No. 20-35472

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

THE ERISA INDUSTRY COMMITTEE,

Plaintiff-Appellant,

v.

CITY OF SEATTLE,

Defendant-Appellee.

On Appeal from the United States District Court
for the Western District of Washington (Hon. Thomas S. Zilly)
No. 2:18-cv-01188-TSZ

BRIEF OF APPELLANT

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, The ERISA Industry Committee identifies its parent corporation and publicly held companies owning 10% or more of stock (if any) as follows: The ERISA Industry Committee is a District of Columbia non-profit corporation with no parent company or subsidiaries and no publicly or privately issued stock.

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JURISDICTIONAL STATEMENT

Plaintiff-Appellant The ERISA Industry Committee ("ERIC") filed an action in the District Court against Defendant-Appellee City of Seattle ("the City") asserting that the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, preempts a recently enacted health-benefits measure known as Seattle Municipal Code 14.28 ("SMC 14.28" or "Ordinance"). The District Court had subject-matter jurisdiction because this case arises under federal law, including the U.S. Constitution's Supremacy Clause, U.S. Const. art. VI. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983). The District Court also had subject-matter jurisdiction based on diversity of citizenship pursuant to 28 U.S.C. § 1332. Excerpts of Record ("ER") at 26.

The District Court dismissed ERIC's case under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim upon which relief can be granted and entered a final judgment on May 11, 2020. ER4. ERIC timely appealed on May 29, 2020. ER1. This Court has appellate jurisdiction pursuant to 28 U.S.C. § 1291.

STATEMENT OF THE ISSUE PRESENTED FOR REVIEW

Did the District Court err in dismissing pursuant to Rule 12(b)(6) ERIC's claim that ERISA preempts SMC 14.28, which requires large hotel employers and ancillary hotel businesses in the City to provide money directly to certain

employees or to cover them in the employers' health benefit plans so that the employees can better access healthcare?

STATEMENT OF THE CASE

The case has its genesis in a predecessor law to SMC 14.28 and ERIC's challenge to it. In the sections below, ERIC first describes the predecessor, turns then to detailing SMC 14.28's provisions, and thereafter reviews the District Court's disposition of the case. Where mentioned, the facts are taken from the First Amended Complaint (whose well-pled allegations are assumed to be true, *see infra* p. 16).

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

In 2016, the City's voters through the initiative process enacted the predecessor to SMC 14.28, which was Part 3 of former SMC 14.25 ("Part 3"). ER27. Part 3 required certain large hotel employers to pay additional wages to covered employees for health insurance expenses; however, the employer could avoid the obligation to pay additional wages if it provided health coverage through an employer-sponsored health benefit plan at a level equal to or above a gold-level plan on the Washington Health Benefit Exchange. ER27-28. In response, ERIC – a national trade association of large multistate companies who are concerned with maintaining a nationally uniform regime of legal requirements for employee benefits – sued the City in the District Court, contending that ERISA preempts Part

3. ER28. While the case was pending, one or more ERIC member companies affected by Part 3 altered their employer-sponsored plans to offer coverage consistent with Part 3, since the direct-payment requirement was financially more onerous in comparison and given that there was no assurance under Part 3 that an employee who received additional wages (rather than coverage under the employer's plan) necessarily would use the monies reasonably on healthcare. *Id.*

Eventually, the District Court stayed ERIC's case, to account for state-court proceedings in which an appeals court had declared former SMC 14.25 illegal in its entirety (including Part 3), as violating the Washington Constitution's initiative requirements. *Id.*; *see Am. Hotel & Lodging Ass'n v. City of Seattle*, 432 P.3d 434, 445 (Wash. Ct. App. 2018), *review granted*, 439 P.3d 1069 (Wash. 2019). The state litigation, however, was mooted when the City, in September 2019, repealed former SMC 14.25 and enacted, among other successors, SMC 14.28 as a replacement for Part 3. ER28. The District Court then lifted the stay, and ERIC filed a First Amended Complaint to challenge SMC 14.28. *Id.*

B. SMC 14.28's Basic Provisions

At the outset, SMC 14.28 states its purpose to be "requiring certain employers to make required healthcare expenditures to or on behalf of certain employees for the purpose of improving access to medical care." SMC 14.28 (preamble). The Ordinance's "intent . . . is to improve low-wage hotel employees'

access, through additional compensation, to high-quality, affordable health coverage for the employees and their spouses or domestic partners, children, and other dependents." *Id.* § 14.28.025; *accord* Seattle Office of Labor Standards, *Improving Access to Medical Care for Hotel Employees Ordinance: Questions and Answers* 1 (June 22, 2020) [hereinafter "Regulatory Questions & Answers"]; *see generally* Seattle Office of Labor Standards, Seattle Human Rights Rules, Ch. 190 (June 24, 2020) [hereinafter "SHRR"].[1]

Under SMC 14.28, eligible employees are those who work an average of 80 hours or more per month and are not managers, supervisors, or confidential employees. SMC 14.28.030.A, 14.28.020. Covered employers are owners or operators of a hotel with 100 or more guest rooms in the City, as well as ancillary hotel businesses with 50 or more employees worldwide (the latter not having been subject to the predecessor, Part 3). *Id.* §§ 14.28.040, 14.28.020. "Ancillary hotel

[1] SMC 14.28 is contained in an Addendum to this Brief and is also available at http://seattle.legistar.com/LegislationDetail.aspx?ID=3993855&GUID=A3ACB5DC-6D4C-4EF1-A6F9-AFD275F25343&Options=ID|Text|&Search=125930 (last visited Aug. 22, 2020). The Addendum likewise contains the Regulatory Questions & Answers and provisions of the SHRR. Those also are, respectively, available at https://www.seattle.gov/laborstandards/ordinances/hotel-employee-protections/improving-access-to-medical-care-for-hotel-employees-ordinance (click link "Improving Access to Medical Care for Hotel Employees Ordinance Q&A") and https://www.seattle.gov/laborstandards/ordinances/hotel-employee-protections (click link "Rules: SHRR Chapter 190"). The Seattle Office of Labor Standards did not issue the Regulatory Questions & Answers or the relevant provisions of the SHRR until after the District Court dismissed this case.

business" is "any business that (1) routinely contracts with the hotel for services in conjunction with the hotel's purpose; (2) leases or sublets space at the site of the hotel for services in conjunction with the hotel's purpose; or (3) provides food and beverages, to hotel guests and to the public, with an entrance within hotel premises." *Id.* § 14.28.020.

SMC 14.28 requires covered employers to make, each month, "[r]equired healthcare expenditures" for "covered employee[s]" of $420 if an employee has no spouse, domestic partner, or dependents; $714 for an employee with dependents only; $840 for an employee and spouse/domestic partner; and $1260 for an employee with spouse, domestic partner, and dependents. *Id.* § 14.28.060.A.1-A.4. These are the rates in effect for 2020 and are "subject to annual adjustments based on the medical inflation rate." *Id.* § 14.28.060.A; *see* Regulatory Questions & Answers 7 (Q. 30). Moreover, "the rate applicable to an individual employee is determined by the employee's family composition," irrespective of whether the employee seeks the expenditures for his or her entire family and "regardless of whether th[e] spouse, domestic partner, or dependent(s) is covered or eligible to be covered by an employer's group health plan." Regulatory Questions & Answers 7 (Q. 31, 33). That is, "[t]he rates set by the law are based on the presence or absence of a spouse, domestic partner, or dependent(s)." *Id.* at 7 (Q. 33); *see* SHRR 190-230(1). "An employer must make reasonable efforts to obtain accurate

information to determine the employee's rate" and "family status." Regulatory Questions & Answers 7 (Q. 33); *see* SHRR 190-230(2).

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

- *First option*: "Additional compensation paid directly to the covered employee" (*id.* § 14.28.060.B.1);
- *Second option*: "Payments to a third party, such as to an insurance carrier or trust, or into . . . tax favored health programs, (including health savings accounts, medical savings accounts, health flexible spending arrangements, and health reimbursement arrangements) for the purpose of providing healthcare services to the employee or the spouse, domestic partner, or dependents of the covered employee (if applicable)" (*id.* § 14.28.060.B.2); and
- *Third option*: "Average per-capita monthly expenditures for healthcare services made to or on behalf of covered employees or [the

spouse, partner, or dependents] by the employer's self-insured and/or self-funded insurance program(s)." *Id.* § 14.28.060.B.3.[2]

Under all of the options, there is a potential delay in the Ordinance's application for new hires. "[I]f an employer imposes a waiting period before new hires can be enrolled in its employer-sponsored plan (or the plan or insurer carrier mandates such a period), the employer will not be required to satisfy the health expenditures described in 14.28.060.A until the sooner of sixty days from the date of hire or the expiration of the waiting period." *Id.* § 14.28.060.C; *see also* Regulatory Questions & Answers 4 (Q. 14) ("[N]ewly hired employees that are subject to a waiting period for enrollment in an employer-sponsored health plan are temporarily exempted from the law for 60 days or the expiration of the waiting period, whichever is shorter.").

C. SMC 14.28's Exceptions and Waiver Requirements

SMC 14.28 contains several exceptions, as well as a waiver regime to ensure no abuse of the exceptions. One exception provides that an employer will be

[2] As relevant here, there are two types of ERISA health benefit plans that employers traditionally sponsor: insured and self-funded. *See FMC Corp. v. Holliday*, 498 U.S. 52, 60-64 (1990). Insured plans are those sponsored by an 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.

"deemed to have satisfied" its monthly obligations under *any* of the three options, if "an employee voluntarily declines an employer's offer" of compliance through the second and third options – *i.e.*, an offer of coverage under the employer's insured or self-funded health plan. SMC 14.28.060.D. For the offer to be valid, the employer "must not require the employee to pay more than a dollar amount equivalent to 20 percent of the monthly required healthcare amount described in subsection 14.28.060.A.1," through the employee's portion of an insurance premium or cost-sharing. *Id.* § 14.28.060.D.1. For example, for an employee entitled to a healthcare expenditure just for him- or herself, the employee shall "not [be] required to pay more than an amount equaling 20% of the single employee healthcare expenditure rate (in 2020, $84/month) towards the employer-sponsored health insurance plan." Regulatory Questions & Answers 8 (Q. 36). A declination occurs when the employer "obtain[s] a signed waiver from the employee, free from coercion." SMC 14.28.060.D.2.

In turn, SMC 14.28 regulates the terms and conditions for an employer to obtain the employee's waiver to substantiate the declination permitted under § 14.28.060.D. "The employer must offer [a] waiver in the employee's primary language and on a form issued by the Director [of the Office of Labor Standards]." *Id.* § 14.28.060.D.2. "Prior to offering the waiver, the employer must provide the employee with a written disclosure of the rights being waived, the form and

content of which shall be prescribed by the Director." *Id.*; *see* Seattle Office of Labor Standards, *SMC 14.28 Voluntary Ordinance Waiver* 1-2 (June 2020), https://www.seattle.gov/laborstandards/ordinances/hotel-employee-protections/improving-access-to-medical-care-for-hotel-employees-ordinance (click link "Ordinance Coverage Waiver"). And, again, the employer must perform these functions without "coercing or unduly inducing an employee to waive coverage." SMC 14.28.050. Ultimately, if the employer makes the offer of coverage, if the employer complies with the waiver requirements, and if the employee who receives the waiver form "refuses to sign such waiver" and "continues to decline, in whole or in part," the employer "will be deemed to have satisfied its required healthcare expenditure rate for that employee." *Id.* § 14.28.060.D. In that situation, the employer must keep records of "the employee's receipt of the waiver and written disclosures . . . and the employee's subsequent refusal to sign the waiver." *Id.*

There also is an exception for an employee "who receives health coverage from another source, including but not limited to employer-sponsored health insurance through an employer other than the covered employer." *Id.* § 14.28.030.B.2. Such an employee may waive coverage by signing the requisite waiver form to indicate "high-quality and affordable health coverage from another source." *Id.* § 14.28.030.B.2.a.

Still another exception is for situations where a covered employee seeks to exclude his or her spouse, domestic partner, or dependents from coverage that an employer offers. Thus, where "[a]n employer plans to meet [its] obligations through payments to an insurance carrier to provide health insurance to an employee and their spouse," but the employee "does not want to enroll their spouse in their employer's health insurance plan and, therefore, declines the expenditure in part," the employer satisfies its obligations by making the offer of coverage for the family. Regulatory Questions & Answers 9 (Q. 39). "If the employee signs [a] waiver or refuses to sign but continues to decline part of the expenditure, the employer will be deemed to have satisfied their obligations under this law." *Id.*; *see* SHRR 190.250(6)(a). Though not thereafter required, the "employer *may* still offer the employee the opportunity to individually enroll in the health insurance." Regulatory Questions & Answers 9 (Q. 39) (emphasis added).

D. SMC 14.28's Record-Keeping and Enforcement Provisions and Effective Date

Employers must retain, for three years, records documenting compliance with SMC 14.28. *See* SMC 14.28.110; Regulatory Questions & Answers 9 (Q. 38); SHRR 190.250(5). Hence, where an employer satisfies its obligations by making an offer of coverage through the second or third option that is declined, the employer must keep records of its disclosures to the employee regarding the offer

of coverage, the provision of a waiver form to the employee, and the employee's refusal to sign the waiver. *See* SMC 14.28.060.D.

More specifically, "the employer must have proof that the employee received the waiver and evidence that the employee continued to decline the healthcare expenditure"; "[i]n the absence of such affirmative evidence of declination, the employer shall provide the healthcare expenditure to the employee." Regulatory Questions & Answers 9 (Q. 38). "Examples of proof that the employee received the waiver include but are not limited to a written, sworn statement under penalty of perjury affirming that the Expenditure Waiver was given to the employee and the date upon which such service was made." *Id.*; *see* SHRR 190.250(3)(a). "Examples of evidence of continued declination include but are not limited to: A written statement from the employee indicating that the employee declines the expenditure that is dated after the date the waiver was provided to the employee; [or t]he employee's refusal to authorize a payroll deduction for a premium payment after being given a reasonable opportunity to do so." Regulatory Questions & Answers 9 (Q. 38).

With respect to enforcement, the City may investigate violations, has subpoena authority, may levy fines and penalties, and can fashion other remedies. SMC 14.28.130, 14.28.150.E, 14.28.160.C.1. The Ordinance also provides a

private right of action to "[a]ny person or class of persons that suffers [an] injury as a result of a violation." SMC 14.28.230.A.

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

E. The District Court's Decision Dismissing the Case

In response to ERIC's filing of the First Amended Complaint challenging SMC 14.28 as preempted by ERISA (*see supra* p. 3), the City moved to dismiss the case pursuant to Rule 12(b)(6) for failure to state a claim upon which relief can be granted. In the order now on appeal, the District Court, Senior Judge Zilly, granted the motion. The District Court said that a pleading can be dismissed under Rule 12(b)(6) where there is an "absence of a cognizable legal theory." ER8 (citing *Robertson v. Dean Witter Reynolds, Inc.*, 749 F.2d 530, 534 (9th Cir. 1984)). The District then rejected each of the arguments proffered by ERIC in support of ERISA preemption, instead reaching the "legal conclusion that the Ordinance is not preempted by ERISA." ER18. The District Court believed that the case was controlled "by the Ninth Circuit precedent set more than a decade ago in *Golden Gate*," which had held, according to the District Court, that a supposedly "identical

local ordinance was not preempted by ERISA." ER17; *see generally Golden Gate Rest. Ass'n v. City & Cty. of San Francisco*, 546 F.3d 639 (9th Cir. 2008).

SUMMARY OF ARGUMENT

I. ERISA contains an expansive express preemption provision, designed to ensure nationwide uniformity in the administration of employee benefit plans sponsored by private employers. The provision mandates preemption of state and local laws that "relate to" employee benefit plans. 29 U.S.C. § 1144(a). Under the governing case law, a state law "relate[s] to" employee benefit plans when it makes "reference to" or has "connection with" them. *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016). Under any of the theories that ERIC has pressed, SMC 14.28 "relate[s] to" employee benefit plans – *i.e.*, refers to or is connected with them.

II. As a threshold matter, there is no presumption against ERISA preemption here. The Supreme Court recently foreswore its earlier adoption of such a presumption for instances – as under ERISA – where a federal statute contains an express preemption provision. Furthermore, even if the former presumption regime still prevailed, there is no presumption against preemption of SMC 14.28, since the Ordinance regulates health benefits *coverage*, not the *provision* of healthcare.

III. SMC 14.28 references ERISA plans because each of its options necessitates the creation or maintenance of ERISA plans. There is no real controversy that the second and third options (focused on the value of employer-supplied health insurance or employer-supplied self-funded health coverage) require ERISA plans for compliance. As to the first option, an employer's direct payments under it too constitute an ERISA plan under ERISA's definition of "welfare plan," 29 U.S.C. § 1002(1). The relevant case law, especially *Aloha Airlines, Inc. v. Ahue*, 12 F.3d 1498 (9th Cir. 1993), and *Bogue v. Ampex Corp.*, 976 F.2d 1319 (9th Cir. 1992), likewise indicates that the first option qualifies as an ERISA plan, because it requires an administrative scheme for compliance, as a result of, at a minimum, the employer's obligation to determine employee eligibility, to fix the amount owed based on the employee's spousal, partner, and dependent status, and to implement the waiver system.

Golden Gate Restaurant Ass'n v. City & County of San Francisco, 546 F.3d 639 (9th Cir. 2008), is distinguishable, as the local law there at issue did not concern an intricate employer-to-employee direct-payment regime (and accompanying administrative system), as the first option under SMC 14.28 does. And *Golden Gate*'s extension to new circumstances is unjustified in light of the current non-application of the presumption against preemption on which *Golden Gate* rested.

IV. Separately, SMC 14.28 makes impermissible "reference to" ERISA plans because the full operation of the Ordinance is intertwined with covered employers' ERISA plans. Among the aspects of the Ordinance that hinge on ERISA plans are the commencement point for healthcare expenditures for new hires, the waiver system that deems employer compliance to occur where ERISA-plan coverage is offered but declined, and even the "Effective date" provision.

V. In numerous ways, SMC 14.28 has "connection with" ERISA plans, any one of which compels preemption. The Ordinance forces employers to alter their ERISA plans by following the second and third options, because the first option is not a realistic alternative due to it being more expensive and otherwise less appealing to employers and employees. The District Court, wrongly, failed to accept as true ERIC's factual allegations on this front, insisting ERIC at the pleadings stage must "*show[]* that the Ordinance effectively binds employers to [a] particular choice." ER16 n.8 (emphasis added). Additionally, SMC 14.28 impermissibly adds to ERISA's record-keeping and disclosure requirements, particularly as a result of the Ordinance's complicated waiver system. Last, SMC 14.28 structures employer choices regarding their ERISA plans and burdens plan administrators, by either steering them to offer ERISA coverage to affected employees or, otherwise, requiring the tracking – potentially nationally – of opt-out alternatives.

STANDARD OF REVIEW

The Court reviews *de novo* a district court's dismissal of claims under Rule 12(b)(6). *See Dougherty v. City of Covina*, 654 F.3d 892, 897 (9th Cir. 2011). In its review, the Court applies the same legal standard regarding the propriety of dismissal under Rule 12(b)(6) as a district court: "a complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (internal quotation marks and citation omitted). Not only does the Court "'accept[] all factual allegations in the complaint as true," it also "construe[s] 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)).

ARGUMENT

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

The appellate question for decision is whether the District Court erred in dismissing ERIC's claim that ERISA preempts SMC 14.28. With ERISA as the focus of the appeal, a good place to start is with ERISA's nature and scope and its general preemption standards.

ERISA's coverage extends to any employee benefit plan established or maintained by a private employer or employee organization (such as a union). *See* 29 U.S.C. § 1003(a), (b). Despite ERISA's broad 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); *accord Conkright v. Frommert*, 559 U.S. 506, 516 (2010). 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)). Uniformity and affordability in the regulation and administration of ERISA plans were paramount to Congress: "[r]equiring 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 v. Liberty Mutual Ins. Co.*, 136 S. Ct. 936, 944 (2016) (internal quotation marks and citations omitted).

In furtherance of nationally "uniform standards," Congress included in ERISA an express preemption provision. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983). The preemption provision states: 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) (emphasis added). "State law[s]" 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]." *Id.* § 1144(c)(1)-(2).

Following from the "relate to" term 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 Enf't v. Dillingham Constr., N.A.*, 519 U.S. 316, 324 (1997) ("*Dillingham*") (internal quotation marks and citations omitted) (cataloging statements in prior precedents). In its most recent ERISA preemption decision, the Supreme Court confirmed (again) that ERISA's preemption section has a "broad scope," adding that, through the provision,

Congress intended the regulation of employee benefit plans to be "'exclusively a federal concern.'" *Gobeille*, 136 S. Ct. at 944 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)).

Still, while emphasizing § 1144(a)'s breadth, the Supreme Court has also cautioned against applying the provision too "'literal[ly].'" *Id.* at 943 (quoting *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) ("*Travelers*")). Otherwise, "'[i]f "relate to" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course.'" *Id.* (quoting *Travelers*, 514 U.S. at 655).

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

A state law has a "connection with" ERISA plans 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).

Put in terms of this case, ERISA preempts SMC 14.28 if the ordinance makes a reference to or has a connection with ERISA plans. And in determining if SMC 14.28 is invalid under those standards, the "guide[s]" are "the objectives of the ERISA statute" – which, again, are to ensure nationally uniform standards for the operation and administration of ERISA plans – and "the nature of the effect of the state law on ERISA plans." *Id.* (internal quotation marks and citation omitted).

II. THERE IS NO PRESUMPTION AGAINST PREEMPTION IN THIS CASE

Though the District Court acknowledged that the ERISA-preemption touchstones for deciding the City's motion to dismiss were whether SMC 14.28 has "'a connection with or reference to [ERISA] plan[s],'" it freighted the inquiry with

a threshold presumption against preemption. ER15 (quoting *Shaw*, 463 U.S. at 96-97). In response to ERIC's assertion that very recent Supreme Court case law had upended earlier instructions on using a presumption against ERISA preemption, the District Court simply cited old decisions from the Supreme Court and this Court on the issue and said that "the Ordinance is entitled to a presumption against preemption by federal law." ER11. The District Court erred, for no presumption against preemption currently applies under ERISA's express preemption provision.

Historically, the Supreme Court had not applied any presumption against preemption under § 1144(a), instead characterizing ERISA's preemption provision as the statute's "'crowning achievement'" and revolutionary for its time. *Shaw*, 463 U.S. at 99 (quoting 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent)); *see Franchise Tax Bd. v. Constr. Laborers Vacation Tr.*, 463 U.S. 1, 24 n.26 (1983) (describing § 1144(a) as a "virtually unique pre-emption provision"). Nonetheless, by the time of *Travelers* in 1995, the Supreme Court did direct for ERISA's preemption section a "starting presumption that Congress does not intend to supplant state law . . . in fields of traditional state regulation." *Travelers*, 514 U.S. at 654-55. Contemporaneously, the Supreme Court's general trend was to extend to express-preemption situations the "presumption against the pre-emption of state police power regulations" typically applied in ordinary conflict-preemption

circumstances governed by the Constitution's Supremacy Clause. *Cipollone v. Liggett Grp.*, 505 U.S. 504, 518 (1992) (federal food and drug statute).

But the Supreme Court's thinking changed in the twenty years following *Travelers*, so that by the mid-2010s a majority of Justices had registered dissatisfaction with a presumption against preemption when Congress had included a preemption command in the statute's express terms. *E.g.*, *CTS Corp. v. Waldburger*, 573 U.S. 1, 19-20 (2014) (Scalia, J., concurring, and joined by Roberts, C.J., and Thomas and Alito, J.J.); *Ariz. v. Inter Tribal Council of Ariz., Inc.*, 570 U.S. 1, 21 (2013) (Kennedy, J., concurring). Then, in *Gobeille*, the Court refused to recognize at all the existence of a presumption against preemption. *See* 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).

Finally, in *Puerto Rico v. Franklin California Tax-Free Trust* ("*Franklin*"), the Supreme Court formally ruled that, where a "statute 'contains an express pre-emption clause,' we do not invoke any presumption against pre-emption." 136 S. Ct. 1938, 1946 (2016) (quoting *Chamber of Commerce v. Whiting*, 563 U.S. 582, 594 (2011)). Though *Franklin* was not an ERISA case, the Court in *Franklin* cited *Gobeille* in support of the proposition that there is no presumption against

preemption if a statute contains an express preemption provision. *See id.* After *Franklin*, courts have begun to reject a presumption against preemption when applying ERISA's express preemption provision, determining *Travelers* to have been overtaken on the point. *See Dialysis Newco, Inc. v. Cmty. Health Sys. Grp. Health Plan*, 938 F.3d 246, 259 (5th Cir. 2019) ("Given that *Franklin* specifically references *Gobeille* – an ERISA case – when holding that there is no presumption [against] preemption when the statute contains an express preemption clause, we conclude that holding is applicable here.").

Though the Ninth Circuit has not yet squarely addressed *Franklin*'s application in the ERISA context, it has followed *Franklin* to reject a presumption against preemption for another statute that "speaks expressly to the question of preemption." *Atay v. Cty. of Maui*, 842 F.3d 688, 699 (9th Cir. 2016) (applying express preemption provision in the Plant Protection Act, 7 U.S.C. § 7756(b)). In *Dialysis Newco*, the Fifth Circuit relied on *Atay* as support for its holding that, after *Franklin*, there is no presumption against preemption under ERISA's preemption provision. *See Dialysis Newco*, 938 F.3d at 258.

In light of *Franklin* and its progeny, the Court should reject a presumption against preemption when applying ERISA's express preemption clause. In fact, the Court can, and should, view with a skeptical eye earlier precedents rejecting preemption under § 1144(a), if a presumption against preemption undergirded the

decision. *See, e.g.*, *id.* at 259 ("because *Rapides* [*i.e.*, an earlier Fifth Circuit ERISA-preemption decision] was built upon a presumption against preemption that the Supreme Court appears to have walked back from, we decline to extend *Rapides*'s reasoning to the facts of this case"). That *Franklin* stands as a barrier to the easy extension of earlier ERISA precedents founded on an anti-preemption presumption has special force in this appeal: the District Court relied heavily – almost exclusively – on *Golden Gate Restaurant Ass'n v. City & County of San Francisco*, which "beg[an] by noting that state and local laws enjoy a presumption against preemption." 546 F.3d 639, 647 (9th Cir. 2008); *accord id.* ("This presumption informs our preemption analysis."); *id.* at 654 (further invoking presumption against preemption in the "connection with" prong of the analysis).

In any event, even if the pre-*Franklin* presumption scheme still governed, no presumption would apply in this case. The presumption operated when a state enacted "general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661. For instance, in *Golden Gate*, the San Francisco ordinance there at issue creates "the Health Access Plan (HAP)," which is "a City-administered health care program" that "*provides* enrollees with 'medical services with an emphasis on wellness, preventive care and innovative service delivery.'" *Golden Gate*, 546 F.3d at 642, 645 (quoting S.F. Admin. Code § 14.2(f)) (emphasis added). The San Francisco ordinance then sets forth a series

of employer financing mechanisms for the HAP, from which the employer is "exempt . . . if it [already] makes health care expenditures" at a certain average rate on behalf of its workers (between $1 and $2 per hour worked by its workforce). *Id.* at 645. In that situation, the Ninth Circuit (pre-*Franklin*) held that there is a presumption against ERISA preemption because "[t]he field in which the [San Francisco] Ordinance operates is the *provision of health care services* to persons with low and moderate incomes," and "[s]tate and local governments have traditionally *provided* health care services to such persons." *Id.* at 648 (emphasis added).

In contrast, SMC 14.28 involves no *provision* of health care services. Rather, as even the City has acknowledged, SMC 14.28, "at its core, seeks to 'improve low-wage hotel employees' access, through additional compensation, to . . . health *coverage*.'" ER21 (quoting SMC 14.28.025) (emphasis added; ellipses in original). Unlike the actual *provision* of health care services to low-income segments of society, health benefits *coverage* for employees is not an area of traditional state concern. Since 1974, it has been an area of exclusively federal interest, through ERISA. Because "the states have not traditionally occupied the field" of private-sector employee health benefits *coverage*, the Court should "apply no presumption against preemption." *United States v. Ariz.*, 641 F.3d 339, 348 (9th Cir. 2011), *rev'd on other grounds*, 567 U.S. 387 (2012); *accord Aloha Airlines*,

Inc. v. Ahue, 12 F.3d 1498, 1505 (9th Cir. 1993) (holding that Hawaii law requiring direct reimbursement by employers of costs of medical exams "does not represent a regulation of traditional state authority" and is preempted by ERISA) (emphasis removed).

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

A. With Respect to This Argument, the Controversy Centers on Whether SMC 14.28's First Option Requires the Creation of ERISA Plans

ERISA preempts SMC 14.28 for a series of reasons, each of which is sufficient alone to necessitate invalidation of the Ordinance. An initial reason is that, under any of its options, SMC 14.28 requires the creation or maintenance of an ERISA plan. If a state or local law, through its operation, "creates an ERISA plan," it "almost certainly makes an impermissible 'reference to' an ERISA plan." *Golden Gate*, 546 F.3d at 648; *Martori Bros. Distribs. v. James-Massengale*, 781 F.2d 1349, 1358 (9th Cir. 1986) (considering whether ERISA preempted a state law alleged to require employer to "create new ERISA plans"); *see generally Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 12-13 (1987) (describing *Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *summarily aff'd*, 454 U.S. 801 (1981), as "illustrat[ing]" that ERISA preempts "a state statute requiring the establishment of a benefit plan").

The District Court recognized that the second and third options required the establishment or maintenance of ERISA plans. It noted that "employers subject to SMC 14.28 have multiple options to comply," and then described the first option as "expenditures directly to employees," but the latter two as involving expenditures through "an existing ERISA plan" or by "establish[ing] a new ERISA plan." ER15-16.

Indeed, it follows straightforwardly from ERISA's definitional section that at least SMC 14.28's second and third options require the establishment or maintenance of ERISA plans for compliance. In relevant part, ERISA defines a "welfare 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.

29 U.S.C. § 1002(1) (emphasis added). SMC 14.28's second option authorizes compliance with the Ordinance's required expenditure amounts through employer purchases of insurance for its employees' healthcare needs, arrangements that fit the welfare-plan definition (especially the italicized language above) to a tee; likewise, the third option authorizes compliance via expenditures through "the employer's self-insured and/or self-funded insurance program(s)," which requires

the existence of ERISA plans (namely, self-funded ones) even to be operational. SMC 14.28.060.B.3.

Instead, the controversy is over whether the first option – involving direct payments to covered employees – constitutes an ERISA plan. Siding with the City, the District Court held that "SMC 14.28 does not *require* the creation of an ERISA plan because the direct to employee payment option is not an ERISA plan." ER13 (emphasis added). As shown below, the District Court reached the wrong conclusion, both because the first option satisfies ERISA's definition of welfare plan and because it likewise satisfies the criteria articulated in the case law for the existence of an ERISA plan.[3]

B. SMC 14.28's First Option Satisfies ERISA's Definition of a Welfare Plan

As with SMC 14.28's other two options for compliance, the first option (*i.e.*, the direct-payment option) satisfies ERISA's definition of welfare plan. As relevant here, the critical parts of the definition are the existence of an employer-

[3] ERIC here focuses on showing that the first option (like the second and third) mandates the establishment of an ERISA plan, so that the statute inevitably *requires* the creation or maintenance of ERISA plans for its operation (*i.e.*, it leaves no route for compliance that avoids ERISA plans). Later, ERIC shows that, even if compliance through the first option does not constitute creation of an ERISA plan, it is neither a realistic option nor, if it were, sufficient otherwise to avoid the Ordinance having a "connection with" ERISA plans. *See supra* pp. 51-60.

sponsored "plan, fund, or program" for the purpose of providing medical or sickness "benefits" to employees. 29 U.S.C. § 1002(1). When key terms are not statutorily defined, as words like "plan," "program," and "benefits" are not further defined in ERISA, courts will "normally interpret[] [the] statute in accord with the ordinary public meaning of its terms at the time of its enactment." *Bostock v. Clayton Cty.*, 140 S. Ct. 1731, 1738 (2020). Consequently, the direct-payment option's qualification as an ERISA plan should rest on "what did [the statutory terms] mean in 19[74]," when ERISA was enacted. *Id.* at 1740; *see Intel Corp. Inv. Policy Comm. v. Sulyma*, 140 S. Ct. 768, 777, 776 (2020) (focusing on statutory terms' "normal definitions" when "[w]hen Congress passed ERISA," and thus 1970s-era dictionaries, to construe terms in ERISA's statute of limitations); *DB Healthcare, LLC v. Blue Cross Blue Shield of Ariz., Inc.*, 852 F.3d 868, 874 (9th Cir. 2017) (noting that "ERISA does not define the word 'benefit'" and relying on "dictionary definitions of 'benefit'").

With respect to the initial part of the welfare-plan definition, the ordinary public meaning of "plan" and "program" necessarily encompasses what an employer must establish to make direct payments under the first option. The 1974 definition of a "plan" was "a method for achieving an end." "Plan," *Webster's New Collegiate Dictionary* (1975) [hereinafter "*Webster's 1975 Dictionary*"]; *cf. Bostock*, 140 S. Ct. at 1740 (referencing same dictionary to determine meaning of

terms of Civil Rights Act of 1964). Similarly, in 1974, a "program" was a "system under which action may be taken toward a goal." "Program," *Webster's 1975 Dictionary*.[4]

At a minimum, SMC 14.28's first option requires employers – to satisfy their legal obligations – to determine who is eligible (only those working 80 hours per month and in non-exempt positions), how much each employee is entitled to receive in direct payments (by investigating whether the employee has a spouse, domestic partner, or dependents), whether a waiver applies, and how to provide notice regarding the employee's rights so as properly to obtain a waiver where applicable; moreover, the employer must repeat at least some of these efforts every month and must keep records regarding its actions for three years. It would be impossible to accomplish these tasks in a regular, memorialized manner without some sort of system or method being in place, which are the keys to the definition of "plan" and "program."

Next, acting for the purpose of providing health coverage translates to acting for the purpose of providing medical "benefits" or benefits in the event of illness,

[4] Throughout this definitional analysis, ERIC utilizes the *1975 Webster's Dictionary*, as *Bostock* did. But other contemporary dictionaries, such as *Webster's Seventh New Collegiate Dictionary* (1967), *American Heritage Dictionary* (1973), and *Ballentine's Law Dictionary* (1969), which were referenced in *Sulyma*, contained similar definitions of all of the key terms. *See Sulyma*, 140 S. Ct. at 776-77.

as the ERISA definition necessitates. While health coverage might not, itself, be a medical benefit, the health coverage prompts the payment of medical and sickness benefits. To that end, under the Ordinance, "'Health coverage' means payment or reimbursement of costs for healthcare services." SMC 14.28.020. In 1974, among the definitions of "benefit" were "financial help in time of sickness, old age or unemployment" and "a payment or service provided for under an annuity, pension plan, or insurance policy." "Benefit," *Webster's 1975 Dictionary*; *see DB Healthcare*, 852 F.3d at 874 (holding that "[t]he term 'benefit' in [ERISA] . . . refers to the specific *advantages* provided to covered employees, as a consequence of their employment, for particular purposes connected to alleviating various life contingencies") (emphasis added). Because medical benefits (*i.e.*, payments for the costs of medical services) are the fruits of health coverage, an employer who takes action to promote health coverage necessarily acts to further the payment of benefits for medical care, whether through the direct "purchase of insurance" or "otherwise" through the supplying of money for the purchase of insurance. 29 U.S.C. § 1002(1).

The District Court found the definition unmet because, in its view, "[t]here is little to differentiate the payments under this option from regular wages, and they can be coordinated with employees' regular pay periods." ER13. To the contrary, the Ordinance itself instructs that the direct payments are not regular wages. *See*

SMC 14.28.060.E ("[t]he required healthcare expenditure[s] . . . will not be considered wages for purposes of determining compliance with hourly wage and hourly compensation laws and regulations"). Furthermore, wages typically are based on hours worked and labor exerted. *See Doty v. Town of S. Prairie*, 93 P.3d 956, 959-60 (Wash. Ct. App. 2004), *aff'd*, 120 P.3d 941 (Wash. 2005); "Wage," *Merriam-Webster's Collegiate Dictionary* (11th ed. 2014) ("a payment usu. of money for labor or services usu. according to contract and on an hourly, daily, or piecework basis"). Here, the direct payments under SMC 14.28 do not vary at all with the hours worked, as the amount owed to the employee remains the same if the employee works, say, twenty hours per week, or twenty-five, or more. Also, the direct payments increase each year based on the "medical inflation rate" (not the ordinary inflation rate), showing that these are not ordinary wages, but instead monies specially earmarked for medical purposes. SMC 14.28.020.

In fact, if the direct payments are deemed tantamount to regular wages they may become illegal under Washington State law. The direct payments vary *based on spousal, domestic partner, and dependent status* (*i.e.*, those with a spouse are entitled to more money than those without one, etc.), and Washington law prohibits discrimination in compensation based on being single (or married). *See* Wash. Rev. Code Ann. § 49.60.180(3).

The District Court also suggested that the Ordinance's first option could not constitute an ERISA plan because "the direct payments need not be used for medical care at all," notwithstanding that "the admirable goal of SMC 14.28 is to improve employee access to medical care." ER13 n.5. But ERISA's definition of welfare plan speaks only of the *employer's purpose* in establishing its program, not the employee's conduct. If the employer establishes the program "for the purpose of" providing medical benefits, the employer triggers ERISA's definition. 29 U.S.C. § 1002(1). On its face, the Ordinance states that "employers . . . make . . . expenditures . . . *for the purpose of* improving access to medical care." SMC 14.28 (preamble) (emphasis added).

C. SMC 14.28's First Option Qualifies as an ERISA Plan Under the Case Law

"[L]eading precedents" can help "confirm[]" what a "statute's plain terms suggest." *Bostock*, 140 S. Ct. at 1743. In this instance, prior precedent supports the result from the ordinary meaning of ERISA's welfare plan definition, namely, that the Ordinance's direct-payment option constitutes an ERISA plan.

In prior decisions, this Court has found similar employer-to-employee direct-payment schemes to constitute ERISA plans. In *Aloha Airlines, Inc. v. Ahue*, 12 F.3d 1498, 1502-05 (9th Cir. 1993), the Ninth Circuit held that a Hawaii requirement of annual or semi-annual payments by airline employers to employees to defray the cost of FAA-mandated pilot exams constituted an ERISA plan. In

Bogue v. Ampex Corp., 976 F.2d 1319, 1323 (9th Cir. 1992), the Ninth Circuit found that even just a one-time payment of money in the event of employment termination constituted an ERISA plan. These decisions had three chief ingredients.

First, in order to pay the benefits, the employers needed "to establish an administrative scheme," and the "establishment of such a scheme clearly implicates an ERISA plan." *Aloha Airlines*, 12 F.3d at 1505. The employers needed to create an administrative scheme because "'the circumstances of each employee's'" situation had "'[to be] analyzed in light of [certain] criteria.'" *Bogue*, 976 F.2d at 1323 (quoting *Fontenot v. NL Indus., Inc.*, 953 F.2d 960, 962-63 (5th Cir. 1992)) (brackets in original). In *Aloha Airlines*, the direct payment turned on "a pilot's current rank," since only captains and first officers needed the FAA pilot exams for which the state required employer payments. *Aloha Airlines*, 12 F.3d at 1505. In *Bogue*, eligibility for the job-termination payment turned on whether, upon termination, the employee was "offer[ed] 'substantially equivalent' employment." *Bogue*, 976 F.2d at 1321. In both instances, the need for "ongoing, particularized . . . analysis" by the employer to determine each employee's eligibility meant "there was no way to administer the program without an administrative scheme." *Id.* at 1323.

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

Third, the programs in *Aloha Airlines* and *Bogue* did not involve merely predictable, rote payments. In *Aloha Airlines*, in particular, the Ninth Circuit emphasized that "an airline cannot often predict how many pilots of a particular status it will need during the coming year," and therefore "an airline employer cannot necessarily determine the amount of monies to budget for such payments

well in advance of the expected payment date." *Aloha Airlines*, 12 F.3d at 1503. As a result, the "periodic payments" were less "analogous to salary payments," which are "fixed" and "regular[]," and instead "would require an airline to establish a plan to administer and manage them." *Id.*

The direct employee payments pursuant to the first option of SMC 14.28 have the "hallmark[s]" of an ERISA plan, as in *Aloha Airlines* and *Bogue*. *Bogue*, 976 F.2d at 1322. The large-hotel and ancillary-business employers subject to SMC 14.28 would need to establish an administrative scheme even with the first option, because each employee's individual circumstances would need to be analyzed for eligibility. For one thing, the employer would need to determine *who* is eligible, by analyzing which employees averaged 80 hours per month and were not exempt (supervisory) personnel. Just as important, employers would need to determine *how much* covered employees are entitled to receive. The employer must investigate each employee's marital, partner, and family situation to determine the owed amount (adjusting regularly for changed circumstances, *see* SHRR 190-230(2)), with the amount depending on whether at the time the employee has a spouse, domestic partner, and dependents. These characteristics put the program required by SMC 14.28 precisely on par with the system required in *Aloha Airlines*. *See Aloha Airlines*, 12 F.3d at 1505 ("the statute effects the primary administrative functions of Aloha's plans because it compels Aloha to

ascertain whether a pilot is eligible for a particular benefit (by determining that pilot's rank and status periodically) and to assess the amount of the benefit").

Moreover, in the case of SMC 14.28, the waiver process makes further individualized assessment necessary. No covered employee would be entitled to a direct payment if he or she had access to high quality healthcare elsewhere (through, for instance, coverage offered to a family member or another employer for whom the employee works), and he or she signed a waiver (after proper pre-waiver disclosure from the employer). Likewise, no one would be entitled to a direct payment if the employer had offered health benefits under the second or third option (with no more than the 20% employee contribution), and the employee declined (for whatever reason, including not wishing to include coverage for a spouse or dependent). *See supra* pp. 7-8. Keeping track of all of these moving parts for each potentially eligible employee "requires [the employer] to establish an administrative scheme" to pay the "recurring" benefits. *Aloha Airlines*, 12 F.3d at 1505.

Plus, the receipt of a direct payment is not solely within the "employee's control." *Id.* at 1503. The employer controls the number of hours offered to, and thus worked by, each employee and, as a consequence, the employees' eligibility; and the employer is the entity "obligated to decide" who qualifies each month and to make payments to individuals. *Bogue*, 976 F.2d at 1323. The employer likewise

has control over the process for determining the amount of an employee's direct payment, because it is the employer's duty to investigate the employee's marital, partner, and dependent situation, with the employer being absolved even of paying what may ultimately be an incorrect amount once it has made "reasonable effort" to determine the employee's status. Regulatory Questions & Answers 7 (Q. 33); *see* SHRR 190-230(2).

Of significance, the employer also influences whether anyone can even claim a direct payment. Again, if *the employer* offers an individual (and the spouse, domestic partner, and dependents) health benefits coverage through an insured or self-funded plan, with the obligation that the employee pay 20% of the cost (as is allowed under SMC 14.28.060), and the employee declines the offer, then the employer need not provide the coverage *or* make a direct payment. It is conceivable that an unscrupulous employer might strategize to make such offers to those it knows cannot afford the 20% cost (especially for an entire family, who *must* be covered under SMC 14.28 if any coverage is to be offered, *see supra* pp. 5, 10), obtain the declinations, and thereby limit the individuals subject to SMC 14.28.[5]

[5] An example serves to show the potential for the employer to escape all obligations under SMC 14.28 by simply *offering* coverage to lower-paid employees with the Ordinance's allowance for a 20% employee cost-sharing requirement. If health insurance coverage is, on average, $1,666 per month (*i.e.*,

(footnote continued on next page)

Finally, with direct payments under the first option, an employer cannot readily determine "the amount of monies to budget." *Aloha Airlines*, 12 F.3d at 1503. A large hotel employer or ancillary business, in one month, might need innumerable part-time (*i.e.*, 80-hours-per-month) employees; and other months, none. The current COVID-19 crisis illustrates the point, with large hotel employers regrettably needing to furlough even permanent employees. The upshot is that an employer will likely spend "varying amounts for different numbers of [employees]" each month on payments, depending on its workforce needs. *Id.* at 1505. The amounts will also vary depending on whether a particular employee gets married, becomes a partner to another, has children, or otherwise takes on additional dependents, since the amount owed to the employee hinges on family size and cannot even be limited to the individual alone by the individual.

$20,000 annually) for family coverage, the employee's share would be $333 per month. If the employee worked 80 hours monthly at a wage of $12 per hour (*i.e.*, Washington's minimum wage), his or her weekly pay would be $960 per month, with tax withholding not even considered. *See* Kaiser Family Foundation, *Employer Health Benefits: 2019 Summary of Findings* 1, http://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2019 ("[t]he average annual premiums for employer-sponsored health insurance in 2019 are $7,188 for single coverage and $20,576 for family coverage"). The employee would be required to devote about 35% of his or her limited dollars to the health insurance and, seemingly, in many cases would turn it down as too expensive under the circumstances. The employer then would owe nothing under SMC 14.28. The point is that the Ordinance's facial terms trigger the concern (expressed in the case law in finding the existence of ERISA plans) about employer discretion utilized to prevent the payment of benefits.

The District Court relegated *Aloha Airlines* and *Bogue* to a footnote in its decision, saying conclusorily that the "payment scheme[s]" in the two cases involved "discretionary-decision making," whereas purportedly "[t]he direct payment to employee option in SMC 14.28 requires no such particularized analysis or discretionary decision-making." ER14 n.7. But the District Court, in this context, addressed none of the parts of the Ordinance that *do* require particularized analysis for each employee, such as the number of hours worked, the investigation into the employee's spousal, partner, and family status, and whether the employee properly was offered, but declined, coverage with the requisite limit on cost-sharing.[6]

[6] In reality, the direct-payment option under SMC 14.28 has even *more* characteristics of an ERISA plan than the program in *Aloha Airlines*. As even the District Court recognized, the particularized analysis in *Aloha Airlines* involved merely determining the "pilot rank" of the individual to establish "who qualified for the program." ER14 n.7. In contrast, the first option under SMC 14.28 requires analysis of the number of hours worked, spousal and family status, and whether the employee declined qualifying coverage for any of a number of reasons. Moreover, there was question in *Aloha Airlines* as to whether the payment to a pilot even qualified as "medical benefits" under ERISA's welfare plan definition, because the purpose of payment was to reimburse the pilot for an exam "undertaken by a pilot involuntarily to maintain his [federal] flying certificate," not "direct[ly] or immediate[ly]" to ensure his or her general well-being. *Aloha Airlines*, 12 F.3d at 1502. There should be little question with respect to direct payments under SMC 14.28 that the monies are for the purpose of accessing medical coverage and care. *See supra* pp. 3-4.

The District Court also tried to align SMC 14.28's first option with the employer practices the Supreme Court held not to constitute ERISA plans in *Mass. v. Morash*, 490 U.S. 107 (1989), and *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987). *See* ER13. However, the Ninth Circuit distinguished those cases in *Aloha Airlines* and *Bogue* on grounds equally applicable here. *See Aloha Airlines*, 12 F.3d at 1503 (holding that, notwithstanding the state-required payments "can be paid from Aloha's general assets" as in *Morash*, "the *Morash* Court's reasoning supports the conclusion that employer payments for FAA-mandated examinations implicate ERISA's principal concerns," because employers cannot "budget" for the costs like typical payroll matters and need "to establish a plan to administer and manage [the payments]"); *id.* at 1505 ("[u]nlike the state law in *Fort Halifax*, which required an employer to make a one-time, lump-sum severance payment, [the Hawaii law] requires Aloha to establish an administrative scheme to pay *recurring* medical benefits") (emphasis added); *accord Bogue*, 976 F.2d at 1323.

D. *Golden Gate* Is Inapposite on Whether SMC 14.28's First Option Qualifies as an ERISA Plan, and It Should Not Be Extended to This Situation

The District Court also relied on *Golden Gate* (as it did for nearly all aspects of its decision) to find that the direct-payment option is not an ERISA plan, saying "the Ninth Circuit explicitly rejected this exact challenge in *Golden Gate*." ER13. In reality, *Golden Gate* is readily distinguishable.

The part of the San Francisco ordinance involved in *Golden Gate* on which the District Court focused its attention (and that *Golden Gate* said was not an ERISA plan) was the "City-payment option" – *i.e.*, the aspect of the San Francisco law that creates a city-wide program (the HAP) providing healthcare to individuals, financed through tax-like payments to San Francisco by employers who otherwise do not provide health benefits. *Golden Gate*, 546 F.3d at 651; *see supra* pp. 24-25. But the City-payment option has none of the characteristics that make SMC 14.28's first option an ERISA plan. First of all, in the San Francisco situation, there is no payment *by an employer directly to any employee* based on eligibility criteria that the employer applies; instead, employers pay an aggregate amount *to San Francisco* based on a rate set by San Francisco times the overall "number of hours their employees work." *Id.*

The San Francisco ordinance's City-payment option also has less particularized analysis associated with determining the amount to pay San Francisco, compared to an employer's obligations under SMC 14.28 to determine both *who* receives benefits and *how much*. Under the San Francisco law, the only variable is whose hours to aggregate (and then multiply the total workforce hours by the rate established by San Francisco), with the employer needing just to determine who "work[ed] at least ten hours per week," "worked for the employer at least ninety days," and is not an exempt employee. *Id.* at 644. In contrast, an

employer under SMC 14.28 must not only evaluate the threshold criteria of who works 80 hours per month and if the employee is exempt, but it then must also investigate *each* employee's spousal, partner, and family situation to determine the amount to pay *each* employee; and that amount turns solely on the employer's "reasonable" investigation into the employee's spousal, partner, and family status. Regulatory Questions & Answers 7 (Q. 33).

And the San Francisco law had no elaborate waiver system, with specific employer disclosure requirements, like SMC 14.28, which meant only limited "subjective judgments" for employers under San Francisco's process. *Golden Gate*, 546 F.3d at 651. In San Francisco, the only waiver available is for "employees who already receive health care services from other sources." ER14 n.6. SMC 14.28 contains that waiver, plus significant others: where the employer offers coverage with a 20% cost-sharing requirement and the employee declines, or where the employer offers spousal or family coverage to an employee with a spouse, partner, or dependents (which it must in order to comply under the second and third options) and the employee refuses it because he or she wants to cover only him- or herself. Unlike any waiver under the San Francisco law, these latter waivers under SMC 14.28 are, in the first instance, under the control of the *employer*, since it decides whether or not to offer coverage as an alternative to direct payments.

All of these distinctions matter because it is "'ongoing, particularized, administrative, discretionary analysis'" by the employer that triggers an ERISA plan's existence. *Golden Gate*, 546 F.3d at 651 (quoting *Bogue*, 976 F.2d at 1323). Whereas it was said in *Golden Gate* that an employer's obligations there under the local law "involve[d] mechanical record-keeping," "'d[id] not depend on contingencies outside the employee's control,'" and "d[id] not run the risk of mismanagement of funds or other abuse," SMC 14.28's considerably different features make it, in contrast, "'an ongoing administrative scheme.'" *Id.* (quoting *Velarde v. Pace Membership Warehouse, Inc.*, 105 F.3d 1313, 1317 (9th Cir. 1997), and *Morash*, 490 U.S. at 115). The District Court failed to do a close, careful analysis of the actual workings of the two laws, and therefore wrongly found *Golden Gate* controlling. *See Gobeille*, 136 S. Ct. at 943 (noting that ERISA preemption analysis depends on "'the nature of the effect of the state law'") (quoting *Dillingham*, 519 U.S. at 325).

Rather than closely analyze the terms and effect of SMC 14.28, the District Court superficially relied on *dicta* in *Golden Gate* to bring the Ordinance within *Golden Gate*'s ambit. It cited this sentence in *Golden Gate*: "'[I]f employers made the payments directly to the employees . . . those payments would not be enough to create an ERISA plan." ER13 (quoting *Golden Gate*, 546 F.3d at 650). The statement is *dicta* because, in reality, the San Francisco ordinance established no

direct-to-employee payment option, only the tax-like employer payments *to San Francisco* for San Francisco's beneficial use on the HAP. The Court is "'not bound to follow [its] dicta in a prior case in which the point now at issue was not fully debated.'" *Entler v. Gregoire*, 872 F.3d 1031, 1043 n.21 (9th Cir. 2017) (quoting *Cent. Va. Cmty. Coll. v. Katz*, 546 U.S. 356, 363 (2006)).

Nor should the Court extend the *dicta* to this situation. As noted, there are marked, material differences between the San Francisco law and SMC 14.28 that give the latter's direct-payment option the administrative, discretionary characteristics that would be lacking in even a hypothetical direct employer-to-employee payment option in San Francisco having the general characteristics of its City-payment option.

Ultimately, even if *Golden Gate* somehow had salience for SMC 14.28, the Court, respectfully, would be "ill-advised to extend [*Golden Gate*'s] reasoning to the facts of this case." *Dialysis Newco, Inc. v. Cmty. Health Sys. Grp. Health Plan*, 938 F.3d 246, 257 (5th Cir. 2019). *Golden Gate* was "built upon a starting presumption against ERISA preemption" that no longer obtains. *Id.* at 258; *see Golden Gate*, 546 F.3d at 647-48. It is quite possible that, stripped of the presumption against preemption, the Court would have reached the result there promoted by the eight Judges dissenting to the Court's denial of rehearing *en banc* – *i.e.*, that ERISA preempts the San Francisco ordinance. *See Golden Gate Rest.*

Ass'n v. City & Cty. of San Francisco, 558 F.3d 1000, 1004-10 (9th Cir. 2009) (M. Smith, J., dissenting from denial of pet'n for rehearing *en banc*, and joined by Kozinski, O'Scannlain, Kleinfeld, Tallman, Bybee, Callahan, and Bea, J.J).[7]

IV. ERISA PREEMPTS SMC 14.28 BECAUSE THE ORDINANCE REFERENCES ERISA PLANS THROUGHOUT ITS PROVISIONS

Another reason that ERISA preempts SMC 14.28 – independent of the fact that it requires the creation of ERISA plans under each of its options – is that the Ordinance makes "reference to" ERISA plans in other ways, acting immediately and exclusively upon ERISA plans and with the existence of ERISA plans being essential to the law's operation. *See supra* p. 19. The references are numerous and pervade all three options for compliance:

- On its face, the second option makes compliance turn on the employer paying an "insurance carrier or trust," which is a reference to an ERISA plan. SMC 14.28.060.B.2.
- On its face, the third option makes compliance turn on whether the employer makes average per capita payments through "the employer's

[7] ERIC believes *Golden Gate* was wrongly decided, as the Department of Labor asserted at the time (*see Golden Gate*, 558 F.3d at 1008 (M. Smith, J., dissenting)), and preserves its right to seek, if necessary, *en banc* review to overturn the precedent. However, because *Golden Gate* also is distinguishable and should not be extended to new situations, this appeal can be decided in ERIC's favor without outright abrogation of *Golden Gate*. *See Dialysis Newco*, 938 F.3d at 259 n.11.

self-insured and/or self-funded insurance program(s)," which is a reference to an ERISA plan. *Id.* § 14.28.060.B.3.

- On the face of SMC 14.28, the starting point for monthly healthcare expenditures for a new hire under any of the three options is measured by the waiting period in any "employer-sponsored plan" the employer has, which is a reference to an ERISA plan. *Id.* § 14.28.060.C.
- An employer will be deemed to have satisfied SMC 14.28, under any of its options, if the employee refuses an employer's offer of coverage under an employer-sponsored insured or self-funded plan where the employee's cost sharing is no greater than "20 percent of the monthly required healthcare amount," which is a reference to an ERISA plan and its specific terms. *Id.* § 14.28.060.D.1.
- SMC 14.28's scope excludes individuals who have "employer-sponsored health insurance through an employer other than the covered employer," which is a reference to an ERISA plan. *Id.* § 14.28.030.B.2.
- An employer who makes its monthly required health expenditures through "an employer-sponsored plan" in partial satisfaction of the required health expenditure rate must satisfy the remaining portion though direct payments (under the first option) or additional coverage

(under the second and third option), which is a reference to an ERISA plan. *Id.* § 14.28.060.C.

- SMC 14.28's "Effective date" provision fixes the Ordinance's start date for large hotel employers based on "the earliest annual open enrollment period for health coverage, if offered, after July 1, 2020" (and, for ancillary hotel businesses, at a similar time in 2025), which is a reference to an ERISA plan and its enrollment terms. *Id.* § 14.28.260.B.

Though, in these references, SMC 14.28 does not in every instance use the exact term "ERISA plan," the Supreme Court has recognized that references to employer-based coverage, employer-sponsored insurance, or an employer's program is the equivalent of an actual, exact reference to an ERISA plan. *See D.C. v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130 (9th Cir. 1992) ("*Greater Washington*") (holding that a state law's mention of "'health insurance coverage'" and the "'benefit level'" in that coverage were each references to ERISA plans) (quoting state law); *FMC Corp. v. Holliday*, 498 U.S. 52, 59 (1990) (holding that a state law's mention of "'any program, group contract or other arrangement for payment of benefits'" constituted a reference to ERISA plans) (quoting state law); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990) (mention of "employee's pension fund" in state cause of action is a reference to ERISA plans).

The District Court did not specifically address most of these references, instead saying generally that, supposedly, "the Seattle Ordinance is . . . 'fully functional' in the absence of a single ERISA plan" and, therefore, ERISA plans are not essential to its workings. ER16 (quoting *Golden Gate*, 546 F.3d at 659). Assumedly, what the District Court meant was that an employer could choose to comply through the first option, which – in the District Court's view – is divorced from ERISA plans. However, as already shown, each option involves the creation of an ERISA plan, so that, no matter what, SMC 14.28 "'acts immediately and exclusively upon ERISA plans.'" *Gobeille*, 136 S. Ct. at 943 (quoting *Dillingham*, 519 U.S. at 325).

In any event, even if the first option is not an ERISA plan, its full operation still hinges on the existence and terms of ERISA plans, as the above set of bullet points shows. For instance, the date direct payments begin for a new hire under the first option is tied to the waiting period existing *in the employer's ERISA plans*; an employer's obligation to make direct payments in the first place turns on whether the employee has turned down coverage *under an ERISA plan* with a 20% or greater employee cost-sharing requirement (*i.e.*, declining such coverage absolves the employer of any obligations under SMC 14.28), as well as on whether the employee has coverage *under another employer's ERISA plan*; and even the start date for the Ordinance, and thus the employer's obligation to make any direct

payments, depends on the open enrollment period *under the employer's ERISA plan*. Accordingly, even with the first option, "[w]e are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan." *Ingersoll-Rand Co.*, 498 U.S. at 139; *see Greater Wash.*, 506 U.S. at 130 (holding that state law governing non-ERISA plans referenced ERISA plans when it made the non-ERISA plans' terms hinge on the terms of any existing analogous ERISA coverage).

These ties among the various options and the employer's ERISA plans necessarily have "some effect on the referenced plans." *WSB Elec., Inc. v. Curry*, 88 F.3d 788, 793 (9th Cir. 1996); *see supra* p. 19. They encourage the employer to adopt waiting periods in their ERISA plans, to set employee cost-sharing rates at certain levels in their ERISA plans, and to establish open seasons as late as possible for their ERISA plans – all in order to delay, limit, or altogether avoid making direct payments under the first option, as well as to delay, limit, or avoid the obligation to provide coverage under the second or third options.

The one reference that the District Court did address, and reject as insufficient, was that an employer's obligation to make direct payments under the first option is triggered when the employer fails to supply coverage of a sufficient value *under ERISA plans* pursuant to the second and third options. ER17. In the District Court, ERIC highlighted this reference in response to the City's contention

that the direct-payment option lacked ties to ERISA plans because the first option turned on expenditure levels under the second and third options, rather than benefit levels. Even assuming the City's contention had some force, it cannot negate the many other references to ERISA plans pervading the Ordinance (as noted in the bullet list). Nevertheless, the City's contention and the District Court's acceptance of it are barred by precedent. *See Golden Gate*, 546 F.3d at 658 (finding that *Greater Washington* would require preemption of a state law that "calculates its required payments based on . . . *the value* or nature of the benefits") (emphasis added); *Local Union 598 v. J.A. Jones Constr. Co.*, 846 F.2d 1213, 1219 (9th Cir. 1988) (a "statute which mandates employer contributions to benefit plans and which effectively dictates the level at which those required contributions must be made has a most direct connection with an employee benefit plan" and is "clearly preempted by ERISA"), *summarily aff'd*, 488 U.S. 881 (1988).

V. ERISA PREEMPTS SMC 14.28 BECAUSE THE ORDINANCE HAS A CONNECTION WITH ERISA PLANS

A final basis for ERISA preempting SMC 14.28 is that it has a "connection with" ERISA plans. The Ordinance has at least three separate connections with ERISA plans, any one of which warrants preemption.

A. The Ordinance Forces Covered Employers to Comply by Altering Their ERISA Plans

SMC 14.28 effectively compels large hotel employers and ancillary businesses to alter their current insured or self-funded coverage both to make eligible for coverage those employees covered by SMC 14.28 and to provide benefits consistent with the value-level requirements of the second and third options. As noted earlier, a state law will 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). *Golden Gate* added that this standard is satisfied where, if a state law purports to offer various routes for compliance, the law does not offer "employers a *realistic* alternative to creating or altering ERISA plans." 546 F.3d at 660 (emphasis added); *e.g.*, *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 197 (4th Cir. 2007) (holding that Maryland health-benefits law that "leaves employers no reasonable choices except to change how they structure their employee benefit plans" is preempted because it "directly regulates employers' provision of healthcare benefits" and has a "'connection with' covered employers' ERISA plans").

SMC 14.28 requires the creation of ERISA plans under any of its options, as already noted; so, the Court need not proceed to the question of whether it actually

pushes employers to do so, instead of choosing a non-ERISA option (as there is no such non-ERISA option). Yet, if the Court determines that the first option does not involve the creation of an ERISA plan, then SMC 14.28 still has an impermissible connection with ERISA plans because the law does not meaningfully allow employers to choose the first option over the second and third options.

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 First Amended Complaint, *see* ER39-40):

- If they are required to spend additional corporate funds, rational employers will do so in a manner whereby they can ensure that the money will be used for health benefits for their workers (as is the case under the second and third options).
- Direct payments are costlier to employers because – in order to provide the same benefits as if they choose the second or third options – they may have to pay the employer share of federal employment taxes on the direct payments, whereas expenditures on health coverage under the second and third options are not subject to federal employment taxes.
- Offering health coverage to the employee is more financially advantageous to the employee, and thus more appealing to the employer, because the employee too may have to pay his or her share of federal

employment taxes, as well as income taxes, on the direct payments but not the health coverage.

- Offering health coverage to the employee through insured or self-funded employer-sponsored plans is more advantageous to the employee who actually wants health coverage, and thus more appealing and administratively feasible to the employer, because greater coverage for the same amount typically can be obtained through a program covering a large group than individually.
- The City's earlier passage of Part 3 (the predecessor law) resulted in employers covered by that law altering their ERISA plans to bring them into compliance with Part 3, and it is unrealistic to expect employers who have already done the difficult work of adjusting their employee-benefit arrangements to cover the additional individuals to undo the new administrative regime in favor of direct payments (especially when the direct payments are also financially more onerous and otherwise problematic).

The District Court rejected these allegations, again in a footnote, saying that ERIC "has not *shown* that the Ordinance effectively binds employers to any particular choice." ER16 n.8 (emphasis added). But ERIC at this juncture had no obligation to "show" anything, in response to a Rule 12(b)6) motion; after all, the

City had not filed a summary-judgment motion under Rule 56. Under Rule 12(b)(6), ERIC's factual allegations are to be assumed true, and ERIC needed only to set forth a "plausible" set of facts indicating that it is unrealistic to expect an employer to adopt the direct-payment option over other alternatives. *See supra* p. 16. That, it has done. Indeed, the City never, below, even disputed (because it could not) that employers responded to Part 3 by altering their ERISA plans, which is proof in itself that reasonable corporate actors would not choose a direct-payment option, for they have not in the past, as all appear to agree.

B. The Ordinance Impermissibly Adds to ERISA's Disclosure and Record-Keeping Requirements

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

Here, SMC 14.28 has unique disclosure and record-keeping requirements associated with the waivers. Specifically, an employer who offers coverage under its insured or self-funded ERISA plan (at a 20% or less cost-share for the

employee) has no obligation further to comply with SMC 14.28 – including the direct-payment requirement – if the employee declines the coverage. However, SMC 14.28 has strict disclosure requirements about the ERISA plan coverage that the employer must meet (including in various languages and using City-generated forms, *see* SMC 14.28.030.B.2.a), and also mandates records be kept regarding the offer and the circumstances of the declination, even to the extent of requiring employer sworn statements verifying facts and the retention of those legal documents for at least three years. *See supra* pp. 10-11.

These records are well beyond the typical tax and wage data that employers must keep for general legal compliance and concern nothing other than the terms and availability of the employer's insured and self-funded ERISA plans. Unlike in *Golden Gate* – which had no similar waiver framework – these burdens exist only *if* "a covered employer has an ERISA plan." *Golden Gate*, 546 F.3d at 657. "Pre-emption [of SMC 14.28] is necessary to prevent the States from imposing novel, inconsistent, and burdensome [disclosure and] reporting requirements on plans." *Gobeille*, 136 S. Ct. at 945.

C. SMC 14.28 Impermissibly Structures Employers' Choices Regarding Their Existing ERISA Plans and Otherwise Burdens ERISA-Plan Administrators

A final connection that the Ordinance has with ERISA plans comes through the burdens it places on employers and ERISA-plan administrators seeking to

navigate its requirements, even assuming that the first option does not constitute an ERISA plan. This point was well-stated by the Judges dissenting to the *Golden Gate* denial of rehearing *en banc*, as delineated below with paraphrasing to transfer their reasoning from the San Francisco situation to SMC 14.28:

> In *Egelhoff* [*v. Egelhoff*, 532 U.S. 141 (2001)], the [Supreme] Court dismissed the argument that states can avoid preemption by offering employers a theoretical means to avoid changing their current ERISA plans. [*Id.*] at 147-48. Although employers were able to "opt out" of the state law requirement, the law had "a connection with" the ERISA plan and was thus preempted. *Id.* at 150. The court held that "[t]he statute is not any less of a regulation of the terms of ERISA plans simply because there are two ways of complying with it." *Id.* The [City's] Ordinance at issue here is similarly connected, as it structures employers' choices with respect to their existing ERISA plans. Non-complying [Seattle] employers have a choice: either increase or maintain their health care expenditures under their own plans, or, pay enough [directly to employees] to satisfy that mandated minimum. Per *Egelhoff*, a law like [the City's] [O]rdinance is ERISA-preempted because it frames employers' choices in this fashion.
>
> Further, allowing [Seattle] to pose such a choice would strike at the heart of ERISA because the plan administrators would have to account for potential opt-out provisions in all 50 states. *Id.* at 15. *Egelhoff* explained this burden:
>
> > It is not enough for plan administrators to opt out of this particular statute. Instead, they must maintain a familiarity with the laws of all 50 sates so that they can update their plans as necessary to satisfy the opt-out requirements of other, similar statutes. They also must be attentive to changes in the interpretations of those statutes by state courts. This "tailoring of plans and employers conduct to the peculiarities of the law of each jurisdiction" is exactly the burden ERISA seeks to eliminate.
>
> *Id.* (quoting *Ingersoll-Rand*, 498 U.S. at 142).

Golden Gate, 558 F.3d at 1007 (M. Smith, J., dissenting); *accord Merit Constr. Alliance v. City of Quincy*, 759 F.3d 122, 130 (1st Cir. 2014) ("Such balkanization of benefit administration is exactly the sort of outcome ERISA was designed to prevent. The upshot is to defenestrate the City's insistence that we attach decretory significance to an employer's ability to comply with the Ordinance *by means of a non-ERISA plan*.") (emphasis added).

While all that the dissenters had to say easily fits the current situation, as much as San Francisco's a decade ago, there is even more to condemn in this instance. Not only does the Ordinance structure an employer's choices and – even with the first option – demand coordination with the benefits and terms of the employer's ERISA plans, the employers *necessarily* would need to alter their ERISA plans to choose the first option. The City's earlier enactment of Part 3 caused covered employers, during the pendency of ERIC's challenge to Part 3, to alter their ERISA plans to provide Part 3's required health-benefits coverage to the very same class of employees. *See* ER28. If employers nevertheless now do undo their prior work enhancing their ERISA plan benefits and eligibility, this change

itself would be an amendment to ERISA plans resulting from the employer's choice to pursue the first option under SMC 14.28.[8]

Of course, the dissenters did not prevail in *Golden Gate*. However, as noted earlier, *Golden Gate* did not involve *individualized employer-to-employee payments*, but instead tax-like levies in the aggregate on an employer by San Francisco to pay for government-provided health services. That distinction – under SMC 14.28, a more direct, particularized burden on employers and plan administrators to coordinate their plans, benefits, and operations for employees – warrants departure from the *Golden Gate* panel's determination; and it makes even more pressing the concerns of the dissenters to the denial of rehearing *en banc*, concerns that, anyway, were based on the controlling decision in *Egelhoff*. *See Merit Constr. Alliance*, 759 F.3d at 130 (distinguishing *Golden Gate* and stating that *Golden Gate* "did not purpose to lay down a blanket rule that whenever compliance can come through a *non-ERISA option*, ERISA preemption is

[8] The District Court refused to credit the employers' compliance with Part 3, saying that "[a]n employer's decision to prematurely comply with the ordinance before it goes into effect does not change the Court's analysis." ER16 n.8. But this is a patent factual error by the District Court: Part 3 took effect no later than July 2018, well before the Washington Court of Appeals invalidated it. *See* SHRR 150-300 (issued May 31, 2018 and revised July 12, 2018), https://www.seattle.gov/Documents/Departments/LaborStandards/Rules_Chapter150_071218.pdf. Thus, there was nothing "premature" about the employers' compliance.

unavailable") (emphasis added). And again, the Supreme Court's rejection of the presumption against preemption calls for limiting the *Golden Gate* panel opinion to its exact facts. *See supra* pp. 23-24.

CONCLUSION

The District Court's decision dismissing the action should be reversed.

Respectfully submitted,

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Counsel for Appellant The ERISA Industry Committee

STATEMENT OF RELATED CASES

Pursuant to Rule 28-2.6, as to related cases, Appellant states that there is some relation among the preemption issues here presented and those in *Howard Jarvis Taxpayers Ass'n v. California Secure Choice Retirement Savings Program*, No. 20-15591 (9th Cir.), currently pending in this Court.

CERTIFICATE OF COMPLIANCE

Pursuant to FRAP 32(a)(7)(C), the undersigned certifies that this brief complies with the type-volume limitations of FRAP 32(a)(7)(B). Exclusive of the exempted portions identified in FRAP 32(a)(7)(B), the brief contains 13,873 words, as calculated by the word-processing system used to prepare the brief. The brief has been prepared in a proportionally spaced typeface using Microsoft Word version 2010, using 14-point Times New Roman font.

August 27, 2020

/s/ Anthony F. Shelley
Anthony F. Shelley

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on August 27, 2020. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system on the following:

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/s/ Anthony F. Shelley
Anthony F. Shelley

ADDENDUM

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Addendum Page

SEATTLE CITY COUNCIL

Legislative Summary

CB 119555

Record No.: CB 119555 **Type:** Ordinance (Ord) **Status:** Passed

Version: 3 **Ord. no:** Ord 125930 **In Control:** City Clerk

File Created: 06/19/2019

Final Action: 09/25/2019

Title: AN ORDINANCE relating to employment in Seattle; requiring certain employers to make required healthcare expenditures to or on behalf of certain employees for the purpose of improving access to medical care; adding a new Chapter 14.28 to the Seattle Municipal Code (SMC); and amending Sections 3.15.000 and 6.208.020 of the SMC.

Notes:

Sponsors: Mosqueda,González

Date

Filed with City Clerk:

Mayor's Signature:

Vetoed by Mayor:

Veto Overridden:

Veto Sustained:

Attachments:

Drafter: patrick.wigren@seattle.gov

Filing Requirements/Dept Action:

History of Legislative File **Legal Notice Published:** ☐ Yes ☐ No

Ver-sion:	Acting Body:	Date:	Action:	Sent To:	Due Date:	Return Date:	Result:
1	City Clerk	06/19/2019	sent for review	Council President's Office			
	Action Text: The Council Bill (CB) was sent for review. to the Council President's Office						
1	Council President's Office	06/21/2019	sent for review	Housing, Health, Energy, and Workers' Rights Committee			
	Action Text: The Council Bill (CB) was sent for review. to the Housing, Health, Energy, and Workers' Rights Committee						
1	City Council	06/24/2019	referred	Housing, Health, Energy, and Workers' Rights Committee			

Legislative Summary Continued (CB 119555)

1	Housing, Health, Energy, and Workers' Rights Committee	06/27/2019		
	Action Text:	The Council Bill (CB) was discussed in Committee.		
1	Housing, Health, Energy, and Workers' Rights Committee	07/02/2019		
1	Housing, Health, Energy, and Workers' Rights Committee	08/01/2019	held	
	Action Text:	The Council Bill (CB) was held.		
1	Housing, Health, Energy, and Workers' Rights Committee	08/15/2019	discussed	
	Action Text:	The Council Bill (CB) was discussed in Committee.		
	Notes:	Amendments were considered at this meeting.		
2	Housing, Health, Energy, and Workers' Rights Committee	09/12/2019	pass as amended	Pass
	Action Text:	The Committee recommends that City Council pass as amended the Council Bill (CB).		
		In Favor: 3	Chair Mosqueda, Sawant, González	
		Opposed: 0		
2	City Council	09/16/2019	passed as amended	Pass
	Action Text:	The Motion carried, the Council Bill (CB) was passed as amended by the following vote, and the President signed the Bill:		
	Notes:	ACTION 1:		

Motion was made by Councilmember Mosqueda, duly seconded and carried, to amend Council Bill 119555, Seattle Municipal Code Sections 14.28.030 and 14.28.060, as shown on Attachment 1 to the Minutes.

ACTION 2:

Motion was made and duly seconded to pass Council Bill 119555 as amended.

In Favor:	9	Councilmember Bagshaw, Councilmember González , Council President Harrell, Councilmember Herbold, Councilmember Juarez, Councilmember Mosqueda, Councilmember O'Brien, Councilmember Pacheco, Councilmember Sawant
Opposed:	0	

3	City Clerk	09/18/2019	submitted for Mayor's signature	Mayor
3	Mayor	09/24/2019	Signed	
	Action Text:	The Council Bill (CB) was Signed.		
3	Mayor	09/25/2019	returned	City Clerk
	Action Text:	The Council Bill (CB) was returned. to the City Clerk		
3	City Clerk	09/25/2019	attested by City Clerk	
	Action Text:	The Ordinance (Ord) was attested by City Clerk.		

Dan Eder & Karina Bull
LEG Access to Medical Care ORD
D5

CITY OF SEATTLE

ORDINANCE 125930

COUNCIL BILL 119555

AN ORDINANCE relating to employment in Seattle; requiring certain employers to make required healthcare expenditures to or on behalf of certain employees for the purpose of improving access to medical care; adding a new Chapter 14.28 to the Seattle Municipal Code (SMC); and amending Sections 3.15.000 and 6.208.020 of the SMC.

WHEREAS, the City has identified a need to provide immediate protection to low-wage hotel employees by passing a package of new labor standards ordinances; and

WHEREAS, ensuring that low-wage hotel employees have access through additional compensation to high-quality, affordable health coverage can help create greater workplace satisfaction, healthier employees, and healthier customers, and improve population health; NOW, THEREFORE;

BE IT ORDAINED BY THE CITY OF SEATTLE AS FOLLOWS:

Section 1. A new Chapter 14.28 is added to the Seattle Municipal Code as follows:

Chapter 14.28 IMPROVING ACCESS TO MEDICAL CARE FOR HOTEL EMPLOYEES

14.28.010 Short title

This Chapter 14.28 shall constitute the "Improving Access to Medical Care for Hotel Employees Ordinance" and may be cited as such.

14.28.020 Definitions

For the purposes of this Chapter 14.28:

"Adverse action" means denying a job or promotion, demoting, terminating, failing to rehire after a seasonal interruption of work, threatening, penalizing, engaging in unfair immigration-related practices, filing a false report with a government agency, changing an employee's status to a nonemployee, or otherwise discriminating against any person for any reason prohibited by Section 14.28.120. "Adverse action" for an employee may involve any aspect of employment, including pay, work hours, responsibilities or other material change in the terms and conditions of employment;

"Agency" means the Office of Labor Standards and any division therein;

"Aggrieved party" means an employee or other person who suffers tangible or intangible harm due to an employer or other person's violation of this Chapter 14.28;

"Ancillary hotel business" means any business that (1) routinely contracts with the hotel for services in conjunction with the hotel's purpose; (2) leases or sublets space at the site of the hotel for services in conjunction with the hotel's purpose; or (3) provides food and beverages, to hotel guests and to the public, with an entrance within the hotel premises;

"Annual open enrollment period" means a period, as defined in the Code of Federal Regulation (C.F.R.) at 45 CFR § 155.20 governing the Affordable Care Act (or as established by Director's rule), during which a qualified individual may enroll or change health coverage;

"City" means the City of Seattle;

"Compensation" means payment owed to an employee by reason of employment including, but not limited to, salaries, wages, tips, overtime, commissions, piece rate, bonuses, rest breaks, promised or legislatively required pay or paid leave, and reimbursement for

employer expenses. For reimbursement for employer expenses, an employer shall indemnify the employee for all necessary expenditures or losses incurred by the employee in direct consequence of the discharge of the employee's duties, or of the employee's obedience to the directions of the employer, even though unlawful, unless the employee, at the time of obeying the directions, believed them to be unlawful;

"Covered employee" means an employee who meets the criteria established by Section 14.28.030;

"Covered employer" means an employer who meets the criteria established by Section 14.28.040;

"Dependents" means the same as the definition provided in the Code of Federal Regulations (C.F.R.) at 26 C.F.R. 54.9801-2 (or as established by Director's rule);

"Director" means the Director of the Office of Labor Standards or the Director's designee;

"Employ" means to suffer or permit to work;

"Employee" means "employee" as defined under Section 12A.28.200, including but not limited to full-time employees, part-time employees, and temporary workers. An alleged employer bears the burden of proof that the individual is, as a matter of economic reality, in business for oneself (i.e. independent contractor) rather than dependent upon the alleged employer;

"Employer" means any individual, partnership, association, corporation, business trust, or any entity, person or group of persons, or a successor thereof, that employs another person and

includes any such entity or person acting directly or indirectly in the interest of the employer in relation to the employee. More than one entity may be the "employer" if employment by one employer is not completely disassociated from employment by any other employer;

"Healthcare services" means medical care, services, or goods that may qualify as tax deductible medical care expenses under Section 213 of the Internal Revenue Code, or medical care, services, or goods having substantially the same purpose or effect as such deductible expenses. "Healthcare services" does not include vision or dental services;

"Health coverage" means payment or reimbursement of costs for healthcare services;

"Hotel's purpose" means services in conjunction with the hotel's provision of short term lodging including food or beverage services, recreational services, conference rooms, convention services, laundry services, and parking;

"Hours" means (1) each hour for which an employee is paid, or is entitled to payment, for the performance of duties for the employer; and (2) each hour for which the employee is paid, or is entitled to payment, by the employer for a period during which no duties are performed due to vacation, holiday, illness, legally required paid leave, incapacity (including disability), layoff, jury duty, military duty, or leave of absence;

"Large hotel" means a hotel or motel, as defined in Section 23.84A.024, containing 100 or more guest rooms or suites of rooms suitable for providing lodging to members of the public for a fee, regardless of how many of those rooms or suites are occupied or in commercial use at a given time;

"Medical inflation" means the average annual rate of growth of spending in the private health insurance market, as determined annually by the Center for Medicare & Medicaid Services National Health Expenditures;

"Qualifying life event" means the events, as may be set forth in a covered employer's health plan document (or as established by Director's rule), which permit eligibility for a "special enrollment period," if offered, allowing enrollment in health coverage outside the annual open enrollment period for enrollment in employer-sponsored plan.

"Rate of inflation" means 100% of the annual average growth rate of the bi-monthly Seattle-Tacoma-Bellevue Area Consumer Price Index for Urban Wage Earners and Clerical Workers, termed CPI-W, for the 12 month period ending in August, provided that the percentage increase shall not be less than zero;

"Respondent" means an employer or any person who is alleged to have committed a violation of this Chapter 14.28;

"Special enrollment period" means a period, as defined in the Code of Federal Regulations (C.F.R.) at § 155.20 governing the Affordable Care Act (or as established by Director's rule), during which a qualified individual or enrollee who experiences certain "qualifying life events" may enroll in, or change enrollment in health coverage outside of the initial and annual open enrollment periods;

"Successor" means any person to whom an employer quitting, selling out, exchanging, or disposing of a business sells or otherwise conveys in bulk and not in the ordinary course of the employer's business, a major part of the property, whether real or personal, tangible or

intangible, of the employer's business. For purposes of this definition, "person" means any individual, receiver, administrator, executor, assignee, trustee in bankruptcy, trust, estate, firm, corporation, business trust, partnership, limited liability partnership, company, joint stock company, limited liability company, association, joint venture, or any other legal or commercial entity;

14.28.025 Intent

The intent of this Chapter 14.28 is to improve low-wage hotel employees' access, through additional compensation, to high-quality, affordable health coverage for the employees and their spouses or domestic partners, children, and other dependents.

14.28.030 Employee coverage

A. For the purposes of this Chapter 14.28, covered employees are limited to employees who work for a covered employer at a large hotel in the City and for an average of 80 hours or more per month, the calculation of which shall be determined by Director's rule.

B. For the purposes of this Chapter 14.28, a covered employee does not include:

1. An employee who is a manager, supervisor, or a confidential employee;

2. An employee who receives health coverage from another source, including but not limited to employer-sponsored health insurance through an employer other than the covered employer, either as an employee or by virtue of being the spouse, domestic partner, child, or other dependent of another person. If an employee receives health coverage from another source, the following conditions must be met in order for the employee to be excluded from being treated as a "covered employee":

a. The employer must obtain a signed waiver from the employee, free from coercion as described in Section 14.28.050 and under penalty of perjury, that the employee has access to high-quality and affordable health coverage from another source for themselves and, if applicable, their spouse, domestic partner, or dependents. The employer must offer the waiver in the employee's primary language and on a form issued by the Director as described in Section 14.28.050. Prior to offering the waiver, the employer must provide the employee with a written disclosure of the rights being waived, the form and contents of which shall be prescribed by the Director.

b. The employer is not required to verify the accuracy of the attestation in the employee's waiver.

C. A waiver of the requirements of this Chapter 14.28, as described in subsection 14.28.030.B., is revocable by the employee during any period of annual open enrollment in the covered employer's employer-sponsored plan or due to a qualifying life event.

14.28.040 Employer coverage

A. For the purposes of this Chapter 14.28, covered employers are limited to those who either: (a) own, control, or operate a large hotel in the City; or (b) own, control, or operate an ancillary hotel business in the City with 50 or more employees worldwide regardless of where those employees are employed, including but not limited to chains, integrated enterprises, or franchises associated with a franchisor or network of franchises that employee 50 or more employees in aggregate.

B. To determine the number of employees for the current calendar year:

1. The calculation shall be based upon the average number per calendar week of employees who worked for compensation during the preceding calendar year for any and all weeks during which at least one employee worked for compensation. For employers that did not have employees during the previous calendar year, the number of employees will be calculated based upon the average number per calendar week of employees who worked for compensation during the first 90 calendar days of the current year in which the employer engaged in business; and

2. All employees who worked for compensation shall be counted, including but not limited to:

a. Employees who are not covered by this Chapter 14.28;

b. Employees who worked inside the City;

c. Employees who worked outside the City; and

d. Employees who worked in full-time employment, part-time employment, joint employment, temporary employment, or through the services of a temporary services or staffing agency or similar entity.

C. Separate entities that form an integrated enterprise shall be considered a single employer under this Chapter 14.29. Separate entities will be considered an integrated enterprise and a single employer under this Chapter 14.29 where a separate entity controls the operation of another entity. The factors to consider include, but are not limited to:

1. Degree of interrelation between the operations of multiple entities;

2. Degree to which the entities share common management;

3. Centralized control of labor relations; and

4. Degree of common ownership or financial control over the entities.

14.28.050 Prohibition on coercing or unduly inducing a waiver

A covered employer is prohibited from coercing or unduly inducing an employee to waive coverage of this Chapter 14.28.

14.28.060 Required healthcare expenditures for covered employees

A. Covered employers must make a monthly required healthcare expenditures to or on behalf of each covered employee in the amount of the following 2019 rates and subject to annual adjustments based on the medical inflation rate:

1. $ 420 per month for an employee with no spouse, domestic partner, or dependents;

2. $ 714 per month for an employee with only dependents;

3. $ 840 per month for an employee with only a spouse or domestic partner;

4. $ 1,260 per month for an employee with a spouse or domestic partner and one or more dependents.

B. Covered employers have discretion as to the form of the monthly required healthcare expenditures they choose to make for their covered employees. Employers may satisfy their monthly obligations through any one or more of the following forms:

1. Additional compensation paid directly to the covered employee; and/or

2. Payments to a third party, such as to an insurance carrier or trust, or into a tax favored health programs, (including health savings accounts, medical savings accounts,

health flexible spending arrangements, and health reimbursement arrangements), for the purpose of providing healthcare services to the employee or the spouse, domestic partner, or dependents of the covered employee (if applicable); and/or

3. Average per-capita monthly expenditures for healthcare services made to or on behalf of covered employees or the spouse, domestic partner, or dependents of the employees (if applicable) by the employer's self-insured and/or self-funded insurance program(s).

C. If a covered employer makes its monthly required health expenditures through an employer-sponsored plan, whether in partial or full satisfaction of the monthly required health expenditure rate (if in partial satisfaction of the monthly required health expenditure rate, the employer is required to satisfy the remaining portion of the monthly health expenditure rate through one of the forms outlined in 14.28.060 B), and if the employer imposes a waiting period before new hires can be enrolled in its employer-sponsored plan (or the plan or insurer carrier mandates such a period), the employer will not be required to satisfy the health expenditures as described in subsection 14.28.060.A until the sooner of sixty days from the date of hire or the expiration of the waiting period. This temporary exemption from the obligation to satisfy the health expenditure requirements described in subsection 14.28.060.A shall only apply to a newly-hired employee who is subject to the waiting period and shall have no effect on the employer's obligations to its other covered employees.

D. If an employee voluntarily declines an employer's offer of a monthly required healthcare expenditure in full satisfaction of the requirements described in subsections

14.28.060.A, the employer will be deemed to have satisfied its required healthcare expenditure rate for that employee provided that the following conditions are met:

1. The employer's offered form of such monthly required healthcare expenditure under subsection 14.28.060.B must not require the employee to pay more than a dollar amount equivalent to 20 percent of the monthly required healthcare amount described in subsection 14.28.060.A.1; and

2. The employer must obtain a signed waiver from the employee, free from coercion as described in Section 14.28.050 and under penalty of perjury, that the employee is waiving the employer's offer of the monthly required healthcare expenditure in full satisfaction of the requirements described in subsections 14.28.090.A and B. The employer must offer the waiver in the employee's primary language and on a form issued by the Director as described in Section 14.28.050. Prior to offering the waiver, the employer must provide the employee with a written disclosure of the rights being waived, the form and content of which shall be prescribed by the Director.

If an employee receives the wavier and written disclosures described in this subsection 14.28.060.D.2, the employee refuses to sign such waiver, and the employee continues to decline, in whole or part, the employer's offer of a monthly required expenditure in full satisfaction of the requirements described in subsection 14.28.060.A and this subsection 14.28.060.D.1, the employer will be deemed to have satisfied its required healthcare expenditure rate for that employee. The employer must maintain records, as prescribed by Director's rule, regarding the employee's receipt of the waiver and written disclosures described in this subsection

14.28.060.D.2, and the employee's subsequent refusal to the sign the waiver described in this subsection 14.28.060.D.2.

E. The required healthcare expenditure is in addition to, and shall not be deemed satisfied by, any amount otherwise required to be paid by federal, state, or local law; and the required healthcare expenditure will not be considered as wages paid for purposes of determining compliance with hourly wage and hourly compensation laws and regulations. Any additional compensation paid to the covered employee to meet the monthly required healthcare expenditure shall be paid as ordinary income no later than the employee's last regular pay date of each calendar month and, with respect to new hires, must commence the earlier of when the waiting period to enroll in the employer-sponsored plan, if applicable, expires (if the employer makes its monthly required health expenditures through an employer-sponsored plan in partial satisfaction of the health expenditure requirement) or sixty days from the date of hire.

F. The healthcare expenditure rates required by subsection 14.28.060.A shall be adjusted annually based upon the average medical inflation rate as defined in Section 14.28.020. The adjustment shall not be calculated by the Agency. The Agency shall post the calculated annual rate and file such amount with the City Clerk before the third quarter of each year to determine the monthly required healthcare expenditure rate for the next calendar year.

14.28.100 Notice and posting

A. The Agency shall create and make available a poster that gives notice of the rights afforded by this Chapter 14.28. The Agency shall create the poster in English, Spanish, and other languages. The poster shall give notice of:

1. The right to improved access to medical care through employer required healthcare expenditures, as provided by Section 14.28.060;

2. The right to be protected from retaliation for exercising in good faith the rights protected by this Chapter 14.28; and

3. The right to file a complaint with the Agency or bring a civil action for violation of the requirements of this Chapter 14.28.

B. Employers shall display the poster in a conspicuous and accessible place at any workplace or job site where any of their employees work. Employers shall display the poster in English and Spanish and in the primary languages of the employee(s) at the particular workplace. Employers shall make a good faith effort to determine the primary languages spoken by the employees at that particular workplace. If display of the poster is not feasible, including situations when the employee works remotely or does not have a regular workplace or job site, employers may provide the poster on an individual basis in an employee's primary language in physical or electronic format that is reasonably conspicuous and accessible.

14.28.110 Employer records

A. Each employer shall retain records that document compliance with this Chapter 14.28, including:

1. Proof of each required healthcare expenditure made each month to or on behalf of each current and former employee pursuant to Section 14.28.060;

2. Copies of waiver forms executed pursuant to Sections 14.28.030 and 14.28.060; and

3. Pursuant to rules issued by the Director, other records that are material and necessary to effectuate the terms of this Chapter 14.28.

B. Records required by subsection 14.28.110.A shall be retained for a period of three years.

C. If the employer fails to retain adequate records required under subsection 14.28.110.A, there shall be a presumption, rebuttable by clear and convincing evidence, that the employer violated this Chapter 14.28 for the periods for which records were not retained for each employee for whom records were not retained.

14.28.120 Retaliation prohibited

A. No employer or any other person shall interfere with, restrain, deny, or attempt to deny the exercise of any right protected under this Chapter 14.28.

B. No employer or any other person shall take any adverse action against any person because the person has exercised in good faith the rights protected under this Chapter 14.28. Such rights include but are not limited to the right to make inquiries about the rights protected under this Chapter 14.28; the right to inform others about their rights under this Chapter 14.28; the right to inform the person's employer, union or similar organization, and/or the person's legal counsel or any other person about an alleged violation of this Chapter 14.28; the right to file an oral or written complaint with the Agency or bring a civil action for an alleged violation of this Chapter 14.28; the right to cooperate with the Agency in its investigations of this Chapter 14.28; the right to testify in a proceeding under or related to this Chapter 14.28; the right to refuse to

participate in an activity that would result in a violation of city, state, or federal law; and the right to oppose any policy, practice or act that is unlawful under this Chapter 14.28.

C. No employer or any other person shall communicate to a person exercising rights protected under this Section 14.28.120, directly or indirectly, the willingness to inform a government employee or contracted organization that the person is not lawfully in the United States, or to report, or to make an implied or express assertion of a willingness to report, suspected citizenship or immigration status of an employee or a family member of the employee to a federal, state, or local agency because the employee has exercised a right under this Chapter 14.28.

D. It shall be considered a rebuttable presumption of retaliation if the employer or any other person takes an adverse action against a person within 90 calendar days of the person's exercise of rights protected in this Section 14.28.120. However, in the case of seasonal employment that ended before the close of the 90 calendar day period, the presumption also applies if the employer fails to rehire a former employee at the next opportunity for work in the same position. The employer may rebut the presumption with clear and convincing evidence that the adverse action was taken for a permissible purpose.

E. Proof of retaliation under this Section 14.28.120 shall be sufficient upon a showing that the employer or any other person has taken an adverse action against a person and the person's exercise of rights protected in this Section 14.28.120 was a motivating factor in the adverse action, unless the employer can prove that the action would have been taken in the absence of such protected activity.

F. The protections afforded under this Section 14.28.120 shall apply to any person who mistakenly but in good faith alleges violations of this Chapter 14.28.

G. A complaint or other communication by any person triggers the protections of this Section 14.28.120 regardless of whether the complaint or communication is in writing or makes explicit reference to this Chapter 14.28.

14.28.130 Enforcement power and duties

A. The Agency shall investigate violations of this Chapter 14.28, as defined herein, and shall have such powers and duties in the performance of these functions as are defined in this Chapter 14.28 and otherwise necessary and proper in the performance of the same and provided for by law.

B. The Agency shall be authorized to coordinate implementation and enforcement of this Chapter 14.28 and shall promulgate appropriate guidelines or rules for such purposes.

C. The Director of the Agency is authorized and directed to promulgate rules consistent with this Chapter 14.28 and Chapter 3.02. Any guidelines or rules promulgated by the Director shall have the force and effect of law and may be relied on by employers, employees, and other parties to determine their rights and responsibilities under this Chapter 14.28.

14.28.140 Violation

The failure of any respondent to comply with any requirement imposed on the respondent under this Chapter 14.28 is a violation.

14.28.150 Investigation

A. The Agency shall have the power to investigate any violations of this Chapter 14.28 by any respondent. The Agency may initiate an investigation pursuant to rules issued by the Director including, but not limited to, situations when the Director has reason to believe that a violation has occurred or will occur, or when circumstances show that violations are likely to occur within a class of businesses because either the workforce contains significant numbers of workers who are vulnerable to violations of this Chapter 14.28 or the workforce is unlikely to volunteer information regarding such violations. An investigation may also be initiated through the receipt by the Agency of a report or complaint filed by an employee or any other person.

B. An employee or other person may report to the Agency any suspected violation of this Chapter 14.28. The Agency shall encourage reporting pursuant to this Section 14.28.150 by taking the following measures:

1. The Agency shall keep confidential, to the maximum extent permitted by applicable laws, the name and other identifying information of the employee or person reporting the violation. However, with the authorization of such person, the Agency may disclose the employee's or person's name and identifying information as necessary to enforce this Chapter 14.28 or for other appropriate purposes.

2. The Agency may require the employer to post or otherwise notify employees that the Agency is conducting an investigation, using a form provided by the Agency and displaying it on-site, in a conspicuous and accessible location, and in English and the primary language(s) of the employee(s) at the particular workplace. If display of the form is not feasible, including situations when the employee works remotely or does not have a regular workplace,

the employer may provide the form on an individual basis in physical or electronic format that is reasonably conspicuous and accessible.

3. The Agency may certify the eligibility of eligible persons for "U" visas under the provisions of 8 U.S.C. § 1184(p) and 8 U.S.C. § 1101(a)(15)(U). The certification is subject to applicable federal law and regulations, and rules issued by the Director.

C. The Agency's investigation must commence within three years of the alleged violation. To the extent permitted by law, the applicable statute of limitations for civil actions is tolled during any investigation under this Chapter 14.28 and any administrative enforcement proceeding under this Chapter 14.28 based upon the same facts. For purposes of this Chapter 14.28:

1. The Agency's investigation begins on the earlier date of when the Agency receives a complaint from a person under this Chapter 14.28, or the Agency provides notice to the respondent that an investigation has commenced under this Chapter 14.28.

2. The Agency's investigation ends when the Agency issues a final order concluding the matter and any appeals have been exhausted; the time to file any appeal has expired; or the Agency notifies the respondent in writing that the investigation has been otherwise resolved.

D. The Agency's investigation shall be conducted in an objective and impartial manner.

E. The Director may apply by affidavit or declaration in the form allowed under RCW 9A.72.085 to the Hearing Examiner for the issuance of subpoenas requiring the attendance and testimony of witnesses, or any document relevant to the issue of whether any employee or group

of employees has been or is afforded proper amounts of compensation under this Chapter 14.28 and/or to whether the employer has violated any provision of this Chapter 14.28. The Hearing Examiner shall conduct the review without hearing as soon as practicable and shall issue subpoenas upon a showing that there is reason to believe that a violation has occurred if a complaint has been filed with the Agency, or that circumstances show that violations are likely to occur within a class of businesses because the workforce contains significant numbers of workers who are vulnerable to violations of this Chapter 14.28 or the workforce is unlikely to volunteer information regarding such violations.

F. An employer that fails to comply with the terms of any subpoena issued under subsection 14.28.150.E in an investigation by the Agency under this Chapter 14.28 prior to the issuance of a Director's Order issued pursuant to subsection 14.28.160.C may not use such records in any appeal to challenge the correctness of any determination by the Agency of liability, damages owed, or penalties assessed.

G. In addition to other remedies, the Director may refer any subpoena issued under subsection 14.28.150.E to the City Attorney to seek a court order to enforce any subpoena.

H. Where the Director has reason to believe that a violation has occurred, the Director may order any appropriate temporary or interim relief to mitigate the violation or maintain the status quo pending completion of a full investigation or hearing, including but not limited to a deposit of funds or bond sufficient to satisfy a good-faith estimate of compensation, interest, damages, and penalties due. A respondent may appeal any such order in accordance with Section 14.28.180.

14.28.160 Findings of fact and determination

A. Except when there is an agreed upon settlement, the Director shall issue a written determination with findings of fact resulting from the investigation and statement of whether a violation of this Chapter 14.28 has or has not occurred based on a preponderance of the evidence before the Director.

B. If the Director determines that there is no violation of this Chapter 14.28, the Director shall issue a "Determination of No Violation" with notice of an employee or other person's right to appeal the decision, subject to the rules of the Director.

C. If the Director determines that a violation of this Chapter 14.28 has occurred, the Director shall issue a "Director's Order" that shall include a notice of violation identifying the violation or violations.

1. The Director's Order shall state with specificity the amounts due under this Chapter 14.28 for each violation, including payment of civil penalties, fines, and penalties payable to the aggrieved party pursuant to subsection 14.28.170.B and 14.28.170.D; and unpaid compensation, liquidated damages, civil penalties, penalties payable to aggrieved parties, fines, and interest pursuant to subsection 14.28.170.C for retaliation.

2. The Director's Order may specify that civil penalties due to the Agency can be mitigated for respondent's timely payment of remedy due to an aggrieved party under subsection 14.28.170.A.4.

3. The Director's Order may specify that civil penalties and fines are due to the aggrieved party rather than due to the Agency.

4. The Director's Order may direct the respondent to take such corrective action as is necessary to comply with the requirements of this Chapter 14.28, including, but not limited to, monitored compliance for a reasonable time period.

5. The Director's Order shall include notice of the respondent's right to appeal the decision, pursuant to Section 14.28.180.

14.28.170 Remedies

A. The payment of unpaid compensation, liquidated damages, civil penalties, penalties payable to aggrieved parties, fines, and interest provided under this Chapter 14.28 are cumulative and are not intended to be exclusive of any other available remedies, penalties, fines and procedures. Pursuant to subsection 14.28.160.C.3, the Director may specify that civil penalties and fines are due to the aggrieved party rather than due to the Agency.

1. The amounts of all civil penalties, penalties payable to aggrieved parties, and fines contained in this Section 14.28.170 shall be increased annually to reflect the rate of inflation and calculated to the nearest cent on January 1 of each year. The Agency shall determine the amounts and file a schedule of such amounts with the City Clerk.

2. If a violation is ongoing when the Agency receives a complaint or opens an investigation, the Director may order payment of unpaid compensation plus interest that accrues after receipt of the complaint or after the investigation opens and before the date of the Director's Order.

3. Interest shall accrue from the date the unpaid compensation was first due at 12 percent annum, or the maximum rate permitted under RCW 19.52.020.

4. If there is a remedy due to an aggrieved party, the Director may waive part or all of the amount of civil penalties due to the Agency based on timely payment of the full remedy due to the aggrieved party.

a. The Director may waive the total amount of civil penalties due to the Agency if the Director determines that the respondent paid the full remedy due to the aggrieved party within ten days of service of the Director's Order.

b. The Director may waive half the amount of civil penalties and fines due to the Agency if the Director determines that the respondent paid the full remedy due to the aggrieved party within 15 days of service of the Director's Order.

c. The Director shall not waive any amount of civil penalties and fines due to the Agency if the Director determines that the respondent has not paid the full remedy due to the aggrieved party after 15 days of service of the Director's Order.

5. When determining the amount of liquidated damages, civil penalties, penalties payable to aggrieved parties, and fines due under this Section 14.28.170, for a settlement agreement or Director's Order, including but not limited to the mitigation of civil penalties and fines due to the Agency for timely payment of remedy due to an aggrieved party under subsection 14.28.170.A.4, the Director shall consider:

a. The total amount of unpaid compensation, liquidated damages, penalties, fines, and interest due;

b. The nature and persistence of the violations;

c. The extent of the respondent's culpability;

d. The substantive or technical nature of the violations;

e. The size, revenue, and human resources capacity of the respondent;

f. The circumstances of each situation;

g. The amounts of penalties in similar situations; and

h. Other factors pursuant to rules issued by the Director.

B. A respondent found to be in violation of this Chapter 14.28 shall be liable for full payment of unpaid compensation plus interest in favor of the aggrieved party under the terms of this Chapter 14.28, and other equitable relief.

1. For a first violation of this Chapter 14.28, the Director may assess liquidated damages in an additional amount of up to twice the unpaid compensation.

2. For subsequent violations of this Chapter 14.28, the Director shall assess an amount of liquidated damages in an additional amount of twice the unpaid compensation.

3. For purposes of establishing a first and subsequent violation for this Section 14.28.170, the violation must have occurred within ten years of the settlement agreement or Director's Order.

C. A respondent found to be in violation of this Chapter 14.28 for retaliation under Section 14.28.120 shall be subject to any appropriate relief at law or equity including, but not limited to, reinstatement of the aggrieved party, front pay in lieu of reinstatement with full payment of unpaid compensation plus interest in favor of the aggrieved party under the terms of this Chapter 14.28, and liquidated damages in an additional amount of up to twice the unpaid

compensation. The Director also shall order the imposition of a penalty payable to the aggrieved party of up to $5,000.

D. A respondent found to be in violation of this Chapter 14.28 shall be subject to civil penalties. Pursuant to subsection 14.28.160.C.3, the Director may specify that civil penalties are due to the aggrieved party rather than due to the Agency.

1. For a first violation of this Chapter 14.28, the Director may assess a civil penalty of up to $500 per aggrieved party.

2. For a second violation of this Chapter 14.28, the Director shall assess a civil penalty of up to $1,000 per aggrieved party, or an amount equal to ten percent of the total amount of unpaid compensation, whichever is greater.

3. For a third or any subsequent violation of this Chapter 14.28, the Director shall assess a civil penalty of up to $5,000 per aggrieved party, or an amount equal to ten percent of the total amount of unpaid compensation, whichever is greater. The maximum civil penalty for a violation of this Chapter 14.28 shall be $20,000 per aggrieved party, or an amount equal to ten percent of the total amount of unpaid compensation, whichever is greater.

4. For purposes of this Section 14.28.170, a violation is a second, third, or subsequent violation if the respondent has been a party to one, two, or more than two settlement agreements, respectively, stipulating that a violation has occurred; and/or one, two, or more than two Director's Orders, respectively, have issued against the respondent in the ten years preceding the date of the violation; otherwise, it is a first violation.

E. For the following violations, the Director may assess a fine up to the amounts set forth below:

Violation	**Fine**
Failure to comply with prohibitions against coercing or unduly inducing an employee into waiving coverage under Section 14.28.050	$1,000 per aggrieved party
Failure to provide the required healthcare expenditure as required by Section 14.28.060	$500 per aggrieved party
Failure to provide employees with written notice of rights under Section 14.28.100	$500
Failure to maintain records for three years under Section 14.28.110	$500 per missing record
Failure to comply with prohibitions against retaliation for exercising rights protected under Section 14.28.120	$1,000 per aggrieved party
Failure to provide notice of investigation to employees under subsection 14.28.150.B.2	$500
Failure to provide notice of failure to comply with final order to the public under subsection 14.28.210.A.1	$500

The fine amounts shall be increased cumulatively by 50 percent of the fine for each preceding violation for each subsequent violation of the same provision by the same employer or person within a ten year period. The maximum amount that may be imposed in fines in any one year period for each type of violation listed above is $5,000 unless a fine for retaliation is issued, in which case the maximum amount is $20,000.

F. A respondent who willfully hinders, prevents, impedes, or interferes with the Director or Hearing Examiner in the performance of their duties under this Chapter 14.28 shall be subject to a civil penalty of not less than $1,000 and not more than $5,000.

G. In addition to the unpaid compensation, penalties, fines, liquidated damages, and interest, the Agency may assess against the respondent in favor of the City reasonable costs incurred in enforcing this Chapter 14.28, including but not limited to reasonable attorney's fees.

H. An employer that is the subject of a settlement agreement stipulating that a violation shall count for debarment, or final order for which all appeal rights have been exhausted, shall not be permitted to bid, or have a bid considered, on any City contract until such amounts due under the final order have been paid in full to the Director. If the employer is the subject of a final order two times or more within a five-year period, the employer shall not be allowed to bid on any City contract for two years. This subsection 14.28.170.H shall be construed to provide grounds for debarment separate from, and in addition to, those contained in Chapter 20.70 and shall not be governed by that chapter, provided that nothing in this subsection 14.28.170.H shall be construed to limit the application of Chapter 20.70. The Director shall notify the Director of Finance and Administrative Services of all employers subject to debarment under this subsection 14.28.170.H.

14.28.180 Appeal period and failure to respond

A. An employee or other person who claims an injury as a result of an alleged violation of this Chapter 14.28 may appeal the Determination of No Violation Shown, pursuant to the rules of the Director.

B. A respondent may appeal the Director's Order, including all remedies issued pursuant to Section 14.28.170, by requesting a contested hearing before the Hearing Examiner in writing within 15 days of service of the Director's Order. If a respondent fails to appeal the Director's

Order within 15 days of service, the Director's Order shall be final. If the last day of the appeal period so computed is a Saturday, Sunday, or federal or City holiday, the appeal period shall run until 5 p.m. on the next business day.

14.28.190 Appeal procedure and failure to appear

A. Contested hearings shall be conducted pursuant to the procedures for hearing contested cases contained in Section 3.02.090 and the rules adopted by the Hearing Examiner for hearing contested cases. The review shall be conducted de novo and the Director shall have the burden of proof by a preponderance of the evidence before the Hearing Examiner. Upon establishing such proof, the remedies and penalties imposed by the Director shall be upheld unless it is shown that the Director abused discretion. Failure to appear for a contested hearing will result in an order being entered finding that the employer committed the violation stated in the Director's Order. For good cause shown and upon terms the Hearing Examiner deems just, the Hearing Examiner may set aside an order entered upon a failure to appear.

B. In all contested cases, the Hearing Examiner shall enter an order affirming, modifying, or reversing the Director's Order.

14.28.200 Appeal from Hearing Examiner order

A. The respondent may obtain judicial review of the decision of the Hearing Examiner by applying for a Writ of Review in the King County Superior Court within 30 days from the date of the decision in accordance with the procedure set forth in chapter 7.16 RCW, other applicable law, and court rules.

B. The decision of the Hearing Examiner shall be final and conclusive unless review is sought in compliance with this Section 14.28.200.

14.28.210 Failure to comply with final order

A. If a respondent fails to comply within 30 days of service of any settlement agreement with the Agency, or with any final order issued by the Director or the Hearing Examiner for which all appeal rights have been exhausted, the Agency may pursue, but is not limited to, the following measures to secure compliance:

1. The Director may require the respondent to post public notice of the respondent's failure to comply in a form and manner determined by the Agency.

2. The Director may refer the matter to a collection agency. The cost to the City for the collection services will be assessed as costs, at the rate agreed to between the City and the collection agency, and added to the amounts due.

3. The Director may refer the matter to the City Attorney for the filing of a civil action in any court of competent jurisdiction to enforce such order or to collect amounts due. In the alternative, the Director may seek to enforce a settlement agreement, a Director's Order or a final order of the Hearing Examiner under Section 14.28.220.

4. The Director may request that the City's Department of Finance and Administrative Services deny, suspend, refuse to renew, or revoke any business license held or requested by the employer or person until such time as the employer complies with the remedy as defined in the settlement agreement or final order. The City's Department of Finance and

Administrative Services shall have the authority to deny, refuse to renew, or revoke any business license in accordance with this subsection 14.28.210.A.4.

B. No respondent that is the subject of a settlement agreement or final order issued under this Chapter 14.28 shall quit business, sell out, exchange, convey, or otherwise dispose of the respondent's business or stock of goods without first notifying the Agency and without first notifying the respondent's successor of the amounts owed under the settlement agreement or final order at least three business days prior to such transaction. At the time the respondent quits business, or sells out, exchanges, or otherwise disposes of the respondent's business or stock of goods, the full amount of the remedy, as defined in the settlement agreement or the final order issued by the Director or the Hearing Examiner, shall become immediately due and payable. If the amount due under the settlement agreement or final order is not paid by respondent within ten days from the date of such sale, exchange, conveyance, or disposal, the successor shall become liable for the payment of the amount due, provided that the successor has actual knowledge of the order and the amounts due or has prompt, reasonable, and effective means of accessing and verifying the fact and amount of the order and the amounts due. The successor shall withhold from the purchase price a sum sufficient to pay the amount of the full remedy. When the successor makes such payment, that payment shall be deemed a payment upon the purchase price in the amount paid, and if such payment is greater in amount than the purchase price the amount of the difference shall become a debt due such successor from the employer.

14.28.220 Debt owed The City of Seattle

A. All monetary amounts due under a settlement agreement or Director's Order shall be a debt owed to the City and may be collected in the same manner as any other debt in like amount, which remedy shall be in addition to all other existing remedies, provided that amounts collected by the City for unpaid compensation, liquidated damages, penalties payable to aggrieved parties, or front pay shall be held in trust by the City for the aggrieved party and, once collected by the City, shall be paid by the City to the aggrieved party.

B. If a respondent fails to appeal a Director's Order to the Hearing Examiner within the time period set forth in subsection 14.28.180.B the Director's Order shall be final, and the Director may petition the Seattle Municipal Court to enforce the Director's Order by entering judgment in favor of the City finding that the respondent has failed to exhaust its administrative remedies and that all amounts and relief contained in the order are due. The Director's Order shall constitute prima facie evidence that a violation occurred and shall be admissible without further evidentiary foundation. Any certifications or declarations authorized under RCW 9A.72.085 containing evidence that the respondent has failed to comply with the order or any parts thereof, and is therefore in default, or that the respondent has failed to appeal the Director's Order to the Hearing Examiner within the time period set forth in subsection 14.28.180.B and therefore has failed to exhaust the respondent's administrative remedies, shall also be admissible without further evidentiary foundation.

C. If a respondent fails to obtain judicial review of an order of the Hearing Examiner within the time period set forth in subsection 14.28.200.A, the order of the Hearing Examiner shall be final, and the Director may petition the Seattle Municipal Court to enforce the Director's

Order by entering judgment in favor of the City for all amounts and relief due under the order of the Hearing Examiner. The order of the Hearing Examiner shall constitute conclusive evidence that the violations contained therein occurred and shall be admissible without further evidentiary foundation. Any certifications or declarations authorized under RCW 9A.72.085 containing evidence that the respondent has failed to comply with the order or any parts thereof, and is therefore in default, or that the respondent has failed to avail itself of judicial review in accordance with subsection 14.28.200.A, shall also be admissible without further evidentiary foundation.

D. In considering matters brought under subsections 14.28.220.B and 14.28.220.C, the Municipal Court may include within its judgment all terms, conditions, and remedies contained in the Director's Order or the order of the Hearing Examiner, whichever is applicable, that are consistent with the provisions of this Chapter 14.28.

14.28.230 Private right of action

A. Any person or class of persons that suffers injury as a result of a violation of this Chapter 14.28 or is the subject of prohibited retaliation under Section 14.28.120 may bring an action in a court of competent jurisdiction against the employer or other person violating this Chapter 14.28 and, upon prevailing, may be awarded reasonable attorney's fees and costs and such legal or equitable relief as may be appropriate to remedy the violation including, without limitation, the payment of any unpaid compensation plus interest due to the person and liquidated damages in an amount up to twice the unpaid compensation; a penalty payable to any aggrieved party of no less than $100 and not more than $1000 for each day the employer was in

violation. Interest shall accrue from the date the unpaid compensation was first due at 12 percent per annum, or the maximum rate permitted under RCW 19.52.020.

B. For purposes of this Section 14.28.230, "person" includes any entity a member of which has suffered injury or retaliation, or any other individual or entity acting on behalf of an aggrieved party that has suffered injury or retaliation.

C. For purposes of determining membership within a class of persons entitled to bring an action under this Section 14.28.230, two or more employees are similarly situated if they:

1. Are or were employed by the same employer or employers, whether concurrently or otherwise, at some point during the applicable statute of limitations period,

2. Allege one or more violations that raise similar questions as to liability, and

3. Seek similar forms of relief.

D. For purposes of subsection 14.28.230.C, employees shall not be considered dissimilar solely because their:

1. Claims seek damages that differ in amount, or

2. Job titles or other means of classifying employees differ in ways that are unrelated to their claims.

E. An order issued by the court may include a requirement for an employer to submit a compliance report to the court and to the City.

14.28.235 Collective bargaining agreement

A. The requirements of this Chapter 14.28 shall not apply to any employees covered by a bona fide collective bargaining agreement to the extent that such requirements are expressly

waived in the collective bargaining agreement, or in an addendum to an existing agreement including an agreement that is open for negotiation, in clear and unambiguous terms; provided, however, that in either case, the agreement must be ratified by the employees and must contain alternative safeguards that meet the public policy goals of this Chapter 14.28.

B. With the exception of any waiver permitted by Section 14.28.030, any waiver by an individual employee of any provisions of this Chapter 14.28 shall be deemed contrary to public policy and shall be void and unenforceable.

14.28.240 Other legal requirements

This Chapter 14.28 provides hotel employee protection requirements and shall not be construed to preempt, limit, or otherwise affect the applicability of any other law, regulation, requirement, policy, or standard that provides for greater protections; and nothing in this Chapter 14.28 shall be interpreted or applied so as to create any power or duty in conflict with federal or state law. Nor shall this Chapter 14.28 be construed to preclude any person aggrieved from seeking judicial review of any final administrative decision or order made under this Chapter 14.28 affecting such person.

14.28.250 Severability

The provisions of this Chapter 14.28 are declared to be separate and severable. If any clause, sentence, paragraph, subdivision, section, subsection, or portion of this Chapter 14.28, or the application thereof to any employer, employee, or circumstance, is held to be invalid, it shall not affect the validity of the remainder of this Chapter 14.28 or the validity of its application to other persons or circumstances.

14.28.260 Effective date

A. For ancillary hotel businesses with between 50 and 250 employees that contract, lease, or sublease with a hotel as of the date of passage of this Chapter 14.28, the provisions of this Chapter 14.28 shall take effect upon the later of July 1, 2025 or the earliest annual open enrollment period for health coverage, if offered, after July 1, 2025.

B. For all other covered employers, the provisions of this Chapter 14.28 shall take effect upon the later of July 1, 2020 or the earliest annual open enrollment period for health coverage, if offered, after July 1, 2020.

Section 2. Section 3.15.000 of the Seattle Municipal Code, last amended by Ordinance 125684, is amended as follows:

3.15.000 Office of Labor Standards created – Functions

There is created within the Executive Department an Office of Labor Standards, under the direction of the Mayor. The mission of the Office of Labor Standards is to advance labor standards through thoughtful community and business engagement, strategic enforcement and innovative policy development, with a commitment to race and social justice. The Office of Labor Standards seeks to promote greater economic opportunity and further the health, safety, and welfare of employees; support employers in their implementation of labor standards requirements; and end barriers to workplace equity for women, communities of color, immigrants and refugees, and other vulnerable workers.

The functions of the Office of Labor Standards are as follows:

A. Promoting labor standards through outreach, education, technical assistance, and training for employees and employers;

B. Collecting and analyzing data on labor standards enforcement;

C. Partnering with community, businesses, and workers for stakeholder input and collaboration;

D. Developing innovative labor standards policy;

E. Administering and enforcing City of Seattle ordinances relating to minimum wage, and minimum compensation (Chapter 14.19), paid sick and safe time (Chapter 14.16), use of criminal history in employment decisions (Chapter 14.17), wage and tip compensation requirements (Chapter 14.20), secure scheduling (Chapter 14.22), improving access to medical care for hotel employees (Chapter 14.28), commuter benefits (Chapter 14.30), and other labor standards ordinances the City may enact in the future.

Section 3. Subsection 6.208.020.A of the Seattle Municipal Code, which section was last amended by Ordinance 125684, is amended as follows:

6.208.020 Denial, revocation of, or refusal to renew business license

A. In addition to any other powers and authority provided under this Title 6, the Director, or the Director's designee, has the power and authority to deny, revoke, or refuse to renew any business license issued under the provisions of this Chapter 6.208. The Director, or the Director's designee, shall notify such applicant or licensee in writing by mail of the denial, revocation of, or refusal to renew the license and on what grounds such a decision was based. The Director may

deny, revoke, or refuse to renew any license issued under this Chapter 6.208 on one or more of the following grounds:

1. The license was procured by fraud or false representation of fact.

2. The licensee has failed to comply with any provisions of this Chapter 6.208.

3. The licensee has failed to comply with any provisions of Chapters 5.32, 5.35, 5.40, 5.45, 5.46, 5.48, 5.50, or 5.52.

4. The licensee is in default in any payment of any license fee or tax under Title 5 or Title 6.

5. The property at which the business is located has been determined by a court to be a chronic nuisance property as provided in Chapter 10.09.

6. The applicant or licensee has been convicted of theft under subsection 12A.08.060.A.4 within the last ten years.

7. The applicant or licensee is a person subject within the last ten years to a court order entering final judgment for violations of chapters 49.46, 49.48, or 49.52 RCW, or 29 U.S.C. 206 or 29 U.S.C. 207, and the judgment was not satisfied within 30 days of the later of either:

a. The expiration of the time for filing an appeal from the final judgment order under the court rules in effect at the time of the final judgment order; or

b. If a timely appeal is made, the date of the final resolution of that appeal and any subsequent appeals resulting in final judicial affirmation of the findings of violations of chapters 49.46, 49.48, or 49.52 RCW, or 29 U.S.C. 206 or 29 U.S.C. 207.

8. The applicant or licensee is a person subject within the last ten years to a final and binding citation and notice of assessment from the Washington Department of Labor and Industries for violations of chapters 49.46, 49.48, or 49.52 RCW, and the citation amount and penalties assessed therewith were not satisfied within 30 days of the date the citation became final and binding.

9. Pursuant to subsections 14.16.100.A.4, 14.17.075.A, 14.19.100.A.4, 14.20.080.A.4, 14.22.115.A.4, 14.28.210.A.4, and 14.30.180.A.4, the applicant or licensee has failed to comply, within 30 days of service of any settlement agreement, with any final order issued by the Director of the Office of Labor Standards, or any final order issued by the Hearing Examiner under Chapters 14.16, 14.17, 14.19, 14.20, 14.22, 14.28, and 14.30, for which all appeal rights have been exhausted, and the Director of the Office of Labor Standards has requested that the Director deny, refuse to renew, or revoke any business license held or requested by the applicant or licensee. The denial, refusal to renew, or revocation shall remain in effect until such time as the violation(s) under Chapters 14.16, 14.17, 14.19, 14.20, 14.22, 14.28, and 14.30 are remedied.

10. The business is one that requires an additional license under this Title 6 and the business does not hold that license.

11. The business has been determined under a separate enforcement process to be operating in violation of law.

* * *

Section 4. If any section or subsection of the Seattle Municipal Code affected by this ordinance is amended by ordinance without reference to amendments made by this ordinance, each ordinance shall be given effect to the extent that the amendments do not conflict in purpose, and the code reviser may publish the section or subsection in the official code with all amendments incorporated therein.

* * *

Section 5. This ordinance shall take effect and be in force 30 days after its approval by the Mayor, but if not approved and returned by the Mayor within ten days after presentation, it shall take effect as provided by Seattle Municipal Code Section 1.04.020.

Passed by the City Council the 16th day of September, 2019, and signed by me in open session in authentication of its passage this 16th day of September, 2019.

President _____ of the City Council

Approved by me this 24th day of September, 2019.

Jenny A. Durkan, Mayor

Filed by me this 25th day of September, 2019.

Monica Martinez Simmons, City Clerk

(Seal)

Seattle Office of Labor Standards

Improving Access to Medical Care for Hotel Employees Ordinance

Questions and Answers

Seattle's Improving Access to Medical Care for Hotel Employees Ordinance, Seattle Municipal Code (SMC 14.28) requires covered employers to make healthcare expenditures to or on behalf of covered employees to increase their access to medical care.

The **Seattle Office of Labor Standards (OLS)** is responsible for administering this law. OLS provides outreach, compliance assistance and enforcement services.

If you have a question that this Q&A does not cover, visit the Office of Labor Standards website. You may also call 206-256-5297 or reach us electronically:

- Employees with questions and complaints – submit an online inquiry form.
- Employers with requests for technical assistance – submit an on-line inquiry form.

OLS created this document to provide an explanation of the law. *Note: Information provided by OLS does not constitute legal advice, create an agency decision, or establish an attorney-client relationship with the reader.*

Table of Contents

General Information

1. **What is the Improving Access to Medical Care for Hotel Employees Ordinance?**
   This law requires covered employers to make healthcare expenditures to or on behalf of covered employees to increase their access to medical care. Covered employers have several ways that they can make healthcare expenditures, including through monthly ordinary income payments, payments towards employer-sponsored health insurance, or payments to other things like health savings accounts, flexible savings accounts, and health reimbursement arrangements.

2. **Where can I access a copy of the law and the rules that apply to this law?**
   The language of the law can be viewed by clicking here. To view the rules, visit the Office of Labor Standards Hotel Employee Protection webpage and download a copy of the Seattle Human Rights Rules, Chapter 190.

3. **When does this law go into effect?**
   Ancillary hotel businesses that contract, lease, or sublease with a covered hotel and that have between 50 to 250 employees worldwide must comply with this law starting on July 1, 2025, or at the earliest annual open enrollment period for health coverage (if the employer offers health coverage to their employees).

   All other covered employers must comply with the law starting on July 1, 2020, or at the earliest annual open enrollment period for health coverage (if the employer offers health coverage to their employees).

   For more information about the covered employers, including ancillary hotel businesses and hotel employers, please see the Employer Section of this document.

4. **Which City department administers this law?**
   The City of Seattle's Office of Labor Standards (OLS) administers this law. OLS provides a range of services for employees and employers including education and compliance assistance. OLS also investigates potential violations of this law.

5. **Where do employees call with questions? Can employees remain anonymous?**
   Employees can call 206-256-5297, email workers.laborstandards@seattle.gov, or submit an online inquiry. Upon request, and to the extent permitted by law, OLS protects the identifying information (e.g. name, job title) of employees who report violations and witnesses who provide information during investigations. OLS will not disclose the person's identifying information during or after the investigation, to the extent permitted by law. OLS may need to release names of employees who are owed payment as a result of an investigation.

6. **What happens when employees call OLS?**
   Employees may call OLS with questions or complaints. When employees call OLS, they will be directed to an intake investigator who will provide information about the law or gather information about issues at the workplace. If employees wish to make a complaint, OLS may collect information from additional witnesses and/or request documents from employees. After reviewing information provided by employees, OLS will decide if and how it can help, which may take a variety of forms, including simply providing information to the employer, trying to informally resolve the issue without a full investigation, or conducting a formal investigation. If OLS decides to investigate, and if OLS cannot investigate the employer immediately, it may place the case on a waitlist.

7. **Does an employee's immigration status impact coverage or application of the law?**
   No, immigration status does not impact coverage or application of the law. As a matter of policy, the City of Seattle does not ask about the immigration status of anyone using City services. Read OLS' Commitment to Immigrant and Refugee Communities for more information.

8. **Can employers call OLS with their questions?**
   Yes! OLS provides compliance assistance and training for employers. Employers can call 206-256-5297, send an email to business.laborstandards@seattle.gov, or submit an online inquiry form. OLS does **not** share information about the identity of employers with our enforcement team. Phone conversations and email conversations are kept separate from the investigation process.

9. **What happens when an employer calls OLS with a question about compliance?**
   OLS encourages employers to call or email their questions to our office. Our goal is to help employers attain full compliance with Seattle's labor standards and we will answer many types of labor standards questions. OLS has staff dedicated to business engagement who respond to inquiries and who are not members of the enforcement team. Phone conversations and email exchanges with the business engagement staff are kept separate from the investigation process.

10. **Does OLS provide language interpretation for its services?**
    Yes. If OLS staff do not speak your preferred language, OLS will arrange for an interpreter to help with the conversation. OLS's services are free of charge regardless of whether interpretation services are required.

Employees

11. **Which employees are protected by this law?**
    The law applies to hourly employees who work an average of 80 hours or more per month for a covered employer.

    Hourly employees are those employees who are entitled to Seattle's Minimum Wage, Seattle Municipal Code 14.19. For more information about employees who are entitled to Seattle's Minimum Wage, visit OLS's Seattle Minimum Wage webpage.

12. **How does an employer determine whether an employee works an average of 80 hours or more per month?**
    To determine whether an employee works for an average of 80 hours or more per month, an employer must make a reasonable estimate of the average monthly hours that the employee will work over the course of the calendar year, or over the course of the period of employment if the employee will be working for a period shorter than a year (e.g. temporary or seasonal work).

    a. **What happens if the employer underestimates the number of hours the employee works?**
       An employer's estimate will be unreasonable if it results in an underestimation of the actual average hours worked by the employee over the course of the calendar year or over the period of employment for employment that is less than a year. In this circumstance, the employer is responsible for making retroactive healthcare expenditures in the form of ordinary income to the employee, plus interest.

    b. **What happens if the employer overestimates the number of hours the employee works?**
       If an employer's estimate results in an overestimation of the average work hours, an employer is prohibited from recovering any healthcare expenditures from the employee resulting from such overestimation.

13. **What are considered "hours" for the purpose of the calculation of an employee's average hours?**
    The law defines "hours" as:
    - Each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and
    - Each hour for which the employee is paid, or entitled to payment, by the employer for a period during which no

duties are performed due to vacation, illness, legally required paid leave, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

14. Are any employees exempted or excluded from this law?

Yes. The following categories of employees are excluded from coverage:

1. Employees who voluntarily waive the rights granted by the ordinance,
2. Employees who are managers, supervisors, or employees who help to create or effect management policies about labor relations (who are also known as "confidential employees"),
3. Those who are not entitled to Seattle's Minimum Wage, and
4. Those who do not work at least an average of 80 hours per month.

Additionally, newly hired employees that are subject to a waiting period for enrollment in an employer-sponsored health plan are temporarily exempted from the law for 60 days or the expiration of the waiting period, whichever is shorter.

15. How does an employee voluntarily waive coverage of this ordinance?

If an employee is receiving health coverage from another source, the employee is permitted to sign the OLS Voluntary Ordinance Waiver (ORD Waiver). The ORD Waiver verifies that the employee is receiving health coverage through another source other than the employee (such as a spouse/domestic partner or parent's employer, or an employee's second job) and that the employee knowingly and voluntarily waives the right to have their (covered) employer make healthcare expenditures to them or on their behalf.

Employers must use the OLS ORD Waiver form, which OLS developed to ensure that the employee understands their rights under the law, so that the waiver is a knowing and voluntary one. Employers may not alter the form in any manner, other than to complete the portions designated for the employer to complete. Other forms provided by third-party vendors or health insurance carriers cannot be used in lieu of OLS's form.

The waiver must be provided to employees in their primary language. To assist with employer compliance with the language requirements of the ordinance, OLS intends to translate the waiver in several languages. Employers are not required to provide the waiver in languages other than English until OLS makes the necessary translation available. Employers are encouraged to notify OLS of the need for additional translations. For more information about this waiver and the rules governing its validity, please view the waiver by downloading it from the OLS website and viewing Seattle Human Rights Rule 190-220.

16. What makes a Voluntary Ordinance (ORD) Waiver form valid?

For a waiver form to be valid, the employee must fully understand their rights under the law, and the waiver must be voluntarily completed by the employee without pressure or coercion from coworkers, the employer, or anyone connected to the employer.

The form will be invalid if the employee fails to state that they are receiving health coverage through another source or leaves that section of the waiver blank or fails to sign the waiver. A completed waiver is effective on the date it is signed by the employee and is valid for one year. Employees who wish to waive their rights for more than one year must sign a new waiver each year when the prior form expires.

Employees have the right to cancel the voluntary waiver during any period of annual open enrollment in the covered employer's employer-sponsored plan or due to a qualifying life event.

An electronic signature is acceptable on the ORD Waiver form so long as:

1. The form is an exact replica of the official OLS ORD Waiver,

2. The employee can view the entire form at the same time as they sign it (the information is not broken up into multiple click-through screens and/or the signature is not on a separate page), and
3. No language on the website suggests the employee must sign the form.

Employers must keep a copy of the signed form for record retention requirements. Employees are encouraged to keep a signed copy of the form.

17. What is an open annual enrollment period?
An annual open enrollment period is a period during which an individual may enroll or change health coverage.

18. What is a qualifying life event?
A qualifying life event is an event(s) that allows enrollment in health coverage outside the annual open enrollment period of an employer-sponsored health plan. These events are typically set forth in an employer's health plan document and could include things like: marriage, divorce, new child, etc.

19. Can an employee cancel their voluntary waiver?
Yes. Employees have the right to cancel the voluntary waiver during any period of annual open enrollment in the covered employer's employer-sponsored plan or due to a qualifying life event.

Employers

20. Which employers are *covered employers* and must follow this law?
This law applies to:
- Employers that own, control, or operate a Seattle hotel or motel with 100 or more guest rooms (referred to as a large hotel or covered hotel); and
- Ancillary hotel business employers with 50 or more employees worldwide.

21. What is an *ancillary hotel business*?
An ancillary hotel business is a business that has one or more of the following relationships with a covered hotel:
- Routinely contracts with a hotel to provide services in conjunction with the hotel's purpose;
- Leases or subleases space at the site of the hotel to provide services in conjunction with the hotel's purpose; or
- Provides food and beverages to hotel guests and to the public and has an entrance within the hotel.

22. *Ancillary Hotel Businesses – Routine contract:* What does it mean to *routinely contract* with a hotel?
A routine contracting relationship contemplates a business relationship that is sustained and longer in nature. A business that has an isolated and/or short-term business relationship will not be considered to routinely contract with a hotel. A business relationship that is in existence for less than one year is not a routine contract.

23. *Ancillary Hotel Businesses – Entrance within hotel:* What does it mean to have an entrance within the hotel premises? Does an entrance that is primarily used to gain access to a restroom that is located within the hotel count as an *entrance within the hotel*?
An ancillary hotel business has an entrance within the hotel premises when the entrance is promoted and used by the business's guests as an access point into the business.

A passage that is promoted as and used by the business's customers to access a restroom facility located within the hotel is not considered an entrance within the hotel premises. A sign identifying the business for purposes of navigation to and from the restroom facility is not promotion of the business.

24. *Ancillary Hotel Businesses – Services:* What is meant by providing *services*?
For the purposes of the ancillary hotel business definition, services provide a direct, specific benefit to the guest. The *services* contemplated in this definition excluded anything that provides an indirect benefit that benefits the general welfare of guests.

For example:
- Direct benefit: A business that provides the hotel with an employee who helps guests navigate the elevator (e.g. directs guests to different floors). This business provides a direct benefit to a guest and provides services for the purpose of determine whether the business is an ancillary hotel business.
- Benefits the general welfare: A business that has a contract with the hotel to maintain and repair the guest elevators. This business provides an indirect benefit serving the general welfare of guests who are able to use working elevators. This business does not provide services for the purpose of determine whether the business is an ancillary hotel business.

The sale of goods is not a "service."

25. *Ancillary Hotel Businesses – Hotel's purpose:* What does it mean to provide services in conjunction with the *hotel's purpose?*
A hotel's purpose is defined as services that further the hotel's provision of short-term lodging, which include food or beverage services, recreational services, conference rooms, convention services, laundry services, and parking.

26. *Ancillary Hotel Businesses – Multiple locations:* When a business has multiple locations, but where only one location has a relationship described in the ancillary hotel business definition, which locations are covered?
The portion of the business enterprise that provides services to guests or at the site of the hotel is covered. For example, where a restaurant has many locations, but where only one location has an entrance within a covered hotel, only the location that has an entrance within the hotel is covered.

Healthcare Expenditures

27. What does the law require employers to do? What is a healthcare expenditure?
A covered employer must make a monthly healthcare expenditure to or on behalf of each covered employee. A healthcare expenditure is a certain amount of money that a covered employer must pay to an employee or on behalf of the employee that will enable the employee, their spouse/domestic partner, and/or dependents to access healthcare services.

28. What are healthcare services?
Healthcare services are medical care, services, or goods that may qualify as tax deductible medical care expenses under Section 213 of the Internal Revenue Code, or medical care, services, or goods having substantially the same effect as such deductible expenses. For the purposes of this law, healthcare services do not include vision or dental services.

29. Does this law require an employer to provide health coverage to its employees?

No. This law does not mandate that an employer provide health coverage to its employees or regulate health insurance plans. These kinds of requirements are regulated by federal law.

This law requires an employer to make payments to or on behalf of their employee to enable the employee and their spouse, domestic partner, and dependents (if applicable) to access healthcare services. One of several ways in which an employer can meet its healthcare expenditure obligations is to make payments towards health insurance for the employee (and their spouse, domestic partner, and/or dependents).

30. How much is a covered employer required to spend on healthcare expenditures for each covered employee?

There are four monthly rates. The rate applicable to an individual employee is determined by the employee's family composition, as categorized below:

- Employee with no spouse, domestic partner or dependents (single employee);
- Employee with only dependents (any number);
- Employee with only a spouse or domestic partner; and
- Employee that has both a spouse/domestic partner and dependents.

These rates are adjusted each year based on a "medical inflation rate." OLS announces the new rate each year. To ensure notification of the change in rate, please sign up for OLS's newsletter.

31. What are the 2020 rates?

Employee with no spouse/domestic partner or children	$420
Employee with only dependents (any number)	$714
Employee with only a spouse/domestic partner	$840
Employee with spouse/domestic partner and any number of dependents	$1,260

32. Who are dependents?

A dependent is any person who would be considered as a "qualifying child" or a "qualifying relative" for tax purposes (26 U.S.C. §151-153). To find more information, please visit the Internal Revenue Service's webpage and view IRS Publication 501 that provides more information about these kinds of dependents.

33. How does an employer determine the employee's healthcare expenditure rate?

The rates set by the law are based on the presence or absence of a spouse, domestic partner, or dependent(s), regardless of whether that spouse, domestic partner, or dependent(s) is covered or eligible to be covered by an employer's group health plan.

An employer must make reasonable efforts to obtain accurate information to determine the employee's rate. If an employer is unable to obtain the information to determine the employee's rate, the employer may assume that the employee qualifies for the rate for an employee with no spouse/domestic partner or dependents, until otherwise notified by the employee. An employer may request that an employee notify them of a change that would impact their rate (e.g. divorce, marriage, additional or removal of a dependent).

Caution: An employer's efforts to obtain this information must not violate local, state, or federal laws. Employers must use caution when asking for the personal information needed to determine the employee's applicable rate. Employers are encouraged to provide enough information about the reason for their inquiry and only ask for information after the employee has been hired. Improper inquiries about family status during the hiring process and

in some other employment contexts may constitute unlawful discrimination. For more information, please visit the Seattle Office for Civil Rights.

34. What methods can an employer use to meet the expenditure?

An employer may make the monthly expenditure through any one or more of the following ways:

- Ordinary income payments (additional compensation) paid directly to the employee.
- Payments to a third-party for the purposes of providing healthcare services to the employee or to the covered employee's spouse, domestic partner, or dependents (if applicable). These include, but are not limited to, payments to an insurance carrier or trust, or into programs that reimburse employees for out-of-pocket healthcare costs ("tax-favored health program").
- Average per-capita monthly expenditures for healthcare services made to or on behalf of covered employees or their spouse, domestic partner, or dependents (if applicable) by the employer's self-insured/self-funded insurance program.

35. Does an employee get to choose how the employer makes the expenditure?

No. The employer has the discretion as to which method(s) of the monthly healthcare expenditure they choose to make for their employees. Whichever method(s) the employer chooses, the employer must satisfy the entire expenditure owed to the employee.

36. Are there any circumstances in which an employer will be deemed to have satisfied its obligation to provide an expenditure, but not have made any payments?

There is one limited situation where this can occur. An employer will be deemed to have satisfied its obligation with respect to an employee if:

- The employer makes an offer of a healthcare expenditure that fully satisfies the relevant monthly expenditure rate for the employee (which will necessarily include payments toward an employer-sponsored health insurance plan);
- The employee is not required to pay more than an amount equaling 20% of the single employee healthcare expenditure rate (in 2020, $84/month) towards the employer-sponsored health insurance plan; and
- The employee voluntarily waives the offer of healthcare expenditure in writing using the OLS Voluntary Expenditure (EXP) Waiver Form.

Employers must use OLS's EXP Waiver Form. The waiver must be provided to employees in their primary language. To assist with employer compliance with the language requirements of the ordinance, OLS intends to translate the waiver in several languages. Employers are not required to provide the waiver in languages other than English until OLS makes the necessary translation available. Employers are encouraged to notify OLS of the need for additional translations. For more information about this waiver and the rules governing its validity, please view the waiver by downloading it from the OLS website and by viewing Seattle Human Rights Rule 190-250.

NOTE: This waiver is separate and distinct from a waiver of an offer of employer-sponsored health insurance. This is a waiver of the ordinance's grant of a healthcare expenditure.

37. What makes a Voluntary Expenditure (EXP) Waiver valid?

For a waiver form to be valid, the employee must fully understand their rights under the law, and the waiver must be voluntarily completed by the employee without pressure or coercion from coworkers, the employer, or anyone connected to the employer.

The form will be invalid if the employee fails to complete the form in its entirety. A completed waiver is effective on the date it is signed by the employee and is valid for one year. Employees who wish to waive their rights for more than one year must sign a new waiver each year when the prior form expires.

Employees have the right to cancel the voluntary waiver during any period of annual open enrollment in the covered employer's employer sponsored plan or due to a qualifying life event.

An electronic signature is acceptable on the EXP Waiver form so long as:

1. The form is an exact replica of the official OLS EXP Waiver,
2. The employee can view the entire form at the sign time as they sign it (the information is not broken up into multiple click-through screens and/or the signature is not on a separate page), and
3. No language on the website suggests the employee must sign the form.

Employers must keep a copy of the signed form for record retention requirements. Employees are encouraged to keep a signed copy of the form.

38. **What if the employee continues to decline the expenditure, but refuses to sign the EXP Waiver form?**
In the event the employee refuses to sign the waiver and the employer seeks to show that the employee continued to decline the healthcare expenditure, the employer must have proof that the employee received the waiver and evidence that the employee continued to decline the healthcare expenditure. If the employer has the affirmative evidence of declination, the employer will be deemed to have satisfied the expenditure for that employee. In the absence of such affirmative evidence of declination, the employer shall provide the healthcare expenditure to the employee.

Examples of proof that the employee received the waiver include but are not limited to a written, sworn statement under penalty of perjury affirming that the Expenditure Waiver was given to the employee and the date upon which such service was made.

Examples of evidence of continued declination include but are not limited to:

- A written statement from the employee indicating that the employee declines the expenditure that is dated after the date the waiver was provided to the employee;
- The employee's refusal to authorize a payroll deduction for a premium payment after being given a reasonable opportunity to do so.

The employer must keep evidence of proof of service of the EXP Waiver and any evidence of continued declination for three years.

39. **Hypothetical Situation: An employer plans to meet their obligations through payments to an insurance carrier to provide health insurance to an employee and their spouse. The employee wants to enroll in the health insurance plan, but does not want to enroll their spouse in their employer's health insurance plan and, therefore, declines the expenditure in part. Their employer wants to honor the employee's desire to enroll themself and to decline spousal enrollment but doesn't want to violate the ordinance. What happens?**
In this situation, the employer can provide the employee with the OLS EXP Waiver and give them the opportunity to waive their right to the expenditure. If the employee signs the wavier or refuses to sign but continues to decline part of the expenditure, the employer will be deemed to have satisfied their obligations under this law. However, even though the employee has waived rights under this ordinance, the employer may still offer the employee the opportunity to individually enroll in the health insurance.

As noted before, a waiver of the right to an expenditure under this law is separate and distinct from a waiver of employer-sponsored health insurance. Nothing in this law prevents an employer from offering an employee employer-sponsored health insurance and nothing in this law requires an employer to offer or provide employees with health insurance.

40. What if the amounts paid toward any given method do not reach the minimum healthcare expenditure required by the law?
The employer must meet its full obligation to the employee for each month the employee is considered covered by the ordinance. If the payment toward one method does not cover the entire obligation, the employer must make up the difference via a different expenditure method.

Take this hypothetical example of a single employee who is owed the 2020 monthly expenditure of $420/month. The employer decides to meet its obligation to this employee through payments to a third-party insurance carrier to provide the employee with health insurance. However, the monthly premium only costs $400/month. The employer must make up the difference through one of the other methods to make up the $20 monthly shortfall. This could take the form of ordinary income payments or payments towards a tax-favored health program.

41. How does an employee know which rate applies to them?
On an annual basis, an employer must notify covered employees, including those who have previously waived their rights to the ordinance, of:
- The rate for which the employee is eligible,
- How an employee should notify the employer of a change that would impact the employee's rate,
- Which healthcare expenditure form(s) the employer will use to satisfy its obligations under the law, and
- If an employer uses payments into a tax-favored health plan to meet some or all of its obligations: information about the tax-favored health plan, how to access information about the plan, how to contact the plan administrator (if applicable), any carryover requirements, grace periods, and whether funds revert back to the employer at any time.

42. Is an employee owed a healthcare expenditure if they separate from employment before the end of the month?
Unless otherwise required by law or by contract, an employer is not obligated to make a final monthly required healthcare expenditure to or on behalf of an employee who separates from employment prior to the end of a calendar month.

Note: this only means the employer is not obligated to comply with the requirement of SMC 14.28 to make a healthcare expenditure for that final month; however, employers may be required by other laws, by contract, or their own policies to make payments (e.g. for an employee's health insurance premium, tax-favored health program, or to pay out claims as with self-funded health insurance programs).

Ordinary Income

43. What is ordinary income?
Ordinary income is compensation paid in cash, direct deposit, or check that can be converted into cash.

44. If an employer chooses to meet some or all its expenditure obligations by paying ordinary income to an employee, when is the amount due?
Whether the ordinary income payment satisfies all or a portion of the employer's expenditure obligation, this amount must be paid to the employee no later than the employee's last regular pay date of following calendar month. An employer may choose to make this ordinary income payment earlier, or more frequent, than once per month.

Payments to a Third-Party for Healthcare Services

45. What is a third-party payment? Which kinds of third-party payments qualify?
A third-party payment is a sum of money paid to a third-party that is made for the purpose of providing healthcare services to the employee or to the employee's spouse, domestic partner, or dependents (if applicable).

These kinds of third-party payments include, but are not limited to:

- Payments to an insurance carrier for health insurance coverage,
- Payments into a trust health plan, and
- Payments into a tax-favored health program that allows for reimbursement for out-of-pocket costs for healthcare services.

46. What is a tax-favored health program?

A tax-favored health programs includes programs like flexible spending arrangements, health reimbursement arrangement plans, health savings accounts, or substantially similar programs. For information about these kinds of tax-favored health plans, please visit the Internal Revenue Service website and look at the most current version of Publication 969.

47. When must the payment to a third-party be made?

The timing of the employer's payment to the third-party may vary depending on the contractual arrangement that the employer has with the third-party or on employee-specific situations. Regardless of the timing of the employer's payment to a third-party, the employee must receive the *benefit* of that expenditure every month that the employee is considered an employee covered by the ordinance.

For example:

- An employer may pay the health insurance carrier retroactively for multiple months of an employee's health insurance premium.
- An employer may pay a lump sum to a third-party for an employee's access to health services over multiple months.

Although the employer's payment was not made monthly, the employee received the benefit of that payment in each month that the employee was covered by the law.

48. How does an employer calculate a lump sum payment to a third-party that will provide healthcare services to an employee for multiple months?

If an employer makes a lump sum payment to a third-party that will provide healthcare services to the employee over multiple months, the employer may divide that sum by the number of months that the employee will be provided healthcare services.

Payments to an Employer's Self-funded Insurance Program

49. What is a self-funded or self-insured insurance program?

A self-funded insurance program (also known as a self-insured plan) is one where the employer assumes the financial risk for providing health care benefits for its employees. Employers pay for claims as they are presented instead of paying a pre-set premium to an insurance carrier. Because the amount of claims each year varies, an employer must use some method to estimate how much it must earmark to pay claims that are incurred during the year.

50. What is an "average per-capita" monthly expenditure for healthcare services by the employer's self-funded/insured program?

The "average per-capita monthly expenditures" means the average cost of healthcare services paid by the employer for each employee who participates in the same health plan during a plan year. This amount includes costs for participating spouses, domestic partners, and/or dependents. This amount does not include any premium payments made by employees or refunds or credits given to an employer at the end of the plan year. An employer may choose whether to base the "average per-capita monthly expenditures" on all participating employees in the plan or upon

only covered employees who participate in the plan. The "same health plan" means a plan with the same benefit design for each enrolled covered employee, including but not limited to the same co-pay requirements, out-of-pocket maximums, deductibles, coverage tiers, and eligibility criteria.

51. How does an employer with a self-funded plan determine if its expenditures meet or exceed the required rate for a given employee?

An employer may use the "monthly premium equivalent rate" (also known as a "premium budget rate") to estimate its average per-capita monthly expenditures. The "monthly premium equivalent rate" is the *expected* "average per-capita monthly expenditure."

An employer that obtains an actuarial certification that verifies that its "monthly premium equivalent rate" is an accurate and reasonable estimate of its "average per-capita monthly expenditures" may rely upon its estimate for the purposes of determining whether it has met its healthcare expenditure obligation for a given employee.

An employer that does not obtain an actuarial certification must conduct an audit at the end of the plan year to verify that covered employees received the expenditure owed. If the actual "average per-capita monthly expenditures" is less than its "monthly premium equivalent rate," the employer must make up the shortfall by contributing to one or more of the other forms set forth in SMC 14.28.060.B. The audit must be completed by the end of the third month following the end of the plan year.

52. What is a plan year?

A plan year is a calendar, policy, or fiscal year of benefits coverage as established by an employer's group health plan.

Notice, Posting, and Recordkeeping Requirements

53. What is the notice and posting requirement of this law?

Employers must display one of two notice of rights posters that OLS will make available for electronic download on its website. One of the posters is for employees of hotels (Notice of Rights for Hotel Employees) and one is for employees of ancillary hotel businesses (Notice of Rights for Employees of Ancillary Hotel Businesses). These posters contain the information that employers must post to comply with the notice and posting requirements of all four hotel employee protection laws (Seattle Municipal Codes 14.26-14.29).

Employers must display the poster at any workplace or job site their employees work, in a visible and accessible location. Employers must display the poster in English and in the primary languages of employees at that workplace. Employers must make a good-faith effort to determine the primary languages of employees to post posters in the correct languages.

54. Where can employers get these posters?

These posters are available electronically on the OLS website. OLS creates and updates these posters and will make them available for electronic downloading in English and other languages. Currently, OLS is unable to make printed versions available.

36. What if OLS does not have the poster(s) in a specific language?

To assist with employer compliance with the language requirements of the ordinance, OLS intends to translate posters in several languages. Employers are not required to provide these notices in languages other than English until OLS makes the necessary translation available. Employers are encouraged to notify OLS of the need for additional translations.

55. What records must an employer keep?

Employers must keep records that show compliance with the ordinance. These records must be kept for three years. At a minimum, these include:

- Proof of each required healthcare expenditure that was made each month to each current and former employee;
- Records related to Waiver Forms, including:
    a. Copies of any signed forms,
    b. Copies of signed cancellations (revocation) of waivers, and
    c. For Waivers described in SMC 14.28.060, evidence of proof of service of the waiver form and, when applicable, records proving that the employee continued to decline the healthcare expenditure.

Prohibition on Retaliation

56. Does the law prohibit retaliation?

Yes. Retaliation is illegal. Employers are prohibited from taking an adverse action against employees who assert or exercise their rights in good faith.

These rights include (but are not limited to):

- Asking questions about the law or the rights given by the law,
- Informing someone about potential or actual violations of the law,
- Filing a complaint with the Office of Labor Standards or participating in an investigation about potential or actual violations of the law,
- Talking to the Office of Labor Standards or coworkers about the rights granted by this law, and
- Informing other employees about their rights.

An employee is still protected from retaliation even if they are mistaken about the right afforded.

57. What is considered an *adverse action*?

An adverse action is some action that negatively impacts any aspect of employment, including pay, work hours, responsibilities, or other material change in the terms or condition of employment.

Some examples of adverse actions include: denying a job or promotion, demoting, terminating, failing to rehire after a seasonal interruption of work, threatening, penalizing, engaging in unfair immigration-related practice, filing of a false report with a government agency, changing employment status, or unlawfully discriminating against an employee.

Collective Bargaining Agreement Waiver

58. Can employees who are a party to a collective bargaining agreement waive the protections of this law?

Employees covered by a bona fide collective bargaining agreement may waive the protections of this law if the waiver is express, clear, and unambiguous and if the ratified agreement contains alternative safeguards that meet the goals of this law.

Seattle Office of Labor Standards

SEATTLE OFFICE OF LABOR STANDARDS
Seattle Human Rights Rules - Chapter 190

Practices for administering hotel employee protections under
Seattle Municipal Codes 14.26, 14.27, 14.28, and 14.29

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GENERAL PROVISIONS

SHRR 190-010 Purpose and applicability of Rules

These Rules (Chapter 190) govern the practices of the Seattle Office of Labor Standards in administering requirements for the following laws (collectively referred to as the "Hotel Employee Protections"):

1. Hotel Employees Safety Protections Ordinance, Seattle Municipal Code (SMC) 14.26;
2. Protecting Hotel Employees from Injury Ordinance, SMC 14.27;
3. Improving Access to Medical Care for Hotel Employees Ordinance, SMC 14.28; and
4. Hotel Employees Job Retention Ordinance, SMC 14.29.

SHRR 190-020 Practice where Rules do not govern

If a matter arises in administering these Hotel Employee Protections that is not specifically covered by these Rules, the Director of the Seattle Office of Labor Standards shall specify the practices to be followed.

SHRR 190-030 Construction of Rules

These Rules shall be liberally construed to permit the Seattle Office of Labor Standards to accomplish its administrative duties in implementing and carry out the purposes of the Hotel Employee Protections.

SHRR 190-040 Severability

These Rules are declared to be separate and severable. If any clause, sentence, paragraph, subdivision, section, subsection, or portion of these rules or the application thereof to any employer, employee, or circumstance, is held to be invalid, it shall not affect the validity of the remainder of these rules, or the validity of the application of the rules to other persons or circumstances.

EMPLOYEES

SHRR 190-050 Confidential Employee

The term "confidential employee," as used in SMCs 14.28 and 14.29, means an employee who assists and acts in a confidential capacity to persons who formulate, determine and effectuate management policies about labor relations or regularly substitute for employees that have such duties. Mere access to confidential labor relations material or personnel records does not make an employee a "confidential employee."

SHRR 190-060 Manager

The term "manager," as used in SMCs 14.28 and 14.29, means an employee who has authority to formulate, determine, and effectuate employer policies by expressing and making operative the decisions of the employer and who has discretion in the performance of their job independent of the employer's established policies.

SHRR 190-070 Supervisor

The term "supervisor," as used in SMCs 14.28 and 14.29, means any individual having authority, in the interest of the employer and in use of independent judgment, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibility to direct them, or to adjust their grievances, or effectively to recommend such action.

EMPLOYERS

SHRR 190-080 Joint employers

1. In general. "Employer" means any individual, partnership, association, corporation, business, trust, or any entity, person or group of persons, or a successor thereof, that employs another person and includes any such entity or person acting directly or indirectly in the interest of an employer in relation to an employee. More than one entity may be the "employer" if employment by one employer is not completely disassociated from employment by the other employer.

2. Joint employer. Separate entities may be treated as joint employers under the Hotel Employee Protection ordinances. Joint employers may be separate and distinct entities with separate owners, managers, and facilities.

3. Determination of joint employment. Determining whether employment is joint employment, or separate and distinct employment, depends upon all the facts in the particular case. Where the employee performs work that simultaneously benefits two or more employers, or works for two or more employers at different times during the workweek, a joint employment relationship generally will be considered to exist in situations such as:
   a. Where there is an arrangement between the employers to share the employee's services, as, for example, to interchange employees; or
   b. Where one employer is acting directly or indirectly in the interest of the other employer (or employers) in relation to the employee; or
   c. Where the employers are not completely disassociated with respect to the employment of a particular employee and may be deemed to share control of the employee, directly or indirectly, by reason of the fact that one employer controls, is controlled by, or is under common control with the other employer.

4. Joint and several liability. If the facts establish that the employee is jointly employed by two or more employers, all joint employers are responsible, both individually and jointly, for compliance with all of the applicable provisions of the law(s) with respect to the entire employment for the particular work week and pay period.

SHRR 190-090 Ancillary Hotel Business

1. Ancillary Hotel Businesses. The following Rules apply to the meaning of "ancillary hotel business" as defined in SMC 14.26.020, SMC 14.28.020, and SMC 14.29.020.

   a. Meaning of "business." The word "business," as used in the definition of "ancillary hotel business," means the portion of the business enterprise that provides services to guests or at the site of the hotel.

   b. Meaning of "services." The term "services," as used in SMCs 14.26.060, 14.28.020, and 14.29.020 and in these Rules, refers to the provision of a direct, specific benefit to a guest as opposed to an indirect benefit that serves the general welfare of guests. The sale of goods is not a "service."

   c. Meaning of "routinely contracts." A business that has an isolated and/or short-term business relationship will not be considered to "routinely contract" with the hotel. A business will not be considered to "routinely contract" if the business relationship is in existence for less than one year.

d. Meaning of "site of the hotel." The "site of the hotel" includes any building, structures, or grounds that are kept, used, maintained, advertised, or held out to the public to be a part of the hotel.

e. Entrance within the hotel premises. An ancillary hotel business has an entrance "within the hotel premises" when the entrance opens into the hotel premises and is promoted and used by the business's guests as an access point into the business. On the other hand, a passage that is promoted as and used by the business's customers to access a restroom facility located within the hotel premises is not considered an "entrance within the hotel." A sign identifying the business for purpose of navigation to and from the restroom facility is not "promoting" the business.

2. Hotel's Purpose. The following Rules apply to the meaning of "hotel's purpose" as defined in SMCs 14.26.020, 14.28.020, and 14.29.020.

a. Recreational Services. "Recreational services" include but are not limited to indoor and outdoor fitness and leisure activities.

b. Convention Services. "Convention services" are services related to the coordination and facilitation of a gathering of persons that meet for a common purpose. These services include but are not limited to event planning and coordination, provision of food and beverage, and facility set up and tear down.

PROTECTING HOTEL EMPLOYEES FROM VIOLENT OR HARASSING CONDUCT ORDINANCE – RULES SPECIFIC TO SMC 14.26

SHRR 190-100 Panic Button – Effectiveness Criteria

1. Effectiveness Criteria. An employer shall be considered to have violated its obligation to provide a panic button if the panic button fails to meet the effectiveness criteria set forth in SMC 14.26.020 and as further clarified by this Rule.

a. Easy activation. An employee must be able to easily activate the panic button. A panic button will not be considered "easy to activate" if it requires continued effort by the employee to sustain a signal or if activation is delayed as in situations where the employee must enter passcodes, click through multiple screens or applications, or wait for the system to turn on.

b. Employee's specific location. The panic button must provide enough information about the employee's location to allow responders to accurately identify their specific location.

c. Reliability. The panic button must reliably work in all locations that the employee performs their work and during all shifts that the employee works.

d. Signal clarity. The panic button's signal must be distinguishable from other sounds or other audible or visual alarms. The activation of one panic button must not obscure the activation of others.

SHRR 190-110 Panic button –Providing access to ancillary hotel business employees

A hotel employer must allow an employee of an ancillary hotel business to use the hotel's panic buttons when the employee works in, or makes deliveries to, one of the hotel's guest rooms. A hotel employer must inform the ancillary hotel business how to obtain and operate the hotel's panic buttons and of details of the hotel's response to an activated panic button. The hotel must promptly inform the ancillary hotel business of any change in this information.

SHRR 190-120 Guest Notification – Other means for special circumstances

1. Individual notice. Consistent with SMC 14.26.070.A.2, an employer must inform guests of its policy against violent or harassing conduct by guests prior to or at time of guest check in and through other means for special circumstances. Employers shall use a method reasonably designed to provide individual notice to guests. Examples of methods reasonably designed to provide individual notice:

    a. Verbal or written notification. An employer provides a written copy or verbally notifies guests of the hotel's policy at time of check-in.

    b. In-room guest materials. An employer may display a written policy in the guest room or include the policy in in-room welcome materials.

    c. Electronic notification. An employer may distribute the policy by electronic notification by a booking/reservation confirmation email, pre-booking terms of service, or booking/reservation confirmation webpage.

    d. Distribution to person other than guest ("guest agent"). An employer distributes the policy to a guest's agent and requires that the guest agent distribute the policy to the guest.

SHRR 190-130 Paid time – In additional to other required paid leave

The 16-hours referenced in SMC 14.26.090.A.4 must be provided in addition to any time provided pursuant to local, state, or federal paid sick and safe leave requirements, including but not limited to Seattle's Paid Sick and Safe Time Ordinance, SMC 14.16, the Domestic Violence Leave Act, RCW 49.76, and the Washington Minimum Wage Requirements and Labor Standards Act, RCW 49.46.

SHRR 190-140 Paid Time – Reasonable notice

1. Reasonable Notice. Consistent with SMC 14.26.090.A.5, an employer may require employees to give reasonable notice of an absence from work for the use of paid time for an authorized purpose under SMC 14.26.090.A.4. Employers may require employees to comply with the employer's notification policies, as long as such policies do not interfere with an employee's lawful use of this paid time.

    a. Advance notice for foreseeable leave. When the use of paid time is foreseeable, the employee shall make a reasonable effort to schedule the use of paid time in a manner that does not unduly disrupt the operations of the employer. And, an employee shall give advance oral or written notice of the employee's intention to take leave under SMC 14.26.090.A.4 as early as practicable in advance of the use of the paid leave.

    b. Notice for unforeseeable leave. If the need for paid leave is unforeseeable, the employee must provide notice as soon as possible before the required start time of their shift. The employee must generally comply with an employer's reasonable, normal notification policies and/or call-in procedures, unless it is not practicable to do so. In the event it is impracticable for the employee

to provide notice in compliance with the employer's normal policy and procedure, the employee, or a person on the employee's behalf, should provide notice to the employer. Such notice must be provided no later than the end of the first day that the employee takes such leave.

2. Inquiries into request for paid leave. If the employee does not volunteer sufficient information to identify their request as one for the use of paid leave granted under SMC 14.26 as opposed to a request for use of other paid leave, an employer may make a general inquiry as to whether the leave is granted by this ordinance. However, an employer may not ask the employee to explain, specify, or clarify the specific nature of the use. If an employer obtains any health information about an employee, the employer must treat such information in a confidential manner consistent with applicable privacy laws.

3. Conflict with other law. Nothing in this rule shall require an employer to violate requirements of Seattle's Paid Sick and Safe Time Ordinance, SMC 14.16, the Domestic Violence Leave Act, RCW 49.76, and the Washington Minimum Wage Requirements and Labor Standards Act, RCW 49.46.

SHRR 190-150 Other legal requirements

Nothing in this Chapter or in SMC 14.26 shall be construed to cause violations of RCW 19.48.020, which requires guest arrivals and departures to be recorded for one year, or to prevent an employer from disclosing records with identifying information about guests to comply with a lawful subpoena or court order.

PROTECTING HOTEL EMPLOYEES FROM INJURY ORDINANCE – RULES SPECIFIC TO SMC 14.27

SHRR 190-160 Strenuous room cleaning – 36-hour calculation

The start of the 36-hour period referenced in SMC 14.27.020 begins when a clean room is first occupied by a guest(s).

SHRR 190-170 Workday

A workday is a fixed and regularly recurring period of 24 hours. It may begin on any hour of the day. Once the beginning time of an employee's workday is established it remains fixed but may be changed if the change is intended to be permanent and is not designed to evade premium pay requirements or the health and safety policy goals of SMC 14.27. In the absence of a workday established by an employer, the workday automatically defaults to the 24-hour period starting at 12:00 a.m. and ending at 11:59 p.m.

SHRR 190-180 Team cleaning

1. Performing room cleaning together ("team cleaning"). As set forth in SMC 14.27.050, "if more than one employee performs the room cleaning together, the guest room floor space is divided equally based on the number of employees performing the room cleaning." Employees will be considered to have performed the room cleaning "together" if more than one employee contributed to completing the room cleaning.

2. Team cleaning – Voluntariness. Employers may only assign employees to perform team cleaning if the employee has agreed to perform team cleaning. An employer shall not imply or indicate that an employee must agree to team cleaning.

    a. Reasonable method for requesting. An employer may develop a reasonable system to determine whether an employee voluntarily agrees to team clean and to track the employee's consent or

refusal. Any approach taken must inform employees how to withdraw their consent and whether the agreement is time limited.

b. **Employee's right to refuse.** An employee may refuse an employer's request to perform team cleaning unless required for employee safety or by law as defined in SHRR 190-180.3.

c. **Withdrawal of consent**. An employee may withdraw their consent to team clean at any time unless it is a situation required for employee safety or by law as defined in SHRR 190-180.3. The employer shall give effect to that withdrawal no later than seven calendar days after the withdrawal or the employee's next work schedule occurring after the withdrawal, whichever is shorter.

d. **Employer's discretion**. An employer maintains its discretion to determine whether team cleaning will be performed and which consenting employees are assigned together.

e. **Records**. An employer must document an employee's consent to perform team cleaning and an employee's withdrawal of consent. An employer must retain this documentation for three years.

3. **Team cleaning – When required "for employee safety or by law."** In accordance with SMC 14.27.050, an employer may require multiple employees to perform team cleaning without their consent if such assignment is required "for employee safety or by law."

a. **Meaning of "required for employee safety."** Employers are permitted to assign team cleaning if it is required to preserve the employee's safety. For example, an employer may assign team cleaning if a room cleaning work task would likely cause injury if performed alone or in the situation where team cleaning is required to successfully assign an employee light duty in accordance with RCW 51.31.090. To the extent that training or performance coaching is required for employee safety, employers may assign team cleaning under these circumstances.

b. **Meaning of "required by law."** Employers are permitted to assign team cleaning if required to meet the requirements of a local, state or federal law. For example, if an employee's reasonable accommodation for a disability involves team cleaning, an employer's actions must comport with local, state, and federal employment discrimination laws (e.g. Seattle's Fair Employment Practices Law, SMC 14.04, Washington's Law Against Discrimination, RCW 49.60, and the Americans with Disabilities Act, 42 U.S.C. Chapter 126).

SHRR 190-190 Employee request to leave work early

SMC 14.27.050.H applies to situations when an employee's request to leave work early causes the employee to exceed the maximum floor space allowed by the ordinance.

INCREASING HOTEL EMPLOYEE'S ACCESS TO MEDICAL CARE ORDINANCE – RULES SPECIFIC TO SMC 14.28

SHRR 190-200 Definitions

1. **Definitions.** The following definitions apply to those terms as used in SMC 14.28 and SHRR 190-200-250.
   a. **Annual open enrollment.** "Annual open enrollment" is a period during which an individual may enroll or change health coverage.

b. **Dependents.** The term "dependent" means any person for whom the employee is allowed an exemption under the "qualifying child" or "qualifying relative" tests of the Internal Revenue Code, 26 U.S.C. §151-153.

c. **Domestic partner.** "Domestic partner" has the same meaning as set forth for "state registered domestic partners" in Revised Code of Washington 26.60.

d. **Ordinary income.** "Ordinary Income" means compensation paid in cash, direct deposit, or check that can be converted into cash.

e. **Plan year.** A "plan year" is the calendar, policy, or fiscal year of benefits coverage as established by an employer's group health plan.

f. **Special enrollment period.** "Special enrollment period" means a period during which an individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, health coverage outside of the initial and annual enrollment periods.

g. **Tax-favored health programs.** "Tax-favored health programs" include flexible spending arrangements, as defined by the Internal Revenue Code 26 USC §125, health reimbursement arrangement plans, as defined by 29 C.F.R. 54.9815-2711(d)(6)(i), health savings accounts, as defined by the Internal Revenue Code, 26 USC §223, or substantially similar programs.

h. **Workweek**. "Workweek" has the same meaning as set forth in the Washington Administrative Code 296-128-015.

SHRR 190-210 Employee Coverage – Calculating the 80-hour average

1. **Reasonable estimate of average.** To determine whether an employee works for an average of 80 hours or more per month, an employer must make a reasonable estimate of the average monthly work hours of an employee for the calendar year or over the course of the period of employment for employment that is less than a year. If that reasonable estimate shows that an employee is expected to work an average of 80 hours or more in a month, the employee is covered employee by SMC 14.28.

2. **Result of unreasonable estimate.** An employer's estimate will be deemed unreasonable if it results in an underestimation of the actual average hours worked by the employee over the calendar year or over the period of employment for employment that is less than a year. In this circumstance, the employer is responsible for making retroactive healthcare expenditures in the form of ordinary income to the employee plus interest.

3. **Prohibition on recovering overestimated expenditure.** If an employer's estimate results in an overestimation of the average work hours, an employer is prohibited from recovering any healthcare expenditures from the employee resulting from such overestimation.

4. **Separation from employment.** Unless otherwise required by law or by contract, an employer is not required to make a final monthly required healthcare expenditure to or on behalf of an employee who separates from employment prior to the end of a calendar month. "Separates from employment" means the end of the last day on which an employee is authorized or required by the employer to be on duty on the employer's premises or at a prescribed workplace.

SHRR 190-220 Employee Coverage Exclusions – Waiver, health coverage from another source

1. **SMC 14.28 Ordinance Voluntary Waiver Form ("Ordinance Waiver") – Requirements.** For an employee's waiver of the ordinance to be considered valid, all conditions set forth in SMC 14.28.030.B must be met, as well as the following conditions:
   a. Except for as set forth in SHRR 190-220.2, employers must use the Ordinance Waiver provided by the Office of Labor Standards. This Ordinance Waiver is available at the department's office or on its website at: www.seattle.gov/laborstandards.
   b. The employer may not alter the Ordinance Waiver in any manner or use other forms, including those provided by third-party vendors or health insurance carriers.
   c. The employee must be provided the Ordinance Waiver in the employee's primary language.
   d. The Form must be voluntarily completed in full by the employee without pressure or coercion from the employee's coworkers or the employer, including, supervisor(s), manager(s), or their agents.
   e. If any portion of the waiver is incomplete, the waiver is invalid.
   f. The employer may not state, suggest, or imply that the employee is required to sign the form.

2. **Electronic version of Ordinance Waiver.** Employers may use an electronic version of the Ordinance Waiver. For such a waiver to be valid, all the conditions described in SMC 14.28.030.B. and SHRR 190-220.1 must be satisfied, as well as the following conditions:
   a. The text of the electronic form must be identical to the Ordinance Waiver;
   b. The signature, electronic signature, or other authorization must be on the same screen as the text of the form, such that the employee can view the entirety of the form at the same time as the employee provides an electronic signature or authorization;
   c. The website containing the form may not state or imply that the employee is required to sign the form.

3. **Period of Effectiveness and Revocation.** An Ordinance Waiver is valid for one year after which the employee may choose to sign a new voluntary waiver. Employees may revoke their voluntary waiver during any period of annual open enrollment or due to a qualifying life event. The revocation must be in writing.

4. **Employer Records.** An employer must retain copies of all waivers and any written revocation of a waiver for three years.

SHRR 190-230 Determining an employee's healthcare expenditure rate

1. **Rates.** The rates set forth in SMC 14.28.060.A are based upon the presence or absence of a spouse, domestic partner, or dependent(s) regardless of whether that spouse, domestic partner, or dependent(s) is covered or eligible to be covered by an employer's group health plan.

2. Determination of rate. An employer must make reasonable efforts to obtain accurate information to determine the employee's rate. If an employer is unable to obtain the information to determine the employee's rate, the employer may assume that the employee falls into the rate for an employee with no spouse, domestic partner, or dependents, until otherwise notified by the employee. An employer may request that an employee notify them of a change that would impact their rate (e.g. divorce, marriage, addition or removal of a dependent). An employer's efforts to obtain this information must not violate local, State, or federal laws.

3. Employee notification. On an annual basis, an employer must notify covered employees, including employees who have previously waived as allowed by SMC 14.28.030.B.2 or 14.28.060.D, of the following information:
   a. the rate for which the employee is eligible;
   b. how an employee should notify the employer of a change that would impact the employee's rate;
   c. which healthcare expenditure form(s) the employer will use to satisfy its obligations under SMC 14.28;
   d. if an employer uses payments into a tax-favored health plan to meet some or all of its obligations: information about the tax-favored health plan, including: how to access information about the tax-favored health plan, how to contact the plan administrator (if applicable), any applicable carryover requirements, grace periods, and whether funds revert back to the employer at any time.

SHRR 190-240 Calculating and making healthcare expenditures

1. Full satisfaction required. Employers must make the full healthcare expenditure to or on behalf of each covered employee. If the contributions to one form, as described in SMC 14.28.060.B, do not satisfy the employer's entire obligation, an employer must contribute to one or more of the other forms.

2. Employer-paid portions. An employer may count only the employer's payments toward healthcare coverage or services for the employee or the employee's spouse, domestic partner, and/or dependents if the employee has a spouse, domestic partner, or dependents. Payments originating from the employee do not count toward an employer's obligation. These payments include but are not limited to premium payments paid by the employee and an employee's tax-deductible contributions into a tax-favored health plan.

3. Amounts otherwise required to be paid by federal, state, or local law. The required healthcare expenditure is in addition to, and shall not be deemed satisfied by, any amount otherwise required to be paid by federal, state or local law. These amounts include but are not limited to payments made to meet an employer's obligations under local, State, or federal minimum wage or compensation laws and regulations or payments made to directly or indirectly to obtain worker's compensation, unemployment insurance, disability insurance, Social Security, Medicare, and Washington's State Paid Family and Medical Leave.

4. Allowed administrative costs. Healthcare expenditures shall include administrative costs paid to a third party for the purpose of providing healthcare services or coverage for covered employees but shall not include administrative costs incurred by the employer, but not paid to a third party. Such costs are considered a business expense of the employer.

5. Deference to ERISA plan administration. Nothing in these rules is intended to supplant or alter any administrative scheme for a plan covered by the Employee Retirement Income Security Act, 29 USC Chapter 18.

6. Ordinary income paid directly to the employee - Timing. As set forth in SMC 14.28.060.E., each monthly payment of ordinary income must be made no later than the employee's last regular pay date of the following calendar month. Nothing shall prevent an employer from making payments earlier, or that are more frequent, than once per month.

7. Payments to a third-party for healthcare coverage or services. The following rules apply to healthcare expenditures satisfied in whole or in part by "payments to a third-party" as described in SMC 14.28.060.B.2.

    a. Timing - Benefit of expenditure. Regardless of the timing of the employer's payment to a third-party, the covered employee must receive the benefit of that expenditure every month that the employee is a covered employee. Nothing shall prevent an employer from making expenditures in advance of the month so that the employee may acquire healthcare services during the eligible month.

    b. Lump sum payments. If an employer makes a lump sum payment to a third-party that will provide healthcare services to the employee over multiple months, the employer may divide that sum by the number of months that the employee will be provided healthcare services for the purposes of determining the monthly healthcare expenditure.

8. Payments to a self-insured or self-funded insurance program. The following rules apply to monthly healthcare expenditures satisfied in whole or in part by "average per-capita monthly expenditures" as described in SMC 14.28.060.B.3.

    a. "Average per-capita monthly expenditures." "Average per-capita monthly expenditures" means the average cost of healthcare services, as defined in SMC 14.28.020, paid by the employer for each employee who participates in the same health plan during a plan year. This amount includes costs for participating spouses, domestic partners, and/or dependents. This amount does not include any premium payments made by employees or refunds or credits given to an employer at the end of the plan year. An employer may choose whether to base the "average per-capita monthly expenditures" on all participating employees in the plan or upon only covered employees who participate in the plan. For the purposes of this rule, the "same health plan" means a plan with the same benefit design for each enrolled covered employee, including but not limited to the same co-pay requirements, out-of-pocket maximums, deductibles, coverage tiers, and eligibility criteria.

    b. Calculation of average per-capita expenditures. An employer may use the "monthly premium equivalent rate" (also known as a "premium budget rate") to estimate its average per-capita monthly expenditures. The "monthly premium equivalent rate" is the *expected* "average per-capita monthly expenditure."

        i. Actuarial certification. An employer that obtains an actuarial certification that verifies that its "monthly premium equivalent rate" is an accurate and reasonable estimate of its

"average per-capita monthly expenditures" may rely upon its estimate for the purposes of satisfying its obligation as set forth in SMC 14.28.060.

ii. **End of plan year audit.** An employer that does not obtain an actuarial certification must conduct an audit at the end of the plan year to verify that covered employees received the expenditure owed. If the actual "average per-capita monthly expenditures" is less than its "monthly premium equivalent rate", the employer must make up the shortfall by contributing to one or more of the other forms set forth in SMC 14.28.060.B. The audit must be completed by the end of the third month following the end of the plan year.

SHRR 190-250 Healthcare expenditure – Waiver, employee declining expenditure

1. **SMC 14.28 Expenditure voluntary waiver form ("Expenditure Waiver") -- Requirements.** For an employee's waiver of a healthcare expenditure to be considered valid, all conditions described in SMC 14.28.060.D must be met, as well as the following conditions:
   a. Except for as set forth in SHRR 190-250.2, employers must use the Expenditure Waiver provided by the Office of Labor Standards. This Expenditure Waiver is available at the department's office or on its website at: www.seattle.gov/laborstandards.
   b. The employer may not alter the Expenditure Waiver in any manner or use other forms, including those provided by third-party vendors or health insurance carriers.
   c. The employee must be provided the Expenditure Waiver in their primary language.
   d. The employer must fully and accurately complete the portions of the Expenditure Waiver designated for the employer.
   e. An employee may not be pressured or coerced into signing the waiver by the employee's coworkers or the employer, including, supervisor(s), manager(s), or their agents.

2. **Electronic version of Expenditure Waiver.** Employers may use an electronic version of the Expenditure Waiver. For such a waiver to be valid, all the conditions described in SMC 14.28.060.D. and SHRR 190-250.1 must be satisfied, as well as the following conditions:
   a. The text of the electronic form must be identical to the Expenditure Waiver;
   b. The signature, electronic signature, or other authorization must be on the same screen as the text of the form, such that the employee can view the entirety of the form at the same time as the employee provides an electronic signature or authorization;
   c. The website containing the form may not state or imply that the employee is required to sign the form.

3. **Evidence of continued declination required.** In the event the employee refuses to sign the waiver and the employer seeks to show that the employee continued to decline the healthcare expenditure, the employer must have proof that the employee received the waiver and evidence that the employee continued to decline the healthcare expenditure. In the absence of such affirmative evidence of declination, the employer shall provide the healthcare expenditure to the employee.

   a. Examples of proof that the employee received the waiver include but are not limited to a written, sworn statement under penalty of perjury affirming that the waiver meeting the requirements set forth in SHRR 190-250.1 was given to the employee and the date upon which such service was made.

b. Examples of evidence of continued declination include but are not limited to:
   i. A written statement from the employee indicating that the employee declines the expenditure that is dated after the date the waiver was provided to the employee;
   ii. the employee's refusal to authorize a payroll deduction for a premium payment after being given a reasonable opportunity to do so.

4. Period of Effectiveness and Revocation. An Expenditure Waiver is valid for one year. Employees may revoke their voluntary waiver during any period of annual open enrollment or due to a qualifying life event. The revocation must be in writing.

5. Employer Records. An employer must retain copies of all waivers, evidence of proof of service and continued declination as described in SHRR 190-250.3, and written revocation of a waiver for three years.

6. Offer of employer-sponsored health insurance. Nothing in these rules shall prevent an employer from offering an employee employer-sponsored health insurance in the event that an employee waives the employer's offer of the monthly required healthcare expenditure as set forth in SMC 15.28.060.D. This ordinance also does not require an employer to offer or provide employees with health insurance.

   a. Example: An employee is eligible for the healthcare expenditure rate for an employee with spouse. The employer's plan to meet the monthly healthcare expenditure involves payments to a third party to provide health insurance to the employee and their spouse. The employee's spouse does not wish to receive employer-sponsored health insurance, but the employee does. The employee chooses to waive the employer's offer of healthcare expenditure and their rights under the law. Even though the employee has waived rights under SMC 14.28, the employer may still offer the employee the opportunity to individually enroll in the health insurance.

HOTEL EMPLOYEES JOB RETENTION ORDINANCE – RULES SPECIFIC TO SMC 14.29

SHRR 190-260 Meaning of seniority

"Seniority," as used in SMC 14.29.060.B.2 and 14.29.060.E.1, is determined by the employee's seniority within their most recent classification. If the employee's classification seniority is unavailable to the incoming employer, the employee's seniority is determined by the employee's start date of hire as indicated on the outgoing employer's preferential hiring list.

SHRR 190-270 Offer of employment - Ten business days calculation

1. Business Day. "Business day" means a day upon which normal business operations are conducted by the employer.

2. Delivery by personal service or in-person delivery. If the written offer of employment is delivered in person, the ten-business day period referenced in SMC 14.29.060.C begins on the day following the day the written offer is hand delivered to the employee.

3. Email or electronic delivery. If the written offer of employment is delivered by email or other electronic delivery, the ten-business day period referenced in SMC 14.29.060.C begins on the day following the day the written offer is emailed to the employee.

4. By mail, mail delivery service, or mailbox. If the written offer of employment is delivered by mail or mail delivery service, or left in a mailbox for pickup by the U.S. Postal Service, the ten-business days period referenced in SMC 14.29.060.C begins on the third day following the day the written offer is placed in the mail or mailbox, or provided to the mail delivery service.

SHRR 190-280 Discharge from employment for just cause

"Discharge for just cause," as referenced in SMC 14.29, requires that a fair and objective investigation produced evidence that the employee violated a reasonable and consistently applied workplace standard of which the employee knew or reasonably should have known, and that discharge was reasonably related to the seriousness of the employee's conduct and was the consistently applied punishment for a violation of that workplace standard.

NOTICE, POSTING, AND REQUIRED NOTIFICATIONS

SHRR 190-290 Translation requirements

1. Primary language. "Primary language" means the language in which the employee feels most comfortable communicating. Employers shall make a good faith effort to determine the primary languages of employees at the particular workplace.

2. Employers.
   a. Notices. Employers shall provide the notices and documents required by the following ordinances in English and any language that the employer knows or has reason to know is the primary language of the employee(s) at the particular workplace:
      i. Notice of hotel employee rights, SMC 14.26.100.A.1, SMC 14.26.100.A.3, SMC 14.27.100.A.1., SMC 14.28.100.A.1, and SMC 14.29.100.A.1;
      ii. Notice of community and crime victim advocate services, SMC 14.26.100.A.2; and
      iii. The waivers and notice of rights referenced in SMC 14.28.030.B.2 and 14.28.060.D.2.

   b. Policy. As required by SMC 14.26.070.A, employers are required to provide the written policy against violent or harassing guest conduct in English. OLS encourages employers to provide notice to the employee and the customer in their primary language(s).

3. Office of Labor Standards. To facilitate employer compliance with translation requirements, OLS shall create and make available translated versions of the documents outlined in SHRR 190-290.2.a. Employers are not required to provide these documents in languages other than English until OLS makes the necessary translation available. Employers are encouraged to notify OLS of the need for additional translations.

INDIVIDUAL WAIVER AND COLLECTIVE BARGAINING AGREEMENT WAIVERS

SHRR 190-300 Individual employee waiver

1. Where prohibited. Any waiver by an individual employee of any provisions of SMC 14.26, SMC 14.27, or SMC 14.29 shall be deemed contrary to public policy and shall be void and unenforceable.

2. Where permissible. An individual employee may waive provisions of SMC 14.28 provided that all required steps outlined in SMC 14.28 and in these Rules are satisfied. See SMC 14.28.030.B. and SHRR 190-220, and 14.29.060.D and SHRR 190-250.

SHRR 190-310 Collective bargaining agreement waiver

1. **Where prohibited.** Any waiver by a party to a collective bargaining agreement of any provisions of SMC 14.26 shall be deemed contrary to public policy and shall be void and unenforceable.

2. **Where permissible.** The requirements under SMCs 14.27, 14.28, and 14.29 shall not apply to any employees covered by a bona fide collective bargaining agreement to the extent that the agreement contains a clear and unambiguous waiver, is ratified by the employees, and contains alternative safeguards that meet the public policy goals of the law being waived. A clear and unambiguous waiver also may be contained in an addendum to an existing agreement, including an agreement that is open for negotiation.

    a. **Clear and unambiguous terms.** A clear and unambiguous waiver must reference the ordinance by name and citation and reference the specific provision or provisions that are being waived by the collective bargaining agreement.

    b. **Impasse.** A waiver contained in a collective bargaining agreement implemented by an employer after a bargaining impasse does not constitute a valid waiver of these ordinances.

NON-DISCLOSURE

SHRR 190-320 Non-disclosure

1. **Non-disclosure.** In accordance with SMC 14.26.150.B.1, SMC 14.27.150.B.1, SMC 14.28.150.B.1, SMC 14.29.150.B.1, information that would tend to identify complainants, victims, or witnesses who have furnished information to the Seattle Office of Labor Standards regarding alleged violations of law and who have requested non-disclosure at the time of the complaint shall be protected from disclosure, to the maximum extent permitted by applicable laws, except as provided in SHRR 190-320.2.

2. **Agreement to disclose.** Unless otherwise required by law, or valid disclosure has been made by other means, the identification of persons described in SHRR 190-320.1 may only be disclosed under these Rules pursuant to an agreement to disclose such information between the person to be identified and the Director.

ENFORCEMENT

SHRR 190-330 Practice and procedure for enforcement of ordinances

The enforcement practices and procedures for these ordinances are determined by the Seattle Office of Labor Standards Rules, Chapter 140.

EFFECTIVE DATE OF RULES

SHRR 190-340 Effective date

These Rules shall take effect on date that they are filed with the City of Seattle Clerk or July 1, 2020, whichever is earlier.