

**In The
Supreme Court of the United States**

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GOLDEN GATE RESTAURANT ASSOCIATION,
Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO, ET AL.,
Respondents.

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**On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit**

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SUPPLEMENTAL BRIEF OF RESPONDENT

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1. As written, the Patient Protection and Affordable Care Act (“PPACA”), as amended by the Health Care and Education Reconciliation Act of 2010 (“HCERA”), does not preempt San Francisco’s health care spending requirement (although, as the brief of the United States points out, the full preemptive force of the new law may not be discernible until the government adopts implementing regulations). Because the new law does not presently preempt the City’s employer spending requirement, petitioner is correct that this case is not “moot” in the jurisdictional sense. As a practical matter, however, federal health care reform almost certainly renders obsolete the ERISA preemption question presented by this petition. Under the new law, the federal government is investing hundreds of billions of dollars to ensure that the majority of people currently without health coverage will receive it. Among other things, the new law: (i) requires individuals to purchase health insurance, PPACA § 1501; (ii) provides subsidies to many individuals for the purchase of insurance, PPACA § 1401; (iii) provides tax credits to employers to provide health coverage for their employees, PPACA § 1421; and (iv) expands Medicaid eligibility. PPACA § 2002. Given the dramatic steps the federal government has taken to extend coverage to so many uninsured persons, the incentive of state and local governments to take matters into their own hands by adopting programs such as San Francisco’s has all but disappeared.

2. Statements by San Francisco officials that they will not dismantle the HAP (now called Healthy San Francisco) in the wake of federal health care reform do not constitute evidence that this ERISA preemption question is likely to recur. The officials have made clear that one of the primary reasons the HAP remains relevant is that it covers undocumented immigrants, while the federal law does not. *See, e.g.,* Heather Knight, *Healthy San Francisco expected to continue*, S.F. Chron., March 23, 2010 at A-10 (“Newsom said the 20 million not covered are largely undocumented immigrants living in metropolitan areas”). It is one thing to decide that an existing government-run health program will not be dismantled. It is quite another to start from scratch and adopt a massive, largely taxpayer-funded program akin to San Francisco’s, primarily for the purpose of covering undocumented immigrants. Aside from the statements of San Francisco officials, which are off point, petitioner has provided no basis for its speculation that, given the new landscape, other jurisdictions retain any incentive to embark upon the journey San Francisco had largely completed by the time federal health care reform was adopted.

3. Furthermore, although San Francisco officials have stated the HAP will not be dismantled, they have never suggested the Health Care Security Ordinance (“HCSO”) would not change as a result of health care reform. Given the breadth and complexity of health care reform, and given the large role that states and local governments will play in its

implementation, it is self-evident that the contours of San Francisco's program, including possibly the aspects of it about which petitioner complains, will need to be reexamined as the federal legislation is implemented. For example, many who presently qualify for participation in Healthy San Francisco may no longer do so because they will receive subsidized coverage through an insurance exchange mandated by the new legislation. And to the extent a San Francisco employer makes health care expenditures to comply with federal requirements, the City presumably would need to ensure that the expenditures count towards satisfaction of the HCSO's expenditure requirements, even if an amendment to the ordinance is required. Of course, these matters may not be definitively addressed at present, because the federal program is only in its infancy, with years of administrative interpretations and implementing regulations to come. The only certainty is that San Francisco's policymakers will reexamine – and likely make many changes to – the City's program in light of health care reform.

4. Petitioner makes passing reference to the possibility that, even if national health care reform has the practical effect of mooted the question presented by this petition, an analogous question might arise in the context of other benefits mentioned by ERISA. Reply to SG 4. But petitioner has identified no local law (or proposed law, for that matter) outside the context of health care that is similar in concept

or structure to the HCSO. In the event such a measure were ever proposed and enacted, courts would presumably have ample opportunity to address the applicability of the decision below in those other contexts.

5. Although it hardly matters given the diminished importance of the question presented, enactment of the PPACA further weakens petitioner's substantive argument that ERISA preempts San Francisco's health care spending requirement. ERISA's preemption provision states that ERISA shall not "be construed to . . . impair . . . any law of the United States." 29 U.S.C. § 1144(d). This provision applies to laws enacted subsequent to, as well as prior to, ERISA. *See, e.g., Tompkins v. United Healthcare of New England, Inc.*, 203 F.3d 90, 96 (1st Cir. 2002) (Americans with Disabilities Act). It is possible, depending upon the shape the federal health care program takes in the coming years, that if ERISA were construed to preempt San Francisco's program, it would "impair" the new federal health care law. For example, the PPACA requires individuals to obtain "minimum essential coverage," and it imposes penalties on large employers under certain circumstances if they do not provide minimal essential coverage. PPACA §§ 1501, 1513. The Secretary of Health and Human Services has authority to determine whether a particular arrangement constitutes "minimum essential coverage" within the meaning of the PPACA. *Id.* at § 1501(f)(1)(E). Should the Secretary deem the HAP to provide minimum essential coverage, an

interpretation of ERISA's preemption provision that undermines or precludes participation in the HAP would impair the PPACA.

This is but one example of the many ways in which the new federal health care law may interact with state and local programs, depending upon the manner in which the law is implemented. After all, it is beyond dispute that the new legislation contemplates – indeed relies upon – significant interaction with state programs. This further counsels against a grant of certiorari, where a decision could indirectly affect or limit the manner in which health care reform is carried out.

6. *Conkright v. Frommert*, 130 S.Ct. 1640 (2010) does not assist petitioner on the issue of “uniformity.” The Court’s opinion simply observes that *Firestone* deference helps to avoid “a patchwork of *different interpretations of a plan*, like the one here, that covers employees in different jurisdictions. . . .” 130 S.Ct. at 1649 (emphasis added). Because the present case does not involve “different interpretations of a plan . . . in different jurisdictions,” it is difficult to see the relevance of *Conkright*, other than to underscore petitioner’s continuing failure to acknowledge the difference between plan uniformity, which ERISA protects, and cost uniformity, which “was almost certainly not an object of ERISA pre-emption” *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 662 (1995).

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