

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 THE FIRST AMENDED
COMPLAINT**

ORAL ARGUMENT REQUESTED

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INTRODUCTION

1
2 The motion to dismiss that Defendant City of Seattle (“City”) has filed can be summed
3 up this way: *Golden Gate, Golden Gate, Golden Gate*. That is, pretending that its recently
4 enacted health-benefits ordinance – Seattle Municipal Code (“SMC”) 14.28 – is nothing but a
5 reprise of the local law upheld in *Golden Gate Restaurant Ass’n v. City & County of San*
6 *Francisco*, 546 F.3d 639 (9th Cir. 2008), the City cites or quotes the Ninth Circuit’s decision
7 more than twenty times in seeking to dismiss the preemption challenge under the Employee
8 Retirement Income Security Act of 1974 (“ERISA”) brought by Plaintiff The ERISA Industry
9 Committee (“ERIC”). But SMC 14.28 is very different than the local law in *Golden Gate*.
10 Unlike the ordinance in *Golden Gate*, SMC 14.28 requires the formation of ERISA plans, no
11 matter how employers seek to fulfil their new obligations. Unlike the ordinance in *Golden*
12 *Gate*, SMC 14.28 is rife with references to and dependence on ERISA plans throughout its
13 provisions. Unlike the ordinance in *Golden Gate*, SMC 14.28, at bottom, seeks to – and does –
14 compel employers to adjust their existing insured or self-funded ERISA plans to conform to its
15 requirements. As a result, unlike the ordinance in *Golden Gate*, SMC 14.28 is preempted by
16 ERISA.

17 Because ERISA preempts SMC 14.28, and given that the City’s motion to dismiss the
18 First Amended Complaint (“FAC”) is predicated solely on the notion that there is no preemption
19 here, the Court should deny the motion on its merits. In due course, ERIC will seek summary
20 judgment in its favor on the merits.

BACKGROUND

A. The Predecessor to SMC 14.28 and ERIC’s Challenge

22 In 2016, the City’s voters through the initiative process enacted the predecessor to SMC
23 14.28, which was Part 3 of former SMC 14.25 (“Part 3”). FAC ¶ 17. Part 3 required certain
24 large hotel employers to pay additional wages to covered employees for health insurance
25 expenses; however, the employer could avoid the obligation to pay additional wages if it
26

1 provided health coverage through an employer-sponsor health benefit plan at a level equal to or
2 above a gold-level plan on the Washington Health Benefit Exchange. *Id.* ¶ 19. In response,
3 ERIC – a national trade association of large multistate companies who are concerned with
4 maintaining a nationally uniform regime of legal requirements for employee benefits – sued the
5 City in this Court, contending that ERISA preempts Part 3. *Id.* ¶ 21. While the case was
6 pending, one or more ERIC member companies affected by Part 3 altered their employer-
7 sponsored plans to offer coverage consistent with Part 3, since the direct-payment requirement
8 was financially more onerous in comparison and given that there was no assurance under Part 3
9 that an employee who received additional wages (rather than coverage under the employer’s
10 plan) necessarily would use the monies reasonably on healthcare. *Id.* ¶ 20.

11 Ultimately, the Court stayed ERIC’s case, to account for state-court proceedings in
12 which an appeals court had declared former SMC 14.25 illegal in its entirety, as violating the
13 Washington Constitution’s initiative requirements. *Id.* ¶ 21. The state litigation, however, was
14 mooted when the City, in September 2019, repealed former SMC 14.25 and enacted, among
15 other successors, SMC 14.28 as a replacement for Part 3. *Id.* ¶ 22. This Court then lifted the
16 stay, and ERIC filed the FAC to challenge SMC 14.28. *Id.*

17 **B. SMC 14.28’s Basic Provisions**

18 At the outset, SMC 14.28 states its purpose to be “requiring certain employers to make
19 required healthcare expenditures to or on behalf of certain employees for the purpose of
20 improving access to medical care.” SMC 14.28 (preamble).¹ The ordinance’s “intent . . . is to
21 improve low-wage hotel employees’ access, through additional compensation, to high-quality,
22 affordable health *coverage* for the employees and their spouses or domestic partners, children,
23 and other dependents.” *Id.* § 14.28.025 (emphasis added).

24 Under SMC 14.28, eligible employees are full or part-time or temporary workers, must
25 work an average of 80 hours or more per month, and must not be a manager, supervisor, or

26 _____
¹ SMC 14.28 is available at <http://seattle.legistar.com/LegislationDetail.aspx?ID=3993855&GUID=A3ACB5DC-6D4C-4EF1-A6F9-AFD275F25343&Options=ID|Text|&Search=125930> (last visited Mar. 19, 2020).

1 confidential employee. *Id.* §§ 14.28.030, 14.28.020. Covered employers are owners or
2 operators of a hotel with 100 or more guest rooms in the City, as well as ancillary hotel
3 businesses with 50 or more employees worldwide (the latter not having been subject to Part 3).
4 *Id.* §§ 14.28.040, 14.28.020. “Ancillary hotel business” is “any business that (1) routinely
5 contracts with the hotel for services in conjunction with the hotel’s purpose; (2) leases or sublets
6 space at the site of the hotel for services in conjunction with the hotel’s purpose; or (3) provides
7 food and beverages, to hotel guests and to the public, with an entrance within hotel premises.”
8 *Id.* § 14.28.020.

9 SMC 14.28 requires covered employers to make, each month, “[r]equired healthcare
10 expenditures for covered employees” of \$420 if an employee has no spouse, domestic partner,
11 or dependents; \$714 for an employee with dependents only; \$840 for an employee and
12 spouse/domestic partner; and \$1260 for an employee with spouse, domestic partner, and
13 dependents. *Id.* § 14.28.060.A.1-A.4. These are “2019 rates” and are “subject to annual
14 adjustments based on the medical inflation rate.” *Id.* § 14.28.060.A.

15 Covered employers “have discretion as to the form of the monthly required healthcare
16 expenditures they choose to make for their covered employees.” *Id.* § 14.28.060.B. They “may
17 satisfy their monthly obligations through any one or more of the following [three] forms (*id.*),”
18 either individually or in combination:

- 19 1. First option: “Additional compensation paid directly to the covered employee”
20 (*id.*);
- 21 2. Second option: “Payments to a third party, such as to an insurance carrier or
22 trust, or into . . . tax favored health programs, (including health savings accounts,
23 medical savings accounts, health flexible spending arrangements, and health
24 reimbursement arrangements) to provide healthcare services, for the purpose of
25 providing healthcare services to the employee or the spouse, domestic partner, or
26 dependents of the covered employee (if applicable)” (*id.*); and

1 3. Third option: “Average per-capita monthly expenditures for healthcare services
2 made to or on behalf of covered employees or [the spouse or dependents] by the
3 employer’s self-insured and/or self-funded insurance program(s).” *Id.*²

4 For purposes of the second and third options, “[h]ealthcare services” are medical care
5 and services under Internal Revenue Code (26 U.S.C.) § 213, which allows a deduction for such
6 care and services not covered by insurance. SMC 14.28.020. Also for purposes of these
7 options, “if an employer imposes a waiting period before new hires can be enrolled in its
8 employer-sponsored plan (or the plan or insurer carrier mandates such a period), the employer
9 will not be required to satisfy the health expenditures described in 14.28.060.A until the sooner
10 of sixty days from the date of hire or the expiration of the waiting period.” *Id.* § 14.28.060.C.

11 C. SMC 14.28’s Exceptions and Waiver Requirements

12 SMC 14.28 contains several exceptions and a waiver regime to ensure no abuse of the
13 exceptions. One exception provides that an employer will be “deemed to have satisfied” its
14 monthly obligations under *any* of the three options, if “an employee voluntarily declines an
15 employer’s offer” of compliance through the second and third options – *i.e.*, an offer of
16 coverage under the employer’s insured or self-funded health plan. *Id.* § 14.28.060.D. For the
17 offer to be valid, the employer “must not require the employee to pay more than a dollar amount
18 equivalent to 20 percent of the monthly required health amount described in subsection
19 14.28.060.A.1,” assumedly through the employee’s portion of an insurance premium or cost-
20 sharing. *Id.* § § 14.28.060.D.1. A declination occurs when the employer “obtain[s] a signed
21 waiver from the employee, free from coercion.” *Id.* § 14.28.060.D.2.

22 In turn, SMC 14.28 regulates the terms and conditions for an employer to obtain the
23 employee’s waiver to substantiate the declination permitted under § 14.28.060.D. The waiver

24 ² As relevant here, there are two types of ERISA health benefit plans that employers traditionally sponsor: insured
25 and self-funded. *See FMC Corp. v. Holliday*, 498 U.S. 52, 60-64 (1990). Insured plans are those sponsored by an
26 employer who purchases insurance, with the insurer then administering the plan and carrying the risk. With self-
funded plans, the employer self-insures and thus carries the risk, and it typically hires a third party to administer
the plan. SMC 14.28’s second option concerns insured ERISA plans, while its third option concerns self-funded
ERISA plans.

1 process begins with the employer, in that “[t]he employer must offer [a] waiver in the
2 employee’s primary language and on a form issued by the Director [of the Office of Labor
3 Standards].” *Id.* § 14.28.060.D.2. “Prior to offering the waiver, the employer must provide the
4 employee with a written disclosure of the rights being waived, the form and content of which
5 shall be prescribed by the Director.” *Id.* And again, the employer must perform these functions
6 without “coercing or unduly inducing an employee to waive coverage.” *Id.* § 14.28.050.
7 Ultimately, if the employer makes the offer of coverage, if the employer complies with the
8 waiver requirements, and if the employee who receives the waiver form “refuses to sign such
9 waiver” and “continues to decline, in whole or in part,” the employer “will be deemed to have
10 satisfied its required healthcare expenditure rate for that employee.” *Id.* § 14.28.060.D. In that
11 situation, the employer must keep records of “the employee’s receipt of the waiver and written
12 disclosures . . . and the employee’s subsequent refusal to sign the waiver.” *Id.*

13 Another exception is for an employee “who receives health coverage from another
14 source, including but not limited to employer-sponsored health insurance through an employer
15 other than the covered employer.” *Id.* § 14.28.030.B.2. Such an employee may waive coverage
16 from § 14.28 by signing a waiver that he or she “has access to high-quality and affordable health
17 coverage from another source.” *Id.* § 14.28.030.B.2.a.

18 A final exception is for “any employees covered by a bona fide collective bargaining
19 agreement.” *Id.* § 14.28.235.A. This exception applies only if SMC 14.28’s requirements “are
20 expressly waived in the collective bargaining agreement.” *Id.*

21 **D. SMC 14.28’s Record-Keeping and Enforcement Provisions**

22 Employers must retain records documenting compliance with SMC 14.28. *See id.* §
23 14.28.110. In particular, as noted, where an employer satisfies its obligations by making an
24 offer of coverage through the second or third options that is declined, the employer must keep
25 records of its disclosures to the employee regarding the offer of coverage, the provision of a
26 waiver form to the employee, and the employee’s refusal to sign the waiver. *Id.* § 14.28.060.D.

1 With respect to enforcement, the City may investigate violations of SMC 14.28 and has
 2 subpoena authority. *Id.* §§ 14.28.130, 14.28.150.E. In the event of a violation, the City may
 3 levy civil fines and penalties payable to the City, as well as require “unpaid compensation,
 4 liquidated damages, civil penalties, [and] penalties payable to aggrieved parties.” *Id.*
 5 § 14.28.160.C.1. Section 14.28.230 provides a private right of action to “[a]ny person or class
 6 of persons that suffers an injury as a result of a violation” of SMC 14.28.

7 The effective date for SMC 14.28 is the later of July 1, 2020, or the earliest annual open
 8 enrollment period for health coverage after July 1, 2020, except that ancillary hotel businesses
 9 with 50 to 250 employees shall have until similar dates in 2025 to comply. *Id.* § 14.28.260.

STANDARD UNDER RULE 12(b)(6)

11 Rule 12(b)(6), which the City has invoked to dismiss the FAC, authorizes dismissal
 12 where a plaintiff’s complaint “fail[s] to state a claim upon which relief can be granted.” Fed. R.
 13 Civ. P. 12(b)(6). In determining whether a complaint meets that threshold, the Court ““accept[s]
 14 all factual allegations in the complaint as true and constru[es] them in the light most favorable to
 15 the nonmoving party.”” *Stoyas v. Toshiba Corp.*, 896 F.3d 933, 938 (9th Cir. 2018) (quoting
 16 *Fields v. Twitter, Inc.*, 881 F.3d 739, 743 (9th Cir. 2018)). Ultimately, “[t]he Court inquires
 17 whether the complaint at issue contains ‘sufficient factual matter, accepted as true, to state a
 18 claim of relief that is plausible on its face.’” *Harris v. Cty. of Orange*, 682 F.3d 1126, 1131 (9th
 19 Cir. 2012) (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). Dismissal is warranted only
 20 “based on either a lack of a cognizable legal theory or the absence of sufficient facts alleged
 21 under a cognizable legal theory.” *Kwan v. SanMedica Int’l*, 854 F.3d 1088, 1093 (9th Cir.
 22 2017) (internal quotation marks and citation omitted).

ARGUMENT

I. ERISA BROADLY PREEMPTS ANY STATE LAW HAVING A REFERENCE TO OR CONNECTION WITH AN ERISA PLAN

25 The FAC alleges that ERISA preempts SMC 14.28, and the City seeks dismissal
 26 exclusively on the ground that, under ERISA’s preemption tests, there is here no plausible basis

1 for preemption. Accordingly, to decide the pending dismissal motion (and, ultimately, the case
2 as a whole), the place to start is with ERISA’s general preemption standards.

3 ERISA contains an express preemption provision. It provides: ERISA “shall supersede
4 any and all State laws insofar as they may now or hereafter *relate to* any employee benefit
5 plan.” 29 U.S.C. § 1144(a) (emphasis added). Following from the “relate to” term Congress
6 chose, the Supreme Court has repeatedly characterized § 1144(a)’s text as “clearly expansive,”
7 having “an expansive sweep,” “conspicuous for its breadth,” “deliberately expansive,” and
8 “broadly worded.” *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, 519 U.S.
9 316, 324 (1997) (internal quotation marks and citations omitted) (cataloging statements in prior
10 precedents). In its most recent ERISA preemption decision, the Court confirmed (again) that
11 ERISA’s preemption section has a “broad scope,” adding that, through the provision, Congress
12 intended the regulation of employee benefit plans to be “exclusively a federal concern.”
13 *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943, 944 (2016) (quoting *Alessi v. Raybestos-*
14 *Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). Still, while emphasizing § 1144(a)’s breadth, the
15 Supreme Court has also cautioned against applying the provision too “literal[ly],” for “[i]f
16 “relate to” were taken to extend to the furthest stretch of its indeterminacy, then for all practical
17 purposes pre-emption would never run its course.” *Id.* at 943 (quoting *N.Y. State Conf. of Blue*
18 *Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (“*Travelers*”).

19 In devising guardrails for § 1144(a), the “case law to date has described two categories
20 of state laws that ERISA pre-empts”: (1) state laws that make a “reference to” ERISA plans;
21 and (2) state laws that have a “connection with” ERISA plans. *Id.* In turn, a state law makes a
22 “reference to” ERISA plans when it “acts immediately and exclusively upon ERISA plans” or
23 “the existence of ERISA plans is essential to the law’s operation.” *Id.* (quoting *Dillingham*,
24 519 U.S. at 325). The Ninth Circuit has put the relevant standard this way: a state or local law
25 references ERISA plans where it “mentions or alludes to ERISA plans, and has some effect on
26 the referenced plans.” *WSB Elec., Inc. v. Curry*, 88 F.3d 788, 793 (9th Cir. 1996).

1 A state law has a “connection with” ERISA plans when it “‘governs . . . a central matter
2 of plan administration’ or ‘interferes with nationally uniform plan administration.’” *Gobeille*,
3 136 S. Ct. at 943 (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001)). Included among
4 state laws proscribed in those categories are state measures “that mandate[] employee benefit
5 structures or their administration.” *Travelers*, 514 U.S. at 658. “A state law also might have an
6 impermissible connection with ERISA plans if ‘acute, albeit indirect, economic effects’ of the
7 state law ‘force an ERISA plan to adopt a certain scheme of substantive coverage or effectively
8 restrict its choice of insurers.’” *Gobeille*, 136 S. Ct. at 943 (quoting *Travelers*, 514 U.S. at 668).

9 II. THERE IS NO PRESUMPTION AGAINST PREEMPTION IN THIS CASE

10 Though the City agrees that the ERISA-preemption touchstones for deciding its motion
11 to dismiss are whether SMC 14.28 makes a “reference to” or has a “connection with” ERISA
12 plans, it seeks to freight the inquiry with a threshold presumption against preemption. Indeed,
13 the City spends four pages in its motion trying to establish that there is “a strong presumption
14 against preemption by federal law.” Def.’s Mot. to Dismiss the FAC at 9 (ECF No. 37) (“Def.’s
15 Mot.”); *see generally id.* at 9-12. The City is incorrect: there, in fact, is no presumption against
16 preemption in this case.

17 Historically, the Supreme Court had not applied any presumption against preemption
18 under § 1144(a), instead characterizing ERISA’s preemption provision as the statute’s
19 “‘crowning achievement’” and revolutionary for its time. *Shaw v. Delta Air Lines, Inc.*, 463
20 U.S. 85, 99 (1983) (quoting 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent)); *see*
21 *Franchise Tax Bd. v. Constr. Laborers Vacation Tr.*, 463 U.S. 1, 24 n.26 (1983) (describing §
22 1144(a) as a “virtually unique pre-emption provision”). Nonetheless, by the time of *Travelers*
23 in 1995, the Court did instruct for ERISA’s preemption section a “starting presumption that
24 Congress does not intend to supplant state law . . . in fields of traditional state regulation.” 514
25 U.S. at 654-55. Such a presumption against preemption under § 1144(a) coincided with the
26 Supreme Court’s general trend at the time of extending to situations involving a statute with an

1 express preemption provision the “presumption against the pre-emption of state police power
2 regulations” typically applied in ordinary conflict-preemption circumstances (*i.e.*, circumstances
3 where a statute is devoid of a preemption provision but the Constitution’s Supremacy Clause
4 might require the ousting of state law). *Cipollone v. Liggett Grp.*, 505 U.S. 504, 518 (1992)
5 (federal food and drug statute).

6 But the Supreme Court’s thinking changed in the twenty years following *Travelers*, so
7 that by the mid-2010s a majority of Justices had registered dissatisfaction with a presumption
8 against preemption when Congress had included a preemption command in the statute’s express
9 terms. *E.g.*, *CTS Corp. v. Waldburger*, 573 U.S. 1, 19-20 (2014) (Scalia, J., concurring, and
10 joined by Roberts, C.J., and Thomas and Alito, J.J.); *Ariz. v. Inter Tribal Council of Ariz., Inc.*,
11 570 U.S. 1, 21 (2013) (Kennedy, J., concurring). Then, in *Gobeille*, the Court refused to
12 recognize at all the existence of a presumption against preemption, prompting a dissent from
13 Justice Ginsburg. *Compare* 136 S. Ct. at 946 (“*Any* presumption against pre-emption, *whatever*
14 its force in other instances, cannot validate a state law that enters a fundamental area of ERISA
15 regulation and thereby counters the federal purpose in the way this state law does.”) (emphasis
16 added) *with id.* at 954 (Ginsburg, J., dissenting) (relying heavily on a “[t]he presumption against
17 preemption”). Finally, in *Puerto Rico v. Franklin California Tax-Free Trust*, the Court formally
18 ruled that, where a “statute ‘contains an express pre-emption clause,’ we do not invoke any
19 presumption against pre-emption.” 136 S. Ct. 1938, 1946 (2016) (quoting *Chamber of*
20 *Commerce v. Whiting*, 563 U.S. 582, 594 (2011)). Though *Franklin* was not an ERISA case, the
21 Court in *Franklin* cited *Gobeille* in support of the proposition that there is no presumption
22 against preemption if a statute contains an express preemption provision. *See id.*

23 After *Franklin*, courts have begun to reject a presumption against preemption when
24 applying ERISA’s express preemption provision, determining *Travelers* to have been overruled
25 on the point. *See Dialysis Newco, Inc. v. Cmty. Health Sys. Grp. Health Plan*, 938 F.3d 246,
26 259 (5th Cir. 2019) (“Given that *Franklin* specifically references *Gobeille* – an ERISA case –

1 when holding that there is no presumption of preemption when the statute contains an express
2 preemption clause, we conclude that holding is applicable here.”). Though the Ninth Circuit has
3 not yet squarely addressed *Franklin*’s application in the ERISA context, it has followed
4 *Franklin* to reject a presumption against preemption for another statute that “speaks expressly to
5 the question of preemption.” *Atay v. Cty. of Maui*, 842 F.3d 688, 699 (9th Cir. 2016) (applying
6 express preemption provision in the Plant Protection Act, 7 U.S.C. § 7756(b)); *see Dialysis*
7 *Newco*, 938 F.3d at 258 (finding *Atay* to support proposition that, after *Franklin*, there is no
8 presumption against preemption under ERISA’s preemption provision).

9 In light of *Franklin* and its progeny, the Court should reject a presumption against
10 preemption when applying ERISA’s express preemption clause. In fact, the Court can, and
11 should, review with a skeptical eye earlier precedents rejecting preemption under § 1144(a), if
12 the decision was based heavily on a presumption against preemption. *See, e.g., Dialysis Newco*,
13 938 F.3d at 259 (“because *Rapides* [*i.e.*, an earlier Fifth Circuit ERISA-preemption decision]
14 was built upon a presumption against preemption that the Supreme Court appears to have
15 walked back from, we decline to extend *Rapides*’s reasoning to the facts of this case”).

16 The City asserts that *Franklin*’s holding is limited to situations where “the preemption
17 provision’s language is plain,” and apparently the City believes § 1144(a)’s text is less than
18 plain. Def.’s Mot. at 9 n.7 (emphasis removed). *Dialysis Newco*, however, rejected that same
19 argument. *See* 938 F.3d at 258. Moreover, just because § 1144(a)’s text may be “frustrating” to
20 apply does not make it un-plain. *Travelers*, 514 U.S. at 656. To the contrary, by using the
21 “relate to” language it did, Congress obviously – or plainly – intended ERISA’s preemption
22 provision to be “broad[ly]” interpreted, as *Gobeille* most recently reiterates. 136 S. Ct. at 943.
23 The Supreme Court has called § 1144(a)’s text “terse but comprehensive,” not ambiguous or
24 some other adjective opposite of plain. *Id.* The key to applying that curt text is – again, as
25 *Gobeille* instructs – to implement the “workable” standards fashioned under the “reference to”
26 and “connection with” rubrics, not to rely on a judge-made presumption against preemption. *Id.*

1 In any event, even if the pre-*Franklin* presumption scheme still governed, no
2 presumption would apply in this case. The presumption operated when a state enacted “general
3 health care regulation, which historically has been a matter of local concern.” *Travelers*, 514
4 U.S. at 661. For instance, in *Golden Gate*, the fundamental element of the San Francisco
5 ordinance there at issue was the creation of “the Health Access Plan (HAP),” which is “a City-
6 administered health care program” that “*provides* enrollees with ‘medical services with an
7 emphasis on wellness, preventive care and innovative service delivery.’” *Golden Gate*, 546
8 F.3d at 642, 645 (quoting S.F. Admin. Code § 14.2(f)) (emphasis added). The ordinance then
9 sets forth a series of employer financing mechanisms for the HAP, from which the employer is
10 “exempt . . . if it [already] makes health care expenditures” at a certain average rate on behalf of
11 its workers (between \$1 and \$2 per hour worked by its workforce). *Id.* at 645. In that situation,
12 the Ninth Circuit (pre-*Franklin*) held that there is a presumption against ERISA preemption
13 because “[t]he field in which the [San Francisco] Ordinance operates is the *provision of health*
14 *care services* to persons with low and moderate incomes,” and “[s]tate and local governments
15 have traditionally *provided* health care services to such persons.” *Id.* at 648 (emphasis added).

16 In contrast, SMC 14.28 involves no *provision* of health care services. Rather, as even
17 the City acknowledges, SMC 14.28, “at its core, seeks to ‘improve low-wage hotel employees’
18 access, through additional compensation, to . . . health *coverage*” Def.’s Mot. at 21
19 (quoting SMC 14.28.025) (emphasis added; ellipses in original). Unlike the actual *provision* of
20 health care services to low-income segments of society, health benefits *coverage* for employees
21 is not an area of traditional state concern. Since 1974, it has been an area of exclusively federal
22 interest, through ERISA. Because “the states have not traditionally occupied the field” of
23 private-sector employee health benefits *coverage*, the Court should “apply no presumption
24 against preemption.” *United States v. Arizona*, 641 F.3d 339, 348 (9th Cir. 2011), *rev’d on*
25 *other grounds*, 567 U.S. 387 (2012); *see also Aloha Airlines v. Ahue*, 12 F.3d 1498, 1505 (9th
26 Cir. 1993) (holding that Hawaii law requiring direct reimbursement by employers of costs of

1 medical exams “does not represent a regulation of traditional state authority”) (emphasis
2 removed).³

3 **III. ERISA PREEMPTS SMC 14.28 BECAUSE, UNDER ANY OF ITS OPTIONS,
4 SMC 14.28 REQUIRES THE CREATION OF ERISA PLANS**

5 ERISA preempts SMC 14.28 for a series of reasons, each of which is sufficient alone to
6 necessitate invalidation of the ordinance. An initial reason is that, under any of its options,
7 SMC 14.28 requires the creation or maintenance of an ERISA plan. If a state or local law,
8 through its operation, “creates an ERISA plan,” it “almost certainly makes an impermissible
9 ‘reference to’ an ERISA plan.” *Golden Gate*, 546 F.3d at 648.

10 The City does not appear to dispute that SMC 14.28 requires the establishment of
11 ERISA plans for compliance under at least the second and third options. Nor could it. ERISA
12 defines a welfare plan as

13 any plan, fund, or program which was heretofore or is hereafter established or
14 maintained by an employer . . . to the extent that such plan, fund, or program was
15 established or is maintained for the purpose of providing for its participants or their
16 beneficiaries, *through the purchase of insurance or otherwise*, . . . medical,
17 surgical, or hospital care or benefits, or benefits in the event of sickness

18 29 U.S.C. § 1002(1) (emphasis added). SMC 14.28’s second option authorizes compliance with
19 the ordinance’s required expenditure amounts through employer purchases of insurance for its
20 employees, arrangements that fit the welfare-plan definition (especially the italicized language
21 above) to a tee; likewise, the third option authorizes expenditures through “the employer’s self-
22 insured and/or self-funded insurance programs,” which requires the existence of ERISA plans
23 (namely, self-funded ones) even to be operational. SMC 14.28.060.B.3.

24 The dispute is over whether the first option – involving direct payments to workers –
25 constitutes an ERISA plan. It does. By its terms, the first option for compliance constitutes an

26 ³ To support a presumption against preemption, and later to define the “reference to” standard, the City relies on
Bd. of Trs. of Glazing Health & Welfare Tr. v. Chambers, 903 F.3d 829, 846 (9th Cir. 2018), adding the
innocuous-sounding modifier of “*vacated on unrelated grounds*[,] 941 F.3d 1195 (9th Cir. 2019) (*en banc*).”
Def.’s Mot. at 8; *see id.* at 22. The City’s citation and use of the case violated an express order from the Ninth
Circuit. In granting *en banc* review, the Ninth Circuit instructed that “[t]he three-judge panel disposition in this
case shall not be cited as precedent by or to any court of the Ninth Circuit.” *Bd. of Trs. of Glazing Health &
Welfare Tr. v. Chambers*, 923 F.3d 1162, 1163 (9th Cir. 2019).

1 employer-based regimen of repeated payments to employees to defray the employees’ medical
2 costs, which – on its face – satisfies ERISA’s welfare plan definition of a program established
3 or maintained by the employer for the purpose of providing benefits in the event of sickness or
4 medical need. Here, the monthly payments directed by the City so that the employee can access
5 health coverage are the benefit, as the Ninth Circuit has established that money payments
6 themselves to employees are an ERISA benefit when made for purposes of covering healthcare
7 costs. *See, e.g., DB Healthcare, LLC v. Blue Cross Blue Shield of Ariz., Inc.*, 852 F.3d 868, 874
8 (9th Cir. 2017) (holding that “[t]he term ‘benefit’ in [ERISA] . . . refers to the specific
9 *advantages* provided to covered employees, as a consequence of their employment, for
10 particular purposes connected to alleviating various life contingencies”) (emphasis added).

11 In prior decisions, the Ninth Circuit has found similar employer-to-employee direct-
12 payment schemes to constitute ERISA plans. In *Aloha Airlines, Inc. v. Ahue*, 12 F.3d 1498,
13 1502-05 (9th Cir. 1993), the Ninth Circuit held that a Hawaii requirement of annual or semi-
14 annual payments by airline employers to employees to defray the cost of FAA-mandated pilot
15 exams constituted an ERISA plan. In *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1323 (9th Cir.
16 1992), the Ninth Circuit found that even just a one-time payment of money in the event of
17 employment termination constituted an ERISA plan. These decisions had three key ingredients.

18 First, in order to pay the benefits, the employers needed “to establish an administrative
19 scheme,” and the “establishment of such a scheme clearly implicates an ERISA plan.” *Aloha*
20 *Airlines*, 12 F.3d at 1505. The employers needed to create an administrative scheme because
21 “the circumstances of each employee’s” situation had “[to be] analyzed in light of [certain]
22 criteria.” *Bogue*, 976 F.2d at 1323 (quoting *Fortenot v. NL Indus., Inc.*, 953 F.2d 960, 962-63
23 (5th Cir. 1992) (brackets in original)). In *Aloha Airlines*, the direct payment turned on “a pilot’s
24 current rank,” since only captains and first officers needed the FAA pilot exams for which the
25 state required employer payments. *Aloha Airlines*, 12 F.3d at 1505. In *Bogue*, eligibility for the
26 job-termination payment turned on whether, upon termination, the employee was “offer[ed]

1 ‘substantially equivalent’ employment.” *Bogue*, 976 F.2d at 1321. In both instances, the need
2 for “ongoing, particularized . . . analysis” by the employer to determine each employee’s
3 eligibility meant “there was no way to administer the program without an administrative
4 scheme.” *Id.* at 1323.

5 Second, ERISA plans were implicated because the “payments . . . may depend on
6 contingencies outside the . . . employee’s control.” *Aloha Airlines*, 12 F.3d at 1503; *see Bogue*,
7 976 F.2d at 1322. Where the employer – rather than just the employee – has some
8 “discretionary” authority to qualify individuals for the program (*Bogue*, 976 F.2d at 1323), then
9 “ERISA’s concerns with the abuse and mismanagement of funds accumulated to finance
10 employee benefits” more readily come into play and necessitate that the program be deemed an
11 ERISA plan. *Aloha Airlines*, 12 F.3d at 1503. In *Aloha Airlines*, the “pilot’s status” was under
12 the employer’s control and could “change . . . depending upon an airline’s needs,” and, again, it
13 was pilot status as a captain or first officer that triggered the need for an FAA exam and thus the
14 “employer payments required by the statute.” *Id.* In *Bogue*, the employer not only determined
15 who would receive “substantially equivalent” employment, but also “remained obligated to
16 decide whether a complaining employee’s job was ‘substantially equivalent’ to his pre-
17 acquisition job.” *Bogue*, 976 F.2d at 1323.

18 Third, the programs in *Aloha Airlines* and *Bogue* did not involve merely predictable,
19 rote payments. In *Aloha Airlines*, in particular, the Ninth Circuit emphasized that “an airline
20 cannot often predict how many pilots of a particular status it will need during a coming year,”
21 and therefore “an airline employer cannot necessarily determine the amount of monies to budget
22 for such payments well in advance of the expected payment date.” *Aloha Airlines*, 12 F.3d at
23 1503. As a result, the “periodic payments” were less “analogous to salary payments,” which are
24 “fixed” and “regular[,]” and instead “would require an airline to establish a plan to administer
25 and manage them.” *Id.*

26 The direct employee payments pursuant to the first option of SMC 14.28 have the

1 “hallmark[s]” of an ERISA plan, as in *Aloha Airlines* and *Bogue*. *Bogue*, 976 F.2d at 1322.
2 The large-hotel and ancillary-business employers subject to SMC 14.28 would need to establish
3 an administrative scheme even with the first option, because each employee’s individual
4 circumstances would need to be analyzed for eligibility. For one thing, the employer would
5 need to determine, every month, which employees (including part-time employees) averaged 80
6 hours per month and were not exempt (supervisory) personnel, not much differently than the
7 employer in *Aloha Airlines* needed to determine for payment eligibility a pilot’s status. *See*
8 *Aloha Airlines*, 12 F.3d at 1505 (“the statute effects the primary administrative functions of
9 Aloha’s plans because it compels Aloha to ascertain whether a pilot is eligible for a particular
10 benefit (by determining that pilot’s rank and status periodically) and to assess the amount of the
11 benefit”). Moreover, in the case of SMC 14.28, the waiver process makes further individualized
12 assessment necessary. No covered employee would be entitled to a direct payment if he or she
13 had access to high quality healthcare elsewhere (through, for instance, coverage offered to a
14 family member or another employer for whom the worker works), and he or she signed a waiver
15 (after proper pre-waiver disclosure from the employer). Likewise, no one would be entitled to a
16 direct payment if the employer had offered health benefits under the second or third options
17 (with no more than the 20% employee contribution), and the employee declined. Keeping track
18 of all of these moving parts for each potentially eligible employee “requires [the employer] to
19 establish an administrative scheme” to pay the “recurring” benefits. *Id.*

20 Next, the receipt of a direct payment is not solely within the “employee’s control.” *Id.*
21 at 1503. The employer controls the number of hours offered to, and thus worked by, each
22 employee and, as a consequence, the employees’ eligibility; and the employer is the entity
23 “obligated to decide” who qualifies each month and to make payments to individuals. *Bogue*,
24 976 F.2d at 1323. Importantly, the employer also influences whether anyone can even claim a
25 direct payment. Again, if *the employer* offers an individual health benefits coverage through an
26 insured or self-funded plan, with the obligation that the employee pay 20% of the cost (as is

1 allowed under SMC 14.28.060), and the employee declines the offer, then the employer need
2 not provide the coverage *or* make a direct payment. It is conceivable that an unscrupulous
3 employer might strategize to make such offers to those it knows cannot afford the 20% cost,
4 obtain the declinations, and thereby limit the individuals subject to SMC 14.28.

5 Finally, with direct payments under the first option, an employer cannot readily
6 determine “the amount of monies to budget” for direct payments. *Aloha Airlines*, 12 F.3d at
7 1503. A large hotel employer or ancillary business, in one month, might need innumerable part-
8 time (*i.e.*, 80-hours-per-month) employees; and other months, none. The current COVID-19
9 crisis illustrates the point, with large hotel employers regrettably needing to furlough even
10 permanent employees. The point is that an employer will likely spend “varying amounts for
11 different numbers of [employees]” each month on payments, depending on its workforce needs.

12 The City relegates *Aloha Airlines* to a footnote and *Bogue* to a parenthetical (*see* Def.’s
13 Mot. at 16 & n.12), instead trying to align SMC 14.28’s first option with the employer practices
14 the Supreme Court held not to constitute ERISA plans in *Massachusetts v. Morash*, 490 U.S.
15 107 (1989), and *Fort Halifax Co. v. Coyne*, 482 U.S. 1 (1987). However, the Ninth Circuit
16 distinguished those cases in *Aloha Airlines* and *Bogues* on grounds equally applicable here. *See*
17 *Aloha Airlines*, 12 F.3d at 1503 (holding that, notwithstanding the state-required payments “can
18 be paid from Aloha’s general assets” as in *Morash*, “the *Morash* Court’s reasoning supports the
19 conclusion that employer payments for FAA-mandated examinations implicate ERISA’s
20 principal concerns,” because employers cannot “budget” for the costs like typical payroll
21 matters and need “to establish a plan to administer and manage [the payments]”); *id.* at 1505
22 (“[u]nlike the state law in *Fort Halifax*, which required an employer to make a one-time, lump-
23 sum severance payment, [the Hawaii law] requires Aloha to establish an administrative scheme
24 to pay recurring medical benefits”); *accord Bogue*, 976 F.2d at 1323.

25 And of course, the City cites *Golden Gate*, where the Ninth Circuit rejected the
26 argument that employers’ contributions to San Francisco to subsidize its provision of healthcare

1 to low-income individuals constituted an ERISA plan. But the local ordinance there, in its San
 2 Francisco “City-payment option,” had none of the characteristics of an ERISA plan that make
 3 SMC 14.28’s first option an ERISA plan. *Golden Gate*, 546 F.3d at 651. There was no
 4 payment directly to any employee based on eligibility criteria that the employer applied;
 5 instead, the employer paid an *aggregate* amount to the City based on a rate set by the City times
 6 the overall “number of hours their employees work” (with credits then for benefits expenditures
 7 already made). *Id.* Whose hours to count each period might change, but no individual went in
 8 and out of eligibility for a direct payment and was subject to any possible denial of benefits by
 9 their employer. Furthermore, the San Francisco law had no elaborate waiver system, with
 10 specific employer disclosure requirements, like SMC 14.28, which meant only limited
 11 “subjective judgments” for employers under San Francisco’s process. *Id.* In sum, unlike the
 12 ““ongoing, particularized, administrative, discretionary analysis”” under SMC 14.28’s first
 13 option that makes it ““an ongoing administrative scheme,”” an employer’s obligations under the
 14 local law in *Golden Gate* “involve[d] mechanical record-keeping,” ““d[id] not depend on
 15 contingencies outside the employee’s control,”” and “d[id] not run the risk of mismanagement
 16 of funds or other abuse.” *Golden Gate*, 546 F.3d at 651 (quoting *Velarde v. Pace Membership*
 17 *Warehouse, Inc.*, 105 F.3d 1313, 1317 (9th Cir. 1997), and *Morash*, 490 U.S. at 115).⁴

18 **IV. ERISA PREEMPTS SMC 14.28 BECAUSE EACH OF ITS OPTIONS MAKES**
 19 **AN IMPERMISSIBLE REFERENCE TO ERISA PLANS BY MEASURING**
 20 **COMPLIANCE THROUGH THE VALUE OR LEVEL OF BENEFITS**
 21 **PROVIDED**

22 Another reason ERISA preempts SMC 14.28 is that compliance under any of its options

23 ⁴ The waiver provisions are a critical aspect of SMC 14.28, for they steer employers to comply through coverage in
 24 insured or self-funded ERISA plans, which is almost certainly the City’s preference (given the advantages of
 25 ERISA coverage over direct payments for securing health insurance, *see infra* p. 22). Under the waiver process,
 26 an employer avoids direct payments to an employee when the employee has ERISA coverage through another
 source (*i.e.*, another employer) or if the employee declines coverage under the employer’s insured or self-funded
 plan (even if the plan has a 20% employee cost share). Thus, the employer has an incentive to verify ERISA
 coverage elsewhere, or to offer its own ERISA coverage in the first instance (because, in the event it is declined,
 the employer has no obligation at all). Of note, the Supreme Court has “virtually taken it for granted that state
 laws which are specifically designed to affect employee benefit plans are pre-empted under § [1144](a).”
Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 140 (1990) (internal quotation marks and citation omitted).

1 is measured by the value or level of benefits provided. In *Golden Gate*, while finding that San
2 Francisco’s law avoided preemption because it simply used a mathematical formula of a rate
3 times the employer’s total employee hours worked (with credits then applied) to determine an
4 employer’s liability for the City’s provision of health care services to low-income individuals,
5 the Ninth Circuit said a local law would fare differently if its “obligations were measured by the
6 level of *benefits* provided by the ERISA plan to the employee.” *Golden Gate*, 546 F.3d at 658.
7 In that instance, the law would make an impermissible “reference to” ERISA plans under
8 *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992).

9 Distinguishing *Greater Washington*, the Ninth Circuit said:

10 The employer calculates its required payments based on the hours worked by its
11 employees, rather than *on the value or nature of the benefits* available to ERISA
12 plan participants. Thus, unlike the ordinance in *Greater Washington*, the Ordinance
13 in this case is not determined, in the words of [§ 1144(a)], by ‘reference to’ an
14 ERISA plan.”

15 546 F.3d at 658 (emphasis added).

16 Under SMC 14.28’s first option, the direct monthly payments to the employee to cover
17 expected medical costs are themselves the ERISA benefits (as were the direct payments in
18 *Aloha Airlines and Bogue*), and compliance turns on whether that benefits meet the *value*
19 requirements set out in § 14.28.060.A (for instance, \$420 per month for employee self-only
20 benefits). In fact, because the payment (for future use towards health care) is the benefit, the
21 City overtly sets even the *level of benefits* by establishing the dollar amount to be paid to the
22 employee. *See Aloha Airlines*, 12 F.3d at 1502 (rejecting argument that “only those ‘medical
23 benefits’ that provide . . . immediate aid to a participant employee are within ERISA’s
24 purview”). Under the second option (*i.e.*, the insured plan option), an employer satisfies its
25 obligations only if it purchases for *each* covered employee an insurance plan with sufficient
26 benefits and value as to be priced (the premium associated with that employee) at a level equal
to or above SMC 14.28’s specifications. Under the third option, an employer satisfies its

1 obligations only if, per capita on average, the value of benefits its pays under its self-funded
2 plan is equal to or above SMC 14.28's specifications.

3 **V. ERISA PREEMPTS SMC 14.28 BECAUSE IT OTHERWISE REFERENCES**
4 **ERISA PLANS THROUGHOUT ITS PROVISIONS**

5 Still another reason that ERISA preempts SMC 14.28 is that the ordinance makes
6 "reference to" ERISA plans in other ways, acting immediately and exclusively upon ERISA
7 plans and with the existence of ERISA plans being essential to the law's operation. *See supra* p.

8 7. The references are numerous and pervade all three options for compliance:

- 9 • On its face, the second option makes compliance turn on the employer paying an
10 "insurance carrier or trust," which is a reference to an ERISA plan. SMC
11 14.28.060.B.2.
- 12 • On its face, the third option makes compliance turn on whether the employer makes
13 average per capita payments through "the employer's self-insured and/or self-funded
14 insurance program(s)," which is a reference to an ERISA plan. *Id.* § 14.28.060.B.3.
- 15 • On the face of SMC 14.28, when monthly payments must be made to new hires
16 under the second and third options is measured by the waiting period in the
17 "employer-sponsored plan," which is a reference to an ERISA plan. *Id.* §
18 14.28.060.C.
- 19 • An employer will be deemed to have satisfied SMC 14.28, under any of the three
20 options, if the employee refuses an employer's offer of coverage under an employer-
21 sponsored insured or self-funded plan where the employee's cost sharing is no
22 greater than "20 percent of the monthly required healthcare amount," which is a
23 reference to an ERISA plan and its specific terms. *Id.* § 14.28.060.D.1.
- 24 • SMC 14.28's scope excludes individuals who have "health coverage" from
25 "employer-sponsored coverage through an employer other than the covered
26 employer," which is a reference to an ERISA plan. *Id.* § 14.28.030.B.2.
- SMC 14.28's "Effective date" provision fixes the ordinance's start date, in part,

1 based on “the earliest annual open enrollment period for health coverage, if offered,
2 after July 1, 2020,” which is a reference to an ERISA plan and its enrollment terms.
3 *Id.* § 14.28.260.

4 Though, in these references, SMC 14.28 does not in every instance use the exact term
5 “ERISA plan,” the Supreme Court has recognized that references to employer-based coverage,
6 employer-sponsored insurance, or an employer’s program is the equivalent of an actual, exact
7 reference to an ERISA plan. *See Greater Wash.*, 506 U.S. at 130 (holding that a state law’s
8 mention of ““health insurance coverage”” and the ““benefit level”” in that coverage were each
9 references to ERISA plans) (quoting state law); *FMC Corp. v. Holliday*, 498 U.S. 52, 59 (1990)
10 (holding that a state law’s mention of ““any program, group contract or other arrangement for
11 payment of benefits”” constituted a reference to ERISA plans) (quoting state law); *Ingersoll-*
12 *Rand*, 498 U.S. at 140 (mention of “employee’s pension fund” in state cause of action is a
13 reference to ERISA plans). And these various references in SMC 14.28 are not mere allusions
14 to ERISA plans, but describe the actual modes of compliance, the contours of those compliance
15 modes, and exceptions to compliance.

16 The City minimizes these references by contending that SMC 14.28 could operate in
17 some form (albeit a shell form, other than actually enacted) even if no employer ever adopted an
18 ERISA plan, supposedly proving that ERISA plans are not integral and essential to the
19 ordinance’s operation. *See* Def.’s Mot. at 22-24. That is simply untrue, given that, as shown,
20 *each* option involves the creation of an ERISA plan. Even assuming that the first option were
21 not itself an ERISA plan, ERISA plans nonetheless are key to SMC 14.28’s full operation.
22 Under the terms of the first option (as with the other options), no employer need make a
23 payment if the covered employee has *ERISA coverage* elsewhere; nor must the employer
24 comply with the first option if it offers *ERISA coverage* under the second or third options and
25 the employee declines. Accordingly, ERISA plans are integral to determine even threshold
26 application of the first option. *See Greater Wash.*, 506 U.S. at 130 (holding that state law

1 governing non-ERISA plans referenced ERISA plans when it made the non-ERISA plans' terms
2 hinge on the terms of analogous ERISA coverage).

3 **VI. ERISA PREEMPTS SMC 14.28 BECAUSE IT HAS A CONNECTION WITH**
4 **ERISA PLANS**

5 A final basis for ERISA preempting SMC 14.28 is that it has a "connection with"
6 ERISA plans. In a nutshell, SMC 14.28 effectively compels large hotel employers and ancillary
7 businesses to alter their current or self-funded coverage both to make eligible for coverage those
8 employees covered by SMC 14.28 and to provide benefits consistent with the value-level
9 requirements of the second and third options. As noted earlier, a state law will have an
10 impermissible "connection with" ERISA plans if "acute, albeit indirect, economic effects" of
11 the state law "force an ERISA plan to adopt a certain scheme of substantive coverage or
12 effectively restrict its choice of insurers." *Gobeille*, 136 S. Ct. at 943 (quoting *Travelers*, 514
13 U.S. at 668). *Golden Gate* added that this standard is satisfied where, if a state law purports to
14 offer various routes for compliance, the law does not offer "employers a realistic alternative to
15 creating or altering ERISA plans." *Golden Gate*, 546 F.3d at 660; e.g., *Retail Indus. Leaders*
16 *Ass'n v. Fielder*, 475 F.3d 180, 197 (4th Cir. 2007) (holding that Maryland health-plan law that
17 "leaves employers no reasonable choices except to change how they structure their employee
18 benefit plans" is preempted because it "directly regulates employers' provision of healthcare
19 benefits" and has a "connection with" covered employers' ERISA plans").

20 SMC 14.28 requires the creation of ERISA plans under any of its options, as already
21 noted; so, the Court need not proceed to the question of whether it actually pushes employers to
22 do so, instead of choosing a non-ERISA option (as there is no such non-ERISA option). Yet, if
23 the Court determines that the first option does not involve the creation of an ERISA plan, then
24 SMC 14.28 still has an impermissible connection with ERISA plans because the law does not
25 meaningfully allow employers to choose the first option over the second and third options.

26 The first option is financially more onerous and otherwise problematic, so as not to
make it a reasonable choice over the other options, because (as alleged in the FAC ¶ 55):

- 1 • If they are required to spend additional corporate funds, rational employers will do
2 so in a manner whereby they can ensure that the money will be used for health
3 benefits for their workers (as is the case under the second and third options).
- 4 • Direct payments are costlier to employers because – in order to provide the same
5 benefits as if they choose the second or third options – they may have to pay the
6 employer share of federal employment taxes on the direct payments, whereas
7 expenditures on health coverage under the second and third options are not subject to
8 federal employment taxes.
- 9 • Offering health coverage to the employee is more financially advantageous to the
10 employee, and thus more appealing to the employer, because the employee too may
11 have to pay his or her share of federal employment taxes, as well as income taxes, on
12 the direct payments but not the health coverage.
- 13 • Offering health coverage to the employee through insured or self-funded employer-
14 sponsored plans is more advantageous to the employee who actually wants health
15 coverage, and thus more appealing and administratively feasible to the employer,
16 because greater coverage for the same amount typically can be obtained through a
17 program covering a large group than individually.
- 18 • The City’s earlier passage of Part 3 resulted in employers covered by that law
19 altering their ERISA plans to bring them into compliance with Part 3, and it is
20 unrealistic to expect employers who have already done the difficult work of
21 adjusting their employee-benefit arrangements to cover the additional individuals to
22 undo the new administrative regime in favor of direct payments. Instead, the City’s
23 legislative maneuvering has created “sunk costs” for covered employers, resulting in
24 the only reasonable option being for them now to further adjust the employer-
25 sponsored coverage. And if employers nevertheless did undo their prior work to
26

1 enhance their ERISA plan benefits and eligibility, this change itself would be an
2 amendment to ERISA plans resulting from SMC 14.28.

3 The City addresses none of these points, except in a footnote where it contends that there
4 are insufficient facts alleged in the FAC to support the allegations. Def.'s Mot. at 19 n.14. The
5 footnote is disingenuous, and it belies the detail in the FAC. The City never offers any
6 alternative set of facts or views regarding rational corporate behavior that would differ from the
7 FAC's allegations. Indeed, the City never even disputes (because it cannot) that employers
8 responded to Part 3 by altering their ERISA plans, which is proof in itself that reasonable
9 corporate actors would not choose a direct-payment option, for they have not in the past, as all
10 appear to agree.

11 Last, SMC 14.28 has a separate "connection with" ERISA plans triggering preemption,
12 because of its disclosure and record-keeping requirements (applicable to any of its options).
13 "[R]eporting, disclosure, and recordkeeping are central to, and an essential part of, the uniform
14 system of plan administration contemplated by ERISA." *Gobeille*, 136 S. Ct. at 945.
15 "Differing, or even parallel, regulations from multiple jurisdictions could create wasteful
16 administrative costs and threaten to subject plans to wide-ranging liability" through state
17 enforcement provisions, making "[p]re-emption . . . necessary." *Id.*

18 Here, SMC 14.28 has unique disclosure and record-keeping requirements associated
19 with the waivers. Particularly, an employer who offers coverage under its insured or self-
20 funded ERISA plan (at a 20% or less cost-share for the employee) has no obligation to comply
21 with SMC 14.28 – including the direct-payment requirement – if the employee declines the
22 coverage. However, SMC 14.28 has strict disclosure requirements about the ERISA plan
23 coverage that the employer must meet (including in various languages and using City-generated
24 forms), and also requires records be kept regarding the offer and the circumstances of the
25 declination. These records are well beyond the typical tax and wage data that employers must
26 keep for general legal compliance and concern nothing other than the terms and availability of

1 the employer’s insured and self-funded ERISA plans. Unlike in *Golden Gate* – which had no
2 waiver framework at all – these burdens exists only *if* “a covered employer has an ERISA
3 plan.” *Golden Gate*, 546 F.3d at 657. “Pre-emption [of SMC 14.28] is necessary to prevent the
4 States from imposing novel, inconsistent, and burdensome [disclosure and] reporting
5 requirements on plans.” *Gobeille*, 136 S. Ct. at 945.⁵

6 **CONCLUSION**

7 The Court should deny in its entirety the City’s motion to dismiss the FAC.

8 DATED this 23rd day of March 2020.

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⁵ ERIC plans to move for summary judgment in due course. Given that the Supreme Court currently has before it an important ERISA preemption case, and SMC 14.28’s effective date might not necessitate resolution of ERIC’s FAC before the Supreme Court decides its preemption case, ERIC might reasonably await the Supreme Court’s decision before filing its own affirmative motion. *See Rutledge v. Pharm Care Mgmt. Ass’n*, No. 18-540 (U.S.) (oral argument scheduled for Apr. 27, 2020).

CERTIFICATE OF SERVICE

I certify that on March 23, 2020, I caused a copy of the foregoing document, PLAINTIFF'S OPPOSITION TO DEFENDANT'S MOTION TO DISMISS THE FIRST AMENDED COMPLAINT, to be filed with the Clerk of the Court via the CM/ECF system. In accordance with their ECF registration agreement and the Court's rules, the Clerk of the Court will send e-mail notification of such filing to the following attorneys of record:

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