L. No. 111-148 §§ 1201–51, 124 Stat. 119, 154–62 (2010) (modified by Pub. L. No. 111-148, § 10103, 124 Stat. 892).

132. See Pub. L. No. 111-148, 124 Stat. 119 (2010).

2. *The Individual Mandate*

In addition to the provisions described above, federal reform imposes a mandate on every American to purchase health insurance, known as the “individual mandate.”¹³³ Since federal reform also prevents insurers from denying coverage based on preexisting conditions, the individual mandate exists because if people were not required to buy health insurance, many might wait to purchase it until they developed some form of illness. Therefore, the mandate exists “to bring healthy people into the pool, which keeps average costs down and also ensures that people aren’t riding free on the system by letting society pay when they get hit by a bus.”¹³⁴

When the individual mandate goes into effect in 2014,¹³⁵ U.S. citizens and legal residents must either have health insurance or pay a penalty of \$750 per person (up to a maximum of \$2,085 per family), or 2.5 percent of household income, whichever is greater.¹³⁶ These penalties will be phased in from 2014 until 2016, when they will be fully in effect.¹³⁷ There are exemptions from the individual mandate; it will not apply to undocumented immigrants, American Indians, individuals claiming financial hardship or with religious objections, individuals who have been uninsured for less than three months, incarcerated individuals, individuals for whom the lowest-cost plan option exceeds 8 percent of their income, or those with incomes below the tax-filing threshold.¹³⁸

133. Pub. L. No. 111-148 §§ 1501–02, 124 Stat. 119, 242–50 (2010) (modified by Pub. L. No. 111-148, § 10106, 124 Stat. 907).

134. Ezra Klein, *How Does the Individual Mandate Work?*, WASH. POST (Mar. 25, 2010, 11:55 AM), http://voices.washingtonpost.com/ezra-klein/2010/03/how_does_the_individual_mandat.html.

135. The individual mandate is currently facing challenges to its constitutionality. After the passage of federal reform, nearly two dozen lawsuits were filed claiming that the individual mandate portion of the new law is unconstitutional. See *Health Care Lawsuits*, INDEP. WOMEN’S FORUM, <http://healthcarelawsuits.org> (last visited Feb. 22, 2011) (collecting updated information about the lawsuits challenging federal reform). Of the three district court judges to reach the merits of the case thus far, two have upheld the mandate, while one has found it unconstitutional and has struck it down. See *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882 (E.D. Mich. 2010) (upholding the individual mandate); *Liberty University v. Geithner*, No. 6:10-cv-00015-nkm, 2010 U.S. Dist. LEXIS 125922 (W.D. Va. Nov. 30, 2010) (holding the same); *Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010) (striking down the individual mandate). The dispute will likely reach the Supreme Court. Meanwhile, the Obama administration has said that “if the insurance requirement falls before taking effect in 2014, related changes would necessarily collapse with it, most notably provisions that would prevent insurers from denying coverage to those with pre-existing conditions or charging them discriminatory rates.” Kevin Sack, *Judge Voids Key Element of Obama Health Care Law*, N.Y. TIMES, Dec. 13, 2010, at A1. However, “other innovations, including a vast expansion of Medicaid eligibility and the sale of subsidized insurance policies through state-based exchanges, would withstand even a Supreme Court ruling against the insurance mandate.” *Id.*

136. Pub. L. No. 111-148, §§ 1501–02, 124 Stat. 119, 242–50 (2010) (modified by Pub. L. No. 111-148, § 10106, 124 Stat. 907).

137. *Id.*

138. *Id.*

B. Federal Reform's Impact on Healthy SF

In California, federal reform is projected to provide health insurance to 7.3 million uninsured state residents,¹³⁹ which is likely to increase the number of San Francisco residents who are able to obtain health insurance. This will increase the number of insured City residents and decrease the number of Healthy SF enrollees. However, federal reform will not provide coverage to all current Healthy SF participants, so Healthy SF will remain a vital source of health care to many San Francisco residents.

As noted earlier, Healthy SF provides universal access to health care, but does not provide participants with actual health insurance; for example, Healthy SF participants cannot receive care outside of City limits.¹⁴⁰ For that reason, Healthy SF participants who qualify for federal reform's expanded coverage programs will be incentivized to enroll in those programs, because they will have the opportunity to receive actual health insurance.¹⁴¹ This will almost certainly lower the overall participation rate in Healthy SF. The San Francisco Department of Public Health recently determined that approximately 30,700 of the 51,200 current Healthy SF participants—60 percent of current enrollees—could unenroll from Healthy SF in 2014 in order to enroll in the health insurance options created by federal reform.¹⁴²

However, many of San Francisco's uninsured residents will remain ineligible for the programs federal reform creates.¹⁴³ First, the City's population of undocumented immigrants will not be able to secure health insurance under federal reform.¹⁴⁴ Second, a significant portion of the Healthy SF participant pool will not be eligible for the Medicaid expansion and will also not be able to afford the insurance offered in the exchanges.¹⁴⁵ Third, some individuals may be unable to provide sufficient documentation of public health-insurance eligibility.¹⁴⁶ Finally, some uninsured residents may simply refuse to comply

139. *Health Insurance Reform and California*, HEALTHREFORM.GOV, http://asmdc.org/members/a18/attachments/Healthcare_Reform.pdf (last visited Mar. 14, 2011).

140. HEALTHY SF IN-DEPTH, *supra* note 51, at 9.

141. *See generally* Pub. L. No. 111-148, 124 Stat. 119 (2010).

142. Memorandum from Tangerine Brigham & Colleen Chawla, S.F. Dep't of Pub. Health, through Mitchell H. Katz, to Jim Illig, S.F. Health Comm'n President, and Members of the S.F. Health Comm'n 14 (Apr. 16, 2010) (on file with authors) [hereinafter DPH Memo].

143. It is also important to note that since the Healthy SF program does not offer health insurance, it could not be offered in a health exchange established by the state, and enrollment in Healthy SF *will* meet the individual health-insurance mandate.

144. *Proposed Changes in the Final Health Care Bill*, N.Y. TIMES, <http://www.nytimes.com/interactive/2010/03/19/us/politics/20100319-health-care-reconciliation.html#tab=13> (noting that undocumented immigrants "[c]ould not buy insurance from the exchanges, even if they were able to pay the full cost themselves, without federal subsidies").

145. DPH Memo, *supra* note 142, at 21.

146. *Id.* at 14.

with the individual mandate, and decide not to enroll in the subsidized health insurance exchanges.¹⁴⁷

Because of this limitation on federal reform's scope, San Francisco Public Health Chief Mitchell Katz predicts that thousands of City residents will remain uninsured.¹⁴⁸ Katz estimates that only about half of current Healthy SF participants will qualify for Medicaid or other insurance programs because of their expansion under federal reform.¹⁴⁹ As a result, San Francisco Mayor Gavin Newsom has expressed his dedication to ensuring Healthy SF's viability even after federal reform is fully implemented in 2014.¹⁵⁰ Thus, San Francisco and other cities looking to implement their own versions of local health care reform clearly have an interest in doing so, making ERISA's impact on that reform an important topic. With this in mind, we will now address the Golden Gate Restaurant Association's ERISA preemption challenge to the Ordinance.

III.

THE ORDINANCE'S EMPLOYER-SPENDING REQUIREMENT VERSUS ERISA

In this Part, we introduce ERISA and the legislative materials underlying its regulation of pension funds and welfare benefit plans. We then discuss how the ambiguity inherent in ERISA's preemption clause stems from its broad wording. This broad wording was originally interpreted to supplant all state regulation of welfare benefit plans, but provides scant evidence of congressional intent to achieve a massive usurpation of state regulatory authority in the historically state-regulated field of health benefits.

A. A Brief Primer on ERISA

Congress passed ERISA in 1974 to "safeguard employees from the abuse and mismanagement of funds that had been accumulated to finance various types of employee benefits."¹⁵¹ ERISA governs two broad categories of employee benefits. First, it regulates "pension plans," which provide income to employees once they retire, by providing standards by which the plans must operate.¹⁵² The funds for these plans accrue over the course of an employee's career and then vest after a certain number of years.¹⁵³ Second, it regulates

147. *Id.*

148. Heather Knight, *Healthy San Francisco Expected to Continue*, S.F. CHRON., Mar. 23, 2010, at A10, available at <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2010/03/23/MN4V1CJO00.DTL&#ixzz0j2HA7KdD>.

149. *Id.*

150. *Id.*

151. *Massachusetts v. Morash*, 490 U.S. 107, 112 (1989); see 2 SUBCOMM. ON LABOR OF THE COMM. ON LABOR & PUB. WELFARE, U.S. SENATE, LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, at 3456 (1976).

152. Christen L. Young, *Pay or Play Programs and ERISA Section 514: Proposals for Amending the Statutory Scheme*, 10 YALE J. HEALTH POL'Y L. & ETHICS 197, 204 (2010).

153. *Id.* at 224.

“employee welfare benefit plans,” which offer benefits like health or life insurance and are of a more short-term nature.¹⁵⁴ Since these plans are defined broadly, most employer-sponsored benefits are considered employee benefit plans under ERISA.¹⁵⁵

To help achieve its goal, ERISA creates “extensive reporting, disclosure, and fiduciary duty requirements to insure against . . . poor management by the plan administrator.”¹⁵⁶ In addition to safeguarding employee benefits from loss or abuse, ERISA also establishes uniform national standards, which encourages employers to offer benefit plans to their employees.¹⁵⁷ Although ERISA does not mandate that employers offer benefit plans, it does require that any benefit plans that are created must adhere to its standards.¹⁵⁸ ERISA thereby governs all employee benefit plans, including health care benefit plans; due to its broad application, 65 percent of the country’s population is insured through an ERISA plan.¹⁵⁹

B. The Preemption Provision

One of ERISA’s primary goals is to create “uniformity of regulation” in order to “ease[] the administrative burdens on employers and plan administrators, thereby reducing costs to employers.”¹⁶⁰ To achieve this, ERISA contains a broad preemption provision, Section 514(a), which states that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”¹⁶¹ ERISA also contains a “savings clause,” which is an exception to the preemption provision that allows state laws to regulate the business of insurance.¹⁶² Finally, through its “deemer clause,” ERISA limits the savings clause by preventing states from characterizing a self-insured plan as the business of insurance.¹⁶³

ERISA’s preemption provision has been described as “one of the broadest preemption clauses ever enacted by Congress,” and has “bedeviled the Supreme Court” for many years.¹⁶⁴ As the Ninth Circuit opinion in *GGRA* itself highlights, there is a great deal of complexity and confusion regarding ERISA’s

154. *Id.* at 204.

155. Amy B. Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 U. KAN. L. REV. 1203, 1206 (2007).

156. *Morash*, 490 U.S. at 115.

157. *Id.*

158. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004); *see also* Jacobson, *Opportunities and Limits*, *supra* note 61, at 89.

159. *Aetna Health Inc.*, 542 U.S. at 208.

160. *GGRA*, 546 F.3d at 647

161. 29 U.S.C. § 1144(a) (2006).

162. § 1144 (b)(2)(A).

163. Jacobson, *Opportunities and Limits*, *supra* note 61, at 86.

164. *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1439 (9th Cir. 1990); *Rutledge v. Seyfarth*, 201 F.3d 1212, 1216 (9th Cir. 2000).

preemption clause and the jurisprudence that applies it.¹⁶⁵ As in other preemption contexts, the Supreme Court relies strongly on the congressional intent underlying ERISA.¹⁶⁶ For that reason, it is important to understand both the congressional intent and the rationale behind ERISA's preemption clause before examining the Ordinance in light of the preemption provision.

I. Congressional Intent

When the Supreme Court considers ERISA preemption claims, its analysis often turns on congressional intent.¹⁶⁷ As the Court has explained, Congress's intent "'is the ultimate touchstone' in every pre-emption case,"¹⁶⁸ so understanding the congressional intent behind ERISA is central to resolving any question of preemption. Congress enacted ERISA for two explicit reasons: first, "to promote the interests of employees and their beneficiaries in employee benefit plans,"¹⁶⁹ and second, to protect employers by "eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans" so as to "minimize the administrative and financial burden of complying with conflicting directives."¹⁷⁰ In this way, ERISA attempts to facilitate national, uniform administration of employee benefit plans.

a. ERISA's Focus on Pension Reform

Prior to ERISA's enactment, both Congress and the executive branch spent over a decade studying the abuses and worst practices of the private pension industry during the 1950s and 1960s.¹⁷¹ As a result, ERISA's legislative history is "uncommonly thorough in documenting Congress's purposes and goals" as well as the specific deficiencies that drove the reform efforts.¹⁷² Indeed, after a careful analysis of the legislative materials, it becomes clear that Congress adopted ERISA primarily to comprehensively reform the nation's private pension industry.¹⁷³

165. See *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 334–35 (1997) (Scalia, J., concurring) (noting that, as of 1997, the U.S. Supreme Court had "accepted certiorari in, and decided, no less than 14 cases to resolve conflicts in the Courts of Appeal regarding ERISA pre-emption of various sorts of state law").

166. See, e.g., *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645, 655 (1995) (citing *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992) and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983)).

167. *Id.*

168. *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) (quoting *Retail Clerks Int'l Ass'n, Local 1625 v. Schermerhorn*, 375 U.S. 96, 103 (1963)).

169. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983).

170. *Id.* at 99; *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).

171. See S. REP. NO. 93-127, at 5–8 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4842–45; see also *Bogan*, *supra* note 20, at 964.

172. *Bogan*, *supra* note 20, at 964.

173. *Id.*

The following statement by Senator Jacob Javits effectively characterizes the underlying concern that an unregulated and increasingly wealthy private pension fund market could cause economic harm:

The private pension system itself has grown like “topsy” to the point where it covers an estimated 30 to 35 million workers—nearly half the Nation’s work force. The assets of private plans, estimated to be in excess of \$160 billion, constitute the largest private accumulation of resources which have avoided the imprint of effective governmental supervision.

The absence of any supervision over these funds and the lack of minimum standards to safeguard the interests of plan participants and beneficiaries has over the years led to widespread complaints signaling the need for remedial legislation.¹⁷⁴

As a result, in 1970, the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare (“Subcommittee”) assumed the task of thoroughly investigating the private pension industry.¹⁷⁵ After conducting hearings in cities across the nation, and hearing countless stories of victimized workers who lost their “anticipated retirement benefits due to termination of inadequately funded pension plans, unreasonable participation and vesting requirements, and mismanagement of pension plan assets,” Congress was prepared to act.¹⁷⁶

In 1973, Senator Javits and Representative John Dent introduced bills in their respective chambers that were the precursors to ERISA.¹⁷⁷ These bills demonstrate that Congress’s primary concern underlying its passage of ERISA was private pension industry abuses.¹⁷⁸ For example, the report of the Senate Committee on Labor and Public Welfare stated that “[t]he principal issues affecting the vital and basic needs for legislative reform involve consideration of the essential elements of pensions”: (1) vesting, (2) funding, (3) reinsurance, (4) portability, and (5) fiduciary responsibility and disclosure.¹⁷⁹ Similarly, the report from the House Ways and Means Committee explained that:

This legislation is concerned with improving the fairness and effectiveness of qualified retirement plans in their vital role of providing retirement income. In broad outline, the objective is to increase the number of individuals participating in employer-financed plans; to make sure to the greatest extent possible that those who do participate in such plans actually receive benefits and do not lose their benefits as a result of unduly restrictive forfeiture provisions or failure

174. 120 CONG. REC. 29,934 (1974) (statement of Senator Jacob Javits).

175. S. REP. NO. 92-634, at 1 (1972); *see also* 119 CONG. REC. 30,003 (1973).

176. Bogan, *supra* note 20, at 970; *see* H.R. REP. NO. 93-533, at 5–8 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4643–46.

177. *See* S. 4, 93d Cong. (1973); H.R. 2, 93d Cong. (1973); S. REP. NO. 93-127, at 1 (1973).

178. S. 4, 93d Cong. (1973).

179. S. REP. NO. 93-127, at 8–11 (1973), *reprinted in* 1974 U.S.C.C.A.N. at 4844–47.

of the pension plan to accumulate and retain sufficient funds to meet its obligations; and to make the tax laws relating to qualified retirement plans fairer by providing greater equality of treatment under such plans for the different taxpayer groups concerned.¹⁸⁰

Thus, the above committee reports, as well as the rest of ERISA's legislative history, focus on the regulation and reform of the private pension industry.

Notwithstanding this focus, Section 514(a) of ERISA contains one of the most sweeping preemption provisions ever enacted by Congress, which has been interpreted by the Supreme Court to supplant nearly all state regulation of *welfare* benefit plans. As we will discuss in the next section, welfare benefit plans received little attention in the hearings leading up to the enactment of ERISA, and unsurprisingly, the legislative history contains scant evidence of what Congress intended to achieve through the broad wording of ERISA's preemption clause.

b. Preemption Provision's Legislative History

The complexity and confusion regarding ERISA preemption stem from the statute's broad preemption provision, which purports to remove all types of welfare benefit plans from state regulation, but lacks the legislative materials to demonstrate that Congress intended to enact such sweeping reform. Indeed, while ERISA's pension plan provisions were the result of years of work, its final preemption language "was not disclosed until . . . 10 days before final action was taken on ERISA."¹⁸¹

This late addition occurred because the Conference Committee in charge of reconciling the House and Senate versions of ERISA was given less than a month to produce a finished product in time for a White House bill signing on Labor Day.¹⁸² As ERISA's completion date drew near, the committee "inexplicably broadened ERISA's preemption provision beyond any preemption language previously recommended or considered, without any useful statement in the Conference Committee's report to explain its actions."¹⁸³

180. H.R. REP. NO. 807, at 8 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4670, 4676-77. Relatedly, the Report of the House Committee on Education and Labor stated:

The Employment Benefit Security Act is designed (1) to establish minimum standards of fiduciary conduct for Trustees, Administrators and others dealing with retirement plans, to provide for their enforcement through civil and criminal sanctions, to require adequate public disclosure of the plan's administrative and financial affairs, and (2) to improve the equitable character and soundness of private pension plans by requiring them to: (a) vest the accrued benefits of employees with significant periods of service with an employer, (b) meet minimum standards of funding and (c) guarantee the adequacy of the plan's assets against the risk of plan termination prior to completion of the normal funding cycle by insuring the unfunded portion of the benefits promised.

H.R. REP. NO. 93-533, at 17-18, *reprinted in* 1974 U.S.C.C.A.N. at 4655-56.

181. *See* *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746 n.23 (1985).

182. Michael S. Gordon, *ERISA, ESOPs, and Senator Javits: The Mind of a Reformer*, 7 AM. J. TAX POL'Y 3, 3-4 (1988).

183. Bogan, *supra* note 20, at 979; *see also* H.R. REP. NO. 93-1280, at 383 (1974),

In fact, the only legislative history regarding the current preemption provision is found in floor statements made by three individual members of the conference committee, Representative Dent and Senators Harrison Williams and Javits.¹⁸⁴ The statements from all three, however, are of little help because each member confuses the principles of field and conflict preemption,¹⁸⁵ making it difficult to discern the intended scope of the preemption provision. For example, both Representative Dent and Senator Williams explained that the conference committee intended ERISA to occupy the entire field of employee benefits regulation in order to “eliminat[e] the threat of conflicting and inconsistent state and local regulation.”¹⁸⁶ However, if the primary concern of these two members was inconsistent state regulation, then the assertion of exclusive federal jurisdiction is overbroad.¹⁸⁷ As Professor Donald Bogan explains, “[c]onflict preemption analysis would have been sufficient to nullify all state regulations inconsistent with ERISA without the need to usurp state regulatory authority in the historically state-regulated fields of health, accident, death, and disability benefits that ERISA does not pretend to regulate.”¹⁸⁸

These statements suggest that Congress neither fully contemplated nor necessarily intended the Supreme Court to interpret Section 514(a) with the broad approach to preemption that characterized the first two decades of its ERISA jurisprudence.¹⁸⁹ Indeed, the Supreme Court itself admits that none of these statements are “particularly illuminating.”¹⁹⁰ This ambiguity continues to

reprinted in 1974 U.S.C.C.A.N. 5038, 5162. The Conference Committee report does not provide any explanation for the new, broadened preemption language.

184. Bogan, *supra* note 20, at 980–82.

185. *See id.* at 980. For an explanation of the principles of field and conflict preemption, see Young, *supra* note 152, at 204 n.33 (“Conflict preemption refers to those cases where it is simply impossible to comply with state and federal requirements simultaneously. . . . Field preemption refers to situations where it is technically possible to comply with both state and federal law, but courts determine that the federal government intended to occupy the entire ‘field’ and displace state law. . . . These concepts often overlap; for example, an express preemption clause that speaks to some but not all issues can be used to guide courts in understanding the proper scope of field preemption.”).

186. 120 CONG. REC. 29,197 (1974) (statement of Representative John Dent); 120 CONG. REC. 29, 933 (1974) (statement of Senator Harrison Williams).

187. Bogan, *supra* note 20, at 980–81.

188. *Id.*

189. *Id.* at 982 (“It is apparent from Senator Javits’ remarks that the broadening of ERISA’s preemption language was not carefully considered. Particularly illuminating is his suggestion that any problems with the effects of the preemption provision could be remedied by further regulation ‘at the State or Federal level.’ Obviously, the overbroad application of the field preemption doctrine cannot be fixed by corrective state regulation because field preemption, by definition, ousts the states of all jurisdiction to regulate the subject. Even more telling is the fact that neither Senator Javits, nor any other member of Congress, appears to have anticipated that ERISA’s broad preemption of state laws governing the field of nonpension employee benefits would create the regulatory void that has resulted from ERISA’s super-preemption.”) (citations omitted).

190. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 745 n.23 (1985) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 104 (1983)).

drive the current confusion in the federal judiciary's approach to ERISA preemption.

2. *Presumption Against Preemption*

The Supreme Court has established that there is a presumption against preemption that exists in all preemption cases:

In all pre-emption cases, and particularly in those in which Congress has “legislated . . . in a field which the States have traditionally occupied,” we “start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.”¹⁹¹

The Court applies this presumption in examining the congressional intent behind a federal statute and in answering questions concerning the scope of a federal statute's intended invalidation of state law.¹⁹² In addition, the fact that a state law “implement[s] policies and values lying within the traditional domain of the States” informs any preemption analysis.¹⁹³

Although health benefit plans like the Ordinance necessarily fall within ERISA's scope,¹⁹⁴ the Court has explained that “general health care regulation” has “historically has been a matter of local concern.”¹⁹⁵ Indeed, “the Court has established a presumption that Congress did *not* intend ERISA to preempt areas of ‘traditional state regulation’ that are ‘quite remote from the areas with which ERISA is expressly concerned—reporting, disclosure, fiduciary responsibility, and the like.’”¹⁹⁶ Therefore, when analyzing a state law whose primary purpose is general health care regulation—not one of ERISA's primary concerns—this presumption should be at the forefront.

Accordingly, before the Ninth Circuit began its legal analysis of San Francisco's Ordinance in light of ERISA's preemption clause, it was careful to note that:

The field in which the Ordinance operates is the provision of health care services to persons with low or moderate incomes. State and local governments have traditionally provided health care services to such persons. . . . The Ordinance uses a novel approach to the provision of health services to such persons, but operates in a field that has long been the province of state and local governments, thereby

191. *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)) (citations omitted).

192. *Engine Mfrs. Ass'n v. S. Coast Air Quality Mgmt. Dist.*, 541 U.S. 246, 260–61 (2004) (Souter, J., dissenting) (quoting *Medtronic*, 518 U.S. at 485).

193. *Boggs v. Boggs*, 520 U.S. 833, 840 (1997).

194. *See* 29 U.S.C. § 1144(a) (2006).

195. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645, 661 (1995); *see also* *Rutledge v. Seyfarth*, 201 F.3d 1212, 1217 (9th Cir. 2000).

196. *Rutledge*, 201 F.3d at 1217 (quoting California Div. of Labor Standards Enforcement v. *Dillingham Constr.*, 519 U.S. 316, 330 (1997)).

“implement[ing] policies and values lying within the traditional domain of the States.”¹⁹⁷

With this in mind, let us now look to the Ninth Circuit’s opinion in *GGRA*, in which the court found that ERISA did not preempt the Ordinance.

IV.

THE NINTH CIRCUIT’S OPINION IN *GGRA*

In this Part, we discuss *GGRA*’s majority panel opinion and denial for rehearing en banc as a case study in the complexity and uncertainty inherent in the Supreme Court’s ERISA preemption jurisprudence. As the Court has struggled decade after decade to interpret ERISA’s preemption clause correctly, it has created a series of confusing and often overlapping inquiries that produce tremendous uncertainty for state and local governments seeking to institute their own versions of health care reform.¹⁹⁸ After analyzing the *GGRA* opinions, we find that even the Ninth Circuit judges were divided on a panoply of preemption issues, including the correct application of four preemption tests and whether there was a conflict with a Fourth Circuit case that struck down a Maryland pay-or-play law. The judges even disagreed about the congressional intent underlying the ERISA statute itself.

ERISA governs “employee welfare benefit plan[s],”¹⁹⁹ preempting all state laws that “relate to” those plans.²⁰⁰ To determine whether ERISA preempts the Ordinance’s employer-spending requirement, the Ninth Circuit had to determine: (1) whether the Ordinance’s City-payment option creates an ERISA plan, and (2) whether the employer-spending requirement “relate[s] to” ERISA plans as the term is used in the statute.²⁰¹ After a careful analysis of the spending requirement, the court found that it did neither and therefore was not subject to preemption.²⁰²

197. *Golden Gate Rest. Ass’n v. City & Cnty. of San Francisco*, 546 F.3d 639, 648 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010) (quoting *Boggs*, 520 U.S. at 840).

198. See *infra* note 325 for an explanation of how the Court’s ERISA jurisprudence creates uncertainty for state and local governments seeking to implement their own health care reform initiatives.

199. 29 U.S.C. § 1002(3) (2006).

200. § 1144(a).

201. *Golden Gate Rest. Ass’n*, 546 F.3d at 648.

202. *Id.* at 661; see generally Alek Felstiner, Comment, *Golden Gate Restaurant Ass’n v. City & County of San Francisco: The Ninth Circuit Limits ERISA Preemption, Expands Pay-or-Play Options*, 29 BERKELEY J. EMP. & LAB. L. 473 (2008).

A. The Ninth Circuit's Arguments for Upholding the Ordinance

1. The Ordinance's City-payment Option Does Not Constitute an ERISA "Plan"

The Ninth Circuit first sought to determine whether the Ordinance's City-payment option constitutes an ERISA plan.²⁰³ The City-payment option allows employers to deposit money with the City on behalf of its employees; that money is used to fund their employees' health care and allows employers to meet their employer-spending requirements.²⁰⁴ An ERISA plan is defined as any:

plan, fund, or program which . . . is . . . established or maintained by an employer or by an employee organization . . . for the purpose of providing for its participants . . . , 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 unemployment²⁰⁵

If the court had concluded that the City-payment option was an ERISA plan, then the preemption provision would unquestionably have preempted the employer-spending requirement, and there would have been no need for further analysis.²⁰⁶ However, after examining the mechanics of the City-payment option, the court found that it is not an ERISA plan within the meaning of the statute.²⁰⁷

As in many other areas of ERISA preemption law, the plain meaning of the statute's words provide little guidance regarding what exactly constitutes an ERISA plan.²⁰⁸ For that reason, the Supreme Court's ample ERISA jurisprudence is central to answering any difficult preemption question, and arguments often rely upon analogizing to prior case law. Following this tradition, the Ninth Circuit began its analysis by looking at two Supreme Court cases, *Fort Halifax Packing Co. v. Coyne* and *Massachusetts v. Morash*, which both distinguish state laws that impermissibly force employers to create "benefit plans" from state laws that merely mandate the provision of "benefits," allowing them to survive an ERISA preemption analysis.²⁰⁹

In *Fort Halifax*, the Court upheld a Maine statute that required employers to pay employees one week's pay for each year worked if the employees were

203. *Golden Gate Rest. Ass'n*, 546 F.3d at 649.

204. *City Option*, HEALTHY SAN FRANCISCO, http://www.healthysanfrancisco.org/employers/city_option (last visited Mar. 14, 2011).

205. 29 U.S.C. § 1002(1) (2006); *see also id.* § 1002(3).

206. *See* § 1002(1).

207. *Golden Gate Rest. Ass'n*, 546 F.3d at 649.

208. *See infra* Part III.B for analysis of the "relate to" test.

209. *Golden Gate Rest. Ass'n*, 546 F.3d at 649; *see also Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 16 (1987); *Massachusetts v. Morash*, 490 U.S. 107, 116 (1989).

fired because of a plant closing.²¹⁰ The Court upheld the statute under ERISA because “the requirement of a one-time, lump-sum payment triggered by a single event requires no administrative scheme whatsoever to meet the employer’s obligation.”²¹¹ Similarly, in *Morash*, the Court upheld a Massachusetts statute that required employers to pay fired employees “full wages, including holiday or vacation payments, on the date of discharge.”²¹² The Court found that this too did not create an ERISA plan because “[i]t is unlikely that Congress intended to subject to ERISA’s reporting and disclosure requirements those vacation benefits which by their nature are payable on a regular basis from the general assets of the employer.”²¹³

Both *Fort Halifax* and *Morash* emphasize the importance of analyzing whether a state law conflicts with “the first underlying purpose of ERISA—protecting employees against the abuse and mismanagement of funds.”²¹⁴ As the Court explained, “[o]nly [benefits] ‘plans’ involve administrative activity potentially subject to employer abuse,” so when the risk to the employee is low, courts are less likely to find that a “plan” exists.²¹⁵

The Ninth Circuit applied the principles underlying *Halifax* and *Morash* to the Ordinance and found that the City-payment option did not constitute an ERISA plan.²¹⁶ The court based this holding on two related findings: first, that the administrative obligations under the City-payment option were minimal, and second, that the obligations did not run “the risk of mismanagement of funds or other abuse.”²¹⁷ As the court explained, the Ordinance merely requires an employer to make the required payments for its covered employees and to retain records to prove that it has done so.²¹⁸ And like the Massachusetts statute in *Morash*, employers make their payments “on a regular basis from [their] general assets.”²¹⁹ Even if the City required employers to pay its employees directly, the court determined that “there would be little to differentiate those payments from wages.”²²⁰

The Association emphasized the administrative burdens that the employer-spending requirement imposes on employers,²²¹ because substantial burdens might lead to ERISA preemption of the employer-spending requirement. The administrative burdens the Ordinance imposes on employers are twofold. First, employers must keep track of the number of hours their

210. *Fort Halifax*, 482 U.S. at 4–5.

211. *Id.*

212. *Morash*, 490 U.S. at 109 (1989).

213. *Id.* at 116.

214. *Golden Gate Rest. Ass’n*, 546 F.3d at 639.

215. *Id.* (citing *Fort Halifax*, 482 U.S. at 16).

216. *Id.* at 650.

217. *Id.* at 651.

218. *Id.*

219. *Id.* at 650.

220. *Id.*

221. *Id.*

employees work and whether those hours are worked in San Francisco or elsewhere, and second, employers must determine whether particular employees are covered or whether they are exempted as “supervisory” or “managerial” under the Ordinance.²²² The Association argued that these administrative burdens were significant,²²³ but the Ninth Circuit rejected this argument. The court analogized the Ordinance’s relatively minimal administrative burdens to those required under “federal, state and local laws, such as income tax withholding, social security, and minimum wage laws.”²²⁴

Finally, the court analyzed the Ordinance under the standards established by two prior Ninth Circuit preemption cases,²²⁵ which emphasized employer discretion in plan administration as crucial to finding a “plan.”²²⁶ In those cases, the court expressed that a “plan” requires an employer to possess more than “some modicum of discretion.”²²⁷ There must be “*enough* ongoing, particularized, administrative, discretionary analysis to make the plan an ongoing administrative scheme.”²²⁸ Under this standard, the court characterized the Ordinance as mandating employers to perform two minimal, nondiscretionary tasks, neither of which “run[s] the risk of mismanagement of funds or other abuse.”²²⁹ San Francisco employers “ha[ve] no discretion under the Ordinance to alter . . . [their] books to reduce . . . [their] quarterly spending obligation,” amounting to nothing more than “mechanical record keeping.”²³⁰ Moreover, as in *Morash*, the Ordinance is “typically fixed, due at known times, and do[es] not depend on contingencies outside the employee’s control.”²³¹

2. The Ordinance Does Not “Relate to” ERISA Plans

After finding that the Ordinance does not create an ERISA plan, the court proceeded to answer the second question required under an ERISA preemption analysis: whether the Ordinance “relate[s] to” an employee benefit plan.²³² To make this determination, the Ninth Circuit applied the Supreme Court’s two-step “relate to” inquiry, first asking whether the Ordinance has a “connection with” an employee benefit plan, and if not, then asking whether it makes

222. *Id.* at 651.

223. *Id.* at 652.

224. *Id.* at 650.

225. *See* *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1323 (9th Cir. 1992); *Velarde v. Pace Membership Warehouse, Inc.*, 105 F.3d 1313, 1317 (9th Cir. 1997).

226. *Golden Gate Rest. Ass’n*, 546 F.3d at 650–51.

227. *Id.* at 651 (citing *Velarde*, 105 F.3d at 1317).

228. *Id.*

229. *Id.*

230. *Id.*

231. *Id.*

232. 29 U.S.C. § 1144(a) (2006).

impermissible “reference to” such a plan.²³³ Ultimately, the court concluded that the Ordinance does neither.²³⁴

a. The Ordinance Has No “Connection with” an Employee Benefit Plan

Used in its broadest sense, a plain-text reading of the word “connection” might be applied to preempt numerous state laws unnecessarily. For that reason, the Supreme Court has cautioned against an “uncritical literalism” that could make preemption turn on “infinite connections.”²³⁵ In *California Division of Labor Standards Enforcement v. Dillingham Construction* (“*Dillingham*”), the Court provided the following guidance for how to effectively determine whether a statute has an impermissible “connection with” ERISA:

To determine whether a state law has a connection with ERISA plans, this Court looks both to ERISA’s objectives as a guide to the scope of the state law that Congress understood would survive, and to the nature of the law’s effect on ERISA plans. Where federal law is said to preempt state action in fields of traditional state regulation, this Court assumes that the States’ historic police powers are not superseded unless that was Congress’ clear and manifest purpose.²³⁶

Following this guidance, the Ninth Circuit established that health care was one of the historic police powers left to the states, and then looked to ERISA’s underlying objectives, concluding that it was primarily intended to “provide a uniform regulatory regime over employee benefit plans.”²³⁷ The court then applied these principles to the Ordinance in light of statutes the Supreme Court struck down in *Egelhoff v. Egelhoff* and *Shaw v. Delta Air Lines*, and a statute the Ninth Circuit struck down in *Standard Oil Co. v. Agsalud*. All of the statutes contained impermissible “connection[s] with” ERISA.²³⁸

In *Egelhoff*, the Court found that ERISA preempted a Washington law that required employers to follow certain rules in designating beneficiaries because the law conflicted with the choice provided in an ERISA plan.²³⁹ As the Court explained, when a state or local law “binds ERISA plan administrators to a particular choice of rules for determining beneficiary status,” it possesses an impermissible connection to an ERISA plan.²⁴⁰ Similarly, in *Shaw*, the Court considered two New York laws, one that required employers to structure their ERISA plans in a certain way and one that required employers to pay specific

233. *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 324 (1997).

234. *Golden Gate Rest. Ass’n*, 546 F.3d at 661.

235. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001).

236. *Dillingham*, 519 U.S. at 316–17 (syllabus).

237. *Golden Gate Rest. Ass’n*, 546 F.3d at 655.

238. *Id.*

239. *Egelhoff*, 532 U.S. at 147.

240. *Id.*

types of benefits.²⁴¹ The Court held that ERISA preempted both of them because they both contained impermissible connections with ERISA plans.²⁴² Finally, in *Agsalud* the Ninth Circuit used the impermissible connection rationale to strike down a Hawaii statute that “directly and expressly” regulated the type of benefits that employers provided to their employees.²⁴³

In *GGRA*, the court attempted to distinguish the San Francisco Ordinance from these preempted statutes. It reasoned that unlike the statutes in *Shaw* and *Agsalud*, San Francisco employers are neither required to structure their ERISA plans in a specific way nor required to pay their employees specific types of benefits.²⁴⁴ Rather, the Ordinance allows employers to contribute to their own ERISA plans without any type of modification; its requirement simply ensures that employers meet a minimum level of spending in order to meet their obligation.²⁴⁵ And although the Ordinance may incentivize one choice over another, unlike the statute in *Egelhoff*, it “does not bind plan administrators to any particular choice,” and thus avoids preemption.²⁴⁶

To support the latter argument, the Ninth Circuit also relied heavily on *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.* (“*Travelers*”), in which the Supreme Court upheld a New York law that imposed hospital bill surcharges on patients covered by commercial insurers, except for those patients insured by Blue Cross and Blue Shield.²⁴⁷ In part, New York enacted the law to make it economically viable for Blue Cross and Blue Shield to insure patients who other commercial insurers denied as too risky.²⁴⁸ After acknowledging that the law influenced the choices made by consumers, which impacted ERISA plans, the Court upheld it anyway because it was a general health regulation with an “indirect effect.”²⁴⁹

The *Travelers* approach to preemption signified a turning point in the Court’s jurisprudence.²⁵⁰ Prior to *Travelers*, ERISA cases often resulted in the preemption of local and state regulations, regardless of how remote a regulation’s reference to or connection with an ERISA plan was.²⁵¹ Since

241. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97–100 (1983).

242. *Id.*

243. *Standard Oil Co. v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1980), *aff’d mem.*, 454 U.S. 801 (1981).

244. *Golden Gate Rest. Ass’n v. City & Cnty. of San Francisco*, 546 F.3d 639, 656 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010).

245. *Id.*

246. *Id.* (citing *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659 (1995)).

247. *Travelers*, 514 U.S. at 649.

248. *Id.*

249. *Id.*

250. *Gerosa v. Savasta & Co.*, 329 F.3d 317, 327 (2d Cir. 2003) (explaining how the *Travelers* decision “occasioned a significant change in preemption analysis, and required careful reconsideration of any preexisting precedent dependent on the expansive view of ‘related to’ that held sway before it”).

251. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (“[T]he Human Rights Law,

Travelers, however, courts have been more likely to uphold state health insurance regulations against ERISA preemption challenges when those regulations have only an indirect effect on an employee benefit plan.²⁵²

After examining the Ordinance in light of *Travelers*, the Ninth Circuit found that the employer-spending requirement's effect on employee benefits plans is even less direct than the effect the New York statute had on benefit plans:

In *Travelers*, the required surcharge on benefits provided under ERISA plans administered by commercial insurers inescapably changed the cost structure for those plans' health care benefits and thereby exerted economic pressure on the manner in which the plans would be administered. Here, by contrast, the Ordinance does not regulate benefits or charges for benefits provided by ERISA plans. Its only influence is on the employer who, because of the Ordinance, may choose to make its required health care expenditures to an ERISA plan rather than to the City.²⁵³

Thus, the Ninth Circuit concluded that the employer-spending requirement does not have an impermissible connection with ERISA plans.

b. The Ordinance Does Not Make "Reference to" ERISA Plans

Next, the court applied the "reference to" prong of the "relate to" test.²⁵⁴ To determine whether a state law makes impermissible reference to an ERISA plan, a court must determine whether the law acts "immediately and exclusively upon ERISA plans," and whether the "existence of ERISA plans is essential to the law's operation."²⁵⁵ If a state law does either, then it is preempted. After analyzing the Ordinance, the Ninth Circuit answered both questions in the negative.²⁵⁶

To determine whether the Ordinance acts "immediately and exclusively upon ERISA plans," the court looked to the Supreme Court decision in *Mackey v. Lanier Collection Agency & Service, Inc.*²⁵⁷ In *Mackey*, the Court voided part

which prohibits employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, which requires employers to pay employees specific benefits, clearly 'relate to' benefit plans."); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 55 (1987) ("Considering the common-sense understanding of the saving clause . . . and . . . the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive, we conclude that [the action at issue] is not saved . . . and therefore is pre-empted . . .").

252. *Jacobson, Opportunities and Limits*, *supra* note 61, at 6.

253. *Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 546 F.3d 639, 656 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010).

254. *Id.* at 657.

255. *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 325 (1997).

256. *Golden Gate Rest. Ass'n*, 546 F.3d at 659.

257. *Dillingham*, 519 U.S. at 325; *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988).

of a state garnishment statute that specifically exempted ERISA plans from its operation, upholding only the parts of that statute that did not single out ERISA plans for differential treatment.²⁵⁸ The Court acknowledged that some provisions might impose administrative burdens upon ERISA plans, but not enough to be preempted.²⁵⁹ Comparing the Ordinance to *Mackey*, the Ninth Circuit noted that it might impose similarly minor burdens, but it “does not act on ERISA plans at all, let alone immediately and exclusively.”²⁶⁰

The Ninth Circuit then analyzed the Ordinance under the second “relate to” prong: whether the “existence of ERISA plans is essential to the law’s operation.”²⁶¹ In so doing, the court found that the cases *Ingersoll-Rand Co. v. McClendon*²⁶² and *District of Columbia v. Greater Washington Board of Trade*²⁶³ supported upholding the Ordinance. In *Ingersoll*, the Supreme Court struck down a state law requiring that plaintiffs who wanted to bring a claim under ERISA provisions were required to first plead the existence of an ERISA plan.²⁶⁴ The Court held that any law that makes specific reference to and is premised upon the existence of an ERISA plan is preempted.²⁶⁵ Similarly, in *Greater Washington*, the Court struck down a state law requiring employers to provide workers’ compensation benefits at “the same benefit level” as the employer’s already existing ERISA plans.²⁶⁶ The Court found that this law was preempted by ERISA because the “existence of ERISA plans is essential to the law’s operation”: the employer’s contribution requirement could only be measured by referring to the level of benefits provided by the employer’s ERISA plan.²⁶⁷

The Ninth Circuit distinguished the Ordinance from the two statutes in *Ingersoll* and *Greater Washington* by finding that the Ordinance’s employer-spending requirement was measured by referencing “the *payments* provided by the employer to an ERISA plan or to another entity specified in the Ordinance, including the City.”²⁶⁸ That is to say, an employer’s obligation depends upon the number of hours worked and employer size rather than on “the value or nature of the benefits available to ERISA plan participants.”²⁶⁹ As the Ninth Circuit explained:

258. *Mackey*, 486 U.S. at 828–29.

259. *Id.*

260. *Golden Gate Rest. Ass’n*, 546 F.3d at 657.

261. *Id.*

262. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990).

263. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 144 (1992).

264. *Ingersoll-Rand Co.*, 498 U.S. at 140.

265. *Id.*

266. *Greater Wash.*, 506 U.S. at 128.

267. *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 325 (U.S. 1997) (describing the Court’s holding in *Greater Wash.*); *Greater Wash.*, 506 U.S. at 128.

268. *Golden Gate Rest. Ass’n v. City & Cnty. of San Francisco*, 546 F.3d 639, 658 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010).

269. *Id.*

[T]he Ordinance can have its full force and effect even if no employer in the City has an ERISA plan. Covered employers without ERISA plans can discharge their obligation under the Ordinance simply by making their required health care expenditures to the City.²⁷⁰

Just like the New York statute that was upheld in *Travelers*, here “the [costs] are imposed . . . regardless of whether the . . . coverage . . . is ultimately secured by an ERISA plan, private purchase, or otherwise, with the consequence that the [Ordinance] cannot be said to make ‘reference to’ ERISA plans in any manner.”²⁷¹

3. Distinguishing the Fourth Circuit’s *Fielder* Decision to Avoid a Circuit Split

Before surviving the Ninth Circuit’s scrutiny, the San Francisco Ordinance had one last hurdle to clear: a potential conflict with the Fourth Circuit’s 2007 decision in *Retail Industry Leaders Association v. Fielder*.²⁷² In *Fielder*, the Fourth Circuit struck down, on ERISA preemption grounds, a Maryland pay-or-play law that required employers with 10,000 or more employees to either spend at least 8 percent of their payroll on employees’ health insurance costs or to pay the difference to the State of Maryland.²⁷³ The Association argued that based on the *Fielder* decision, upholding the Ordinance would necessarily create a circuit split.²⁷⁴

However, the law at issue in *Fielder* was unique and, as the Ninth Circuit found, distinguishable from the Ordinance.²⁷⁵ Although the Maryland statute was phrased generally, it actually applied to just one employer in the entire state: Wal-Mart.²⁷⁶ If Wal-Mart chose to contribute to the State of Maryland rather than meeting the 8 percent spending requirement, the state would not use that money to provide health benefits to Wal-Mart’s employees in return for the employer’s contribution.²⁷⁷ Rather, under this “pay” option, Maryland treated the money the same way it treated other sources of state revenue.²⁷⁸ As a result, the Fourth Circuit concluded that this supposed pay-or-play provision was really just a play provision, with the intended purpose of requiring Wal-Mart to spend more money on its employee benefit plans.²⁷⁹ Wal-Mart even “noted by way of affidavit [that] it would not pay the State a sum of money that it could

270. *Id.* at 657.

271. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645, 656 (1995).

272. 475 F.3d 180 (4th Cir. 2007).

273. *Id.* at 183.

274. *Golden Gate Rest. Ass’n v. City & Cnty. of San Francisco*, 546 F.3d 639, 659 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010).

275. *Id.*

276. *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 183 (4th Cir. 2007).

277. *Id.* at 193.

278. *Id.*

279. *Id.*

instead spend on its employees' healthcare."²⁸⁰ As the Fourth Circuit concluded: "the choices given . . . are not meaningful alternatives."²⁸¹

The Maryland law's failure to provide a legitimate payment option enabled the Ninth Circuit to distinguish it from the San Francisco Ordinance.²⁸² The court emphasized that the Ordinance gives San Francisco employers meaningful alternatives that allow them to preserve the existing structure of their ERISA plans, while the Maryland law does not.²⁸³ As the court explained:

If an employer elects to pay the City, that employer's employees are eligible for free or discounted enrollment in [Healthy SF], or for medical reimbursement accounts. In contrast to the Maryland law, the San Francisco Ordinance provides tangible benefits to employees when their employers choose to pay the City rather than to establish or alter ERISA plans.²⁸⁴

Once again, the court used *Travelers* to bolster its argument.²⁸⁵ In *Travelers*, the Supreme Court explained that although the New York law placed some level of influence on the choices of ERISA plan purchasers, it was not preempted because it was not so prohibitive as to "force all health insurance consumers" to make one decision over another.²⁸⁶ While the Maryland law at issue in *Fielder* effectively "mandate[d] that employers structure their employee healthcare plans to provide a certain level of benefits," the San Francisco Ordinance offers real choices.²⁸⁷ The fact that these options may have some indirect impact on an employer's decision regarding ERISA benefits is not enough for the Ordinance to be preempted. Accordingly, the Ninth Circuit reversed the district court and upheld the Ordinance.²⁸⁸

B. Over Strong Dissent, the Ninth Circuit Denies Rehearing En Banc

Following the Ninth Circuit's *GGRA* opinion, the Golden Gate Restaurant Association filed a petition for rehearing en banc.²⁸⁹ The majority found in favor of the City and denied rehearing.²⁹⁰ However, seven judges strongly dissented from that denial, arguing that *GGRA* was wrongly decided because it creates a circuit split with the Fourth Circuit Court of Appeals, renders

280. *Id.*

281. *Id.* at 196.

282. *Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 546 F.3d 639, 660 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010).

283. *Id.*

284. *Id.*

285. *Id.*

286. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645, 664 (1995).

287. *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 193 (4th Cir. 2007).

288. *Golden Gate Rest. Ass'n*, 546 F.3d at 661.

289. *See Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 558 F.3d 1000 (9th Cir. 2009) (denying rehearing en banc).

290. *Id.* at 1001.

meaningless the [“relate to”] tests, . . . conflicts with other Supreme Court cases establishing ERISA preemption guidelines, and, most importantly, flouts the mandate of national uniformity in the area of employer-provided healthcare that underlies the enactment of ERISA.²⁹¹

The dissent disagreed with every aspect of the majority panel’s preemption analysis. The dissent first adopted the reasoning from the *GGRA* district court decision, which held that ERISA preempted the Ordinance because it failed both prongs of the “relate to” test.²⁹² First, with regard to the “connection with” prong, the dissent agreed with the district court’s explanation that the Ordinance has an impermissible connection with affected employer ERISA plans in at least four ways: (1) “the Ordinance affects plan administration, a core area of ERISA concern”; (2) the enforcement provisions impermissibly “impose on employers specific record keeping, inspection and other administrative burdens” which are “ongoing and directly affect” the scheme of health care benefits; (3) “the Ordinance directly and indirectly affects the structure and administration of ERISA plans”; and (4) the Ordinance “has a prohibited connection with ERISA plans because it interferes with nationally uniform plan administration.”²⁹³ The dissent was unconvinced that the Ordinance’s City-payment option was able to save the law from preemption.²⁹⁴

Second, with regard to the “reference to” prong, the dissent agreed with the district court’s finding that the Ordinance impermissibly makes reference to employers’ ERISA plans by defining “health care expenditure” in such a way that compliance can only be determined by referencing employers’ ERISA-regulated health plans.²⁹⁵

The dissent also criticized and eventually rejected the three-judge panel’s attempt to distinguish the state laws struck down by the Fourth Circuit in *Fielder* and by the Supreme Court in *Egelhoff* and *Greater Washington*.²⁹⁶ After analyzing each of these three cases in light of the Ordinance, the dissent drew completely different conclusions from those of the panel majority.²⁹⁷ Whereas the panel found that the Ordinance’s meaningful alternative (the City-payment option) distinguished it from the Maryland statute in *Fielder* because the latter provided nothing in return for state contributions, the dissent found

291. *Id.* at 1004.

292. *Golden Gate Rest. Ass’n v. City and Cnty. of San Francisco*, 535 F. Supp. 2d 968, 980 (N.D. Cal. 2007), *rev’d*, 546 F.3d 639 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010).

293. *Golden Gate Rest. Ass’n*, 535 F.3d at 1005 (citing *Golden Gate Rest. Ass’n*, 535 F. Supp. 2d at 975–77).

294. *Id.* (citing *Golden Gate Rest. Ass’n*, 535 F. Supp. 2d at 976) (“[T]he undeniable fact is that the vast majority of any employer’s healthcare spending occurs through ERISA plans. Thus, the primary subjects of the [expenditure requirements] are ERISA plans, and any attempt to comply with the statute would have direct effects on the employer’s ERISA plans.”).

295. *Id.* (citing *Golden Gate Rest. Ass’n*, 535 F. Supp. 2d at 978).

296. *Id.* at 1006–09.

297. *Id.*

that the Fourth Circuit would have rejected the Maryland law even if there had been another, more meaningful alternative.²⁹⁸ While the panel distinguished the Ordinance from the statute in *Egelhoff* because it did not “bind . . . plan administrators to a particular choice,”²⁹⁹ the dissent found that under *Egelhoff*, the provision of two methods of compliance did not negate the fact that the Ordinance nonetheless “structures employers’ choices with respect to their existing ERISA plans.”³⁰⁰ Finally, while the panel found the Ordinance distinguishable from the statute in *Greater Washington*, it did not find the distinction between contributions and benefits relevant to the preemption analysis. It was not enough that the employer-spending requirement refers to the amount of payments rather than the level of benefits provided by the ERISA plan to the employee.³⁰¹

In fact, the dissent could not even find common ground with the panel’s view of the congressional purpose underlying ERISA.³⁰² The panel concluded that Congress did not intend for ERISA to require “national uniformity in the provision of health care,” but the dissent reached the opposite conclusion:

[T]his case concerns an issue of exceptional national importance . . . national uniformity in the area of employer-provided healthcare The *Golden Gate* panel opinion ignores ERISA’s preemption goals and instead focuses on ERISA’s objective of protecting against misuse of benefit plan funds. While misuse was undoubtedly a concern . . . preemption was central to ERISA’s implementation.³⁰³

Judge William Fletcher concurred with the en banc denial, and responded to each of the dissent’s arguments by reaffirming the three-judge panel’s application of the “relate to” test and its analysis of the Fourth Circuit’s *Fielder* decision.³⁰⁴ He also rejected the dissent’s contention that ERISA carries with it a “mandate of national uniformity” for employer-provided health care.³⁰⁵ Rather, Judge Fletcher contended that Congress passed ERISA to ensure that the administrative practices of a benefit plan are “governed by only a single set of regulations.”³⁰⁶ Because “[n]othing in the Ordinance requires the employer to establish an ERISA plan or to alter an existing ERISA plan, and nothing in the Ordinance interferes in any way with the uniformity of ERISA regulations,” the Ordinance should not be preempted.³⁰⁷ In short, the majority and dissent disagree on almost every single aspect of the ERISA preemption analysis.³⁰⁸

298. *Id.* at 1006.

299. *Id.* at 1003.

300. *Id.* at 1007.

301. *Id.* at 1008.

302. *Id.* at 1009.

303. *Id.* at 1003, 1008–09.

304. *Id.* at 1002–04.

305. *Id.* at 1004.

306. *Id.*

307. *Id.*

308. Interestingly, the only common ground that they do find—that the City-payment

The foregoing demonstrates the level of complexity and uncertainty inherent in the ERISA preemption analysis. Indeed, circuit court judges and legal academics often reach contradictory conclusions on the most basic questions of ERISA jurisprudence. Thus, in the next section, we will discuss non-judicial options that exist for clarifying how the employer-spending requirement and ERISA interact. We think these options would most appropriately resolve the ambiguity and uncertainty central to ERISA preemption and state and local pay-or-play laws.

V.

THE BEST OPTION: AN IMMEDIATE STATUTORY OR REGULATORY SOLUTION

As evidenced above, the legal issues underlying ERISA preemption and pay-or-play laws like the San Francisco Ordinance are complex and have significant implications for multi-jurisdictional businesses, as well as for the cities and states that want to implement their own creative solutions to the health care crisis. Indeed, the Ninth Circuit's opinion is just one of the many cases comprising the substantial body of federal ERISA jurisprudence. This vast amalgamation of court cases makes one thing clear: there is a great deal of uncertainty involved in state and local experimentation with health care.³⁰⁹

Notwithstanding the fact that the Supreme Court declined to hear *GGRA*, we think that the overarching question of whether state and local governments should be allowed to pass pay-or-play laws should be addressed by the political branches. Therefore, in this Part we discuss how Congress or the Department of Labor could solve the ERISA preemption issue as it pertains to pay-or-play laws.

option does not create an ERISA “plan”—has been heavily criticized by at least one tax expert as a flagrant misreading of ERISA. Edward Zelinsky, *Golden Gate III: ERISA Preemption, and the San Francisco Health Care Security Ordinance 2* (Cardozo Sch. of Law, Jacob Burns Inst. for Advanced Legal Studies, Working Paper No. 261, 2009).

309. See California Div. of Labor Standards Enforcement v. Dillingham Constr., 519 U.S. 316, 334–35 (1997) (Scalia, J., concurring); see also Mary Ann Chirba-Martin, *ERISA Preemption of State “Pay or Play” Mandates: How PPACA Clouds An Already Confusing Picture*, 13 J. HEALTH CARE L. & POL’Y 393, 394 (2010) (“What warrants further consideration is why employer mandates have been so difficult to implement at the state level. Obviously, there are numerous reasons for this, with fears of employer exodus from a state, lower wages, higher prices and job losses among them. Beyond the economic factors, though, lies a significant legal obstacle: ERISA preemption of state law.”); Young, *supra* note 152, at 200 (“Of course, absent an amendment to ERISA, many state and local policymakers will continue to fear preemption and will face severe design constraints.”); Brietta Clark, *What the “Healthy San Francisco” Case Means for Local Health Reform*, HEALTH CARE JUSTICE BLOG (June 29, 2010), http://healthcarejusticeblog.org/2010/06/what_the_health.html (“Unfortunately, the case highlights the legal uncertainty facing states and local governments that want to craft local solutions to their health care crises. This uncertainty is unacceptable given the long history of ERISA being used to frustrate state and local reform efforts and the fact that this kind of local reform will probably still be needed even after federal health reform is implemented.”).

A. The Courts' Struggle with ERISA Preemption

In the *GGRA* case alone, the Ninth Circuit's three-judge panel disagreed with the district court's interpretation of ERISA, and seven Ninth Circuit judges then disagreed with the three-judge panel's interpretation on almost every legal finding. This disagreement is not confined to the judiciary; legal commentators and ERISA industry representatives have also criticized the Ninth Circuit's interpretation of ERISA.³¹⁰ In the realm of ERISA preemption jurisprudence, where the statute's complexity is as notorious as its ambiguity, there is very little agreement to be found.³¹¹

Even after years of wrestling with ERISA's confusing preemption language, the Supreme Court still struggles to provide states with guidance.³¹² There is ample evidence that Supreme Court justices are personally unsettled by the development of the Court's ERISA preemption jurisprudence. For example, in 1997, Justice Scalia wrote the following in a concurrence, joined by Justice Ginsburg:

Since ERISA was enacted in 1974, this Court has accepted certiorari in, and decided, no less than 14 cases to resolve conflicts in the Courts of Appeals regarding ERISA pre-emption of various sorts of state law. The rate of acceptance, moreover, has not diminished . . . suggesting that our prior decisions have not succeeded in bringing clarity to the law.³¹³

Proving Justice Scalia's point, there have been at least twenty cases before the Court regarding the narrow issue of whether an HMO law "relates to" an employee benefit plan—just one of a plethora of issues that ERISA preemption raises.³¹⁴

310. See, e.g., *Employer Mandates*, *supra* note 120 (arguing that the Ninth Circuit's opinion was wrongly decided); Press Release, ERISA Industry Committee, ERIC Urges Ninth Circuit to Overturn Panel Ruling that ERISA Does Not Preempt San Francisco Health Ordinance, (Oct. 1, 2008) (on file with author) (stating that the Ninth Circuit's opinion "rejected thirty years of settled law.").

311. Elaine G. Kenney, *For the Sake of Your Health: ERISA's Preemption Provisions, HMO Accountability, and Consumer Access to State Law Remedies*, 38 U.S.F. L. REV. 361, 365 (2004) (explaining that ERISA is "notorious for its complexity and ambiguity" and that misinterpretation has led the Court to harm the interests that it was purportedly created to protect).

312. Bogan, *supra* note 20, at 959 (2000).

313. See *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 334–35 (Scalia, J., concurring).

314. See, e.g., *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997); *Boggs v. Boggs*, 520 U.S. 833 (1997); *California Div. of Labor Standards Enforcement v. Dillingham Constr., Inc.*, 519 U.S. 316 (1997); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86 (1993); *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); *Massachusetts v. Morash*, 490 U.S. 107 (1989); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988); *Fort Halifax*

Even if the Court were to resolve the panoply of issues left unanswered by ERISA's preemption clause, we doubt whether the judiciary would be the appropriate branch to do so.³¹⁵ At its core, ERISA preemption is about federalism, and therefore, its scope should be determined by elected representatives rather than the judiciary.³¹⁶ It is the responsibility of Congress, not the courts, to provide a long-term solution to the uncertainty inherent in state and local pay-or-play laws.³¹⁷ The Court has already strongly deferred to congressional action in the area of ERISA, sending "an unmistakable signal that it does not view its mandate as alleviating market or legislative deficiencies."³¹⁸ However, given the political realities and policy challenges of crafting a long-term solution to ERISA preemption, we think that an administrative agency could provide the best immediate solution to the uncertainty plaguing state and local governments. With this in mind, we now discuss the ways that Congress and the Department of Labor could work in tandem to solve the ERISA preemption issue as it pertains to pay-or-play laws.

Packing Co. v. Coyne, 482 U.S. 1 (1987); Metro. Life Ins. Co. v. Taylor, 481 U.S. 58 (1987); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987); Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985); Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983); Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981). See also Pegram v. Herdrich, 530 U.S. 211 (2000); Varsity Corp. v. Howe, 516 U.S. 489 (1996); Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73 (1995); Mertens v. Hewitt Assocs., 508 U.S. 248 (1993); Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989); Brooks v. Burlington Indus., Inc., 477 U.S. 901 (1986) (mem.); Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985); Franchise Tax Bd. v. Constr. Laborers Vacation Trust for S. Cal., 463 U.S. 1 (1983); Nachman Corp. v. Pension Benefit Guar. Corp., 446 U.S. 359 (1980); Malone v. White Motor Corp., 435 U.S. 497 (1978); Holland v. Burlington Indus., Inc., 772 F.2d 1140 (4th Cir. 1985), *aff'd mem. sub nom.* Brooks v. Burlington Indus., Inc., 477 U.S. 901 (1986); Gilbert v. Burlington Indus., Inc., 765 F.2d 320 (2d Cir. 1985), *aff'd mem.*, 477 U.S. 901 (1986); Standard Oil Co. v. Agsalud, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981).

315. See Lily R. Robinton, *Courting Chaos: Conflicting Guidance from Courts Highlights the Need for Clearer Rules To Govern The Search and Seizure of Digital Evidence*, 12 YALE J. L. & TECH. 311, 342 (2010) ("Legislative action offers several advantages over the solutions implemented by courts. Legislatures are not limited by stare decisis, and thus have more flexibility to design new rules. While courts may stray from precedent when changed conditions and increased knowledge render existing rules unworkable, a court's influence may extend only as far as its jurisdiction. Legislatures can promulgate rules that span jurisdictions, thus facilitating consistent practices. An opinion issued by the Supreme Court could settle controversy across jurisdictions, but the Supreme Court may only address issues presented in the case before it. . . . Legislatures, on the other hand, do not need to wait until a problem presents itself. Legislatures can also effect changes much more quickly than many courts across many jurisdictions.").

316. Jacobson, *Opportunities and Limits*, *supra* note 61, at 96.

317. *Id.*; see also Catherine L. Fisk & Michael M. Oswalt, *Preemption and Civic Democracy in the Battle Over Walmart*, 92 MINN. L. REV. 1502, 1503, 1524 (2008) ("A federal court ruling that state or local law is preempted not only takes away the power of state and local government to address an issue, it takes away the power of grassroots organizers to engage in democracy's most fundamental behavior: to debate whether and how law should address a social problem and to see organizing efforts made into law. . . . Preemption's potential to abruptly obliterate months or even years of successful local political activism through a judicial rationale the average person would probably find perplexing may have real democratic reverberations. As we explain below, preemption both derails democracy and deforms democracy.").

318. Jacobson, *Opportunities and Limits*, *supra* note 61, at 96.

B. A Congressional Solution

The most appropriate long-term solution to the current state of confusion surrounding ERISA's preemption clause is for Congress to legislate a clear and unambiguous response to the issues raised by the *GGRA* lawsuit.³¹⁹ A variety of solutions have been proposed, ranging from revising ERISA's statutory provisions to creating a new federal commission to which states could submit their proposed health care statutes for permission to proceed.³²⁰ However, we think the most effective approach is to modify directly ERISA's preemption clause to give states and localities substantial freedom to experiment with pay-or-play laws. This would prevent state and local governments from being the targets of ERISA preemption litigation, without adding a bureaucratic barrier in the form of a federal commission. Here, we will briefly discuss two possibilities: Congress might consider abolishing ERISA's preemption provision, Section 514(a); or in the alternative, it might amend Section 514(a) to distinguish between pension plans and welfare benefit plans, and then exempt the latter plans from federal preemption.³²¹

1. Option One: Abolishing ERISA's Preemption Provision

The first option, removing Section 514(a) in its entirety, would result in the resolution of questions of ERISA preemption solely through the judicial application of already existing field and conflict preemption doctrine.³²² This means "the Courts would be asked to determine if there were actual conflicts between ERISA's requirements and a state or local pay or play law (conflict preemption), or alternatively if the law wandered too far into an area that Congress intended to occupy (field preemption)."³²³ As a result, the "connection with" and "reference to" inquiries would no longer apply, and the related sub-tests discussed in *GGRA* would become obsolete.

This approach finds support in a concurrence written by Justice Scalia and joined by Justice Ginsburg in *Dillingham*, in which they urged the Court to achieve a de facto abolition of the preemption provision by applying a more narrow interpretation of the phrase "relate to."³²⁴

[I]t would greatly assist our function of clarifying the law if we simply acknowledged that . . . the "relate to" clause of the pre-emption provision is meant, not to set forth a test for pre-emption, but rather to

319. See Robinton, *supra* note 315, at 342.

320. *Id.*; see, e.g., The Health Partnership Act, S. 2772, 109th Cong. (2d Sess. 2006); Zelinsky, *Massachusetts*, *supra* note 83, at 96–97.

321. See Young, *supra* note 152, at 222–24.

322. See *id.* at 223.

323. *Id.* at 222.

324. See *id.*

identify the field in which ordinary field pre-emption applies—namely, the field of laws regulating “employee benefit plan[s].”³²⁵

Legislation reflecting this policy choice would allow local governments to promulgate pay-or-play laws without concern about preemption, but might also create uncertainty in other areas of ERISA by inviting the judiciary to apply its unpredictable preemption doctrines, as well as potentially threatening national administrative uniformity.³²⁶

2. Option Two: Exempt Welfare Benefit Plans From Preemption

To avoid the problems that could result from entirely abolishing ERISA’s preemption provision, Congress might alternatively pass a more narrow amendment that revises Section 514(a) to distinguish between pension plans and welfare benefit plans, and then exempt welfare benefit plans from preemption.³²⁷ Earlier, we discussed how Congress intended ERISA to create uniform national standards to “safeguard employees from the abuse and mismanagement” of pension plans. Welfare benefit plans, such as health and life insurance, were not the primary concern of the Congress that passed ERISA, and as the Court explained in *Travelers*, “nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern.”³²⁸

From a policy perspective, there is a compelling rationale for differentiating between pension plans and welfare benefit plans when considering federal preemption. Pension plans are long-term benefits: they provide income to retirees long after their employment ends and “require a complex set of rules governing how benefits accrue and vest over the course of an employee’s career.”³²⁹ Conversely, welfare benefit plans such as health insurance and life insurance generally provide short-term benefits, posing less

325. *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 336 (1997) (Scalia, J., concurring) (emphasis removed).

326. *Young*, *supra* note 152, at 223 (“In a labor market that is increasingly freed from geographic limitations, the administrative costs of complying with myriad state and local laws (reaching well beyond health benefits) could be tremendous. Field preemption principles would provide some limit to state regulation, especially within a statute that clearly evinces the need for administrative simplicity, but there would undoubtedly be tremendous uncertainty. For instance, states would obviously be barred from regulating appeals from pension denials, since there is a large body of ERISA law on the subject, but appeals related to health insurance denial would be in uncertain waters.”).

327. *Id.* at 224.

328. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645, 661 (1995). *See also* *Rutledge v. Seyfarth*, 201 F.3d 1212, 1217 (9th Cir. 2000). Additionally, a judge on the Third Circuit argues that because ERISA did not provide any federal substitute for the welfare benefit plans, it is unlikely that Congress actually intended for ERISA to entirely displace state and local regulation of such plans. *See DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 467 (3d Cir. 2003) (Becker, J., concurring).

329. *Young*, *supra* note 152, at 224.

of a threat to employers if there is some level of disuniformity.³³⁰ One health policy analyst provides the following hypothetical, which effectively differentiates the underlying concerns of pension and welfare benefit plans:

Imagine an employee who begins a twenty-year career with a single employer in Ohio, spends fifteen years working in Michigan, and transfers to Florida eighteen months before retirement. When this employee retires, disparate pension regulations in Ohio, Michigan, and Florida could cause profound uncertainty and conflict over the terms of his pension benefits, creating a strong imperative for federal preemption. However, when the employee seeks an annual physical under his employer-sponsored health insurance in Ohio, Michigan, or Florida, there is no conflict. His health benefits are only subject to the regulations of one state at a time, and his transfer out of Michigan terminates any effect that Michigan law might have on his coverage.³³¹

Therefore, after considering ERISA's legislative history in its totality, as well as the different policy concerns underlying pension and welfare benefit plans, exempting welfare benefit plans from ERISA's preemption clause would present a more finely tailored solution to the problems facing cities like San Francisco.

However, amending the ERISA preemption provision is only one of many possible routes that Congress might pursue to facilitate state and local experimentation with pay-or-play laws and health care reform. But regardless of how Congress chooses to craft a solution, legislation would clearly be the most effective long-term remedy to the current confusion.³³² Moreover, an amendment of this type, passed with the express purpose of allowing state and local experimentation with health care reform, would likely result in Supreme Court deference based on the rationale that Congress is the branch best suited to craft comprehensive ERISA reform.

Despite the fact that congressional legislation would be the best solution, due to the current political climate and the vested political interests at stake, Congress is the least likely branch to provide the necessary clarification in an expedient manner. Therefore, we must look to the executive branch and the Department of Labor for an immediate administrative solution.

C. An Administrative Agency Solution

Administrative agencies frequently issue regulations interpreting and defining ambiguous terms in the statutes they administer.³³³ The Department of

330. *Id.*

331. *Id.* at 225.

332. *See* Robinton, *supra* note 315, at 342.

333. *Chevron v. Natural Res. Def. Council*, 467 U.S. 837, 843–44 (1984) (“If Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation. . . . Sometimes the legislative delegation to an agency on a particular question is implicit rather than explicit.”).

Labor (“DOL”) is the administrative agency in charge of administering ERISA.³³⁴ The regulations that the DOL issues under ERISA span a wide range of subject matters, including reporting and disclosure requirements,³³⁵ fiduciary responsibility,³³⁶ and procedural regulations.³³⁷ In so doing, the DOL sets forth rules, regulations, and interpretive bulletins that help clarify ERISA’s provisions and guide employers seeking to adhere to them.³³⁸ The Secretary of Labor (“Secretary”) has expansive authority to prescribe regulations “necessary or appropriate” to implement the provisions of Title I of ERISA.³³⁹ This authority includes the power to issue regulations defining what constitutes a “plan” under Title I.³⁴⁰ A reasonable interpretation of the term “plan” is entitled to *Chevron* deference.³⁴¹ Thus, should the Secretary promulgate a regulation clarifying whether and when employers’ coverage under local pay-or-play laws creates ERISA plans, that regulation would be entitled to *Chevron* deference and would therefore alter the preemption analysis.

Accordingly, to provide clarification on the preemption provision’s relationship to state and local health care reform initiatives, the DOL might consider using its power to issue interpretive regulations. The DOL can ensure that the Ordinance and other similar pay-or-play laws can survive without preemption challenges under ERISA in two different ways.

334. See 29 C.F.R. §§ 2509–90 (2009).

335. § 2520.

336. § 2550.

337. § 2570.

338. *Id.*

339. 29 U.S.C. § 1135 (2006).

340. See *Massachusetts v. Morash*, 490 U.S. 107, 116–17 (1989).

341. See *id.* at 116. *Chevron* deference requires courts to apply a two-step process for reviewing an agency’s interpretation of a statute:

First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency’s answer is based on a permissible construction of the statute.

Chevron, 467 U.S. at 842–43 (1984). Further, *National Cable & Telecommunications Ass’n v. Brand X Internet Services* explains that “[i]f a statute is ambiguous, and if the implementing agency’s construction is reasonable, *Chevron* requires a federal court to accept the agency’s construction of the statute, even if the agency’s reading differs from what the court believes is the best statutory interpretation.” 545 U.S. 967, 980 (2005); see also *United States v. Mead Corp.*, 533 U.S. 218, 226–27 (2001) (explaining that “administrative implementation of a . . . provision qualifies for *Chevron* deference when . . . Congress delegated authority to the agency,” such as through “an agency’s power to engage in adjudication or . . . rulemaking,” and “the agency interpretation claiming deference was promulgated in the exercise of that authority”).

1. Option One: Clarify Definitions of Terms Used

The first option, which the DOL has already proposed, is to amend existing regulations to clarify the definitions of the terms “employee welfare benefit plan” and “welfare plan,” and to identify certain practices that do not implicate those plans for the purposes of ERISA preemption.³⁴² On February 22, 2010, the DOL filed a notice with the Office of Management and Budget explaining that the purpose of the proposed regulation was to make state and local governments aware of whether their attempts at health care reform efforts could be thwarted by ERISA preemption challenges.³⁴³

Questions have been raised regarding the extent to which health care reform efforts on the part of state and local governments result in the creation of ERISA-covered employee welfare benefit plans or otherwise implicate ERISA. This regulation is needed to provide certainty to both governmental bodies and employers concerning the application of ERISA to such efforts.³⁴⁴

Under the amended regulation, the DOL would have delineated which practices do and do not fall under the category of employee welfare benefit plans.³⁴⁵ In particular, Section (a)(2) of the proposed regulation stated that employee welfare benefit plans include plans providing “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, or day care centers, scholarship funds, or prepaid legal

342. 29 C.F.R. § 2510.3-1 (2009).

343. Health Care Arrangements Established by State and Local Governments for Non-Governmental Employees, 74 Fed. Reg. 64,275 (proposed Dec. 7, 2009) (to be codified at 29 C.F.R. 2510.3-1).

344. *Id.*

345. Unfortunately, however, the Department of Labor decided not to proceed with its proposed regulation due to the recent passage of comprehensive federal health care legislation. Specifically, as the Solicitor General explained in its Amicus Brief to the Supreme Court in *GGRA*:

[T]he federal legislation has significantly changed the legal landscape governing health care spending requirements. In particular, the legislation includes provisions designed to encourage the provision and availability of health insurance that reduce substantially the likelihood that state and local governments will choose to enact new employer spending requirements like those contained in San Francisco’s HCSO. The federal legislation therefore significantly reduces the importance of the question whether and when such requirements are preempted by ERISA.

Brief for the United States as Amicus Curiae, *Golden Gate Rest. Ass’n v. City & Cnty. of San Francisco*, 546 F.3d 639 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010) (No. 08-1515), at 13. As discussed in Part II.B, this strategic decision is clearly mistaken. While the federal health care legislation may “significantly reduce” the importance of answering this question, it does not obviate it. Cities like San Francisco still retain a strong financial and moral interest in providing health care to their residents in the interim period until the bill’s largest provisions are implemented. Further, there will still be thousands of people left uninsured after full implementation, and cities may want to provide something other than the costly and inefficient emergency room care that would be the only option for the uninsured. *See supra* text accompanying notes 140–151.

services.”³⁴⁶ Section (a)(4) then excluded a variety of practices from being considered employee welfare benefit plans, including certain payroll practices, holiday gifts, remembrance funds, strike funds, and industry advancement programs.³⁴⁷ Under this regulation, state pay-or-play laws, including the San Francisco Ordinance, would not have been classified as employee welfare benefit plans, and thus, would not have been preempted by ERISA.

2. *Option Two: Clearly Interpret ERISA’s Savings Clause*

Alternatively, instead of issuing a regulation defining “employee benefit plan,” the DOL could accomplish the goal of enabling state and local pay-or-play laws by promulgating a regulation interpreting ERISA’s Savings Clause to specify how far states could proceed with health care reform before implicating ERISA preemption.³⁴⁸ The health antitrust guidelines issued by both the Department of Justice and Federal Trade Commission take a similar approach.³⁴⁹ Since the focal point of pay-or-play lawsuits has been whether employer compliance options create a conflict with ERISA and as a result are preempted, “[i]t would be an appropriate regulatory interpretation for DOL to outline valid state options that would be saved from preemption.”³⁵⁰ In its regulation, the DOL could adopt the line of reasoning in the *Travelers* case that distinguished laws that have a “direct” effect on ERISA plans and are preempted, from those that have an “indirect” effect and are saved.³⁵¹ Following the Ninth Circuit’s reasoning in *GGRA*, the regulation’s examples of laws having an “indirect” effect on ERISA plans could include pay-or-play laws, which would thereby save the Ordinance from preemption.³⁵²

Both potential regulations would weaken the current force of ERISA’s preemption clause and make ERISA preemption lawsuits against pay-or-play laws like the Ordinance moot. Although the regulations would inevitably face legal challenges by the health insurance industry and by large employers, such lawsuits would likely be unsuccessful. Courts give agency interpretations of the statutes they administer great deference, overruling an interpretation only if it is deemed an impermissible reading of the ambiguous statutory term at issue.³⁵³ As discussed above, both the phrase “employee benefit plan” and the Savings Clause are ambiguous, causing confusion for plaintiffs, defendants, and judges

346. 74 Fed. Reg. 64,275, *supra* note 343.

347. § 2510.3-1(a)(4).

348. Jacobson, *Opportunities and Limits*, *supra* note 61, at 96.

349. *Id.* at 97.

350. *Id.*

351. *Id.*

352. *Golden Gate Rest. Ass’n v. City & Cnty. of San Francisco*, 546 F.3d 639, 656 (9th Cir. 2008), *cert. denied*, 130 S. Ct. 3497 (2010) (noting that “the influence exerted by the Ordinance is even less direct than the influence in *Travelers*.”).

353. *Chevron v. Natural Res. Def. Council*, 467 U.S. 837, 843 (1984) (“[I]f the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency’s answer is based on a permissible construction of the statute.”).

alike. For that reason, it is likely courts would defer to either of these proposed DOL regulations, and uphold them as permissible statutory interpretations.³⁵⁴ Thus, while congressional legislation is important in the long term, administrative agencies may provide the clearest short-term answers.

CONCLUSION

In the face of a national health care crisis, the City and County of San Francisco combined ingenuity, technical expertise, and a sensitivity to the needs of the City's uninsured residents to provide a groundbreaking solution: the Health Care Security Ordinance. The impact that the Ordinance has had on the City has been overwhelmingly positive, providing superior care to over 50,000 uninsured residents, saving the taxpayers money, and leveling the economic playing field so that employers can support the health of their employees without suffering a competitive disadvantage as a result.

However, such innovative solutions are threatened by the specter of ERISA preemption because the Court's ERISA preemption jurisprudence is as convoluted as it is complex. As the Ninth Circuit's *GGRA* opinion demonstrates, there is little certainty to be found for state and local laws that begin to touch ERISA's provisions. Furthermore, the relationship between ERISA preemption and pay-or-play laws like the Ordinance should be one of policy, not of case law. Thus, we think that a political response is a more appropriate solution to this question than a preemption-based judicial remedy. In this article, we have discussed possible routes that Congress and the DOL might consider pursuing. But if there is any lesson to be learned from the San Francisco Ordinance, it is that local laboratories of experimentation can provide unique and effective results. Even with the implementation of federal health care reform, cities nationwide will likely still struggle with their remaining uninsured populations. Therefore, regardless of approach, we urge the DOL to act soon to provide short-term relief for San Francisco and other cities, with the hope that Congress could begin crafting a viable, long-term solution to solve the conflict between ERISA preemption and state and local health care reform.

354. *Id.* at 843 n.11 (“The court need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the construction, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding.”).