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UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

RESTAURANT LAW CENTER, *et al.*, Plaintiffs, v. AARON BINDER, in his official capacity as Treasurer of the State of New Jersey, and KEVIN D. JARVIS, in his official capacity as Acting Commissioner of the New Jersey Department of Labor and Workforce Development, Defendants.	No. 3:26-cv-10636-ZNQ-RLS

BRIEF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA, AMERICAN BENEFITS COUNCIL, ERISA INDUSTRY COMMITTEE, NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS, NATIONAL FEDERATION OF INDEPENDENT BUSINESS SMALL BUSINESS LEGAL CENTER, INC., NEW JERSEY BUSINESS & INDUSTRY ASSOCIATION, AND NEW JERSEY RETAIL MERCHANTS ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS

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INTEREST OF *AMICI CURIAE*[1]

The Chamber of Commerce of the United States of America ("Chamber") is the world's largest business organization. As the nation's leading advocate for business, the Chamber represents companies and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files *amicus curiae* briefs in cases, like this one, that raise issues of concern to the nation's business community.

The American Benefits Council (the "Council") is a Washington, D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees, and families. Council members include over 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans. The Council regularly participates as *amicus curiae* in cases affecting employee benefit plans.

[1] No counsel for any party authored this brief in whole or in part and no entity or person, aside from *amici curiae*, their members, or their counsel, made any monetary contribution intended to fund the preparation or submission of this brief.

The ERISA Industry Committee ("ERIC") is a national nonprofit trade association representing the interests of approximately 100 of the nation's largest employers in their capacity as sponsors of employee benefit plans for their workers, retirees, and families. ERIC is dedicated to protecting employer-sponsored benefit plans and developing and advancing policies to strengthen Americans' retirement security. ERIC routinely participates as *amicus curiae* in cases arising under the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 *et seq.* ("ERISA"), concerning employee-benefit plan design, expense, regulatory compliance, administration, and/or preemption.

The National Association of Wholesaler-Distributors ("NAW") is an employer and a non-profit, non-stock, incorporated trade association that represents the wholesale distribution industry—the essential link in the supply chain between manufacturers and retailers as well as commercial, institutional, and governmental end users. NAW is made up of direct-member companies and a federation of national, regional, and state associations across 19 commodity lines of trade which together include approximately 35,000 companies operating nearly 150,000 locations throughout the nation. The overwhelming majority of wholesaler-distributors are small-to-medium-size, closely held businesses. As an industry, wholesale distribution generates more than $8 trillion in annual sales volume, providing stable and well-paying jobs to more than 6 million workers.

The National Federation of Independent Business Small Business Legal Center, Inc. ("NFIB Legal Center") is a nonprofit, public interest law firm established to provide legal resources and be the voice for small businesses in the nation's courts through representation on issues of public interest affecting small businesses. It is an affiliate of the National Federation of Independent Business, Inc. ("NFIB"), which is the nation's leading small business association. NFIB's mission is to promote and protect the right of its members to own, operate, and grow their businesses. NFIB represents, in Washington, D.C., and all 50 state capitals, the interests of its members.

The New Jersey Business & Industry Association ("NJBIA") is New Jersey's largest business organization. As the State's leading advocate for business, NJBIA's very diverse membership is composed of companies and professional organizations of every size, in every industry sector, and from every region of the State. NJBIA advocates for the business community before New Jersey's Executive, Legislative, and Judicial branches of government. NJBIA has filed *amicus* briefs for many years in cases like the one at hand, where the issues raised are of concern to the business community and risk negatively affecting its ability to sustain and grow jobs, and support New Jersey's workforce and economy.

The New Jersey Retail Merchants Association ("NJRMA") is a not-for-profit association that promotes the interests of the retail industry in the State of New Jersey. NJRMA's members employ many thousands of employees in New Jersey, and many of NJRMA's members are subject to the requirements and duties of the Employer Healthcare Assistance Contributions Act. Indeed, in the 2024 *Annual Report on Access to Employer-Based Health Insurance*, a precursor to the Act submitted by the New Jersey Department of Human Services, many of NJRMA's members are specifically identified by name. As an organization that, among other things, advocates on behalf of retail industry employers in New Jersey, NJRMA has a substantial interest in the Act.

Amici submit this brief to provide context on the importance of employer-sponsored health plans to the nation's workforce and the business community's interest in ensuring that courts apply ERISA's express preemption provision consistent with its text and established precedent.

INTRODUCTION AND SUMMARY OF ARGUMENT

The majority of Americans get healthcare coverage through an employer-sponsored plan, and private businesses contribute hundreds of billions of dollars toward employee healthcare each year. Their ability to do so depends in substantial part on a legal framework that "minimiz[es] the administrative and financial burdens" of plan administration, freeing up resources for the actual

provision of benefits. *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 321 (2016) (cleaned up). Congress secured that framework through ERISA's express preemption provision, which ensures that employers are not required to "master the relevant laws of 50 states" to provide benefits to their employees. *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 149–50 (2001). The "central design of ERISA" is "to provide a single uniform national scheme for the administration of ERISA plans without interference from laws of the several States." *Gobeille*, 577 U.S. at 326–27.

New Jersey's Employer Healthcare Assistance Contributions Act (the "Act") strikes at that design, and the Act's advocates have not been coy about their objectives. The Act requires employers with 50 or more Medicaid-covered employees to pay a fee of $325, $525, or $725 (depending on the size of the employer) for each employee and dependent who receives coverage through the State Medicaid program. N.J. Stat. Ann. § 34:11F-1.[2] The Governor explained that the Act "asks any company with 50 or more employees on Medicaid . . . to cover their workers, which they should do anyway, or pay a fine." ECF No. 16 ("Am. Compl.") ¶ 28 (quotation omitted). The Legislature's fiscal analysis anticipated that employers would respond to the Act by "enhancing offers of

[2] The Act does not require employers to pay the fee for employees and dependents covered by Medicaid due to a developmental disability, intellectual disability, or permanent physical disability. N.J. Stat. Ann. § 34:11F-1(d).

employer-sponsored health coverage." *Id.* ¶ 29. The Act, in other words, is designed to shape who is covered under ERISA-governed health benefit plans—down to employees' spouses, civil union and domestic partners, and certain unmarried children up to age 31, all of whom are swept into the Act's definition of "dependents." N.J. Stat. Ann. § 34:11F-1(a).

ERISA expressly preempts state laws that "relate to" ERISA plans—i.e., laws that have "a connection with or reference to such a plan." *Egelhoff*, 532 U.S. at 147 (quotation omitted). Laws have an impermissible "connection with" ERISA plans if they govern "a central matter of plan administration" or "interfere[] with nationally uniform plan administration." *Id.* at 147–48. The Fourth Circuit has applied those principles to strike down a state law that, like the Act, was designed to force large employers "to spend more money on employee health benefits and thus reduce [their] employees' reliance on Medicaid." *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 198 (4th Cir. 2007).

The Act is preempted by ERISA for similar reasons, as it is designed to induce employers to offer coverage that aligns with the State's preferences. The Act, for example, requires employers to measure their plans against New Jersey's definition of "dependent," which includes spouses, civil union and domestic partners, and certain unmarried children up to age 31. It also excludes from the fee calculation undefined categories of "employees" including part-time, temporary,

and seasonal workers, further complicating the eligibility line-drawing it calls on employers to conduct. If New Jersey can do this, then other States may follow suit, each with its own definitions and exclusions. The result would be precisely the type of patchwork scheme of state regulation that ERISA's express preemption provision was designed to prevent.

The Act is separately preempted under the "reference to" prong of the preemption test, because the Act's objective—convincing private employers to "enhanc[e] offers of employer-sponsored health coverage," Am. Compl. ¶ 29—can be realized only through the modification or creation of ERISA plans. And sustaining the Act would invite every State to impose its own variant, multiplying plan administrative costs that ultimately harm workers.

ARGUMENT

I. ERISA Expressly Preempts State Laws Like The Act That Effectively Dictate Employee Benefits

A. ERISA's Express Preemption Provision Is Deliberately Expansive

ERISA does not require employers to provide any particular benefits. It leaves them free, "for any reason at any time, to adopt, modify, or terminate welfare plans." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995). Because the provision of benefits is voluntary, Congress recognized that a homogeneous and predictable regulatory system was necessary to encourage employers to establish and maintain robust plans. *See Fort Halifax Packing Co. v.*

Coyne, 482 U.S. 1, 11 (1987) ("Congress intended pre-emption to afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations."). ERISA's design "induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct." *Conkright v. Frommert*, 559 U.S. 506, 517 (2010) (alteration in original) (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002)).

To achieve that aim, Congress included in ERISA an express preemption provision under which federal law "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). The language of this provision is "expansive." *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). It "was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law," with the goal of "minimiz[ing] the administrative and financial burden of complying with conflicting directives" and thereby avoiding "inefficiencies" that "could work to the detriment of plan beneficiaries." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).

Consistent with those goals, ERISA is "primarily concerned with pre-empting laws that require providers to structure benefit plans in particular ways." *Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 86–87 (2020). A state law

"relates to" an ERISA plan—and thus is preempted—"if it has a connection with or reference to such a plan." *Egelhoff*, 532 U.S. at 147 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)); *see United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Mem'l Hosp.*, 995 F.2d 1179, 1191 (3d Cir. 1993) (applying "connection with" and "reference to" tests). A law has an impermissible "connection with" ERISA plans if it "governs a central matter of plan administration or interferes with nationally uniform plan administration," or if its "acute, albeit indirect, economic effects . . . force an ERISA plan to adopt a certain scheme of substantive coverage." *Gobeille*, 577 U.S. at 320 (cleaned up). And a law makes an impermissible "reference to" ERISA plans where it "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *Id.* at 319–20 (cleaned up); *see Rutledge*, 592 U.S. at 87–88.

B. The Act Is Designed To Compel Employers To Adopt A Particular Scheme Of Substantive Coverage

Applying the "connection with" standard, the Supreme Court has concluded that ERISA preempts state laws that, for example, "requir[e] payment of specific benefits" or "bind[] plan administrators to specific rules for determining beneficiary status." *Rutledge*, 592 U.S. at 86–87 (citing *Shaw*, 463 U.S. 85, and *Egelhoff*, 532 U.S. 141). In those cases, as in any other involving ERISA's express preemption provision, the analysis was guided by Congress's objectives in enacting ERISA,

which include "ensuring that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions." *Id.* at 86.

The Act runs afoul of these core ERISA preemption principles, and in fact was designed with the straightforward aim of expanding coverage under employer-sponsored health plans. The Governor described the Act as presenting employers with a choice between "cover[ing] their workers" and "pay[ing] a fine." Am. Compl. ¶ 28 (quotation omitted). And the Legislature's fiscal analysis assumed employers would respond by "enhancing offers of employer-sponsored health coverage." *Id.* ¶ 29. The structure of the fees imposed under the Act confirms the point. Because the fee is assessed on a per-employee or per-dependent basis, the principal way the Act contemplates an employer will seek to avoid its fees is to move those individuals out of Medicaid and into its own plan—for example, by expanding eligibility, reducing employee contribution obligations to make coverage more attractive, or extending dependent coverage to categories specified in the Act, including domestic and civil union partners and certain unmarried children up to age 31. *See* N.J. Stat. Ann. § 34:11F-1(a). Decisions about who is eligible, on what terms, and which dependents can be covered are plan-design choices. A state law that coerces employers to make particular decisions on those points—and penalizes them when they do not—impermissibly requires employers "to structure benefit plans in particular ways." *Rutledge*, 592 U.S. at 86–87.

The Fourth Circuit's decision in *Fielder* is instructive. There, Maryland law required employers with 10,000 or more employees in the State to spend at least eight percent of the total wages they paid to Maryland employees on health insurance costs or pay the shortfall to the State. 475 F.3d at 183–85, 193. The court held that the law was preempted because, in practical effect, its object was to require employers "to spend more money on employee health benefits and thus reduce [employees'] reliance on Medicaid," and it sought to achieve that aim by "requir[ing] [employers] to change, at least in Maryland, [their] employee benefit plans and how they are administered." *Id.* at 198. The Act parallels the Maryland law in *Fielder* in those respects: It is intended to prompt employers to revise (or create) benefit plans and increase benefits spending, with the ultimate objective of shifting workers from Medicaid to employer coverage. As a result, like the Maryland law in *Fielder*, the Act "directly clashes with ERISA's preemption provision and ERISA's purpose of authorizing [employers] to provide uniform health benefits to [their] employees on a nationwide basis." *Id.*

The Act differs in kind from measures courts have held are not preempted because they "merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage." *Rutledge*, 592 U.S. at 88. In *Rutledge*, for example, the Court held that ERISA did not preempt an Arkansas law requiring pharmacy benefit managers to reimburse

pharmacies at least as much as they paid to acquire a drug, because the law was "merely a form of cost regulation" and did not "effectively dictate plan choices." *Id.* In *Travelers*, New York required hospitals to collect surcharges from certain HMOs and patients covered by certain insurers, and the Court held that the surcharges—which raised the price of hospital services that ERISA plans purchased, but applied without regard to whom a plan covered or what benefits it provided—"affect[ed] only indirectly the relative prices of insurance policies" and left administrators free to make their own choices. 514 U.S. at 649, 668. And in *United Wire*, the Third Circuit upheld a New Jersey law establishing a hospital-rate-setting system because the law "increase[d] the charges billed to ERISA plan participants for hospital services" but did not "direct ERISA plans to structure their benefits or conduct their internal affairs in any particular way" or "deprive ERISA plans of any alternative they would otherwise have in these areas." 995 F.2d at 1193.

The Act, by contrast, does not merely affect the costs of goods or services paid for by a plan. A fee that can be avoided by covering particular individuals under an employer plan, and is incurred by declining to do so, regulates *who* is entitled to benefits, which is at the core of what ERISA preempts. *See Rutledge*, 592 U.S. at 86–87. In both substance and intent, the Act seeks to compel private

employers to expand the coverage made available under their plans. That puts the Act firmly on the preempted side of the line.

C. The Act's Attempt To Create New Jersey-Specific Coverage Standards Frustrates Congress's Objective Of Enabling Nationally Uniform Plan Administration

The Act's impermissible connection with ERISA plans is reinforced by its "interfere[nce] with nationally uniform plan administration." *Egelhoff*, 532 U.S. at 148. Uniformity "is impossible . . . if plans are subject to different legal obligations in different States." *Id.* Laws that would require plan administrators to "maintain a familiarity with the laws of all 50 States so that they can update their plans as necessary" are thus preempted by ERISA. *Id.* at 151.

The Act imposes exactly the types of burdens ERISA's express preemption provision was designed to prevent. For a multi-state employer to avoid exposure to the Act's fees, it likely would have to offer its New Jersey workforce coverage that differs from what it offers elsewhere. *See* Am. Compl. ¶ 38. The Act's definition of "dependent" illustrates the problem. It reaches certain unmarried children up to age 31, N.J. Stat. Ann. § 34:11F-1(a), while under the federal Affordable Care Act, plans that choose to offer dependent coverage for children are required to make it available only until age 26, *see* 45 C.F.R. § 147.120(a)(1)—the standard around which many plans nationwide are designed. An employer seeking to avoid the fee for employees' adult children therefore cannot simply

administer its plan as it does everywhere else; it must extend eligibility in New Jersey to a broader class of dependents and then administer that New Jersey rule alongside the rules that govern its plan in every other State.[3] The Act's definition of "dependent" also effectively requires plans to offer coverage for spouses and civil union and domestic partners. Although spousal coverage is typical under many plans, ERISA does not require employers to offer it. *See, e.g.*, *Falcone v. Teamsters Health & Welfare Fund*, 489 F. Supp. 2d 490, 497 (E.D. Pa. 2007) ("no provision of ERISA mandates spousal health and welfare benefit coverage"). Nor does ERISA require extending coverage to civil union and domestic partners as understood under New Jersey law.

As the Fourth Circuit explained of the Maryland law in *Fielder*, such measures, "[i]f permitted to stand," would "force [multi-state employers] to tailor [their] healthcare benefit plans to each specific State, and even to specific cities and counties." *Fielder*, 475 F.3d at 194. That is "precisely the regulatory

[3] The Act's departure from federal law also has tax implications. Federal tax laws align with the ACA's age-26 standard for child dependent coverage, such that favorable tax treatment often associated with employer-sponsored health benefits in some instances may not be available for coverage provided to dependent children older than age 26. *See* I.R.S., *Notice 2010-38: Tax Treatment of Health Care Benefits Provided With Respect to Children Under Age 27* (Mar. 30, 2010), https://www.irs.gov/pub/irs-drop/n-10-38.pdf.

balkanization that Congress sought to avoid by enacting ERISA's preemption provision." *Id.*

D. The Act Also Is Preempted Under The "Reference To" Test

Even apart from its impermissible "connection with" ERISA plans, the Act also is preempted because it makes "reference to" them. A state law makes such a reference where it "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *Gobeille*, 577 U.S. at 319–20 (cleaned up); *Cal. Div. of Lab. Standards Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997). As noted above, the Act's objective is to induce employers to "cover their workers … or pay a fine," Am. Compl. ¶ 28 (quotation omitted), and the Legislature assumed that employers would respond to the Act by "enhancing offers of employer-sponsored health coverage," *id.* ¶ 29. For the private-sector employers the Act reaches, "employer-sponsored health coverage" is, almost by definition, an employee welfare benefit plan governed by ERISA. The Act thus presupposes the existence of ERISA plans as the vehicle through which its objective will be achieved. The fee is the stick, and enrollment of employees and their state-defined dependents in an ERISA plan is the response it was intended to produce.

The Act's design confirms the point. Liability is measured by the number of employees and dependents who receive benefits through the State Medicaid

program, N.J. Stat. Ann. § 34:11F-1(c); the Act's definitions of "employee" and "dependent" address categories of individuals plans might cover, *id.* § 34:11F-1(a); and the Act applies only to private-sector employers, not to State and other governmental employers that are beyond ERISA's reach, *see id.* (defining "employer"); Am. Compl. ¶ 41. Without ERISA plans, there would be no mechanism for the Act to achieve the Legislature's objectives.

The centrality of ERISA plans to the Act's design distinguishes the Act from laws like the prevailing-wage statute the Court held was not preempted in *Dillingham*. There, the law's wage requirements were "indifferent" to whether apprenticeship programs were covered by ERISA, and the statute's objective could be fully achieved even if a program's funding apparatus did not bring it under ERISA. 519 U.S. at 325–28. But the Act is not "indifferent" to ERISA plans; its objective is to influence employers to change the very terms of ERISA plans (or create new plans) to expand the number of individuals covered. A law whose purpose can be realized only through the modification or creation of ERISA plans is one for which "the existence of ERISA plans is essential," and it "acts immediately and exclusively" on those plans. *Gobeille*, 577 U.S. at 319–20 (cleaned up).

II. State Laws Like The Act Create Undue Administrative Burdens And Undermine The Provision Of Employee Benefits

The consequences of sustaining the Act would extend far beyond New Jersey. If one State may levy a fee designed to force employers to expand plan coverage, other States may try to do the same—each with its own fee schedule, employee-count threshold, definition of "dependent," exclusions, assessment timeline, and appeal procedures. Forcing employers to contend with a disparate array of laws penalizing them for not adopting state-specific health benefit plan coverage terms is untenable.

Administering a plan to comply with even one State's version of this regime is a heavy lift. The Act's fee is linked to the absence of plan coverage, so every assessment sends an employer back to its plan records. To validate (or contest) an assessment, plan administrators would need to compare the State's count against their own enrollment, eligibility, and dependent-election data, applying New Jersey's definitions of "employee" and "dependent." Indeed, plan administrators may lack access to the information needed to validate the State's assessment. The fact that an employee is not enrolled in an employer's plan does not demonstrate that the employee (or any dependent) is enrolled in Medicaid. The employee could well be covered by their spouse's plan, for example, but a plan administrator would have no way of knowing so. Further complicating the exercise, the Act's exclusions for part-time, per diem, temporary, or seasonal employees leave those

terms undefined. *See* N.J. Stat. Ann. § 34:11F-1(j). But plans attempting to offer coverage that tracks the contours of the Act necessarily must adopt concrete eligibility standards that draw lines between "part-time" and full-time, or "seasonal" and year-round, employees, and the lines that govern under the Act in New Jersey may not be the same lines that govern elsewhere.

The problems only multiply if other States follow New Jersey's lead and adopt their own laws targeted at expanding coverage under employer-sponsored plans. To comply, a multi-state employer would need to run a separate reconciliation for each State against plan records, under different rules about who counts, or redesign its plan state by state to avoid the fees. Either way, the employer would have to "maintain a familiarity with the laws of all 50 States." *Egelhoff*, 532 U.S. at 151. That is the very burden ERISA's uniform federal framework was meant to lift. And it would fall most heavily on the large cross-jurisdictional employers that provide healthcare coverage to most American workers with employer-sponsored plans.[4]

[4] In the United States, large firms—defined as those with 200 or more employees—provide healthcare coverage to 78 percent of the workers who receive employer-sponsored coverage. KFF, *Employer Health Benefits: Annual Survey 2026* at 24, 26 (Oct. 22, 2026). Nearly all large firms (98 percent) offer healthcare coverage to their employees. *Id.* at 5. Employer-sponsored coverage is also widely offered by smaller employers: in a 2023 survey, 89 percent of respondents with 30 or more employees reported offering healthcare coverage to their workers. NFIB Research Center, *Small Business Health Insurance Survey* at 12 (Mar. 2023),

It is employees who would ultimately bear the costs of such a fragmented regulatory regime. Congress recognized that subjecting plans to conflicting state directives creates "inefficiencies" that "work to the detriment of plan beneficiaries." *Ingersoll-Rand*, 498 U.S. at 142. Money employers spend complying with state-specific requirements has to come from somewhere. And when the cost of providing coverage rises, employers tend to respond by increasing the amounts employees are required to contribute. *See Employer Health Benefits: Annual Survey 2026* at 10–11 (noting the most commonly reported large-firm employer action in response to an increase in the cost of providing health benefits was to increase workers' share of premiums). Rising healthcare costs also make employees "increasingly expensive for employers to retain," driving wages down and unemployment up. Zarek Brot-Goldberg et al., *Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers* at 1, National Bureau of Economic Research Working Paper 32613 (rev. Dec. 2024), https://www.nber.org/papers/w32613. Beyond these general effects, the Act's particular structure may also affect workers in ways that harm, rather than help, them: Because the Act excludes part-time, per diem, temporary, and seasonal workers from its fee

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https://www.nfib.com/wp-content/uploads/2026/07/Health-insurance-survey-NFIB.pdf.

calculation, it may give employers reason to cut hours or shorten tenure, to the detriment of the very workers the State says it wants to help.

States like New Jersey may well have good intentions when adopting laws like the Act. But state-by-state beneficence, aggregated across jurisdictions, drains the resources available for employee benefits everywhere. Congress foresaw this problem and solved it with a single national framework. To preserve the "single uniform national scheme for the administration of ERISA plans" that Congress envisioned, *Gobeille*, 577 U.S. at 326–27, the Court should hold that plaintiffs are likely to succeed on their claim that the Act is preempted by ERISA.

CONCLUSION

For the foregoing reasons, and those stated in plaintiffs' motion, the Court should grant plaintiffs' motion for a preliminary injunction.

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Respectfully Submitted,

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