THE HONORABLE THOMAS S. ZILLY

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

THE ERISA INDUSTRY COMMITTEE, Plaintiff, v. CITY OF SEATTLE, Defendant.	Case No. 2:18-cv-01188 **PLAINTIFF'S OPPOSITION TO DEFENDANT'S MOTION TO DISMISS AND PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT** **NOTE ON MOTION CALENDAR: DECEMBER 6, 2018**

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Plaintiff The ERISA Industry Committee ("ERIC") respectfully submits this combined filing: (1) to oppose the motion to dismiss of Defendant City of Seattle ("Seattle"); and (2) to move in its own right for summary judgment pursuant to Fed. R. Civ. P. 56 on all claims in the complaint.

INTRODUCTION

In 2016, via the initiative process, Seattle passed an ordinance that, in design, terms, and effect, requires certain hotel employers in Seattle to provide a minimum specified level of health benefits to a class of their employees. This past summer, Seattle regulators followed up with implementing regulations. In response, ERIC – on behalf of its membership that includes covered hotel employers – brought this lawsuit. In the suit, ERIC seeks injunctive and declaratory relief to halt operation of the relevant part of the ordinance on grounds that the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, preempts it. Seattle has moved to dismiss the complaint under Fed. R. Civ. P. 12(b)(6), asserting that there is no preemption; in turn, ERIC today moves for summary judgment under Rule 56, contending that, as a matter of law and under the undisputed facts, there is preemption.

The Court should deny Seattle's motion to dismiss and grant ERIC's motion for summary judgment. Pursuant to ERISA's broad, familiar preemption provision, *see* 29 U.S.C. § 1144(a), which ousts state and local laws that "relate to" employee benefit plans, the ordinance is preempted because it – under the preemption clause's well-defined standards – has a "reference to" ERISA plans and a "connection with" them. *See Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016). It refers to them because the ordinance directly measures compliance by reference to an ERISA plan's terms, making the ordinance indistinguishable from the state law preempted in *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992) ("*Greater Washington Board of Trade*"), and the type of state laws that the Ninth Circuit indicated impermissibly refer to ERISA plans in *Golden Gate Restaurant Ass'n v. City & County of San Francisco*, 546 F.3d 639 (9th Cir. 2008). Additionally, the ordinance has a connection with ERISA plans, given that it "amount[s] to an impermissible substantive mandate" to employers to provide a specified level of coverage. *Id.* at 660. Because, with ERISA, Congress

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intended employee benefit plans to be "'exclusively a federal concern,'" and Seattle's ordinance enters into the federal domain, preemption ensues, and the Court should, accordingly, deny Seattle's motion to dismiss and award summary judgment to ERIC. *Gobeille*, 136 S. Ct. at 944 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)).

BACKGROUND

A. Part 3 of Seattle Municipal Code Chapter 14.25

This action concerns a challenge to Part 3 of Chapter 14.25 ("Part 3") of the Seattle Municipal Code. Chapter 14.25, known as the Seattle Hotel Employees Health and Safety Initiative, originated as Initiative Measure No. 124, which Seattle's voters passed in November 2016.[1] Seattle issued final regulations implementing Chapter 14.25, including Part 3, on May 31, 2018, and revised them further on July 12, 2018. *See generally* SHRR §§ 150-160 through -215. It issued additional guidance for Part 3 by posting on its website, in June and July 2018, "Questions & Answers" and a "Toolkit" to aid in compliance.[2] Under the final regulations and guidance, Compliance with Part 3 was required beginning July 1, 2018. *See id.* § 150-300.

Part 3 establishes a new regime for large hotel employers to ensure "access to affordable family medical care for hotel employees." SMC § 14.25.110. Delineating the voters' purposes, Part 3 – in an "Intent" section – singles out "hospitality industry employers" as purportedly among "the least likely to offer health insurance to employees" and at the "lowest" contribution levels. *Id.* The "Intent" section goes on to state that the high contribution share for the employees "force[s]" many of them "to decline such plans." *Id.* Therefore, "[a]dditional compensation reflecting hotel employees' anticipated family medical costs is necessary to improve access to

[1] Seattle included a copy of Chapter 14.25 as Ex. A to its motion to dismiss. In total, Chapter 14.25 consists of seven parts: Part 1, Protecting Hotel Employees from Violent Assault and Sexual Harassment; Part 2, Protecting Hotel Employees from Injury; Part 3, Improving Access to Medical Care for Low Income Hotel Employees; Part 4, Preventing Disruptions in the Hotel Industry; Part 5, Enforcing Compliance with the Law; Part 6, Definitions; and Part 7, Miscellaneous (which contains miscellaneous procedural provisions).

[2] Seattle included a copy of Part 3's implementing regulations at Ex. B. to its motion to dismiss. Additionally, the regulations and other guidance for Chapter 14.25, including Part 3, are available at https://www.seattle.gov/Documents/Departments/LaborStandards/Rules_Chapter150_071218.pdf, https://www.seattle.gov/Documents/Departments/LaborStandards/Rules_Chapter150_RL_071218.pdf, https://www.seattle.gov/Documents/Departments/LaborStandards/Toolkit_071218.pdf, and generally at https://www.seattle.gov/laborstandards/ordinances/hotel-employees-health-and-safety-initiative.

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medical care for low income hotel employees." *Id.*; *see also id.* § 14.25.010 (listing "Findings" underlying Chapter 14.25).

In its substance, Part 3 contains two principal subsections, located in SMC § 14.25.120. They state as follows:

> A. A large hotel employer *shall pay*, by no later than the 15th day of each calendar month, each of its low-wage employees who work full time at a large hotel additional wages or salary in an amount equal to the greater of $200, adjusted annually for inflation[3], or the difference between (1) the monthly premium for the lowest-cost, gold-level policy available on the Washington Health Benefit Exchange and (2) 7.5 percent of the amount by which the employee's compensation for the previous calendar month, not including the additional wage or salary required by this Section 14.25.120, exceeds 100 percent of the federal poverty line. The additional wages or salary required under this Section 14.25.120 are in addition to and will not be considered as wages paid for purposes of determining compliance with the hourly minimum wage and hourly minimum compensation requirements set forth in Sections 14.19.030 through 14.19.050.
>
> B. A large hotel employer *shall not be required to pay* the additional wages or salary required by this Section 14.25.120 with respect to an employee for whom the hotel employer provides health and hospitalization coverage at least equal to a gold-level policy on the Washington Health Benefit Exchange at a premium or contribution cost to the employee of no more than five percent of the employee's gross taxable earnings paid to the employee by the hotel employer or its contractors or subcontractors.

SMC § 14.25.120.A., .B. (emphasis added).

Structurally, then, subsection A establishes a requirement of direct payment to the employee of additional wages based on the cost of purchasing healthcare coverage, tempered by circumstances outlined in subsection B that negate the direct-payment requirement (namely, the employer's provision of healthcare coverage to the employee at a minimum "gold-level" and at low cost to the employee). The implementing regulations summarize Part 3's operation this way: low-wage employees have "[t]he right to additional compensation to cover medical and insurance costs *unless* the employee pays 5% or less of their monthly wages (from the hotel employer) towards an employer-offered gold-level insurance policy (for the employee and enrolled household members)." SHRR § 150-250.4.a. (emphasis added).

[3] Seattle determines the annually adjusted minimum amount, which for 2018 is $275.17. *See* SHRR § 150-215; City of Seattle Hotel Employees Health & Safety Initiative SMC 14.25, *Questions & Answers*, G.7, G.9, https://www.seattle.gov/Documents/Departments/LaborStandards/QA_HEHS_071218.pdf.

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Definitional sections in Part 3 and the regulations further delineate Part 3's scope and application. "Full time" employment, so as to make Part 3 applicable to an employee, is defined as "at least 80 hours in a calendar month." SMC § 14.25.160. Large hotel employer, through a combination of the definitions of "Hotel employer" and "Large hotel," means a person who employs employees who work in hotels with 100 or more guest rooms. *Id.* The "gold-level policy" requirement in Subsection B (whose provision by the employer negates Subsection A's direct-payment requirement) means "one that meets the requirements of a Gold Level Plan as set forth in Section 1302 of the Affordable Care Act ["ACA"] (42 U.S.C. § 18022)." SHRR § 150-200.4. The ACA defines a "Gold Level Plan" as one that includes certain enumerated "essential health benefits" and, on average, pays 80% of a covered individual's total health care costs (*i.e.*, it has an actuarial value of 80%). *See* 42 U.S.C. § 18022(d)(1)(C).[4]

There is one exception to Part 3 that is relevant for present purposes. A "Waiver" section contained elsewhere in Chapter 14.25 provides that Part 3 "may be waived in a bona fide written collective bargaining agreement . . . , if such a waiver is set forth in clear and unambiguous terms." SMC § 14.25.170.C. Part 3's implementing regulations then convert that waiver provision into a full-fledged exemption for "Taft-Hartley Plans," so that an employer enjoys an "[e]xception[]" to the "additional compensation required by SMC 14.25.120(A) when the employer is paying toward an employee's policy under a multi-employer health and welfare

[4] It is important to note that nothing in the ACA requires large hotel employers to offer a gold-level plan. The "metal level" plan descriptions in 42 U.S.C. § 18022 apply to *insurance companies* offering insurance to *individuals*, not groups. The ACA's requirement for large employer groups are less onerous. For instance, whereas through § 18022, an insurance company must include in all of its metal-level plans various benefits that are defined as "essential health benefits" by Washington State regulators (42 U.S.C. § 18022(d)), no such requirement applies for employer-based group coverage. *See* 26 U.S.C. § 4980H(a)(1) (requiring an "applicable large employer" to offer "to its full-time employees (and their dependents)" the opportunity to enroll in "minimum essential coverage" under an "eligible employer-sponsored plan"), (c)(2) (defining "applicable large employers"), (c)(5) (providing for inflation adjustment); 26 C.F.R. § 54.4980H-1(a)(4), (a)(5), (a)(16), (a)(27) (defining "applicable large employer," "employer," and "minimum essential coverage"); *id.* § 54.4980H-2 (regulations governing determination of large employer status); *see also* 26 U.S.C. § 5000A(f) (defining "minimum essential coverage" and "eligible employer-sponsored plan"); 26 C.F.R. §§ 1.5000A-0 - 1.5000A-5 (same). Therefore, by placing in subsection B of SMC § 14.25.120 a requirement that employers offer gold-level coverage consistent with 42 U.S.C. § 18022 in order to lift the direct-payment requirement in subsection A, Seattle obligates covered employers utilizing subsection B to offer coverage at a level the ACA does not mandate. Additionally, the ACA requires large employers to offer coverage to employees who work, on average, 130 hours per month, whereas Part 3 lowers that threshold to 80 hours per month. *Compare* 26 C.F.R. § 54.4980H-1(a)(21), -3(c) *with* SMC § 14.26.160.

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benefit plan established under section 302(C)(5) of the Labor Management Relations Act of 1947, 29 U.S.C. §[§] 401-531 (*i.e.*, Taft-Hartley Act)." SHRR § 150-210.2. (title); *id.* § 150-210.2.c. (title & text). Taft-Hartley plans generally have the following characteristics: (1) one or more employers contribute to the plan; (2) the plan is collectively bargained by a union with each participating employer; (3) the plan's assets are managed by a joint board of trustees with equal representation of labor and management; (4) assets are placed in a trust fund; and (5) employees who move from one participating employer to another will retain their coverage provided the new job is with one of the participating companies. *See generally* 29 U.S.C. § 1002(37).

Violations of Part 3 are punishable by penalties of at least $100 per day per employee, and up to $1,000 per day per employee, with each workday constituting a separate violation. *See* SMC § 14.25.150.E.1. Seattle must remit at least twenty-five percent of any penalties collected to the affected employees. *See id.* § 14.25.150.E.2. In addition, Chapter 14.25 provides a private right of action to employees to enforce Part 3, including the right to seek damages and attorney fees. *Id.* § 14.25.150.C.

Last, a recordkeeping requirement applies under Part 3. Large hotel employers must maintain detailed records for three years for each current and former employee who is eligible under Part 3, including their regular hourly rate of pay and, for each month of full-time employment, the amount of additional wages or salary paid under subsection A of § 14.25.120 as additional compensation reflective of the cost of gold-level medical coverage. *See* SMC § 14.25.150.B.2.

B. ERISA Preemption

Part 3, and this lawsuit challenging it, arise against the backdrop of ERISA and the federal preemption it establishes. "ERISA is a comprehensive federal statutory scheme governing employee benefit plans." *Bd. of Trs. of Glazing Health & Welfare Tr. v. Chambers*, 903 F.3d 829, 837 (9th Cir. 2018) ("*Glazing Health*"). ERISA's coverage extends to any employee benefit

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plan established or maintained by a private employer or employee organization (such as a union). *See* 29 U.S.C. §§ 1002(1), 1003(a), (b).

Despite ERISA's comprehensive coverage, "[n]othing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996); *see also Conkright v. Frommert*, 559 U.S. 506, 516 (2010) ("Congress enacted ERISA to ensure that employees would receive the benefits they had earned, but Congress did not require employers to establish benefit plans in the first place."). Rather, ERISA leaves employers free "for any reason at any time, to adopt, modify, or terminate [benefit] plans." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995).

In enacting ERISA, Congress undertook "a careful balancing" to encourage the creation of employee benefit plans and "'to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'" *Conkright,* 559 U.S. at 517 (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996)). Thus, "ERISA 'induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.'" *Id.* (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002)). Under ERISA, once an employer does decide to offer benefits, it must "'conform to various reporting, disclosure, and fiduciary requirements.'" *Glazing Health*, 903 F.3d at 837 (quoting *Boggs v. Boggs*, 520 U.S. 833, 841 (1997)).

Uniformity in the regulation and administration of ERISA plans was paramount to Congress: "'Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of "minimiz[ing] the administrative and financial burden[s]" on plan administrators – burdens ultimately borne by the beneficiaries.'" *Gobeille,* 136 S. Ct. at 944 (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 149-50 (2001), quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)). To accomplish that goal, Congress included in ERISA an express preemption provision, 29 U.S.C. § 1144(a).

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Section 1144(a) states that "the provisions of [ERISA] . . . shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in [29 U.S.C.] section 1003(a) and not exempt under section 1003(b)." *Id.* (emphasis added). Over the years, the Supreme Court has further distilled the preemption provision's "relate to" language to include any state law that makes a "'reference to'" or has a "'connection with'" ERISA plans, with each standard having its own requirements, developed through voluminous case law. *Egelhoff*, 532 U.S. at 147 (quoting *Shaw* v. *Delta Air Lines, Inc.,* 463 U.S. 85, 97 (1983)); *accord Gobeille*, 136 S. Ct. at 943; *see generally infra* pp. 19, 28.

"State law[s]" for purposes of § 1144(a) are defined to include "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State," with "State," in turn, including "a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate directly or indirectly, the terms and conditions of employee benefit plans covered by [ERISA]." 29 U.S.C. § 1144(c)(1)-(2). Accordingly, a law enacted by a municipality, such as Seattle here, qualifies as a state law within the scope of § 1144(a); *see, e.g.*, *Golden Gate Rest. Ass'n*, 546 F.3d at 648.

C. ERIC's Lawsuit and the Current Motions

ERIC is a national trade association and represents the interests of large employers with 10,000 or more employees that sponsor health, retirement, and compensation benefit plans governed by ERISA. *See* Dkt. #1 ¶¶ 9-10 ("Compl."); *see also* Decl. of Annette Guarisco Fildes ¶¶ 2-3 (Ex. A to this Opp'n & Mot.) [hereinafter "Guarisco Fildes Decl."]. ERIC's member companies voluntarily provide benefits through these plans to millions of workers and their families across the United States. *See* Compl. ¶ 10; *see also* Guarisco Fildes Decl. ¶ 3. ERIC's member companies operate in every major sector of the U.S. economy, including the hospitality industry. *See* Compl. ¶ 11; *see also* Guarisco Fildes Decl. ¶ 4. ERIC's members include employers owning or operating hotels in Seattle with 100 or more guest rooms and employing employees there. *See* Compl. ¶ 11; *see also* Guarisco Fildes Decl. ¶ 4; Decl. of Judith Fennimore

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¶ 2 (Ex. B to this Opp'n & Mot.) [hereinafter "Fennimore Decl."]; Decl. of Dawn Beaudin ¶ 4 (Ex. C. to this Opp'n & Mot.) [hereinafter "Beaudin Decl."].

On behalf of its members, ERIC brought this lawsuit in August 2018 "seek[ing] an injunction halting enforcement of Part 3 . . . on the grounds that [ERISA] preempts Part 3." Compl. ¶ 1. "ERIC also seeks a declaration that ERISA preempts Part 3, as well as all other relief available under federal law." *Id.* The parties thereafter entered a stipulation to stay Seattle's enforcement of Part 3 until the Court resolves the complaint, or until January 1, 2019, whichever is sooner. *See* Dkt. #15. In the "Claim for Relief" in its complaint, ERIC asserts that Part 3 "relate[s] to" ERISA plans, and, therefore, is preempted under ERISA's preemption provision, because Part 3 both impermissibly makes a "reference to" ERISA plans and has a "connection with" them. *See* Compl. ¶¶ 43-51.

Seattle has moved to dismiss the complaint pursuant to Rule 12(b)(6), arguing that ERISA does not preempt Part 3 (and raising no other arguments). *See* Dkt. #18 at p. 20 ("Seattle Mot.") ("the Court should reject ERIC's preemption challenge to the City's requirement that employers pay additional wages to health care [sic: hotel] workers so that those workers will have the ability to afford quality healthcare coverage"). ERIC today opposes Seattle's motion and moves for summary judgment pursuant to Rule 56, on grounds that ERISA does preempt Part 3.[5]

In connection with its summary-judgment motion, ERIC has proffered several supporting declarations, including two from ERIC member companies who are, under Part 3, large hotel

[5] As alleged in the complaint (Compl. ¶ 16), and not challenged by Seattle, ERIC has standing to bring this lawsuit. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992) (stating criteria for standing as (1) injury in fact (2) that is fairly traceable to the defendant's conduct and (3) that is likely to be redressed by a favorable decision). ERIC may bring this action in the interests of its members because "'(a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to [ERIC's] purposes; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit.'" *Ecological Rights Found. v. Pac. Lumber Co.*, 230 F. 3d 1141, 1147 (9th Cir. 2000) (quoting *Hunt v. Washington State Apple Advertising Comm'n*, 432 U.S. 333, 343 (1977)); *accord Warth v. Seldin*, 422 U.S. 490, 511 (1975) (explaining that "association must allege that its members, or any one of them, are suffering immediate or threatened injury"); *see also, e.g.*, *Merit Constr. Alliance v. City of Quincy*, 759 F.3d 122, 126-27 (1st Cir. 2014) (holding that trade association had standing to assert ERISA preemption claim on behalf of its members); *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 186-87 (4th Cir. 2007) (same) ("*RILA*"); *see generally* Guarisco Fildes Decl. ¶¶ 1-5 (noting ERIC's purposes as trade association); Fennimore Decl. ¶¶ 2, 10-13 (ERIC member noting its financial injury from Part 3); Beaudin Decl. ¶¶ 2, 10-11 (same).

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employers. *See* Exs. B, C. The declarations show that Part 3 has already had a significant impact on the companies. Both declarants note that their companies' existing employee benefit plans available to employees offered nationally, including in Seattle, did not meet the eligibility, benefit, and contribution requirements of subsection B of § 14.25.120 (though fully compliant with ERISA and the ACA). *See* Fennimore Decl. ¶¶ 8-10; Beaudin Decl. ¶¶ 7-10. Further, after careful analysis, one company determined that complying with subsection A's direct-payment requirement would cost "approximately two to eight times more than complying with Part 3 by way of Coverage Compliance [under subsection B]." Fennimore Decl. ¶ 11. The other company determined similarly. *See* Beaudin Decl. ¶ 15. As a result, both have adopted amendments to their employee benefit plans "unique for Seattle" and now "offer coverage" compliant with subsection B "in order not to pay the greater amount represented by the additional compensation requirement under Part 3." Beaudin Decl. ¶ 16; *accord* Fennimore Decl. ¶ 12.

The impact of Part 3 on large hotel employers is evident not just from the supporting declarations, but also from Seattle's own public postings and other publicly available information. Those sources, at a minimum, illustrate the high cost of subsection A's direct-payment requirement. The "Toolkit" issued by Seattle shows that an employee with a household size of two (including herself) could be owed additional monthly compensation under Part 3 of $551.54 if her employer does not offer coverage consistent with subsection B.[6] Another employee with a household size of two (including herself) could be owed $615.28 in additional compensation under Part 3, even if she is enrolled in her employer's gold-level plan, if she contributes more than five percent of her gross taxable earnings for coverage. *See* Toolkit at 8 ("Example - Makeda, Employee with gold-level benefits/Paying more than 5% for premium"). In a website sponsored by a Seattle local union, an employee with a household size of three (including herself) could be owed additional compensation of $860.33, even if she is enrolled in her employer's gold-level plan but pays more than five percent of her gross taxable earnings for

[6] *See* City of Seattle, Hotel Empl. Health & Safety Initiative SMC 14.25, *Toolkit for Calculating Additional Comp. Payments for Med. Care* 7, https://www.seattle.gov/Documents/Departments/LaborStandards/Toolkit_071218.pdf ("Example - Issa, Employee without gold-level benefits") [hereinafter "Toolkit"].

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coverage.[7] The Toolkit also makes clear that one step in the employee's determination of whether she is entitled to direct payment under subsection A is identifying whether the employee is covered by a gold-level policy and pays less than the five-percent maximum for coverage. *See* Toolkit at 9 ("Example - Eliana, Employee with gold-level benefits/Paying less than 5% for premium") ("Steps 3 and 4" inquiring about the terms of employee's employer-sponsored coverage and noting that, "[b]ecause she pays less than 5% of her April gross taxable earnings ($2520-$90 x .05 = $121.50) for April's premium, her employer does not have to pay additional compensation to Eliana for April").

DISMISSAL AND SUMMARY JUDGMENT STANDARDS

Rule 12(b)(6) authorizes dismissal where a plaintiff's complaint "fail[s] to state a claim upon which relief can be granted." Fed. R. Civ. P. 12(b)(6). In determining whether a complaint meets that threshold, the Court "'accept[s] all factual allegations in the complaint as true and construe[es] them in the light most favorable to the nonmoving party.'" *Stoyas v. Toshiba Corp.*, 896 F.3d 933, 938 (9th Cir. 2018) (quoting *Fields v. Twitter, Inc.*, 881 F.3d 739, 743 (9th Cir. 2018)). Ultimately, "[t]he Court inquires whether the complaint at issue contains 'sufficient factual matter, accepted as true, to state a claim of relief that is plausible on its face.'" *Harris v. Cty. of Orange*, 682 F.3d 1126, 1131 (9th Cir. 2012) (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). Dismissal is warranted only "based on either a lack of cognizable legal theory or the absence of sufficient facts alleged under a cognizable legal theory." *Kwan v. SanMedica Int'l*, 854 F.3d 1088, 1093 (9th Cir. 2017) (internal quotation marks and citation omitted).

Summary judgment is appropriate where there is "no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *see generally Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986). The moving party bears

[7] *See* UNITE HERE! Local 8, *Access to Affordable Family Healthcare,* Chart: Determining Healthcare Payment under SMC 14.25.120, line 9, https://www.seattleprotectswomen.org/healthcare/ (last visited Oct. 23, 2018). The Court can take judicial notice of the illustration on the union's website, as well as the examples in Seattle's Toolkit. *See Linehan v. AllianceOne Receivables Mgmt., Inc*., No. C15-1012-JCC, 2016 U.S. Dist. LEXIS 124276, at *8 (W.D. Wash. Sept. 13, 2016) ("[T]he Court may judicially notice a fact that is not subject to reasonable dispute because it can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned. Fed. R. Evid. 201(b)(2), (d).").

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the initial burden of informing the Court of the basis for summary judgment, and then the burden shifts to the opposing party to show the existence of a genuine issue of material fact. *Baxter v. MBA Grp. Ins. Tr. Health & Welfare Plan*, 958 F. Supp. 2d 1223, 1227 (W.D. Wash. 2013) (citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)). A "genuine issue of material fact exists only if the evidence is such that a reasonable trier of fact could resolve the dispute in favor of the nonmoving party." *Id.* (citing *Anderson*, 477 U.S. at 249). "'[T]he mere existence of a scintilla of evidence in support of the [nonmovant's] position will be insufficient; there must be evidence on which the [fact-finder] could reasonably find for the [nonmovant].'" *Carpenters Health & Sec. Tr. of W. Wash. v. Paramount Scaffold, Inc.*, 159 F. Supp. 3d 1229, 1233 (W.D. Wash. 2016) (quoting *Anderson*, 477 U.S. at 251).

ARGUMENT

The sole issue for consideration for both Seattle's motion to dismiss and ERIC's motion for summary judgment is whether ERISA preempts Part 3. In showing that ERISA does here effect preemption, thereby requiring the denial of Seattle's motion and the granting of ERIC's motion, ERIC first addresses two preliminary arguments that Seattle presents, involving the general standards for preemption and an alleged presumption against preemption. ERIC then turns to establishing that, under ERISA's preemption provision and the Congressional purposes it embodies, Part 3 is preempted.

I. ERISA PREEMPTION IS READILY AVAILABLE WHERE A STATE OR LOCAL LAW MAKES A REFERENCE TO OR HAS A CONNECTION WITH ERISA PLANS

At the outset of its brief, Seattle seeks to downplay the existence of ERISA preemption, as if it is a rare and unusual occurrence. *See* Seattle Mot. 9-11. In Seattle's words, ERISA preemption is "limited," and the courts supposedly "have significantly narrowed the [ERISA preemption] provision's scope in recent years." *Id.* at 9. In reality, ERISA preemption was intended to have, and continues to have, a "broad scope." *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016).

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The pertinent text of the ERISA preemption provision, again, is as follows: 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). Following from the terms Congress chose, the Supreme Court has repeatedly characterized § 1144(a)'s text as "clearly expansive," having "an expansive sweep," "conspicuous for its breadth," "deliberately expansive," and "broadly worded." *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 324 (1997) ("*Dillingham*") (internal quotation marks and citations omitted) (cataloging statements in prior precedents); *accord Gobeille*, 136 S. Ct. at 943. Near the time of ERISA's enactment, the Supreme Court termed the preemption provision as revolutionary for its era (*see Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 24 n.26 (1983) (describing § 1144(a) as a "virtually unique pre-emption provision")) and the "'crowning achievement'" of the statute. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983) (quoting 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent)). From that time to now, the Court has never wavered from the principle that, with ERISA's preemption provision, Congress intended to make federal regulation of employee benefit plans "'exclusively a federal concern.'" *Gobeille*, 136 S. Ct. at 944 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)).

Additionally, as also mentioned earlier, the Supreme Court has further refined the "relate to" language in § 1144(a), so that the clause applies whenever a state or local law makes a "reference to" or has a "connection with" ERISA plans (standards that ERIC details and applies in later sections of this brief). *See Gobeille*, 136 S. Ct. at 943. As with the tests associated with any federal preemption provision, the "reference to" and "connection with" standards are to be interpreted and applied with an eye toward "the objectives of the . . . statute," which serve "as a guide to the scope of the state law that Congress understood would survive." *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) ("*Travelers*"); *see generally Jones v. Rath Packing Co*., 430 U.S. 519, 539-42 (1977).

To be sure, there was a time in the mid-1990s when the Supreme Court – most notably in *Travelers* – hit the "pause" button on ERISA preemption, to reassess its jurisprudence in the area.

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See, e.g., *Travelers*, 514 US. at 655-56; *see also, e.g.*, *Dillingham*, 519 U.S. at 324; *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 (1997). As a result of the reexamination, the Court instructed the lower courts not to apply woodenly or "literal[ly]" the preemption provision's text and, instead, to redouble their efforts to ensure that preemption in the particular situation furthers Congress's purposes. *Travelers*, 514 U.S. at 656. But it overruled no cases, instead reiterating the validity and applicability of pre-*Travelers* precedents. *See Dillingham*, 519 U.S. at 324-25 (reaffirming results in earlier precedents, including *District of Columbia Board of Trade*); *accord Travelers*, 514 U.S. at 657-58; *see generally De Buono*, 520 U.S. at 813 ("In our earlier ERISA pre-emption cases, it had not been necessary to rely on the expansive character of ERISA's literal language in order to find pre-emption because the state laws at issue in those cases had a clear 'connection with or reference to' . . . ERISA benefit plans.") (quoting *Shaw*, 463 U.S. at 96-97).

Indeed, in its most recent (*i.e.*, post-2000) decisions involving § 1144(a), the Supreme Court has straightforwardly held in favor of preemption. *See, e.g.*, *Gobeille*, 136 S. Ct. at 944-45; *Egelhoff v. Egelhoff*, 532 U.S. 141, 148-49 (2001); *cf. Aetna Health Inc. v. Davila*, 542 U.S. 200, 217 (2004) (finding preemption based on conflict with ERISA's enforcement scheme); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 365 (2002) (finding that state law "relate[d] to" employee benefit plans, but that state law then fell within separate savings clause for insurance regulations). Likewise, the Ninth Circuit has continued to acknowledge that § 1144(a) "broadly preempts" state law (*Fossen v. Blue Cross & Blue Shield of Mont.*, 660 F.3d 1102, 1108 (9th Cir. 2011), albeit with the caveat that the post-*Travelers* "modern approach" to ERISA preemption necessitates ensuring that a holding of preemption furthers ERISA's underlying purposes. *See Glazing Health*, 903 F.3d at 847.

In this case, the parties' doctrinal dispute might best be put in terms of *the degree* to which ERISA preemption operates: is it readily available, or hardly available? The case law and ERIC say the former; Seattle erroneously implies the latter. While § 1144(a) might currently be subject to "narrow[er]" construction than at one time (*see id.* at 846), it remains a "broad preemption

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provision." *Fossen*, 660 F.3d at 1108; *accord Gobeille*, 136 S. Ct. at 943; *cf. id.* at 958 (Ginsburg, J., dissenting) (characterizing the majority re-posturing § 1144(a) "as a 'super-preemption' provision").

II. THERE IS NO PRESUMPTION AGAINST PREEMPTION IN THIS CASE

Seattle next presses for a starting presumption against preemption of Part 3. *See* Seattle Mot. 9-12. As a general matter, in situations involving an express statutory preemption provision (as in the ERISA setting), the notion of a presumption against preemption appears to be – bluntly speaking – near death. Undoubtedly, beginning in 1992, the Supreme Court did invite a "presumption against the pre-emption of state police power regulations," even when applying an express preemption provision. *Cipollone v. Liggett Group*, 505 U.S. 504, 518 (1992). However, since that time, five Justices of the Supreme Court have rejected the principle that a presumption against preemption can apply in such situations. As Justice Scalia has stated, joined by three other Justices:

> I remain convinced that "[t]he proper rule of construction for express pre-emption provisions is . . . the one that is customary for statutory provisions in general: Their language should be given its ordinary meaning." *Cipollone v. Liggett Group, Inc.*, 505 U. S. 504, 548, 112 S. Ct. 2608, 120 L. Ed. 2d 407 (1992) (Scalia, J., concurring in judgment in part and dissenting in part). The contrary notion – that express pre-emption provisions must be construed narrowly – was "extraordinary and unprecedented" when this Court announced it two decades ago, *id.*, at 544, 112 S. Ct. 2608, 120 L. Ed. 2d 407, and since then our reliance on it has been sporadic at best, *see Altria Group, Inc. v. Good*, 555 U.S. 70, 99-103, 129 S. Ct. 538, 172 L. Ed. 2d 398 (2008) (Thomas, J., dissenting).

CTS Corp. v. Waldburger, 134 S. Ct. 2175, 2189 (2014) (Scalia, J., concurring, and joined by Roberts, C.J., and Thomas and Alito, J.J.). Justice Kennedy has added that the principle of a presumption against preemption, insofar as earlier case law supports it, is now better thought of "not as a presumption but as a cautionary principle to ensure that pre-emption does not go beyond the strict requirements of the statutory command." *Ariz. v. Inter Tribal Council of Ariz., Inc.*, 570 U.S. 1, 21 (2013) (Kennedy, J., concurring).

Specifically, too, with respect to § 1144(a), the Supreme Court has suggested the demise of the presumption. True, the Supreme Court did, twenty years ago (in *Travelers*, *Dillingham*,

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and *De Buono*), embrace in ERISA cases a presumption against preemption when the state sought to regulate "in fields of traditional state regulation." *Travelers*, 514 U.S. at 655. But recently in *Gobeille*, the Court refused to recognize at all the existence of a presumption against preemption, prompting a dissent from Justice Ginsburg. *Compare* 136 S. Ct. at 946 ("*Any* presumption against pre-emption, *whatever* its force in other instances, cannot validate a state law that enters a fundamental area of ERISA regulation and thereby counters the federal purpose in the way this state law does.") (emphasis added) *with id.* at 954 (Ginsburg, J., dissenting) (relying heavily on a "[t]he presumption against preemption").[8]

Nonetheless, since the Supreme Court has not yet formally overruled the presumption, this Circuit does continue to apply it in the ERISA context, in an appropriate case. *See Glazing Health*, 903 F.3d at 846-47, 848-49. Still, heavy reliance on the presumption would be out of sync with the current "debate within the Supreme Court." *Bell v. Blue Cross of Blue Shield of Okla.*, 823 F.3d 1198, 1201 (8th Cir. 2016), *cert. denied*, 137 S. Ct. 1812 (2017) (FEHBA case).

In any event, even assuming that an unadulterated presumption against preemption generally still endures, the presumption does not here apply, under the presumption's own terms. A presumption against preemption can operate only in areas of "traditional state regulation," where the states' "'historic police powers'" are at their apex. *Travelers*, 514 U.S. at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). And a corollary of the requirement that the state or locality be regulating in a traditionally state-law area is that the state or locality may not seek to define the field so broadly as to place just about any measure within a favored sphere. "[T]he primacy of the state's police powers is not universal." *Lofton v. McNeil Consumer & Specialty Pharm.*, 672 F.3d 372, 378 (5th Cir. 2012). If definition of a state's police

[8] Even more recently, the Supreme Court illustrated its current distaste for a presumption against preemption in a case involving ERISA's close cousin, the Federal Employees Health Benefits Act ("FEHBA"), which governs health benefit plans for federal employees. There, construing FEHBA's express preemption provision, the Court reversed the non-preemption holding of the lower court, which had – in finding no preemption – relied almost exclusively on an alleged presumption against preemption. *See Coventry Health Care of Mo., Inc. v. Nevils*, 137 S. Ct. 1190, 1195-96, 1198 (2017); *see also Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 393-94 (9th Cir. 2002) (holding that, because FEHBA's preemption clause "closely resembles ERISA's express preemption provision, . . . ERISA and FEHBA cases [can be] refer[red] to interchangeably").

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powers were so elastic, then "the same or similar justifications for the exercise of police power could be advanced for most any business or industry." *Chamber of Commerce of United States v. Bragdon*, 64 F.3d 497, 504 (9th Cir. 1995).

Glazing Health, which is an ERISA preemption case, sheds light on how to determine if a state is exercising its traditional powers, so as to trigger operation of a presumption against preemption. The Ninth Circuit there did find the presumption operative because the state law "target[ed] an area of traditional state concern," not "'the field of laws regulating "employee benefit plan[s]."'" 903 F.3d at 848, 847 (quoting *Dillingham*, 519 U.S. at 336 (Scalia, J., concurring), quoting 29 U.S.C. § 1144(a)). The local law at issue in *Glazing Health* was a Nevada statute "hold[ing] general contractors vicariously liable for the labor debts owed by subcontractors to subcontractors' employees on construction projects"; in particular, recent amendments sought, in various ways, to "limit[] the damages that may be collected from general contractors." *Id.* at 834. Trusts administering ERISA plans found the Nevada regime attractive because it allowed them to sue general contractors for delinquent "benefit contributions" that subcontractors owed, but the amendments then cut back on potential recoveries and even contained specific "notice" requirements applicable to "ERISA trusts." *Id.* at 834-35.

Finding a presumption against preemption, the Ninth Circuit emphasized that "[d]ebt collection is an area of traditional state regulation." *Id.* at 848. In fact, "Nevada ha[d] regulated the particular type of debt collection practice here – vicarious liability for construction debts – since the 1930s." *Id.* Though one aspect of the new amendments focused on ERISA trusts, the "various components [of the amendments were] all of a piece regulating the exposure of general contractors – *who are not parties to ERISA plans* – to vicarious liability for subcontractors' debts." *Id.* at 849 (emphasis added). As such, the Nevada law was not focused on ERISA plans, but "directed at an area of traditional state concern." *Id.* at 846.

In contrast to the situation involved in *Glazing Health*, Seattle with Part 3 has targeted ERISA plans and parties to them, which is the exclusive concern of ERISA. On its face, Part 3 states as its "Intent" the countering of the supposed evil that "hospitality industry employers are

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the least likely to offer *health insurance to employees*"; moreover, Part 3 takes aim at employee contributions to their employer-sponsored plans, emphasizing that, because "[t]he average monthly cost to a hotel employee for family medical coverage through an *employer-offered plan* exceeds $500 per month, . . . nearly half of eligible employees . . . decline *such plans*." SMC § 14.25.110 (emphasis added); *see also id.* § 14.25.010 (listing among the "Findings" for Chapter 14.25 that "hospitality employees have the lowest rate of access *to employer-offered health insurance* of any industry in the State of Washington and face unaffordable monthly premiums for family healthcare") (emphasis added). To remedy those alleged problems, Part 3 establishes a regime that requires direct payments of money to employees if a large hotel employer fails to provide to covered employees a *health benefit plan* whose substantive content qualifies as gold-level and is inexpensive to employees (or otherwise is a Taft-Hartley plan).

With Seattle having targeted the exclusively federally-regulated area of private-employer health benefit plans, the subject-matter of Part 3 "is hardly 'a field which the States have traditionally occupied.'" *Buckman Co. v. Pls.' Legal Comm.*, 531 U.S. 341, 347 (2001) (quoting *Rice*, 331 U.S. at 230) (rejecting presumption against preemption for state anti-fraud cause of action applied to drug companies regulated by the U.S. Food and Drug Administration); *accord Nathan Kimmel, Inc. v. DowElanco*, 275 F.3d 1199, 1205 (9th Cir. 2002). Unlike Nevada in *Glazing Health*, Seattle has not long regulated on the subject matter or addressed liability for a class of parties (*i.e.*, general contractors) lacking a special association with ERISA plans; rather, Seattle has focused on "parties to ERISA plans" where it has identified supposedly inadequate plan benefits and terms, thereby "invad[ing] the federal field." *Glazing Health*, 903 F.3d at 849, 848. As a consequence, "no presumption against pre-emption obtains in this case." *Buckman*, 531 U.S. at 348; *accord Locke v. United States*, 529 U.S. 89, 108 (2000) ("an 'assumption' of nonpre-emption is not triggered when the State regulates in an area where there has been a history of significant federal presence").

Seeing things differently, Seattle predictably asserts (in its briefing) that Part 3 constitutes "general health care regulation," with "health . . . matters" being an area traditionally occupied

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by the states. Seattle Mot. 11-12 (alteration in original; internal quotation marks and citations omitted). To the contrary, Part 3 is not a generic law aimed at medical standards, medical providers, or even health insurance companies; by Seattle's own description of its "Intent" and "Findings" (as noted above), it is a law trained on employers and their health benefit plans, which, again, are ERISA's exclusive concern. Though Seattle did also initially state its "Intent" in the broad terms of "improv[ing] access to affordable family medical care for hotel employees," it identified (in the same "Intent" section) the supposedly inadequate offering of health benefit plans by employers as the root of the problem, which it then seeks to fix with Part 3. SMC § 14.25.110. Under these circumstances, Seattle should fare no better than other states and localities that have unsuccessfully attempted to use expansive incantations of police powers to garner a presumption against preemption for enactments aimed at populations or activities typically federally-regulated. *E.g.*, *Locke*, 529 U.S. at 108 (maritime oil spills); *United States v. Arizona*, 641 F.3d 339, 348 (9th Cir. 2011), *rev'd on other grounds*, 567 U.S. 387 (2012) (immigrants); *Bell*, 823 F.3d at 1201-02 (health benefits for FEHBA-plan enrollees); *Helfrich v. Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090, 1105-06 (10th Cir. 2015) (same); *Epps v. JP Morgan Chase Bank, N.A.*, 675 F.3d 315, 322 (4th Cir. 2012) (national banks); *US Airways, Inc. v. O'Donnell*, 627 F.3d 1318, 1325 (10th Cir. 2010) (alcohol on airline flights).[9]

Finally, the Ninth Circuit's decision in *Golden Gate Restaurant Ass'n v. City & County of San Francisco*, 546 F.3d 639 (9th Cir. 2008), provides no refuge to Seattle for a presumption against preemption here. *See* Seattle Mot. 12. There, in the face of an ERISA challenge, the court did apply a presumption against preemption to a San Francisco law designed to establish a

[9] In a footnote, Seattle hints that a presumption against preemption should exist because Part 3 supposedly is a minimum-wage law, and "'[s]tates possess broad authority under their police powers to regulate the employment relationship to protect workers within the State.'" Seattle Mot. 11 n.9 (quoting *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 756 (1985)). However, in Part 3 itself, Seattle expressly distinguished the legislation from minimum-wage statutes, stating that Part 3's provisions were "in addition to" and "not [to] be considered" when measuring compliance with such statutes. SMC § 14.25.120.A. Additionally, although Seattle now states that Part 3 was intended to supply money to employees "to buy [health] coverage *or not*" (Seattle Mot. 1 (emphasis added)), that is a blatant mischaracterization of Seattle's purposes. Nothing in Part 3 suggests Seattle sought simply to deepen the pockets of hotel employees, as opposed to get them health insurance. Part 3's stated "Intent" declares precisely the opposite. *See* SMC § 14.25.110.

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set level of health-care spending by employers, at the risk of the employer otherwise making payments to the city for the city to provide health insurance to covered employees. The Ninth Circuit described that law as focused on "health care services to persons with low or moderate incomes." 546 F.3d at 648. Importantly (and as explained in greater length later, *see infra* pp. 22-23), the Ninth Circuit emphasized that the law was *not* aimed at *the benefits* employers supplied; nor was the law centered on a single industry that regulators had identified as allegedly offering inadequate ERISA plans. *See* 546 F.3d at 658. Because, in contrast, Seattle has enacted a measure targeting employers and their health benefit plans, it seeks to regulate "'objects'" within ERISA's exclusive sphere, precluding any presumption against preemption. *Glazing Health*, 903 F.3d at 847 (quoting *Boggs v. Boggs*, 520 U.S. 833, 841 (1997)).

III. PART 3 MAKES A REFERENCE TO ERISA PLANS AND THEREFORE IS PREEMPTED

A. Part 3 Impermissibly References ERISA Plans Because It Makes Payment of Additional Wages to Employees Contingent on the Benefits Provided in the Employer's ERISA Plan

Whether or not there is a presumption against preemption in this case, Part 3 easily succumbs to ERISA preemption because it makes a reference to ERISA plans. To meet the test for an impermissible reference to ERISA plans, a state or local law "must both identify ERISA plans and '"act[] immediately and exclusively upon ERISA plans'" or make "'the existence of ERISA plans . . . essential to the law's operation.'"'" *Id.* at 847 (quoting *Gobeille*, 136 S. Ct. at 943, quoting *Dillingham*, 519 U.S. at 325) (emphasis removed). In other words, a state or local law references ERISA plans where it "'mentions or alludes to ERISA plans, and has some effect on the referenced plans.'" *Id.* at 852 (quoting *WSB Elec., Inc. v. Curry*, 88 F.3d 788, 793 (9th Cir. 1996)) (emphasis removed).

Part 3 fails under these standards, because – via the interplay between subsections A and B of § 14.25.120 – the law's operation hinges on the existence and, indeed, the content of large hotel employers' ERISA plans. As noted earlier (*see supra* pp. 3-4), the law is structured in the following way: Subsection A of § 14.25.120 requires the payment of additional compensation

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to affected employees *unless*, under subsection B, "the hotel employer provides health and hospitalization *coverage* at least equal to a gold-level policy on the Washington Health Benefit Exchange at a premium or contribution cost to the employee of no more than five percent of the employee's gross taxable earnings." SMC § 14.25.120.B. (emphasis added). Hence, the requirement to pay the additional compensation under subsection A is facially tied to the non-satisfaction of subsection B – *i.e.,* whether subsection A applies to large hotel employers can be determined only after making the determination under subsection B regarding whether the employer provides health benefits to covered employees at the prescribed gold level and at a sufficiently low cost to the employee.

Further, the mention in subsection B to "coverage" by hotel employers is not just an "'allu[sion]'" to ERISA plans (which would be sufficient, anyway), but a direct mention of them. *Glazing Health*, 903 F.3d at 852 (quoting *WSB Elec.*, 88 F.3d at 793). *All* health benefits coverage administered and funded by a private employer constitutes an ERISA plan. *See* 29 U.S.C. § 1002(1) (ERISA defining an "employee welfare benefit plan" as "any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of *providing* for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . *medical, surgical, or hospital care or benefits, or benefits in the event of sickness*) (emphasis added); *Glazing Health*, 903 F.3d at 848 ("An ERISA 'plan' is a 'set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing *collection of premiums*, *definition of benefits*, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan.'") (quoting *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000)) (emphasis added). In essence, then, by making operation of the direct-payment requirement in subsection A dependent on the level of employer health benefits coverage, which is an ERISA plan, Seattle has made ERISA plans integral – "essential" in *Dillingham*'s jargon – to Part 3's application. *Dillingham*, 519 U.S. at 325.

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Not only does Part 3 identify ERISA plans, it "affects" their operation, because it "'reach[es] in one way or another the "terms and conditions of employee benefit plans."'" *Glazing Health*, 903 F.3d at 853 (quoting *Lane v. Goren*, 743 F.2d 1337, 1339 (9th Cir. 1984), quoting 29 U.S.C. § 1144(c)(2)). By authorizing non-operation of the direct-payment requirement in subsection A if the hotel employer structures its ERISA plan to include gold-level coverage, to limit the cost to the covered employee, and to expand the eligibility terms of the plan to encompass the employee, Part 3 encourages – indeed, inevitably *causes* – changes to the employer's ERISA plan. So long as it is less expensive to alter the ERISA plan to satisfy subsection B's requirements, which ERIC alleges is the case (*see* Compl. ¶¶ 7, 46), rational employers can be expected to do so. To that end, the declaration evidence establishes that ERIC members have, in fact, altered their ERISA plans in order not to be subject to the direct-payment requirement in subsection A, given the onerous cost of compliance with subsection A. *See supra* p. 9. Nor does Seattle appear to dispute that "employers could save money by amending their plans instead of paying additional wages." Seattle Mot. 15.

Two precedents particularly reinforce that Part 3 makes an impermissible reference to ERISA plans. The first is *Greater Washington Board of Trade*. There, the District of Columbia enacted a workers' compensation law that required employers who provided health insurance to their employees to provide equivalent coverage for injured employees eligible for workers' compensation benefits. 506 U.S. at 128-29. The employers had to provide health insurance coverage to the injured employee "at the same benefit level that the employee had at the time the employee received or was eligible to receive workers' compensation benefits." *Id.* at 128 (quotation marks and citation omitted). The Supreme Court found the law preempted even though workers' compensation plans, in and of themselves, are excluded from ERISA's ambit. *See id*. at 131; 29 U.S.C. § 1003(b)(3). It concluded that the law "specifically refers to welfare benefits plans regulated by ERISA" because "[t]he health insurance coverage that . . . employers [must] provide for eligible employees is measured by reference to 'the existing health insurance coverage' provided by the employer and 'shall be at the same benefit level.'" 506 U.S. at 130

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(quoting local law). "The employee's 'existing health insurance coverage,' in turn, is a welfare benefit plan under [29 U.S.C. § 1002(1)], because it involves a fund or program maintained by an employer for the purpose of providing health benefits for the employee 'through the purchase of insurance or otherwise.'" 506 U.S. at 130 (quoting 29 U.S.C. § 1002(1)).

The Supreme Court also highlighted, citing to the D.C. Circuit's decision in the case, that preemption "would advance the policies and purposes served by ERISA pre-emption." *Id.* at 129 (citing *Greater Washington Bd. of Trade v. District of Columbia*, 948 F.2d 1317, 1325-26 (D.C. Cir. 1991)). In that regard, the D.C. Circuit had relied on earlier Supreme Court precedent, stating: "[S]tate laws [that] . . . attempt to dictate what benefits shall be paid under a plan . . . would create the prospect that plan administration would be subject to differing requirements regarding benefit eligibility and benefit levels – precisely the type of conflict that ERISA's pre-emption provision was intended to prevent." 948 F.2d at 1326 (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 13 n.8 (1987)).

Just as in *Greater Washington Board of Trade*, Part 3 impermissibly references ERISA plans by "tying" the law's operation to "benefit levels . . . in an ERISA-covered plan." 506 U.S. at 129. Whereas the District of Columbia law made non-ERISA workers' compensation benefits dependent on the level of ERISA benefits, Part 3 makes operation of the direct-payment requirement dependent on the level of ERISA benefits that the hotel employer provides to covered employees, with gold-level coverage being a necessity to avoid direct payments. In both instances, the local laws "'*could* have a serious impact on the administration *and content* of the ERISA-covered plan.'" *Id.* (quoting 948 F.2d at 1325) (emphasis added).

The other particularly relevant precedent is *Golden Gate Restaurant Ass'n*. As earlier noted, the Ninth Circuit there considered a San Francisco law that required all employers to spend a specified amount on health coverage for their employees or otherwise make certain payments to the city for the city to provide insurance to the covered individuals. *See supra* pp. 18-19. It held that the law did not make a reference to ERISA plans. In so holding, the Ninth Circuit

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distinguished *Greater Washington Board of Trade*, and that discussion is crucially relevant for Part 3:

> There is a critical distinction between the ordinance in *Greater Washington* and the Ordinance in this case. Under the ordinance in *Greater Washington*, obligations were measured by reference to the level of *benefits* provided by the ERISA plan to the employee. Under the Ordinance in our case, by contrast, an employer's obligations to the City are measured by reference to the *payments* provided by the employer to an ERISA plan or to another entity specified in the Ordinance, including the City. The employer calculates its required payments based on the hours worked by its employees, *rather than on the value or nature of the benefits* available to ERISA plan participants. Thus, unlike the ordinance in *Greater Washington*, the Ordinance in this case is not determined, in the words of [§ 1144(a)], by "reference to" an ERISA plan.

546 F.3d at 658 (first two emphases in original; final emphasis added); *accord Glazing Health*, 903 F.3d at 856 (noting that San Francisco ordinance in *Golden Gate Restaurant Ass'n* survived preemption because it "did not regulate benefits owed employees under the plan," but employer "payments *to* ERISA plans") (emphasis in original).

It is impossible to pay fidelity to the Ninth Circuit's words in *Golden Gate Restaurant Ass'n* and still reject preemption in this instance, for Part 3 is indistinguishable from the type of law that the Ninth Circuit insisted *does* – under *Greater Washington Board of Trade* – make an impermissible reference to ERISA plans. Subsection B of § 14.25.120, unlike the San Francisco ordinance, "acts immediately and exclusively" on ERISA plans (*Dillingham*, 519 U.S. at 325) because it makes the direct-payment requirement contingent on the "*value* or *nature* of benefits" the employer offers *in* its ERISA plan, not on the contributions the employer makes *to* ERISA plans. *Golden Gate Rest. Ass'n*, 546 F.3d at 658 (emphasis added). Again, under Part 3, if the hotel employer provides coverage that is gold-level and at a low contribution rate for the covered employee, then the employer is not subject to the direct-payment requirement. Gold-level means coverage that "meets the requirements of a Gold Level Plan" offered in Washington's individual insurance market; under the ACA, a gold-level plan must contain certain specified "essential health benefits" and have limited cost-sharing (*i.e.*, deductibles, copayments, etc.) so that it has an actuarial value of at least 80% (meaning that, for the average population, the plan pays 80% of all of the employee's health care requirements). SHHR § 150-200.4.; *see supra* p. 4 & n.4.

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Part 3 "regulat[es] . . . the plans themselves," not just contributions to the plans, so that it – in contrast to San Francisco's law – makes a reference to ERISA plans. *Glazing Health*, 903 F.3d at 856.

In its motion to dismiss, Seattle raises two arguments to contest that Part 3 makes an impermissible reference to ERISA plans; neither has merit. First, Seattle says that Part 3 does not refer to ERISA plans at all because it "imposes obligations only on *employers*, not ERISA plans." Seattle Mot. 18 (emphasis in original). That argument is quickly dispatched because subsection B makes express reference to the "coverage" that the employer provides (*i.e.*, demanding that the coverage be gold level in order to negate the direct-payment requirement). As explained earlier, the term "coverage" is synonymous with ERISA plan. *See supra* p. 20. Furthermore, the Supreme Court in *Greater Washington Board of Trade* held precisely that a state statutory reference to an employee's "health insurance coverage" means "a welfare benefit plan under ERISA." 506 U.S. at 130; *see also FMC Corp. v. Holliday*, 498 U.S. 52, 59 (1990) (state anti-subrogation law impermissibly made "a 'reference' to benefit plans governed by ERISA" because it addressed "'benefits . . . paid or payable under . . . any program, group contract or other arrangement for payment of benefits,'" including "'benefits payable by a hospital plan corporation or a professional health service corporation'") (quoting 75 Pa. Cons. Stat. §§ 1719-1720).

Second, Seattle maintains that any reference Part 3 does make to ERISA plans is not impermissible because an employer "may comply with the Ordinance without making any changes to its existing benefit plan," presumably by simply making the direct payments called for in subsection A. Seattle Mot. 17. In that sense, according to Seattle, "[a]lthough one *alternative* means of satisfying the Ordinance is for an employer to provide a minimum level of benefits through an ERISA plan, that is not the *exclusive* means of satisfying the Ordinance." *Id.* at 18 (emphasis in original). But Seattle misreads Part 3 in contending that there are two alternatives for compliance offered in the law. Subsection A of § 14.25.120 states what an employer "shall pay," and Subsection B then qualifies that payment obligation by identifying the

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circumstances under which the "hotel employer shall not be required to pay the additional wages." SMC § 14.25.120.A., .B. Subsection A and B are not "either/or" propositions; instead, they *together* establish what is required from an employer. Proving that they are not separate, alternative options, Seattle's own Toolkit guidance for compliance makes, as a step in determining whether a direct payment is owed to the employee, the determination of whether the employer offers coverage consistent with Subsection B. *See supra* p. 10. And again, Seattle has elsewhere described the direct-payment obligation as applying "unless" the employer offers gold-level coverage at low-contribution cost to the employee. *See supra* pp. 3-4.

Nonetheless, even if Subsections A and B did constitute mutually-exclusive alternatives for compliance (which they do not), *Greater Washington Board of Trade* once more spoils Seattle's defense. The District of Columbia there pressed a variation of the same argument, contending that its law "allow[ed] for the provision of health benefits through a separate plan that employers could administer independently of their ERISA-covered plans"; seemingly, its point was that the law did "not require employers to alter ERISA-covered plans," since they could comply simply by matching the existing, available ERISA benefits in their non-ERISA regulated workers' compensation coverage. 948 F.3d at 1325; *accord* 506 U.S. at 129 (noting District of Columbia's argument, which prevailed in the district court). The Supreme Court, however, rejected the argument, *see id.* at 132, as did the D.C. Circuit (whose decision the Supreme Court affirmed). *See* 948 F.2d at 1325-26. Under the scenario the District of Columbia identified, the local law still "burden[ed]" ERISA plans, because every time an employer would thereafter consider adding ERISA-plan benefits, it would have to factor in the added cost of providing matching benefits in its workers' compensation coverage, leaving the employer potentially to decide against changing the ERISA plan. *Id.* at 1325. In an analogous way, utilizing under Part 3 the supposed free-standing alternative of direct payments burdens ERISA plans: employers will have to factor in the added cost of the direct payments when designing their ERISA-plan benefits and might reduce such benefits to account for the costs of direct

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payments or – to the true detriment of the very individuals Part 3 and ERISA were intended to protect – eliminate ERISA coverage for some of the covered employees altogether.

In reality, if Seattle were right that a reference in a state law is not impermissible so long as a less offensive option to ERISA preemption exists under the particular law, there might then never be a state law that fails under the "reference to" prong of ERISA preemption. Instead of complying with the preempted part of the statute, the employer always could choose to pay the penalties associated with non-compliance. Its ERISA plan would go unaffected, because it opted for the financial burden of the penalty. In effect, Seattle offers something very similar: a large hotel employer can preserve its ERISA plan as is, so long as it pays the bounty – *i.e.*, direct payments to the employee under subsection A of § 14.25.120. ERIC knows of no decision from the Supreme Court, the Ninth Circuit, or any other court that authorizes a state to exact a fee from an employer (whether payable to the state or to employees) to enjoy the protections Congress afforded in § 1144(a).

B. Part 3 Impermissibly References ERISA Plans Because of the Exception for Taft-Hartley Plans

Separately, Part 3 makes another impermissible reference to ERISA plans, necessitating preemption. Apparently deriving from Part 3's "Waiver" provision applicable to collective-bargaining situations, the implementing regulations create an exception for Taft-Hartley plans, so that no employer contributing to such a plan need comply with Part 3. *See supra* pp. 4-5. "A 'Taft-Hartley plan' is synonymous with an ERISA plan." *Glazing Health*, 903 F.3d at 836 n.3. Thus, by exempting Taft-Hartley plans, Seattle regulators have divvied out exceptions to Part 3 based on *the type* of ERISA plan that an employer has adopted. If the plan is pursuant to a collective-bargaining agreement with a union and has the other facets qualifying it as a Taft-Hartley plan, the plan is exempt (*see supra* p. 5); otherwise, the plan is subject to Part 3.

A state law that exempts ERISA plans from its operation makes an "express reference to ERISA plans," "singles out ERISA employee welfare benefit plans for different treatment under state [law]," and "is pre-empted under § [1144(a)]." *Mackey v. Lanier Collection Agency &*

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Serv., Inc., 486 U.S. 825, 830 (1988). No less, a state law that exempts *some* ERISA plans but not others makes an impermissible reference to ERISA plans. That was the conclusion of the Eighth Circuit recently in *Pharmaceutical Care Management Ass'n v. Gerhart*, 852 F.3d 722, 729 (8th Cir. 2017), where a state law exempted self-funded ERISA plans (*i.e.*, those where the employer carries the risk of loss) from insured ones (*i.e.*, those where an insurance company carries the risk of loss). "If the effect of a State law is to exclude some employee benefit plans from its coverage, that law has a prohibited reference to ERISA and is preempted under 29 U.S.C. § 1144(a)." *Id.* Here, Part 3 not only has that "effect," the regulations on their face exclude Taft-Hartley plans from Part 3's scope.

The exception for Taft-Hartley plans also has "some effect" on employers subject to Part 3, clinching the case that it constitutes an impermissible reference to ERISA plans. *Glazing Health*, 903 F.3d at 852 (internal quotation marks and citation omitted). Where possible, an employer now has an incentive to opt to terminate its existing non-Taft-Hartley plan and join a Taft-Hartley plan, in order to spare itself from the other provisions of Part 3.

Seattle maintains that, if the exception for Taft-Hartley plans is preempted, it should not result in the "entirety" of Part 3 being invalidated, suggesting Seattle thinks that just the exception should be struck. Seattle Mot. 19. But the presence of the exception itself proves that the focus of Part 3 is on employee benefit plans in the first instance. An exemption for a certain type of ERISA plan is necessary only if the law in the first place "encroaches" on the "field" of employee benefit plans. *Glazing Health*, 903 F.3d at 848. Hence, if the exception fails to make the grade, there is no analytically principled way to say the statute to which the exception is attached instead makes the grade. The circumstances might be different if the exception were to a long-standing general law applicable to business at large, though even there the question is a "close one." *Mackey*, 486 U.S. at 830-31; *see also, e.g.*, *Glazing Health*, 903 F.3d at 853-54. Here, Part 3 in its main portion and its regulatory exception for Taft-Hartley plans "target[s] . . . aspect[s] of the federal field occupied by ERISA." *Id.* at 852.

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IV. PART 3 HAS A CONNECTION WITH ERISA PLANS AND THEREFORE IS PREEMPTED

Because Part 3 references ERISA plans, the Court need not reach the next inquiry – namely, whether Part 3 has a connection to ERISA plans. That is, Seattle's motion to dismiss and ERIC's summary judgment motion can both be resolved – in ERIC's favor – simply based on the "reference to" analysis. Yet, if the Court does go further and inquires whether Part 3 has an impermissible connection with ERISA plans, it should answer "yes."

The standards for the "connection with" prong of ERISA preemption doctrine are not as precise as with the "reference to" prong. The courts, instead, have placed offending state laws into categories, based on the laws' characteristics and practical consequences. A state law has an impermissible connection when it "'governs . . . a central matter of plan administration' or 'interferes with nationally uniform plan administration.'" *Gobeille*, 136 S. Ct. at 943 (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001)). Included among state laws proscribed in those categories are state measures "that mandate[] employee benefit structures or their administration." *Travelers*, 514 U.S. at 658. "A state law also might have an impermissible connection with ERISA plans if 'acute, albeit indirect, economic effects' of the state law 'force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers.'" *Gobeille*, 136 S. Ct. at 943 (quoting *Travelers*, 514 U.S. at 668). In each instance, to confirm if the state law at issue is the kind that has impermissible connection to an ERISA plan, the courts ultimately "'look both to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive," as well as to the nature of the effect of the state law on ERISA plans.'" *Egelhoff*, 532 U.S. at 147 (quoting *Dillingham*, 519 U.S. at 325, quoting *Travelers*, 514 U.S. at 656)).

Part 3 has those disqualifying contours. First of all, Part 3 is a law that mandates benefit structures – *i.e.*, dictates eligibility for benefits, a certain level of benefits, and specific employee contributions levels. Subsection B of § 14.25.120 requires a large hotel employer – at pain of otherwise making substantial direct payments to the employee under subsection A – to establish

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minimum eligibility at 80 worked-hours per month, mandates gold-level benefits and terms, and institutes a 5%-of-gross-taxable-earnings premium contribution level for covered employees. The content of eligibility criteria, benefit requirements, and employee contribution levels are all "central" matters of plan administration (*Gobeille*, 136 S. Ct. at 943); or, as the Ninth Circuit has said, a state has "regulated the core operations of the plans themselves" when it has "'t[old] employers how to write ERISA benefit plans.'" *Glazing Health*, 903 F.3d at 851 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983)) (alterations in original).

In addition, because Part 3 dictates benefits and their administration, it collides with ERISA's key purposes. A central feature of the comprehensive ERISA scheme is to leave it to an employer's discretion whether to offer an employee benefit plan and, if so, to determine the benefits to provide. *See supra* p. 6 (citing decisions in *Conkright*, *Lockheed*, and *Curtiss-Wright*). Congress gave employers that leeway in order to encourage them to offer plans, recognizing that unpredictable and expensive benefit mandates would have the opposite effect. Still further, Part 3 transgresses § 1144(a) chief goal of ensuring a "single uniform national scheme for the administration of ERISA plans without interference from the laws of the several States." *Gobeille,* 136 S. Ct. at 947. No multi-state employer complying with subsection B of § 14.25.120 could administer its ERISA plan in a nationally uniform manner unless it adopts for the whole country the terms mandated by Seattle. *See Travelers*, 514 U.S. at 657 (noting that the New York law in *Shaw* "requir[ing] employers to pay employees specific benefits" transgressed ERISA's objective of "permit[ting] nationally uniform administration of employee benefit plans" because its "mandates affecting coverage could have been honored only by varying the subjects of a plan's benefits whenever New York law might have applied, or by requiring every plan to provide all beneficiaries with a benefit demanded by New York law if New York law could have been said to require it for any one beneficiary"); *accord id.* at 657-58 (describing decision in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), in similar terms).

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Of particular relevance, the Supreme Court's decision in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), concisely explains the problems with state laws mandating benefit structures. The Court there said:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others.

Id. at 9. Thus, "state laws requiring the payment of benefits . . . 'relate to a[n] employee benefit plan' if they attempt to dictate what benefits shall be paid under a plan." *Id.* at 13 n.8 (citation omitted). "To hold otherwise would create the prospect that plan administration would be subject to differing requirements regarding benefit eligibility and benefit levels – precisely the type of conflict that ERISA's pre-emption provision was intended to prevent." *Id.*

Along the way, *Fort Halifax* discussed favorably the Ninth Circuit's earlier decision in *Standard Oil Co. of California* v. *Agsalud*, 633 F.2d 760, 766 (9th 1980), *aff'd*, 454 U.S. 801 (1981) ("*Agsalud*"). In *Agsalud*, the Court of Appeals struck as preempted a Hawaii law that required employers to provide employees with a health plan. As explained by the Supreme Court:

> The Hawaii law was struck down, for it posed two types of problems. First, the employer in that case already had in place a health care plan governed by ERISA, which did not comply in all respects with the Hawaii Act. If the employer sought to achieve administrative efficiencies by integrating the Hawaii plan into its existing plan, different components of its single plan would be subject to different requirements. If it established a separate plan to administer the program directed by Hawaii, it would lose the benefits of maintaining a single administrative scheme. Second, if Hawaii could demand the operation of a particular benefit plan, so could other States, which would require that the employer coordinate perhaps dozens of programs.

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Fort Halifax, 482 U.S. at 12-13. "*Agsalud* thus illustrates that whether a State requires an existing plan to pay certain benefits, or whether it requires the establishment of a separate plan where none existed before, the problem is the same." *Id.* at 13.

Part 3 charges right into the territory cordoned off in *Fort Halifax* and *Agsalud*. Setting, through subsection B in § 14.25.120, the hours level for eligibility, fixing the particular benefits afforded at gold-level, and dictating to employers their and the employees' necessary shares of contributions for the plan that the *employer* has established, Part 3 makes the "administrative efficiencies" of nationally uniform plan administration impossible to attain. *Fort Halifax,* 482 U.S. at 13. For ERIC members, Part 3 has, in fact, already defeated their efforts towards nationally uniform administration, the very right that ERISA preemption seeks to guarantee. In their declarations, two companies attest that, in response to Part 3, they have adopted "Seattle-specific amendment[s]" to their plans "to provide for eligibility rules, health coverage offerings, and employee contribution rules designed to meet Part 3 requirements." Fennimore Decl. ¶ 12; *accord* Beaudin Decl. ¶ 16. One company will even, "as of January 1, 2019, . . . replace its national plan for its employees in Seattle with a separate plan" complying with Part 3. *Id.* ¶ 17.

To make matters worse, the notice, recordkeeping, and reporting requirements associated with Part 3 are onerous, and such requirements have often – sometimes alone, and sometimes in tandem with other features of the state law – resulted in a state law having an impermissible connection with ERISA plans. *E.g.*, *Gobeille*, 136 S. Ct. at 945; *Egelhoff*, 532 U.S. at 148-49. Employers are required to provide notice of employees' rights under Part 3 (*see* SMC § 14.25.150.B.1; SHRR § 150-250.4.), and they must keep records (for reporting to Seattle regulators, when audited or investigated) of the hours that each employee worked and the "additional wages" paid under subsection A of § 14.25.120. SMC § 14.25.150.B.2. Though the number for additional wages recorded by the ERIC members generally would be "zero," given that they have amended their plans in compliance with subsection B, the companies – of necessity – would need to keep records of their compliance with subsection B every month for every

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employee covered by Part 3 in order to sustain, if audited or investigated, the non-payment of additional wages. And the ERIC members' declarations also corroborate:

> In order to continue complying with Part 3, [the company] must and does continue to devote resources to administer the [company's] plan to ensure its Part 3 Employees are enrolled in appropriate health coverage in accordance with the [company's] Seattle Amendment. This administrative and record-keeping effort *is performed only with respect to employees in Seattle*.

Fennimore Decl. ¶ 13; *accord* Beaudin Decl. ¶ 18. These are the sorts of administrative obligations, required on a locality-by-locality basis (should other cities follow Seattle's lead with their own Part 3s), that "'interfere[] with nationally uniform plan administration'" and doom a state law as having a connection with ERISA plans. *Gobeille*, 136 S. Ct. at 945 (quoting *Egelhoff*, 532 U.S. at 148).

Seattle's responses to the "connection with" analysis are similar to its arguments on the "reference to" side. It says that Part 3 avoids having an impermissible connection to ERISA plans because Part 3's obligations are "imposed on the *employer*, not the *plan* or plan administrators." Seattle Mot. 17 (emphasis in original); *see also id.* at 13. Just as in the "reference to" context, the distinction is specious. The logic of Seattle's assertion is that a law will survive if it is worded so that it facially obliges *employers* to offer certain benefits and to adopt specified eligibility and contribution requirements, but be preempted if worded to require *employee benefit plans* to comply with the very same terms. Nothing in ERISA, or the case law, makes preemption hinge on such semantics. *See Golden Gate Rest. Ass'n*, 546 F.3d at 655 ("the Hawaii statute was preempted because it required *employers* to have health plans, and it dictated the specific benefits *employers* were to provide through those plans") (emphasis added).

Seattle's other response is that Part 3 does not mandate benefits or their administration at all, but "'merely . . . provide[s] some measure of economic incentive' for employers 'to comport with the [City's] requirements.'" Seattle Mot. 16 (quoting *Dillingham*, 519 U.S. at 332 (emphasis removed)). The argument is similar in theme to Seattle's contention in the "reference to" context, where it asserts that Part 3 does not act immediately and exclusively on ERISA plans allegedly because of the alternative of complying through direct payments under subsection A. In a like

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vein, Seattle argues here that there can be no mandating of benefit structures when the employer can "choose" subsection A's direct-payment route and avoid altering its plan's terms. *Id.* at 15. The contention arguably has greater force here, since in the "reference to" setting a state law need only have "some effect" on employee benefit plans (in addition to identifying them in its text) to be preempted (*Glazing Health*, 903 F.3d at 852 (internal quotation marks and citation omitted)); contrastingly, the precedents speak of state laws *mandating* benefits or "'*forc[ing]* an ERISA plan to adopt a certain scheme of substantive coverage'" in order to be disqualified as having an impermissible connection with ERISA plans. *Gobeille*, 136 S. Ct. at 943 (quoting *Travelers*, 514 U.S. at 668) (emphasis added).

Yet, even in the "connection with" realm, a state law – to exact improper coercion – need not say in so many words that the employer *must* change its plan. As *Gobeille* emphasizes, facing "'[a]cute'" financial consequences for failure to adopt a state's preferred scheme of coverage is sufficient. *Id.* In *Golden Gate Restaurant Ass'n*, the Ninth Circuit explained that a state's law forces benefit structures on employers when "employers are, *in practical fact*, compelled to alter or establish ERISA plans rather than to make payments [as required under the statute]." 546 F.3d at 660 (emphasis added). That dynamic occurs when the state law imposes "'a fee or a penalty that gives the employer an *irresistible incentive* to provide its employees with a greater level of benefits.'" *Id.* (quoting *RILA*, 475 F.3d at 194) (emphasis added). Other ways the Ninth Circuit put it were that the state law, to avoid preemption, must "offer[] employers . . . a *realistic alternative* to creating or altering ERISA plans," so that the law "does not '*effectively* mandate[] that employers structure their employee healthcare plans to provide a certain level of benefits.'" *Id.* (quoting *RILA*, 475 F.3d at 193) (emphasis added). Or the state statute must offer a "legitimate alternative," a "meaningful alternative," or an option that "'may be *easily* satisfied through means unconnected to ERISA plans.'" *Id.* at 660, 656 (quoting *Keystone Chapter, Associated Builders & Contractors, Inc. v. Foley*, 37 F.3d 945, 960 (3d Cir. 1994)) (emphasis added).[10]

[10] The Ninth Circuit in *Golden Gate Restaurant Ass'n* devised all of these constructs in distinguishing the San Francisco ordinance before it, which it said did provide suitable alternatives to altering ERISA plans, from the Maryland law in *RILA*. The Maryland law demanded a certain level of health care spending on behalf of employees

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Under these standards, Part 3 *does* impermissibly coerce changes to large hotel employers' benefit plans. Subsection A of § 14.25.120 engenders substantial expense with its direct payments, and it "g[ives] nothing in return" to the employer – not even the security that the recipient employee will use the funds for additional health care. *Id.* at 659. Moreover, as one ERIC member has attested, compliance with subsection A would be, for it, two to eight times more expensive than complying through subsection B's eligibility, benefits, and contribution mandates. *See supra* p. 9. Such a costly option does not constitute a meaningful, legitimate, or easily-satisfied alternative; rather, it is "tantamount to a compulsion" to accept the terms and conditions of subsection B. *Dillingham*, 519 U.S. at 333. Even if compliance with subsection A cost the same as subsection B, no "'rational'" employer would choose the path of simply paying additional money to the employee rather than enhancing its relationship with the employee through expanded health benefits – *unless* the employer found administration of a Seattle-unique plan too fraught with administrative problems, which is the exact dilemma ERISA preemption was designed to avoid. *Golden Gate Rest. Ass'n*, 546 F.3d at 660 (quoting *RILA*, 475 F.3d at 193). It is the practical effect of Part 3 and how it "'actually operates'" that matters (*Glazing Health*, 903 F.3d at 852 (quoting *S. Cal. IBEW-NECA Tr. Funds v. Standard Indus. Elec. Co.*, 247 F.3d 920, 929 (9th Cir. 2001))), and Part 3's real-world impact is that it has already caused ERIC's members to alter their ERISA plans to satisfy subsection B.

In sum, Part 3 has an impermissible connection with ERISA plans, and therefore is preempted, because it effectively compels employers to adopt or change benefit structures and, in so doing, makes nationally uniform administration of the employer's ERISA plans impossible. In candor, it is difficult to imagine that "upping" the employers' ERISA coverage for lower-wage hotel employees in Seattle was anything but the true intent of Part 3, given the criticism of employer coverage accompanying Part 3's enactment. *See supra* pp. 2-3, 16-17. "[W]e have

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for one employer in the state, with the alternative being paying a tax to the state. Finding the Maryland law had an impermissible connection to ERISA plans, the Fourth Circuit found the tax option illusory, as no "reasonable employer" would choose to pay the tax rather than spend the same amount on increased benefits for its employees. *RILA*, 475 F.3d at 193.

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virtually taken it for granted that state laws which are 'specifically designed to affect employee benefit plans' are pre-empted under § [1144(a)]." *Mackey*, 486 U.S. at 829 (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987)). Part 3 fits that bill.

V. IN THE CASE'S CURRENT POSTURE, THE COURT CAN AND SHOULD RULE IN ERIC'S FAVOR ON BOTH SEATTLE'S MOTION TO DISMISS AND ERIC'S MOTION FOR SUMMARY JUDGMENT

The last issue to address is whether the pleadings and record at this juncture allow the Court not only to deny Seattle's motion to dismiss but also to grant ERIC's motion for summary judgment, thereby resulting in a final judgment. The issues for determining if ERISA preempts Part 3 are largely legal – *i.e.*, whether Part 3 on its face identifies ERISA plans, whether the regulation of plans is different than the regulation of employers with respect to their plans, and whether Part 3's statutory structure is such that subsections A and B are inextricably intertwined as opposed to separate, discrete alternatives for compliance.

A factual component comes into play in the "reference to" analysis, where the Ninth Circuit requires that a state law specifically identifying ERISA plans must also have "some effect" on ERISA plans in order for the law to be preempted. *Glazing Health*, 903 F.3d at 852 (internal quotation marks and citation omitted). The facts also become pertinent in the "connection with" setting, given that the Court must determine whether, "in practical fact," Part 3 mandates or forces employers to structure ERISA plans a certain way. *Golden Gate Rest. Ass'n*, 546 F.3d at 659. Plainly, the allegations in the complaint plausibly allege both, and therefore are sufficient to require denial of the motion to dismiss, when added to any holdings on the legal issues in ERIC's favor. *See, e.g.*, Compl. ¶ 7 ("Part 3 compels large hotel employers to alter their health coverage for employees – namely, to the "gold" level required by Part 3 – in order to avoid the even more onerous direct-payment mandate."); *accord id.* ¶ 49 (alleging that the direct-payment requirement in subsection A of § 14.25.120 is "more costly" than amending ERISA plans to conform with subsection B).

Respectfully, the Court additionally should find that, on these factual matters, there are no "genuine dispute[s]," so that discovery and further proceedings are unnecessary and summary

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judgment in ERIC's favor also is warranted. Fed. R. Civ. P. 56(a). In ERIC's view there can be no dispute that Part 3 (under the "reference to" inquiry) has "some effect" on employers when: (1) Seattle appears already to have admitted that there is a "difference in cost" if an employer complies with subsection B rather than subsection A (Seattle Mot. 16); (2) Seattle and union publications illustrate the high cost of compliance with subsection A (*see supra* pp. 9-10); and (3) it is basic economic logic that employers will be, as the D.C. Circuit put it in *Greater Washington Board of Trade*, "burdened" by *both* subsections A and B. On that last point, any employers utilizing subsection A will be pressured to reduce ERISA-plan benefits to account for the added cost of now making direct payments to covered employees (if not to eliminate current coverage for some of these employees altogether), and employers using subsection B will need to take measures to ensure that their ERISA plans are compliant in all respects with subsection B's terms and conditions.

Nor should the Court conclude that there are bases for genuine disputes about whether Part 3 mandates or forces ERIC's members (under the "connection with" standard) to structure their ERISA plans in compliance with Part 3. To be sure, the financial consequences of not re-structuring the plans must be "acute" (*see supra* p. 28), which means severe, intense, or urgent. *See* "Acute," *Merriam-Webster's Collegiate Dictionary* (11th ed. 2006). Even if Seattle attempts to dispute that it would cost an employer two to eight times more to make direct payments than to bring its ERISA plan into compliance with subsection B (*see* Fennimore Decl. ¶ 11), a fact that Seattle has no good grounds to contest, there certainly can be no dispute that ERIC members already have changed their plans to comply with Part 3 rather than make direct payments. That uncontestable fact alone should serve to prove that Part 3 has – and already has had – sufficiently severe, intense, and urgent economic effects to "'force an ERISA plan to adopt a certain scheme of substantive coverage.'" *Gobeille*, 136 S. Ct. at 943 (quoting *Travelers*, 514 U.S. at 668). Plus, if there were genuine disputes about coercion, they would need to be addressed only if the Court has already determined that Part 3 survives preemption under the "reference to" inquiry.

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CONCLUSION

The Court should: (1) deny Seattle's motion to dismiss; and (2) grant ERIC's motion for summary judgment, declare that Part 3 and its implementing regulations are preempted by ERISA, and enjoin their enforcement.

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CERTIFICATE OF SERVICE

I, Gwendolyn C. Payton, hereby certify under penalty of perjury of the laws of the State of Washington and the United States of America, that on October 25, 2018, I caused to be served a copy of the attached document PLAINTIFF'S OPPOSITION TO DEFENDANT'S MOTION TO DISMISS AND PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT to the following person(s) in the manner indicated below at the following address(es):

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