INTRODUCTION

While Congress, presidential candidates, and pundits continue to debate health care reform in the United States, local and state governments have moved to expand health care access on their own. Common to these initiatives are “pay or play” provisions that compel employers to choose between providing health care for their employees, typically by offering health insurance plans, or paying a fee in support of government-provided health care for the uninsured. Despite these innovative efforts to keep ahead of the slow pace of national reform, state measures have been held back by a federal law requiring uniform national regulation of employee benefit plans. But a recent San Fran-
Cisco ordinance, the first ever initiative by a municipal government to provide universal health care, may become the first “pay or play” plan to survive federal preemption challenges. If it succeeds, the San Francisco plan should serve as a model for other cities and states seeking to bring about more rapid health care reform.

I. LEGISLATIVE PURPOSE AND HISTORY

The San Francisco Board of Supervisors passed the San Francisco Health Care Security Ordinance unanimously on July 25, 2006. The statute launched a program to provide universal health care access to all adults who live or work in San Francisco, regardless of employment status, immigration status, or pre-existing medical conditions.

The city’s motivation was twofold. First, it regarded universal access to care for the estimated 73,000 uninsured city residents as “morally incumbent” upon the government. Second, by emphasizing access to preventive care, the city also sought to reduce the “burden on San Francisco taxpayers for providing health care for the uninsured” by promoting earlier, more cost-effective medical attention. Currently, many uninsured who cannot afford to seek help sooner wait until their conditions are more serious—and therefore more costly—to seek attention in public hospital emergency rooms, which are required by federal law to treat critical conditions regardless of patients’ ability to pay. San Francisco estimates the annual cost of providing “unnecessarily expensive” emergency and other health care to the city’s uninsured to be $104 million.


4. Id.


7. S.F., Cal., Ordinance 218-06, § 1 (“Declaration of legislative findings and intent”).


9. S.F., Cal., Ordinance 218-06, § 1 (“Declaration of legislative findings and intent”);
Nearly two years earlier, California voters had defeated Proposition 72, a statewide “pay or play” initiative. San Francisco voters, however, had supported the proposition with sixty-nine percent approval. Seeking to capitalize on this strong local support, Mayor Gavin Newsom and Supervisor Tom Ammiano proposed municipal universal health care programs of their own in early 2005.

The ordinance originated as two separate proposed programs: (1) Supervisor Ammiano’s “employer spending requirement” and (2) Mayor Newsom’s Health Access Plan. Ammiano’s proposal mirrored the failed California initiative by adopting a “pay or play” approach. Recent city surveys had shown that most employers wanted to provide health benefits but feared being put at a competitive disadvantage by doing so. Citing these surveys, Ammiano sought to level the playing field by making such expenditures mandatory. The program’s scope, however, was limited to uninsured employees, not universal coverage of all adults.

The mayor’s Health Access Plan, on the other hand, sought universal coverage for all uninsured adults in the city. Originally, however, it did not mandate employer contributions. Rather, it emphasized the “voluntary nature” of the plan, relying on elective contributions from employers to support the plan along with city funds. The proposal noted that “success will depend upon attracting individuals and perhaps their employers who believe that access to comprehensive health services is valuable.” This “voluntary” approach reflected the presence of the San Francisco Chamber of Commerce and small business associations in a working group assembled by the mayor to craft the plan.

Defendant’s Motion for Summary Judgment at 1, Golden Gate Rest. Ass’n v. City & County of San Francisco (GGRA I), No. C06-6997 JSW (N.D. Cal. Dec. 26, 2007) (citing the declaration of the Director of the San Francisco Department of Public Health).


11. Id.

12. Id.


14. Id.


17. Id. at 8.

18. Id.

19. See Press Release, City and County of San Francisco Office of the Mayor, Mayor
In July 2006, the city’s influential head of the Department of Public Health, Dr. Mitchell Katz, encouraged the Board of Supervisors’ Budget and Finance Committee to merge the two plans, noting that Ammiano’s employer spending requirement would be necessary for the Mayor’s more expansive coverage plan to succeed.20 Ultimately, the Board of Supervisors and the Mayor accepted a unified plan that mandated employer spending.21 The compromise was reached despite the objections of city business associations, who quickly signaled that a lawsuit would follow.22

The final version of the ordinance both launched the “San Francisco Health Access Program” (HAP) and provided for the enforcement of required employer health care expenditures.23 The HAP provision outlines a new social service program that is innovative in its design. Because the HAP provision does not directly address funding, however, it has not generated the controversy sparked by the second, “pay or play” provision. These two components—the successors of Newsom’s and Ammiano’s original proposals—will be examined in turn.

II. THE ORDINANCE’S TWIN PROGRAMS

A. The Health Access Program

Without actually creating a new insurance plan or managed care organization, the HAP provides many of the benefits of managed care to San Francisco’s uninsured residents and workers. It accomplishes this through five frugal and creative structural features.

First, the HAP links existing community clinics and the county hospital into a provider “network” that serves program participants.24 This integration allows for easier access to the most critical services of a traditional managed care plan, such as preventive, primary, hospital, emergency, and prescription...
drug care. 25 By limiting HAP services to this network of providers, the program is also able to contain costs. Unlike traditional insurance, HAP coverage does not travel with participants; services rendered by providers outside the established network in San Francisco are not covered. 26 As a result, the HAP’s administrative costs should be significantly lower than those of a typical health plan, due in part to avoiding costs that insurers would incur such as out-of-network claim processing and high reimbursement rates to out-of-network providers. 27

Second, HAP administration is delegated to the Department of Public Health, rather than to a newly created bureaucracy, thus leveraging existing staff and resources as much as possible to avoid unnecessary administrative costs. The ordinance leaves most implementation details, such as identifying additional providers for the network and defining specific medical services to be covered, to the Department. 28

Third, the program adopts the “Medical Home” model, which assigns a primary care provider, such as a physician or nurse practitioner, to each program participant to facilitate their timely and coordinated medical care. 29 From a patient’s perspective, this model represents an industry best practice. Patients benefit from a single point of entry into the health care system, as well as the comfort and continuity of a relationship with a primary care provider. 30 From a systemic perspective, emphasizing primary care and preventive services is widely recognized as producing fewer hospitalizations, improved health outcomes, and lower health care costs. 31

Fourth, by limiting coverage to core services provided within the designated network, the HAP deliberately positions itself as an inferior substitute for true health insurance—though a substitute that is superior to no coverage at all. 32 As a result, it aims to attract the unserved segment of the health care mar-

25. Id. § 14.2(f). The program is not intended to be a comprehensive medical plan, though; vision care, dental care, fertility services, and elective cosmetic services, for example, are not covered.
26. FINAL REPORT TO MAYOR, supra note 16, at 8.
27. See Katz, supra note 6, at 328.
29. Id. § 14.2(c).
32. See, e.g., S.F., CAL., ADMIN. CODE § 14.2(a) (2008) (“The [HAP] is not an insurance plan for [HAP] participants.”); HEALTHY SAN FRANCISCO, PARTICIPANT HANDBOOK 5 (2007) (“The program is not health insurance . . . . So if you have health insurance, do not drop it. Insurance is always the better choice.”).
Fifth, the HAP is carefully designed to supplement, not replace, existing state and federal health services. By providing universal health care access, not universal health care insurance, the HAP does not de-qualify program participants from receiving federal and state benefits that are available only for the uninsured (e.g., subsidized antiretroviral medications for HIV/AIDS patients). Moreover, HAP participants are still counted in the city’s uninsured population, so the city continues to receive approximately $44 million in state and federal funding for caring for this group. These funds are now used to directly subsidize the HAP.

Additional funding for the HAP comes from existing city funds designated for the uninsured, program participant fees, and employer contributions. In 2007, the city budget provided $123 million for care for the uninsured; moving forward, these funds are being redirected to the HAP. Participants themselves are required to pay quarterly participation fees, set on a sliding scale according to household income, as well as point-of-service fees for each service received. Finally, the HAP budget is topped off by contributions from employers who opt to “pay” the city, rather than “play,” to satisfy their employer spending requirement.

B. The Employer Spending Requirement

The second component of the ordinance mandates that “covered employers . . . make required health care expenditures to or on behalf of their covered employees each quarter.” The amount of “required health care expenditures” is a function of the hours for which a covered employee is entitled to be paid “for work performed within the City.” As of January 2008, businesses with over one hundred employees must spend $1.76 per hour per employee, and

33. Katz, supra note 6, at 328.
34. Id.
35. Id.
36. Healthy San Francisco, Healthy San Francisco Regulations: Proposed Program Fee Structure (July 17, 2007) (unpublished chart available at http://www.sfdph.org/dph/files/htlthySFdocs/HlthySFFeeSched4HCAAdoption07172007.pdf). Quarterly fees range from $0 (for households at or below the federal poverty level) to $675 (for households earning at least five times the federal poverty level).
37. S.F., CAL., ADMIN. CODE § 14.3(a) (2008). “Covered employers” are for-profit companies employing an average of at least twenty employees per week in San Francisco, and non-profit organizations employing an average of at least fifty employees per week in the city; small businesses and smaller nonprofit organizations are exempt. “Covered employees” are those working within San Francisco for a minimum number of hours per week who qualify for payment of the San Francisco minimum wage under the city’s Minimum Wage Ordinance. Not covered, however, are “managerial, supervisory, or confidential employees,” so long as they make a minimum salary. See id. §§ 14.1(b)(8, 10). Only employees who have been employed for at least ninety calendar days are counted in this calculation. See id. § 14.3(a).
those with twenty to ninety-nine employees must spend $1.17.39

While the ordinance sets the minimum health care expenditure requirement, it is careful to avoid mandating how those funds are spent. It is entirely at the employer’s discretion whether it chooses to pay the required amount directly to the employee for the purpose of acquiring health care services, to buy health insurance on behalf of the employee, or to make payments “to the City to . . . fund the Health Access Program.”40 As a result, HAP program funding may be low if employers choose to buy insurance rather than make payments to the city; the number of uninsured requiring HAP support, of course, would be lower as well. However employers choose to discharge their expenditure duty, they are required to report their payments to the city’s Office of Labor Standards Enforcement, which is empowered to impose penalties on employers who fail to meet the required payment levels.41

III. ERISA Preemption

A. Background

The ordinance’s deliberate effort to leave employers this discretion suggests a clear attempt to avoid running afoul of the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that blocked a Maryland “pay or play” statute in 2006.42 ERISA was enacted to “protect . . . participants in employee benefit plans and their beneficiaries,” whom Congress found had been harmed by the mismanagement of benefit plans.43 Congress’s remedy was to install a complex federal regulatory scheme for employee pension and welfare plans, including health insurance. Given the new regulatory burden it was imposing, Congress was concerned that any additional burden “of conflicting

40. S.F., CAL., ADMIN. CODE § 14.1(b)(7) (2008). Employers have five options to satisfy their requirement. They may (1) make contributions on behalf of employees to a health savings account, (2) reimburse employees directly for expenses incurred in obtaining health care services, (3) pay a third party (e.g., insurer) to provide health care for employees, (4) incur costs directly by providing health care services to employees, or (5) make payments to the city to be used on behalf of uninsured employees.
41. Id. §§ 14.3(a)-(b), 14.4(e).
42. 29 U.S.C. §§ 1001-1461 (2006); Retail Indus. Leaders Ass’n v. Fielder, 475 F.3d 180 (4th Cir. 2007).
43. 29 U.S.C. § 1001(a)-(b). Congress found, for example, “that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in [benefit] plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered . . . .” Id. § 1001(a).
or inconsistent State and local regulation of employee benefit plans" would cause employers simply to discontinue offering any benefits at all, rather than struggle to cope with patchwork regulation.44

To avoid this result, ERISA includes a preemption clause that is “conspicuous for its breadth.”45 Section 514(a) establishes that ERISA shall “supercede any and all State laws insofar as they now or hereafter relate to any employee benefits plan.”46

Much litigation has sought to define precisely where the outer limits of “relate to” lie, to little avail.47 A state law forbidding discrimination in employee benefit plans on the basis of pregnancy is preempted by ERISA48; a state tax on a hospital run by an insurance plan is not.49 The Second Circuit has called the “relate to” provision a “veritable Sargasso Sea of obfuscation,”50 and the Ninth Circuit has noted that a precise definition “has bedeviled the Supreme Court.”51

Litigation over the Maryland “pay or play” statute was already well underway as the San Francisco ordinance was being drafted, so the city at least suspected that by mandating health care expenditures it was treading close to an ill-defined line.52 Moreover, just eight years earlier, the San Francisco Domes-

47. Note that ERISA preemption case law is considerably more expansive and nuanced than can be covered by the scope of this Note. For greater detail, see, e.g., Zelinsky, supra note 2; Amy B. Monahan, Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts, 55 U. KAN. L. REV. 1203, 1206-10 (2007). Briefly, the controlling definiton from Shaw is that a “law ‘relates to’ an employee benefit plan . . . if it has a connection with or reference to such a plan.” Shaw, 463 U.S. at 97-98. The terms “reference to” and “connection with” have not proved to be more clear than “relate to,” though these two prongs of the Shaw test have each developed their own lines of case law. While the courts evaluating the Health Care Security Ordinance wrestled with these standards, this Note simply distills the doctrinal question to its core, as reflected in the Ninth Circuit’s “simplified test,” infra note 56: Does the ordinance, directly or indirectly, regulate employers’ benefit plans?
48. See Shaw, 463 U.S. at 97 (holding that the law “relates to” an ERISA plan because it “prohibits employers from structuring their employee benefit plans in a [particular] manner”).
49. See De Buono v. NYSA-ILA Med. & Clinical Serv. Fund, 520 U.S. 806, 815 (1997) (holding that the law does not “relate to” an ERISA plan because “[this is not] a case in which the existence of a pension plan is a critical element of a state-law cause of action, or one in which the state statute contains provisions that expressly refer to ERISA or ERISA plans”).
51. Golden Gate Rest. Ass’n v. City & County of San Francisco (GGRA I), No. C 06-06997 JSW, 2007 WL 4570521, at *3 (N.D. Cal. Dec. 26, 2007) (quoting Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson, 201 F.3d 1212, 1216 (9th Cir. 2000)).
52. See Retail Indus. Leaders Ass’n v. Fielder, 435 F.Supp.2d 481 (D. Md. 2006), aff’d 475 F.3d 180 (4th Cir. 2007).
tic Partner Ordinance, another first-of-its-kind local law, was held preempted by ERISA.53 Because it required employers to provide the same benefits to both same-sex and opposite-sex partners, the ordinance “directly interfere[d] with ERISA’s goal of shielding employee benefit plans from inconsistent State and local regulation.”54

The health care plan incorporated lessons learned from this earlier run-in with preemption. Unlike the Domestic Partner Ordinance, the Health Care Security Ordinance attempted to avoid interfering with ERISA-controlled employee benefit plans, such as health insurance. Employers who were already purchasing insurance for their employees could continue to do so without modification. Those who were not already buying insurance would face no obligation to start under the ordinance; instead, they could opt to satisfy their expenditure requirement by paying into the city fund for the HAP. In the hope of circumventing ERISA, the city sought to regulate only the amount employers spend on health care, not benefit plans themselves.55

The city likely expected the ordinance to pass a “simplified” test for ERISA preemption posed by the Ninth Circuit: “Is the state telling employers how to write their ERISA plans, or conditioning some requirement on how they write their ERISA plans? Or is it telling them that regardless of how they write their ERISA plans, they must do something else outside and independent of the ERISA plans? If the latter . . . there is no preemption.”56 To fit within the latter category, the city created a requirement that employers spend a minimum amount on health care, regardless of how they write their insurance plans—indeed, regardless of whether they even have ERISA-controlled benefit plans.

Additionally, in WSB Electric, Inc. v. Curry,57 the Ninth Circuit upheld a California minimum wage statute that permitted employers to include the value of benefits provided to employees in calculating the “wage” they paid. The court noted that while statute enforcement “is measured by reference to employers’ fringe benefit costs . . . each individual employer’s obligation to pay the prevailing wage does not depend on the existence or operation of that employer’s ERISA plans.”58 That is, the existence of an insurance plan would affect the amount of wage remaining to be paid for an employer to meet the statutory minimum wage, but an employer could satisfy this minimum wage without providing any of it through benefits, so there is no preemption. It would seem

55. See S.F., CAL., ADMIN. CODE § 14.1(h)(7) (2008) (providing a non-exhaustive list of methods by which an employer can spend the required amount on employee health care).
56. Employee Staffing Serv., Inc. v. Aubry, 20 F.3d 1038, 1041 (9th Cir. 1994).
57. 88 F.3d 788 (9th Cir. 1996).
58. Id. at 794.
to be no accident, then, that the ordinance defines “covered employees” as those already eligible for the city’s minimum wage. By positioning the employer spending requirement as a form of minimum wage mandate, the city sought to place the requirement within the traditional police powers of the state, rather than within the preempted zone of benefit plan regulation.

B. The Golden Gate Restaurant Association Legal Challenge

The city’s meticulous effort to draft the ordinance just outside ERISA’s zone of preemption made a challenge to the employer spending requirement inevitable. In November 2006, three months after the ordinance became law, the Golden Gate Restaurant Association brought suit in federal court seeking an injunction to prohibit the city from enforcing the ordinance’s sanctions.

The court struck down the expenditure requirement in December 2007. Adopting a broad reading of ERISA’s preemptive scope, the court held that “[t]he Ordinance’s health care expenditure requirements are preempted because they have an impermissible connection with employee welfare benefit plans. By mandating employee health benefit structures and administration, those requirements interfere with . . . ensuring uniform national regulation of such coverage.” The court distinguished WSB, noting that WSB concerned the “calculation of wages,” as opposed to calculations of “benefits [of] the type already regulated by ERISA, [the analysis of which] would alter the administration of existing private ERISA plans.”

Two weeks later, however, the Ninth Circuit found a “strong likelihood” that the city would succeed on appeal and so granted a stay of the judgment of the District Court pending appeal. Because the ordinance “does not require any employer to adopt an ERISA plan . . . [n]or does it require any employer to provide specific benefits through an existing ERISA . . . plan,” the court held that the expenditure requirement is “conceptually similar” to the WSB minimum wage statute and therefore highly unlikely to be preempted. This stay allowed the employer spending requirement to go into effect nearly on-schedule in January 2008.

59. S.F., CAL., ADMIN. CODE § 14.1(b)(2) (2008) (defining a covered employee as “any person who works in the City where such person qualifies as an employee entitled to the payment of a minimum wage from an employer under the Minimum Wage Ordinance as provided under Chapter 12R of the San Francisco Administrative Code . . . ”). 60. Complaint at 9, Golden Gate Rest. Ass’n v. City & County of San Francisco (GGRA I), No. C06-6997 JSW (N.D. Cal. Dec. 26, 2007). 61. GGRA I, 2007 WL 4570521, at *1. 62. Id. at *6. 63. Id. at *10. 64. Golden Gate Rest. Ass’n v. City & County of San Francisco (GGRA II), 512 F.3d 1112, 1119 (9th Cir. 2008). Oral argument on appeal was heard on April 17, 2008. As of the date this Article went to press, the Ninth Circuit had not yet issued its opinion on the merits. 65. Id. at 1121, 1124.
C. Discussion

As a matter of both ERISA law and public policy, the Ninth Circuit’s reasoning is more sensible. Yet the consequences of upholding the ordinance—namely, introducing patchwork local regulation—may nonetheless be at odds with Congress’s purpose in enacting ERISA.

The District Court made two errors in its analysis of the ordinance. First, in holding that the employer spending requirement interfered with “employer autonomy over whether and how to provide employee health coverage,” the court misapplied ERISA precedent.66 While ERISA would preempt a local law mandating that employers buy health insurance, which is a specific benefit regulated by ERISA, nothing in ERISA or its subsequent case law grants employers autonomy over whether to make general payments for health care.67

This distinction hinges on whether the expenditure requirement is more like a minimum wage requirement or a benefit plan regulation. Under their traditional police powers, states are free to mandate local minimum wages, even though employers must then pay non-uniform wages across the country. If the expenditure requirement is a species of minimum wage, then employers have no autonomy over whether to pay, and ERISA provides no immunity from local minimum payment requirements that happen to be for health care. On the other hand, if the expenditure requirement is merely a surreptitious mandate to provide health insurance, then it is preempted because it concerns a specific type of benefit plan.68

In addressing this question, the District Court made its second error. The court relied extensively on Fielder, the case overruling the Maryland law, which held the “pay or play” choice was an illusory one.69 The Fielder court argued that “any reasonable employer” would choose to offer health insurance to its employees (and reap the recruitment and retention benefits such a move would yield) rather than pay money directly to the state (and not benefit its employees at all).70 As a result, “pay or play” was in truth a mandate to “play” and therefore an unlawful requirement to obtain an ERISA plan. Quoting directly from Fielder, the District Court held, “[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 statute are ERISA plans, and any attempt to comply with the statute would have direct effects on the employer’s ERISA
In doing so, the court blinked at the possibility that an employer might actually prefer to meet its spending requirement by paying into the city’s HAP fund rather than purchasing an ERISA plan for its employees. Unlike the Maryland law, which was not accompanied by a new health access program, the San Francisco ordinance creates a viable alternative to health insurance that makes the “pay” option a reasonable one for employers to choose. This is true particularly because when an employer elects to pay the city, its employees receive a seventy-five percent discount on their HAP participant fees, so the employer can directly aid its own employees. Moreover, because the HAP is subsidized by government funds, the employer’s health care spending dollar goes further than it would through an ERISA plan.

Furthermore, as the Ninth Circuit noted, an employer might choose an ERISA plan over paying the city once “faced with an unavoidable obligation to make the required health care expenditure. . . . [But] such influence is entirely permissible [because] ‘an indirect economic influence does not bind plan administrators to any particular choice and thus [it does not] function as a regulation of an ERISA plan itself.”

As a matter of policy, the Ninth Circuit’s reasoning is also more sensible:

71. GGRA I, 2007 WL 4570521, at *7 (emphasis added) (internal quotation marks and brackets omitted).

72. The plan’s opponents argue that this saving feature of the ordinance presents its own preemption challenge, because payment to the HAP is itself an ERISA plan. See Reply Brief of Plaintiff at 4-6, Golden Gate Rest. Ass’n v. City & County of San Francisco (GGRA I), No. C06-6997 JSW (N.D. Cal. Dec. 26, 2007) (“Payments directly to the City would create a de facto welfare benefit plan. . . . The Ordinance thus provides no non-ERISA compliance options. . . .”). This argument misunderstands the purpose of ERISA. ERISA governs an employer’s relationship with a benefit provider, concerning details such as price, coverage, and claims handling—details that are not negotiated between the city and employers under the HAP. Moreover, ERISA regulates private benefit plan providers, not government programs. The fact that the city provides health care services of the type that might be provided by a benefit plan does not make the city program a benefit plan itself. Even the District Court was unconvinced by this argument. See GGRA I, 2007 WL 4570521, at *6 (“Although the Ordinance’s creation of the City’s Health Access Program resembles an alternate ERISA plan in some ways, the Court is not persuaded that the separate public health care plan envisioned by the Ordinance actually creates a separate de facto ERISA plan.”).


74. Before the District Court, San Francisco argued, “[T]he average insurance premium in California is $371 per month. In contrast, for a medium sized employer with an employee who works 20 hours per week, the employer can satisfy its spending obligation by paying the City $96.30 per month. . . . These services cost the City on average $261 per month to provide. In other words, if the employer chooses the government payment option, his employee receives comprehensive health benefits for pennies on the dollar, and the City picks up the rest of the tab.” Defendant’s Motion for Summary Judgment, supra note 9, at 20.

75. Golden Gate Rest. Ass’n v. City & County of San Francisco (GGRA II), 512 F.3d 1112, 1122 (quoting New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 659-60 (1995)).
the Health Care Security Ordinance operates more like a minimum wage statute than a benefit plan. A minimum wage statute is a more narrowly-focused redistributive policy than a corresponding increase in a general tax, for example; only those employers who “underpay” their employees are affected, rather than the general public, and those employers’ costs are passed through to their specific customers rather than the public at large. Similarly, the ordinance’s expenditure requirement impacts only those employers who do not already pay a minimum amount on health care; those who do face no additional burden.

Replacing the employer-funded portion of the HAP budget with an increase in a general tax, as is proposed by the expenditure requirement’s opponents, would yield two related problems. First, the indiscriminate and all-inclusive nature of a tax would sacrifice the efficiency gained by targeting a requirement only at those employers most responsible for the underlying problem the measure seeks to address. One of the ordinance’s more innovative features is that it gives employers “credit” for their existing health care spending, rather than imposing a tax regardless of current spending. Consequently, no employer is unduly burdened by paying twice (for both insurance and a new tax), nor can any employer seek a competitive advantage through avoiding paying anything for health care. Second, if such “credit” were not given for existing expenditures and a blanket tax were instead imposed, employers would have incentive to cease buying health insurance altogether. Instead, they would pay their required tax and leave their employees’ health care to the HAP. This move would lead to more uninsured in San Francisco, not fewer.

Though the Ninth Circuit’s reasoning better applies the formal rules of ERISA’s intricate preemption doctrine and leads to a more efficient policy outcome, mandated health care payments may be at odds with ERISA’s policy objectives nonetheless. ERISA sought national uniformity in benefit plan regulation in part to make it easier for employers to offer benefits free of patchwork local regulation. Congress feared that burdensome, overlapping regulation would discourage employers from providing benefits at all. While the ordinance would not discourage benefits within San Francisco—employers would have no choice but to make health care payments—it could have this discouraging effect outside the city. An employer faced with the burden of administering HAP payments to the city might be less likely to assume the burden of administering benefit plans for employees outside San Francisco, where there is no HAP option. Employers who currently do provide health insurance to all employees, but at a level below the spending requirement, will need to increase spending on San Francisco employees. To balance these new costs, the employer might lower its coverage of employees outside the city. In either of these

76. Bob Egelko & Heather Knight, Federal Judge Rules Against S.F. on Health Care Plan, S.F. CHRON., Dec. 27, 2007, at B1 (quoting the executive director of the Golden Gate Restaurant Association as advocating for a general tax increase to “help fund the program in a legal and sustainable fashion without crushing small businesses”).

cases, what would result is precisely the benefit reduction that ERISA sought to avoid through uniformity.

Neither court commented on the ordinance’s impact outside San Francisco. These potential external effects, however, are no more dispositive of the pre-emption question than the courts’ formal preemption tests. If the ordinance is equivalent to a minimum wage requirement, then external effects are of no moment; employers paying San Francisco’s higher minimum wage may compensate for these costs by paying lower wages elsewhere. On the other hand, if any impact on the provision of ERISA-regulated employee benefits, however speculative or indirect, triggers ERISA preemption, then the ordinance cannot be saved. This latter position is unworkable, however, since every regulation affecting business could in theory have an impact on employer decisions about offering health benefits. Indeed, raising the minimum wage could prompt employers to scale back their employee benefits, yet minimum wage laws are clearly beyond ERISA’s scope.

Nevertheless, the Ninth Circuit (or later, the Supreme Court) could reasonably find that the ordinance’s impact on ERISA plans is not too attenuated because the ordinance concerns the provision of health care, which is a “benefit[] of the type already regulated by ERISA.” That is, despite the city’s creative solutions to provide realistic options for employers to satisfy their spending requirements without any impact on ERISA plans, the simple fact that most health care plans have traditionally been ERISA plans may be enough to justify preempting any alternative health care scheme.

This outcome would be unfortunate, not only for San Francisco’s uninsured, but also for other would-be health care reformers in local and state governments throughout the country. If the San Francisco plan is preempted, it is unlikely that any local or state universal health care scheme would not be, given the plan’s innovations. Such a decision would signal that the locus of change for health care in the United States must be in Congress. Yet it is the very failure of Congress to act effectively that has spurred reform efforts at the local level. Justice Brandeis famously said, “it is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.” Though ERISA was enacted to promote employee welfare, its preemption clause has worked to subvert the local welfare-enhancing “experiments” that are needed to catalyze national health care re-

78. As of January 1, 2008, San Francisco’s minimum wage is $9.36 per hour, while the California minimum wage is $8.00 per hour and the federal minimum wage is $5.85 per hour. See Cecilia M. Vega, City’s Minimum Wage To Go Up to $9.36, S.F. CHRON., Nov. 15, 2007, at B3.
IV. APPLICABILITY TO OTHER CITIES OR STATES

If the employer spending requirement does pass judicial review, however, San Francisco will have succeeded in creating a “pay or play” plan that is not preempted by ERISA. The model is perhaps better termed “pay-plus or play,” because it is the accompanying health care access program that makes the “pay” option a reasonable one. A realistic “pay” option, in turn, saves the ordinance from effectively forcing employers to provide an ERISA plan, as the Maryland law impermissibly did. Other cities—or states—hoping to provide universal health care and to ensure that employers pay their fair share could adopt a similar model.81

It is the very health care access program that saves the ordinance, however, that may also limit the model’s viability in other locations. Such an access program may be more difficult to replicate in municipalities that lack San Francisco’s demographics, institutions, and political climate. First, the city has a significantly smaller uninsured population than the national average: 13% vs. 22% of adults aged 18-64.82 Second, the city already had a large number of community clinics, which needed only to be enrolled to form the HAP’s provider network; such resources do not exist everywhere. Third, as an integrated city-county, San Francisco has more direct access to state health care funding and more complete control over its resources than other cities would. And fourth, the city’s progressive elected officials and residents are more likely to approve of spending the public funds that are needed to heavily subsidize the HAP.83

None of these unique characteristics, however, is a clear prerequisite. So long as a city has at least one public clinic or hospital to make a “Medical Home,” it should be able to adjust employer spending requirements and program participant fees to provide reduced-cost, if not completely free, primary and preventive care to uninsured residents. Doing so would still encourage more employers to provide coverage in the first place, and residents would still have guaranteed access to preventive care. Such changes should lead to the

81. In California, Governor Schwarzenegger’s proposed plan to provide universal health care contained a “pay or play” employer spending requirement similar to the city’s. See Tom Chorneau, California’s Health Care Effort in Doubt, S.F. CHRON., Dec. 28, 2007, at A1. The plan was rejected in committee in the Senate on unrelated grounds (concerning fiscal risks). See Jordan Rau, State Health Plan Killed, Calling It ‘Fundamentally Flawed,’ Senators Reject Gov.’s Proposal, L.A. TIMES, Jan. 29, 2008, at A1. California could look to San Francisco’s model as it considers its next attempt at expanding coverage.


83. See Kevin Sack, San Francisco to Offer Care for Uninsured Adults, N.Y. TIMES, Sept. 14, 2007, at 1.
same improvements in long-term health outcomes and lower emergency medicine costs that San Francisco hopes to realize.

CONCLUSION

The Health Care Security Ordinance ably navigates the politically and legally tempestuous waters of health care access. It regulates employer spending without impermissibly affecting ERISA benefit plans. It establishes universal health care access without undertaking universal health insurance. And it limits itself to the pursuit of specific, obtainable ends: saving money and promoting health by favoring preventive care over emergency care. While a broad reading of ERISA’s policy purpose suggests that any local regulation of health care benefits should be preempted, this reading would undermine local governments’ ability to develop state-of-the-art, welfare-enhancing policy solutions. If the ordinance does survive future court challenges, this innovative legislation should serve as a model for other cities and states struggling to improve the health of their populations and to contain their own health care costs.