No. _____

In the
Supreme Court of the United States

THE ERISA INDUSTRY COMMITTEE,
Petitioner,

v.

CITY OF SEATTLE,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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January 14, 2022

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QUESTION PRESENTED

The Employee Retirement Income Security Act of 1974 (ERISA) preempts all state and local laws that "relate to" employee-benefit plans covered by ERISA. 29 U.S.C. §1144(a). This broad preemption provision encourages employers to offer employee benefit plans by eliminating the costs and complications of tailoring plans to the local policy preferences of every jurisdiction in which they operate. State and local governments, however, have tried to circumvent ERISA preemption by enacting what are commonly called "play-or-pay" laws. These laws unapologetically dictate the content of ERISA plans, but they purport to avoid preemption by deeming employers in compliance if, instead of altering their ERISA plans, they cut a check in the same amount directly to their employees or the local government.

The Seattle ordinance here is just such a law; it mandates that primarily out-of-state employers in the hotel sector make specified monthly healthcare expenditures on behalf of their covered local employees. Employers can comply by creating new ERISA plans, increasing contributions to their existing ERISA plans, or making payments directly to their covered employees. In the decision below, the Ninth Circuit reaffirmed an entrenched circuit split by holding that the direct-payment option saves Seattle's employee-benefits law from preemption.

The question presented is:

Whether state and local play-or-pay laws that require employers to make minimum monthly health-care expenditures for their covered employees relate to ERISA plans and are thus preempted by ERISA.

CORPORATE DISCLOSURE STATEMENT

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.

STATEMENT OF RELATED PROCEEDINGS

This case arises from and is related to the following proceedings in the U.S. District Court for the Western District of Washington and the U.S. Court of Appeals for the Ninth Circuit:

- *The ERISA Industry Committee v. City of Seattle*, No. 18-cv-1188 (W.D. Wa.), judgment issued May 11, 2020
- *The ERISA Industry Committee v. City of Seattle*, No. 20-35472 (9th Cir.), judgment issued March 17, 2021

There are no other proceedings in state or federal trial or appellate courts directly related to this case within the meaning of this Court's Rule 14.1(b)(iii).

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Rule

Other Authorities

PETITION FOR WRIT OF CERTIORARI

ERISA reflects a compromise designed to protect the integrity of employee-benefit plans while not dissuading employers from offering those plans in the first place. To achieve these dual ends, ERISA pairs comprehensive federal rules concerning fiduciary responsibility, reporting, and disclosure with a broad preemption provision designed to free employers from the burden of tailoring their plans and their conduct to the local policy preferences of each jurisdiction in which they operate. In particular, ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. §1144(a). ERISA thus enables employers to administer uniform and comprehensive nationwide benefit plans.

ERISA plainly preempts state and local laws that mandate the ongoing provision of ERISA-covered benefits. A law that simply told national employers to increase their plan's health benefits for local employees would be a non-starter. Such laws obviously "relate to" those plans and contravene Congress' judgment that employers should remain "free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995). But the temptation to advance the interests of local workers at the expense of national employers remains a strong one. Thus, several states and localities have turned in recent years to what are commonly called "play-or-pay" laws. These laws brazenly mandate the provision of certain levels of ERISA-covered benefits, but they also deem employers in compliance if they cut

a check in the same amount directly to their employees or to the government (the "or-pay option"). These laws purport to escape preemption because they provide employers with one option for compliance that supposedly does not require creating or altering an ERISA plan (*i.e.*, making direct cash payments).

The argument that merely offering an or-pay option suffices to render such laws unrelated to ERISA plans seems fanciful, but it nonetheless has given rise to an entrenched circuit split. In *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180 (4th Cir. 2007), the Fourth Circuit held that ERISA preempted a Maryland play-or-pay law, explaining that even the direct-payment option interfered with uniform nationwide plan administration by requiring employers "to keep an eye on conflicting state and local minimum spending requirements and adjust [their] healthcare spending accordingly." *Id.* at 196-197. Shortly thereafter, in *Golden Gate Restaurant Association v. San Francisco*, 546 F.3d 639 (9th Cir. 2008), the Ninth Circuit found a materially identical San Francisco law not preempted. That decision prompted an eight-judge dissent from denial of *en banc* review, observing that "[t]he holdings of *Fielder* and *Golden Gate* stand in clear opposition, and create a circuit split on the issue of whether ERISA preempts 'fair share' or 'play-or-pay' ordinances." *Golden Gate Rest. Ass'n v. San Francisco*, 558 F.3d 1000, 1004 (9th Cir. 2009) (M. Smith, J., dissenting from denial of rehearing).

The *Golden Gate* decision prompted a petition for certiorari, a call for the views of the Solicitor General, and a brief for the United States acknowledging the

circuit conflict but urging denial because it opined that the just-enacted Affordable Care Act (ACA) would make state and local governments unlikely to enact new employer spending requirements. Like many predictions about the ACA, this one proved mistaken. After an initial lull, play-or-pay laws have returned, as the incentives to enhance the health benefits of local employees by imposing new requirements on employers principally headquartered elsewhere have proven irresistible. Exhibit A is the Seattle play-or-pay ordinance upheld by the Ninth Circuit here, which requires large hotels and related businesses to make minimum monthly expenditures for their Seattle employees' healthcare, either by altering their ERISA plans or directly paying their employees an equivalent amount. Exhibit B is the amicus brief filed below by a group of major cities—including Los Angeles, San Francisco, Chicago, Austin, and St. Paul—who confess that "[t]he ACA has not reduced" their desire to regulate health benefits and proclaimed their intent to follow Seattle's lead. Br. of Amici Curiae San Francisco, et al. 28 (9th Cir. Nov. 4, 2020) ("Cities Brief"). And Exhibit C is the expansion of play-or-pay laws to other ERISA-covered benefits, which has caused the circuit split to deepen. *Merit Constr. All. v. City of Quincy*, 759 F.3d 122, 131 (1st Cir. 2014) (holding that ERISA preempts regulation of apprentice training programs).

This entrenched circuit split is especially problematic given that national uniformity is the *raison d'être* of ERISA's broad preemption provision and the Ninth Circuit's reasoning is so obviously flawed. No one doubts that state and local laws forcing national employers to provide greater benefits

to local employees via ERISA plans relate to those ERISA plans and are preempted. States and localities cannot avoid preemption through the simple expedient of adding an or-pay option. Such laws still prevent employers from administering uniform and comprehensive national benefit plans and still impermissibly reference ERISA plans given the reality that most covered employers have pre-existing ERISA plans that localities expect them to modify to come into compliance. Congress' purposefully broad "relates-to" standard for express preemption plainly covers such obvious efforts to thwart Congress' will. Indeed, it is no accident that the Ninth Circuit invoked the presumption against preemption to reach its misguided conclusion, even though this Court and other circuits have made clear that the presumption provides no grounds to narrow the sweep of an express preemption clause. *See, e.g.*, *Puerto Rico v. Franklin Cal. Tax-Free Trust*, 579 U.S. 115, 124-25 (2016).

The importance of this issue cannot be overstated. By allowing Seattle to impose burdensome, locality-specific obligations on employers, the decision below threatens a return to the pre-ERISA state of affairs, when employers faced the prospect of overlapping and conflicting regulations across the country. Congress recognized that such patchwork regulation was unacceptable, and it responded with a uniform federal regulatory scheme and "what may be the most expansive express pre-emption provision in any federal statute." *Gobeille v. Liberty Mut. Ins. Co.,* 577 U.S. 312, 327 (2016) (Thomas, J., concurring). The Ninth Circuit's continued refusal to properly enforce that provision renders ERISA's promise of uniformity illusory. This Court should grant certiorari to correct

that deeply flawed interpretation and restore much-needed uniformity to this area of the law.

OPINIONS BELOW

The Ninth Circuit's opinion is available at 840 F.App'x 248 and is reproduced at App.1-3. The district court's opinion is available at 2020 WL 2307481 and is reproduced at App.5-20.

JURISDICTION

The Ninth Circuit entered its judgment on March 17, 2021, and denied a timely petition for rehearing on September 1, 2021. On October 22, 2021, Justice Kagan granted an application to extend the deadline for filing a petition for certiorari to January 14, 2022. This Court has jurisdiction under 28 U.S.C. §1254(a).

STATUTORY PROVISIONS INVOLVED

ERISA's preemption provision provides, in relevant part: "[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).

Seattle Municipal Code 14.28 is included in the appendix.

STATEMENT OF THE CASE

A. Statutory Background

ERISA comprehensively regulates employers' provision of benefits to their employees. Instead of mandating certain minimum benefits, ERISA creates a uniform regulatory scheme to govern whatever benefits employers choose to provide. Congress recognized that employers who commit to paying employee benefits must "undertake[] a host of obligations, such as determining the eligibility of

claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). The "most efficient way" for an employer to satisfy these obligations "is to establish a uniform administrative scheme" for all of its employees nationwide, but establishing a comprehensive and uniform scheme is impossible if benefits are "subject to differing regulatory requirements in differing States." *Id.*; *see id.* at 13 (discussing importance of allowing employers to "maintain[] a single administrative scheme" for employee benefits). Accordingly, Congress included in ERISA an express preemption provision that broadly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. §1144(a). This preemption provision ensures that employers are not subject to conflicting regulations across multiple jurisdictions and that plan resources are devoted to the provision of benefits rather than to administrative compliance.

This Court has repeatedly emphasized the "expansive" nature of this preemption provision, noting that its "relate to" language sweeps with extraordinary breadth. *E.g.*, *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). Under ERISA's preemption provision, a law "relate[s] to" an employee-benefit plan if it "has a connection with or reference to such a plan." *Id.* at 656. A law has an impermissible "connection with" ERISA plans if it "mandate[s] employee benefit structures or their administration," *id.* at 658, or if it "interferes with nationally uniform plan

administration," *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 148 (2001). A law makes forbidden "reference to" ERISA plans when it "acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation." *Gobeille,* 577 U.S. at 319-20.

B. Factual Background

In September 2019, the Seattle City Council passed SMC 14.28 (the "Ordinance"), which requires covered employers to make minimum monthly healthcare expenditures on behalf of their covered employees. Covered employers are those who own, control, or operate a hotel in Seattle with more than 100 guest rooms, or who own, control, or operate an "ancillary hotel business" in Seattle and have 50 or more employees worldwide. SMC 14.28.020, 14.28.040. An "ancillary hotel business" is one 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." SMC 14.28.020. Covered employees are those who work for a covered employer "for an average of 80 hours or more per month" and are not managers, supervisors, or "confidential employee[s]." SMC 14.28.030.A, 14.28.030.B. The Ordinance's stated 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." SMC 14.28.025.

The mandated minimum monthly contributions vary depending on each covered employee's family composition. Subject to adjustments for inflation, the mandated monthly amounts for 2022 range from $459 for employees with no spouse and no dependents to $1,375 for employees with a spouse and one or more dependents. SMC 14.28.060.A; *see* Seattle Off. of Lab. Standards, *Improving Access to Medical Care for Hotel Employees Ordinance Fact Sheet* 2 (Sept. 15, 2021), https://bit.ly/3Gk50IT. To determine which rate applies to which employees, employers must "make reasonable efforts to obtain accurate information" about their employees' family composition. Seattle Off. of Lab. Standards, *Improving Access to Medical Care for Hotel Employees Ordinance Q&A* 7 (June 22, 2020), https://bit.ly/3Gk1Nci ("Seattle Q&A").

The Ordinance's relation to employee benefits and ERISA plans is obvious. Covered employers have three options to comply with the mandate. First, employers may make the minimum monthly payments to a third party, such as an insurance carrier, "for the purpose of providing healthcare services" to covered employees. SMC 14.28.060.B Second, employers may include covered employees in a self-funded healthcare plan such that average per-capita monthly expenditures for the covered employees matches or exceeds the mandated minimum. *Id.* Third, employers may make direct monthly payments in the required amounts to their covered employees. *Id.* The first two options pre-suppose an existing ERISA plan, whether provided by an insurance carrier or self-funded, and the third option envisions a direct payment outside such existing plans. In other words, employers can comply

either by making expenditures in connection with their existing ERISA plans or by making ongoing payments to employees in an equivalent amount. The employer may combine more than one of these options, *e.g.*, by making a portion of the mandated expenditures into an ERISA plan and paying the remainder directly to covered employees. *Id.*

Consistent with the ongoing obligations imposed by the Ordinance, employers must retain, for three years, records documenting their compliance, including "[p]roof of each required healthcare expenditure made each month to or on behalf of each current and former employee," "[c]opies of waiver forms," and "other records that are material and necessary." SMC 14.28.110. If the employer fails to retain those records, "there shall be a presumption, rebuttable by clear and convincing evidence, that the employer violated this Chapter 14.28." SMC 14.28.110. Employers who violate the Ordinance are subject to an array of remedial measures, including "payment of unpaid compensation, liquidated damages, civil penalties, penalties payable to aggrieved parties, fines, and interest." SMC 14.28.170.

C. Procedural History

Petitioner is a national nonprofit organization advocating exclusively for large plan sponsors that provide health, retirement, paid leave, and other benefits to their nationwide workforces. Petitioner challenged the Seattle Ordinance, arguing that it is preempted by ERISA as applied to Petitioner's member companies. Among other things, Petitioner argued: 1) the Ordinance impermissibly relates to

ERISA plans because all three options, including the or-pay alternative, require altering or creating ERISA plans; 2) the Ordinance has an impermissible "connection with" ERISA plans because its requirements interfere with nationally uniform plan administration; and 3) the Ordinance makes numerous forbidden "reference[s] to" ERISA plans. The district court and the Ninth Circuit both held that Petitioner's claims were foreclosed by the Ninth Circuit's earlier decision in *Golden Gate*, 546 F.3d 639. App.2, 20.

Like this case, *Golden Gate* involved a preemption challenge to a local ordinance that required employers to make mandatory minimum healthcare payments on behalf of their covered employees. *Golden Gate*, 546 F.3d at 643. Employers could comply by making the mandatory payments as contributions to ERISA-covered healthcare plans, by making payments in the same amounts directly to the city, or through any combination of the two. *Id.* at 645. The city would use any direct payments to fund a city-administered healthcare program for which the employees would be eligible. *Id.* at 642-43.

The Golden Gate Restaurant Association challenged the ordinance as preempted by ERISA. The district court agreed and enjoined the employer spending requirement. *Golden Gate Rest. Ass'n. v. San Francisco*, 535 F.Supp.2d 968 (N.D. Cal. 2007). The city appealed, and notwithstanding the Secretary of Labor's amicus participation on behalf of the employers, the Ninth Circuit reversed. The *Golden Gate* panel began its analysis by stating that "[t]he presumption against preemption applies in ERISA

cases." 546 F.3d at 647. Relying on the presumption, the panel held that ERISA did not preempt the San Francisco ordinance. The panel first held that the ordinance did not require employers to alter or create ERISA plans, explaining that the city-payment option "do[es] not create an ERISA plan" because "an employer has no responsibility other than to make the required payments for covered employees, and to retain records to show that it has done so." *Id.* at 650. This burden, the court opined, "is not enough, in itself, to make the payment obligation an ERISA plan." *Id.*

The challenger also argued that the ordinance was preempted because it had both a "connection with" ERISA plans and made "reference to" ERISA plans. The panel rejected those arguments as well. According to the panel, the ordinance did not have a "connection with" ERISA plans because an employer "may fully discharge its expenditure obligations by making the required level of employee health care expenditures … to the City" outside of its existing ERISA plan. *Id.* at 655-56. The panel opined that the ordinance did not undermine plan uniformity because even though it imposes locality-specific obligations to "make expenditures on behalf of covered employees and … maintain records to show that they have complied with the Ordinance," those burdens fall "on the employer rather than on an ERISA plan." *Id.* at 657.

The panel then held that the ordinance does not have a forbidden "reference to" ERISA plans. The district court had held that the ordinance "is akin to the statute the Supreme Court found preempted in *District of Columbia v. Greater Washington Board of*

Trade[, 506 U.S. 125 (1992),] which required the employer to provide the same amount of health care coverage for workers eligible for workers compensation" as it provided for its other workers. *Id.* at 658. But the panel distinguished *Greater Washington* because the scope of the employer's obligations there "were measured by reference to the level of *benefits* provided by the ERISA plan to the employee," whereas the scope of the employer's obligations under the San Francisco ordinance were "measured by reference to the *payments* provided by the employer to an ERISA plan." *Id.* Relying on that benefits-payments distinction, the panel held that the ordinance's obligations were not determined "by 'reference to' an ERISA plan." *Id.*

The panel denied that its holding created a circuit split with the Fourth Circuit's decision in *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180 (4th Cir. 2007), which had found a similar Maryland law preempted. The panel deemed *Fielder* distinguishable because in that case, no rational employer would ever choose the state-payment option (which did not directly inure to the employees' benefit), meaning that any employer's only meaningful choice for compliance was to alter or create ERISA plans. *Golden Gate*, 546 F.3d at 659-60. The panel did not, however, address *Fielder*'s alternative holding that the law was preempted because it would interfere with "uniform nationwide" plan administration by requiring employers "to keep an eye on conflicting state and local minimum spending requirements and adjust [their] healthcare spending accordingly." *Fielder*, 475 F.3d at 196-97.

The employers petitioned for rehearing *en banc*, again with the Labor Department's support. The court denied rehearing over an eight-judge dissent. The dissenting judges explained that the panel's decision "creates a circuit split with the Fourth Circuit Court of Appeals, renders meaningless the tests the Supreme Court set out in [*Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983)], conflicts with other Supreme Court cases establishing ERISA preemption guidelines, and, most importantly, flouts the mandate of national uniformity in the area of employer-provided healthcare that underlies the enactment of ERISA." *Golden Gate*, 558 F.3d at 1004 (M. Smith, J., dissenting from denial of rehearing). According to the dissenting judges, the panel's decision allowed "San Francisco to create an ordinance that effectively requires ERISA administrators to master the relevant laws of 50 States—which in turn undermines the congressional goal of minimizing the administrative and financial burdens on plan administrators." *Id.* (alterations omitted).

The challenger petitioned for certiorari, and this Court called for the views of the Solicitor General. *Golden Gate Rest. Ass'n v. San Francisco*, 558 U.S. 811 (2009). The Solicitor General acknowledged that the Labor Department supported the challengers in the court of appeals by arguing both that "an employer utilizing the city-payment option establishes an ERISA-covered plan for its employees" and that the ordinance's spending requirements "interfere with the uniformity of plan administration." Br. for the United States 10-11, *Golden Gate Rest. Ass'n v. San Francisco*, No. 08-1515 (U.S. May 26, 2010). The Solicitor General further acknowledged that "the

reasoning contained in [the Fourth Circuit's decision] is in tension with reasoning in the decision below." *Id.* at 17. However, because of the belief that the just-enacted Affordable Care Act would "reduce substantially the likelihood that state and local governments will choose to enact new employer spending requirements like those contained in San Francisco's [ordinance]," the Solicitor General opined that "[t]he preemption issue does not warrant this Court's review at this time." *Id.* at 13-14. This Court denied certiorari. *Golden Gate Rest. Ass'n v. San Francisco*, 561 U.S. 1024 (2010).

REASONS FOR GRANTING THE PETITION

This case presents an excellent vehicle to resolve an entrenched and increasingly relevant split of authority over whether ERISA preempts state and local efforts to regulate employee-benefit plans through play-or-pay laws. In the decision below, the Ninth Circuit held that local governments can transform obviously preempted regulations of ERISA plans into valid mandates for additional benefits for local workers by the simple expedient of adding an or-pay option. The Ninth Circuit's decision squarely conflicts with the Fourth Circuit's decision in *Fielder*, which held that ERISA preempts a materially identical play-or-pay law because the law relates to ERISA plans and would interfere with uniform nationwide plan administration. The Ninth Circuit's ruling likewise conflicts with the First Circuit's decision in *Merit Construction*, which held that ERISA preempted a play-or-pay law regulating apprentice programs. Certiorari is thus warranted because the decision below conflicts with "the decision of another

United States court of appeals on the same important matter." S. Ct. R. 10(a).

Certiorari is also warranted because the decision below "conflicts with relevant decisions of this Court," S. Ct. R. 10(c); indeed, it does so three times over. First, like the law this Court invalidated in *Egelhoff*, the Ordinance has an impermissible "connection with" ERISA plans because it interferes with nationally uniform plan administration. Instead of directing their plan administrators to provide self-determined benefits in accordance with their nationwide plan documents, employers must now do Seattle's bidding and create Seattle-specific administrative schemes to ensure compliance with the Ordinance's complex and detailed requirements. Second, just like the law this Court invalidated in *Greater Washington*, the Ordinance makes forbidden "reference to" ERISA plans. The Ordinance cannot ignore that virtually all of the national hotel chains and related national employers targeted by the law have existing ERISA plans. Thus, the Ordinance explicitly ties mandated expenditures, effective dates, waiting periods, waiver procedures, and more to the terms of the employer's existing ERISA plan, meaning that covered employers cannot determine their compliance without referencing their existing ERISA plans. Third, the decision below conflicts with this Court's recent precedents regarding the presumption against preemption, *see Franklin*, 579 U.S. at 124-25, which have made clear that no such presumption applies in cases, like this one, involving an express preemption provision.

A circuit split over the meaning of a federal statute would be undesirable in any circumstance, but it is especially problematic in the context of ERISA's preemption provision—the entire purpose of which is to provide nationwide uniformity for plans and plan sponsors. The lack of uniform and settled law about whether and when ERISA preempts play-or-pay laws leaves plans and plan sponsors in an intractable bind, as they are left to guess which such laws will be enforced (and therefore must be followed) and which such laws will be preempted (and therefore can be ignored). Moreover, circuit split aside, the viability of play-or-pay laws is immensely important to employers across the nation. The temptation for localities to benefit local workers at the expense of national employers is real, and municipalities across the nation have not been bashful about their interest in joining Seattle's efforts. If the decision below is left standing, it will portend a return to the "bad old days" before ERISA's enactment, when an emerging patchwork of state and local regulation threatened to saddle employers with massive administrative costs that would inevitably lead to a reduction in overall benefits. This Court's intervention is necessary to restore a uniform interpretation of ERISA and to rein in state and local efforts to undermine ERISA's uniform nationwide scheme.

I. The Ninth Circuit's Decision Entrenches A Longstanding Split Of Authority Over Whether ERISA Preempts State And Local "Play or Pay" Laws.

The Ninth Circuit's application of ERISA's preemption provision in the decision below and

Golden Gate squarely conflicts with the Fourth Circuit's decision in *Fielder*, 475 F.3d 180. In *Fielder*, the Fourth Circuit held that ERISA preempted a Maryland law that was materially identical to the ordinances at issue here and in *Golden Gate*. Maryland's law, the Fair Share Health Care Fund Act ("Fair Share Act"), required covered employers "to spend at least 8% of their total payrolls on employees' health insurance costs." 475 F.3d at 183. Covered employers could comply either by altering their ERISA plans or by directly paying the State "an amount equal to the difference between what the employer spends for health insurance costs and an amount equal to 8% of the total wages paid to employees in the State." *Id.* at 184. Thus, like the Ordinance at issue here and in *Golden Gate*, covered employers could comply either by altering their ERISA plans or by making direct payments in equivalent amounts, or through some combination of those options.

The Fourth Circuit held that ERISA preempted the Fair Share Act, for two independent reasons. First, the Act had a "connection with" ERISA plans because the only realistic options for compliance required creating or altering ERISA plans. In the court's view, no rational employer would choose the direct-payment option, so "the only rational choice employers have … is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold." *Id.* at 193. Second, the court held in the alternative that even if there were a "meaningful avenue" by which employers could comply without creating or altering ERISA plans, the law would still have an impermissible "connection

with" ERISA plans. *Id.* at 196. That was so, the court explained, because "the Fair Share Act and a proliferation of similar laws in other jurisdictions" would interfere with "uniform nationwide" plan administration by requiring employers "to keep an eye on conflicting state and local minimum spending requirements and adjust [their] healthcare spending accordingly." *Id.* at 196-197.[1]

As the *Golden Gate* dissenters made clear, and as the Government acknowledged in its *Golden Gate* briefs, the second of *Fielder*'s two bases for judgment directly conflicts with the Ninth Circuit's decision in *Golden Gate*, and thus with the decision below. *See Golden Gate*, 558 F.3d at 1007 (M. Smith, J., dissenting from denial of rehearing) ("The holdings of *Fielder* and *Golden Gate* stand in clear opposition, and create a circuit split on the issue of whether ERISA preempts 'fair share' or 'play-or-pay' ordinances."); Br. for the Secretary of Labor as Amicus Curiae 16, *Golden Gate Rest. Ass'n v. San Francisco* (9th Cir. Oct. 2008) ("DOL Br.") ("[T]he panel's decision conflicts with the Fourth Circuit's analysis of the uniformity issue in *Fielder*."). Whereas the Fourth Circuit held that ERISA preempts a law imposing mandatory minimum healthcare spending even though the mandate could be satisfied through non-ERISA spending, the decision below rejected that reasoning and held that the existence of a non-ERISA option for compliance saved the Ordinance from preemption.

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[1] When a court of appeals offers two independent grounds for its judgment, both grounds are holdings of the court and are binding in future cases. *See United States v. Title Ins. & Trust Co.*, 265 U.S. 472, 486 (1924).

The *Golden Gate* court purported to distinguish *Fielder*, but it addressed only *Fielder*'s first basis for judgment—*i.e.*, the determination that no employer would choose the direct-payment option: "Unlike the Maryland law, the San Francisco Ordinance provides employers with a legitimate alternative to establishing or altering ERISA plans." *Golden Gate*, 546 F.3d at 660. The *Golden Gate* panel never even tried to explain how its holding could be reconciled with *Fielder*'s second basis for judgment—*i.e.*, its determination that even if a non-ERISA option for compliance existed, the law still relates to ERISA plans by interfering with uniform nationwide plan administration. As the Labor Department explained in supporting rehearing in *Golden Gate*, "the panel failed to address the Fourth Circuit's conclusion that even if an employer has meaningful ways to comply with a healthcare spending requirement without affecting ERISA plans, the law is still preempted because of its interference with the employer's ability to administer a uniform nationwide healthcare plan." DOL Br.17; *see also Golden Gate*, 558 F.3d at 1004 (M. Smith, J., dissenting from denial of rehearing). The same thing is true here, *see infra* Part II.

Adding to the chorus, numerous commentators contemporaneously recognized that *Golden Gate* created a circuit split. *See, e.g.*, Landon Wade Magnusson, *Golden Gate and the Ninth Circuit's Threat to ERISA's Uniformity and Jurisprudence*, 2010 B.Y.U. L. Rev. 167, 181 (2010) ("[T]he Ninth Circuit … create[d] a split among the circuits."); Samuel C. Salganik, *What the Unconstitutional Conditions Doctrine Can Teach Us About ERISA Preemption*, 109 Colum. L. Rev. 1482, 1484 (2009)

("[T]he *Golden Gate* ruling creates a split with the Fourth Circuit."); Mazda K. Antia, et al., *Overcoming ERISA As an Obstacle*, 2 J. Health & Life Sci. L. 115, 135 (2009) (discussing "the apparent conflict between the Fourth and Ninth Circuits").

That widely recognized conflict has only deepened since *Golden Gate*, and it now extends beyond the healthcare space, as local governments have used similar models to regulate other types of employee benefits. In *Merit Construction Alliance v. City of Quincy*, 759 F.3d 122 (1st Cir. 2014), the First Circuit addressed a city ordinance that required bidders on local public works projects to operate a state-approved apprentice training program. *Id.* at 125; *see* 29 U.S.C. §1002(1) (defining "employee welfare benefit plan" to include "apprenticeship or other training programs"). Relying on *Golden Gate*, the city attempted to defend its mandate against a preemption challenge by arguing that contractors could comply without altering or creating ERISA plans if they funded their city-specific apprentice program through their general assets instead of a dedicated fund. *Merit*, 759 F.3d at 130.

Like the Fourth Circuit in *Fielder*, the First Circuit held that this possibility did not save the ordinance from preemption: "Even though a non-ERISA option might be available for compliance with the Ordinance, the availability of such an option does not save the Ordinance: its mandate still has the effect of destroying the benefit of uniform administration that is among ERISA's principal goals." *Id.* at 131. As the court explained, regardless of how the city-specific apprentice program was funded, "the employer's hope

of uniform administration would be dashed by the Ordinance's demands." *Id.* at 130. "Such balkanization of benefit administration is exactly the sort of outcome ERISA was designed to prevent." *Id.*; *see also Retail Indus. Leaders Ass'n v. Suffolk Cnty.*, 497 F.Supp.2d 403, 418 (E.D.N.Y. 2007) (holding that ERISA preempted a "play or pay" law like the one at issue in *Fielder* because even the non-ERISA options for compliance "would inhibit the administration of a uniform plan nationwide" and "disrupt uniform plan administration").

In sum, two federal courts of appeals have addressed play-or-pay laws and reached the seemingly obvious conclusion that adding the or-pay option does not save such laws from preemption. The Ninth Circuit stands alone in reaching a contrary conclusion, and the decision below makes clear that the circuit split is entrenched and not going away absent this Court's intervention. While the *Golden Gate* decision prompted an eight-judge dissent from the denial of *en banc* review, the decision below was accepted as the straightforward application of circuit law, prompting not a single recorded dissent from the denial of *en banc* review. The responsibility now falls to this Court to restore a correct interpretation of federal law and to eliminate the division of authority on this important nationwide issue on which uniformity is critical.

II. Seattle's Ordinance Is Plainly Preempted.

Certiorari is also warranted because Seattle's Ordinance is plainly preempted and the decision below is irreconcilable with this Court's cases. At the outset, there is no dispute that the Ordinance would be preempted if it did not include the or-pay option.

Absent that option, the Seattle Ordinance—which requires a targeted group of employers overwhelmingly headquartered elsewhere to enhance the benefits provided to local workers via ERISA plans and regulates the details of how those enhanced benefits are administered—would be indisputably preempted.

The simple expedient of adding an or-pay option does not suffice to save Seattle's Ordinance from preemption. It remains a law that relates to ERISA plans. It has an impermissible connection with ERISA plans and undermines the ability of employers to administer uniform and comprehensive nationwide plans. It also impermissibly references ERISA plans in recognition of the realities that most covered employers have ERISA plans and Seattle expects most employers to comply with its law via those plans. Finally, it imposes the kind of ongoing obligations to provide healthcare benefits that would make any effort to comply, including the or-pay option, constitute an ERISA plan. In short, whether employers comply by altering their existing plans or creating Seattle-specific appendages to those plans, the Ordinance precludes them from administering benefits nationwide through a single, uniform plan. Given how clearly the Seattle Ordinance is preempted, it is no accident that the Ninth Circuit invoked the presumption against preemption to read an express preemption clause narrowly in further derogation of this Court's precedents. In sum, Seattle's Ordinance is preempted and the Ninth Circuit's conclusion otherwise cannot be reconciled with this Court's precedents.

A. The Ordinance is Preempted Because it has an Impermissible "Connection With" ERISA Plans.

To determine whether a state law has an impermissible "connection with" ERISA plans, this Court looks "both to the objectives of the ERISA statute … as well as to the nature of the effect of the state law on ERISA plans." *Egelhoff*, 532 U.S. at 147. The core objective of ERISA's preemption provision is to ensure that "plans and plan sponsors [are] subject to a uniform body of benefits laws, thereby minimizing the administrative and financial burden of complying with conflicting directives and ensuring that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions." *Rutledge v. Pharm. Care Mgt. Ass'n*, 141 S.Ct. 474, 480 (2020). In light of that objective, this Court has held that a state law has a prohibited "connection with" ERISA plans if it "interferes with nationally uniform plan administration" by, *e.g.*, imposing "different legal obligations in different states." *Egelhoff*, 532 U.S. at 148. The whole point of the Seattle Ordinance is to enhance the benefits of local workers by imposing additional benefit requirements on employers that Seattle correctly understands are overwhelmingly likely to administer their benefits through ERISA plans. The resulting disuniformity is inevitable and the intended effect of Seattle's Ordinance.

The Ordinance's impermissible "connection with" ERISA plans follows *a fortiori* from this Court's analysis of the preempted law addressed in *Egelhoff*. That case concerned a Washington State law that voided the designation of a spouse as the beneficiary

of a pension plan upon divorce and established rules for determining a new beneficiary. Although compliance did not require altering ERISA plans, the law still had "a prohibited connection with ERISA plans because it interfere[d] with nationally uniform plan administration." *Id.* at 148. Plan administrators could determine plan beneficiaries in 49 other states solely by looking at the plan documents, but they were required to take extra steps with respect to their Washington employees—*i.e.*, to determine "whether the named beneficiary's status has been 'revoked' by operation of law," and if so, to identify the new beneficiary. *Id.* That state-specific requirement undermined ERISA's goal of enabling employers to establish a "set of standard procedures to guide processing of claims and disbursement of benefits." *Id.* Furthermore, even if the burden imposed by the Washington law alone were not enough, allowing states to enforce such laws would require plan administrators to "master the relevant laws of 50 States" and pay plan benefits in a different manner in each one, undermining "the congressional goal of minimizing the administrative and financial burdens on plan administrators—burdens ultimately borne by the beneficiaries." *Id.* at 149-50 (alterations omitted).

The Ordinance is preempted here *a fortiori*. Hotel chains and ancillary hotel businesses with Seattle locations now face an intractable Seattle-specific benefits-administration problem: The employee-benefit plans they administer in 49 other States and in other parts of Washington might not be good enough for Seattle. Instead of directing their plan administrators to pay benefits in accordance with their nationwide plan documents at self-determined

levels, employers must take extra steps with respect to their Seattle employees and do Seattle's bidding—*i.e.*, they must, on an ongoing basis, determine which employees are covered; investigate each covered employee's family composition; calculate their existing per-employee expenditures under their existing ERISA plan; pay the difference to every covered employee (whether through the plan or outside the plan); and create and maintain records of those payments. Requiring employers to stack city-specific rules and processes atop their uniform nationwide plans "interferes with nationally uniform plan administration," *id.* at 148, and deprives employers of "the benefits of maintaining a *single* administrative scheme" for providing benefits to their employees. *Fort Halifax*, 482 U.S. at 13 (emphasis added).

The *Golden Gate* court's basis for distinguishing *Egelhoff* is untenable. The Ninth Circuit recognized that the city-payment option there (like the direct-payment option here) imposed burdens on employers, 546 F.3d at 657, but it deemed those burdens permissible because they fall on employers rather than on plans: "[T]hese burdens … are burdens on the employer rather than on an ERISA plan." *Id.* But this Court has repeatedly rejected any such distinction, explaining that ERISA's preemption provision is "intended to ensure that plans *and plan sponsors* would be subject to a uniform body of benefits law." *Travelers*, 514 U.S. at 656 (emphasis added). What "is fundamentally at odds with the goal of uniformity that Congress sought to implement" is not just the necessity of tailoring *plans* to comply with conflicting local regulations, but also the necessity of "tailoring … *employer conduct* to the peculiarities of

the law of each jurisdiction." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).

Furthermore, as *Egelhoff* recognized but *Golden Gate* ignored, the problem is not limited to disuniformity in one jurisdiction. If a law like this is permissible in Seattle, similar laws are permissible everywhere else, including in all the cities that supported Seattle as amici below. Even if the administrative burden imposed by a single law were tolerable, the cumulative burden could be staggering. Accordingly, the Ninth Circuit should have held that ERISA preempted the law because the burden it and similar laws like it impose on employers interfere with their ability to maintain nationwide plan uniformity. *See, e.g.*, *Fielder*, 475 F.3d at 197.[2]

B. The Ordinance is Preempted Because it Makes Forbidden "Reference To" ERISA Plans.

The Seattle Ordinance also impermissibly relates to ERISA plans and is preempted because it makes repeated "reference to" ERISA plans. Congress broadly preempted such laws because the interaction of those laws with ERISA plans is likely to affect employer conduct and the content of ERISA plans. *See Ingersoll-Rand*, 498 U.S. at 142.

For example, in *Greater Washington*, 506 U.S. 125, this Court considered a District of Columbia law that required employers who provide health insurance

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[2] Whether the Ordinance would be preempted as applied to employers who do not offer ERISA plans is not at issue here, as Petitioner's member companies all offer ERISA-covered benefit plans.

for their employees to provide equivalent health insurance for any employee who becomes eligible for workers' compensation. *Id.* at 127-28. Even though employers did not need to amend their ERISA plans to comply with the law—they could provide the mandated benefits through a separate plan or a non-ERISA plan—this Court held that the law made a forbidden "reference to" ERISA plans. This was so, the Court explained, because the coverage it required "is measured by reference to the existing health insurance coverage provided by the employer" under its ERISA plan. *Id.* at 130. Accordingly, "every time an employer considers changing the benefits under its ERISA-covered plan, it would have to consider the effect that such a change would have on its unique obligations to its District employees receiving workers' compensation," which could lead the employer to "choose to forego such an increase altogether." *Greater Wash. Bd. of Trade v. District of Columbia*, 948 F.2d 1317, 1325 (D.C. Cir. 1991), *aff'd*, 506 U.S. 125 (1992).

The same is true here. The expenditures required to comply with the or-pay option are measured by reference to the contributions the employer makes to its existing ERISA plan. Employers must calculate their per-employee contributions to their existing ERISA plans, compare that amount to the mandated minimum for each employee, and then cover the difference by either altering their ERISA plans or making a direct cash payment in the same amount. *See* SMC 14.28.060.C (employer who does not already pay the mandated minimum through an existing ERISA plan "is required to satisfy *the remaining portion* of the monthly health expenditure rate" (emphasis added)). Either way, employers subject to

the Ordinance "can only determine their compliance by using their current ERISA plans as a reference." *Golden Gate*, 558 F.3d at 1008 (M. Smith, J., dissenting from denial of rehearing). Just like the law in *Greater Washington*, the Ordinance makes a forbidden "reference to" the employer's ERISA plans.

The references to ERISA plans do not stop there. The Ordinance's "effective date" for large hotels depends on the employer's existing ERISA plan's "earliest annual open enrollment period for health coverage, if offered, after July 1, 2020." SMC 14.28.260.B. The date on which the employer must begin making monthly healthcare expenditures for a new hire is measured by the waiting period in any existing "employer-sponsored plan." SMC 14.28.060.C. And an employee's voluntary declination of an employer's offer of monthly healthcare expenditures discharges the employer's duties with respect to that employee only if the employer's existing ERISA plan has a 20% or lesser cost-sharing requirement. SMC 14.28.060.D.1.

While laws that reference ERISA plans are preempted regardless of their actual effect on such plans, *see Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988), the references here are particularly likely to affect the content of ERISA plans. Through its repeated references to existing ERISA plans, the Ordinance encourages employers to increase their contribution levels to avoid having to establish a separate scheme for direct payments; make their open seasons as late as possible to delay the Ordinance's effective date; adopt waiting periods in their ERISA plans to delay the Ordinance's

application to new hires; and set employee cost-sharing rates below 20% to ensure that the Ordinance gives effect to employee waivers. The Ordinance directly and expressly references ERISA plans several times over, including in provisions that cannot be applied without first referring to ERISA plans.

C. The Ordinance Is Preempted Because It Requires Employers to Alter or Create ERISA Plans.

Finally, if the Seattle Ordinance would otherwise escape preemption, then or-pay options, especially Seattle's, properly should be construed to themselves constitute ERISA plans. The vast majority of healthcare benefits that employers extend to their employees qualify as "employee welfare benefit plan[s]," which ERISA defines as "any plan, fund, or program … established or … maintained for the purpose of providing [health benefits] for its participants or their beneficiaries." 29 U.S.C. §1002(1). That aptly describes the payments mandated by the Seattle Ordinance even for employers who choose the or-pay option. To be sure, in *Fort Halifax*, this Court held that a one-time mandated severance payment when a plant closed did not constitute an ERISA "plan" because it did not require "an ongoing administrative program for processing claims and paying benefits." 482 U.S. at 12. Similarly, in *Massachusetts v. Morash*, 490 U.S. 107 (1989), this Court held that a policy of making a one-time payment to discharged employees for unused vacation time did not constitute an ERISA "plan." But the ongoing health benefits mandated by the Seattle Ordinance are fundamentally different. Even in the

unlikely event that an employer chose to make the payments outside its existing ERISA plan, the need for ongoing payments and calculations would itself constitute an ERISA plan.

Unlike the one-time payments in *Fort Halifax* and *Morash*, the or-pay option requires an administrative program through which the employer must determine which employees are covered; investigate covered employees' family composition to determine the Ordinance-mandated expenditures; calculate existing per-employee expenditures; pay the difference to every covered employee; and maintain Ordinance-mandated records of those payments. These determinations are not straightforward. For example, to determine whether an employee is covered, employers must predict "the average monthly hours that the employee will work over the course of the calendar year," including hours on paid leave for "vacation, illness, legally required paid leave, incapacity (including disability), layoff, jury duty, military duty, or leave of absence." Seattle Q&A 3-4. Furthermore, while conducting the mandated investigation into their employees' family composition, employers must walk a precarious tightrope, as Seattle is quick to point out that "inquiries about family status during the hiring process and in some other employment contexts may constitute unlawful discrimination." *Id.* at 7-8. Employers must satisfy equally burdensome requirements for employees who decline coverage, as the Ordinance mandates an intricate system for obtaining, verifying, and retaining records of an employee's declination, with differing requirements depending on why and how the employee declines

coverage. *See* SMC 14.28.060.D; *id.* 14.28.030.B.2; *id.* 14.28.050; Seattle Q&A 9-10.

It would be impossible to accomplish these tasks without "an ongoing administrative program." *Fort Halifax*, 482 U.S. at 12. For that reason, even the or-pay option can be construed to constitute an ERISA-covered plan. And because, under this view, all three options for compliance would require employers to create or alter ERISA plans, the Ordinance would be preempted. One way or the other, a municipality cannot evade ERISA preemption by the simple expedient of adding an or-pay option to an otherwise plainly preempted ordinance.

D. The Ninth Circuit Improperly Relied on a Presumption Against Preemption.

Given that play-or-pay ordinances like those imposed by San Francisco and Seattle relate to ERISA plans, it is no surprise that the Ninth Circuit reached its anomalous no-preemption conclusion only by invoking the presumption against preemption. That presumption has no legitimate role to play in the context of a broad express preemption like that in ERISA, as this Court's precedents make clear. That conflict with this Court's precedents on the proper (and properly limited) role of the presumption and the opportunity to eliminate continuing circuit court confusion on the role of the presumption are additional reasons for this Court to grant plenary review.

In *Golden Gate*, the Ninth Circuit began its analysis "by noting that state and local laws enjoy a presumption against preemption," and made clear that the presumption would "inform[] [its] preemption analysis." 546 F.3d at 647. The court then proceeded

to hold that ERISA did not preempt San Francisco's ordinance. While *Golden Gate* at least had the excuse of pre-dating this Court's more recent decisions underscoring that the presumption has no role to play in the face of an express preemption provision, the decision below doubled down on *Golden Gate*'s anachronistic reliance on the presumption before holding that the Seattle Ordinance was not preempted. App.2-3.

The Ninth Circuit's continuing reliance on the presumption in this context is error. Whatever role such a presumption might play in *implied* preemption cases, when a statute "contains an express pre-emption clause, we do not invoke any presumption against pre-emption but instead focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' pre-emptive intent." *Franklin*, 579 U.S. at 125. While *Franklin* involved the Bankruptcy Code rather than ERISA, the inapplicability of the presumption would seem to apply *a fortiori* to ERISA's notoriously broad express preemption provision. Indeed, *Franklin* confirmed that the principle applies broadly by citing cases involving other express preemption provisions, including *Gobeille*, its then-most-recent ERISA preemption case. *Id.*

Several circuits have since recognized that the presumption against preemption does not apply in *any* case involving an express preemption provision, including ERISA's. *See Pharm. Care Mgmt. Ass'n v. Wehbi*, 18 F.4th 956, 967 (8th Cir. 2021) (refusing to apply presumption in ERISA case); *Dialysis Newco, Inc. v. Cmty. Health Sys. Grp. Health Plan*, 938 F.3d

246, 258-59 (5th Cir. 2019) (same); *Watson v. Air Methods Corp.*, 870 F.3d 812, 817 (8th Cir. 2017) (same for Airline Deregulation Act); *EagleMed LLC v. Cox*, 868 F.3d 893, 903 (10th Cir. 2017) (same). The Third Circuit, in contrast, has twice declined to extend *Franklin* outside the bankruptcy context. *See Lupian v. Joseph Cory Holdings LLC*, 905 F.3d 127, 131 n.5 (3d Cir. 2018) (applying presumption in FAAAA case); *Shuker v. Smith & Nephew, PLC*, 885 F.3d 760, 771 n.9 (3d Cir. 2018) (applying presumption in FDCA case). And litigants, including Seattle and the amici cities below, insist that "federal appellate courts must" continue applying the presumption in ERISA cases until this Court expressly says otherwise. Cities Brief at 3.

Thus, granting review here will not only provide an opportunity to address the entrenched circuit split on whether play-or-pay provisions are preempted and correct the Ninth Circuit's erroneous view, but also to make clear beyond cavil that the presumption against preemption has no role to play in interpreting express preemption provisions. As with other statutory texts, "there is no reason to give" express preemption provisions "anything other than a fair (rather than a 'narrow') interpretation." *Encino Motorcars, LLC v. Navarro*, 138 S.Ct. 1134, 1142 (2018) (quoting Antonin Scalia & Bryan A. Garner, *Reading Law* 363 (2012)).

III. The Question Presented Is Important And This Court's Review Is Urgently Needed.

Whether states and municipalities may impose burdensome, locality-specific obligations on employers is critically important. The temptation of local governments to benefit local employees at the expense

of national employers (and employers' interest in administering uniform and comprehensive nationwide benefit plans) is profound. Indeed, that was the dynamic that motivated Congress to enact ERISA in the first place. In the pre-ERISA days, when there was little to no federal regulation of employee-benefit plans, a patchwork of state and local regulation left employers scrambling to monitor and comply with an array of incompatible rules. Congress recognized that without a uniform national standard, employers would "be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others." *Fort Halifax*, 482 U.S. at 9. Congress further recognized that the associated administrative costs could "lead those employers with existing plans to reduce benefits." *Id.* at 11. Accordingly, with the support of both employers and labor unions, Congress cleared the field of such state and local regulation by enacting "what may be the most expansive express pre-emption provision in any federal statute." *Gobeille,* 577 U.S. at 327 (Thomas, J., concurring).

ERISA's uniform regulatory scheme has allowed employers of all sizes to create effective benefit plans for their employees regardless of where they live, work, or receive healthcare—and to do so without the headache and expense of tailoring those plans to the idiosyncratic policy preferences of every jurisdiction in which they operate. The decision below, however, kicks open the door to state and local regulation of employee-benefit plans by the simple expedient of

adding an or-pay alternative, threatening to unravel the uniformity that ERISA has long provided and imperil the baseline level of benefits on which many employees rely. And this threat is hardly limited to laws mandating minimum monthly contributions. Under the logic of the decision below, there is no reason why a state or locality could not require plans and plan sponsors to adopt specific vesting rules, funding practices, fiduciary responsibilities, leave entitlements, record-keeping processes, disclosure rules, or anything else. As long as the law nominally provides employers with a way to pay their way into compliance (*i.e.*, to comply without directly altering their ERISA plans), the decision below gives state and local lawmakers free rein.

This is no theoretical concern. While the government optimistically suggested that the ACA would eliminate the incentive for states and localities to demand special healthcare benefits for local workers, the ensuing decade has proven that optimism unfounded. Indeed, this Court need look no further than the docket *in this case* to confirm as much: A host of municipalities—including Los Angeles, San Francisco, Chicago, Austin, St. Paul, and Sacramento—filed an amicus brief below, defending the importance of being able to "adopt local laws to promote healthcare access without running afoul of ERISA," including laws that "require[] employers to make certain payments for employee healthcare." Cities Brief 18, 24. According to that brief, "[m]unicipalities across the country have studied the San Francisco model" since *Golden Gate*, "including Denver, Miami, New Orleans, and Pittsburgh," and "New York and Los Angeles … are also pursuing

[similar] local healthcare reforms." *Id.* at 29. That is precisely the outcome that Congress, through ERISA, intended to prevent.

The existence of an entrenched circuit split underscores the need for review. ERISA's preemption provision was designed specifically to provide nationwide uniformity for plans and plan sponsors. But the circuit split means that plans and plan sponsors must now deal not only with disuniformity in their administration of benefits (by creating bespoke administrative schemes to comply with local play-or-pay laws), but also with the disuniformity created by conflicting interpretations of ERISA. In addition to monitoring employee-benefit laws in every jurisdiction in which they operate, plans and plan sponsors must now also study judicial decisions in those jurisdictions to determine whether each play-or-pay law is likely to be deemed enforceable. That sort of legal uncertainty is problematic in any context, but it is especially troubling when the subject of the circuit split is a law whose very reason for being is to provide certainty, predictability, and nationwide uniformity.

In short, this case presents an entrenched circuit split on an "issue of exceptional national importance, *i.e.*, national uniformity in the area of employer-provided healthcare." *Golden Gate*, 558 F.3d at 1008 (M. Smith, J., dissenting from denial of rehearing). It was a lack of uniformity that prompted Congress to enact ERISA in the first place, and this Court's intervention is now needed to restore that uniformity and prevent further state and local efforts to interfere with the federal regulatory scheme.

CONCLUSION

The Court should grant the petition.

Respectfully submitted,

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January 14, 2022

APPENDIX

TABLE OF APPENDICES

Appendix A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 20-35472

THE ERISA INDUSTRY COMMITTEE,

Plaintiff-Appellant,

v.

CITY OF SEATTLE,

Defendant-Appellee.

Argued and Submitted: Mar. 1, 2021
Filed: Mar. 17, 2021

Before: TASHIMA, RAWLINSON, and BYBEE,
Circuit Judges.

MEMORANDUM*

The ERISA Industry Committee (ERIC) appeals the district court's Rule 12(b)(6) dismissal of its action against the City of Seattle (the City). In its complaint, ERIC asserted that the Employee Retirement Income Security Act of 1974 (ERISA) preempted Seattle Municipal Code (SMC) §14.28, a health benefits

* This disposition is not appropriate for publication and is not precedent except as provided by Ninth Circuit Rule 36-3.

ordinance requiring hotel employers and ancillary hotel businesses to provide money directly to designated employees, or to include those employees in the employers' health benefit plan.

Contrary to ERIC's argument, "state and local laws enjoy a presumption against [ERISA] preemption when they clearly operate in a field that has been traditionally occupied by the States." *Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 546 F.3d 639, 647 (9th Cir. 2008) (citation and internal quotation marks omitted); *see also Depot, Inc. v. Caring for Montanans, Inc.*, 915 F.3d 643, 666 (9th Cir. 2019). Even so, unlike the statute in *Gobeille v. Liberty Mutual Ins. Co.*, which required disclosure of health care information and payments, SMC §14.28 does not "enter[] a fundamental area of ERISA regulation," such as reporting and disclosure of health care claims and payments. 136 S. Ct. 936, 940, 946 (2016); *see also N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995) ("[N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern.") (citations omitted).

ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. §1144(a). We agree with the district court that SMC §14.28 does not relate to any employee benefit plan in a manner that triggers ERISA preemption. The outcome of this case is controlled by our decision in *Golden Gate*. *See* 546 F.3d at 661 (concluding that a San Francisco ordinance

requiring business to make certain minimum health care expenditures on behalf of covered employees was not preempted by ERISA). As in *Golden Gate*, SMC §14.28 does not "relate to" employers' ERISA plans because an employer "may fully discharge its expenditure obligations by making the required level of employee health care expenditures, whether those expenditures are made in whole or in part to an ERISA plan, or in whole or in part to [a third party]." *Id.* at 655-56.

ERIC argues that *Golden Gate* is distinguishable because the San Francisco ordinance did not include a direct payment option from the employer to the employee. However, we expressly noted in *Golden Gate* that there was no ERISA preemption "even if the payments are made by the employer directly to the employees who are the beneficiaries of the putative plan." *Id.* at 649 (internal quotation marks omitted). *Golden Gate* relied for this proposition on *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 3, 16 (1987), which explicitly addressed direct payment from the employer to the employee. *See Golden Gate*, 546 F.3d at 649.

Because ERIC failed to distinguish SMC §14.28 on any meaningful point from the ordinance upheld in *Golden Gate*, dismissal in favor of the City was consistent with our precedent. *See* 546 F.3d at 661.

AFFIRMED.

Appendix B

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 20-35472

THE ERISA INDUSTRY COMMITTEE,

Plaintiff-Appellant,

v.

CITY OF SEATTLE,

Defendant-Appellee.

Filed: Sept. 1, 2021

Before: TASHIMA, RAWLINSON, and BYBEE,
Circuit Judges.

ORDER

Judge Rawlinson voted to deny, and Judges Tashima and Bybee recommended denying, the Petition for Rehearing En Banc.

The full court has been advised of the Petition for Rehearing En Banc, and no judge of the court has requested a vote.

Appellant's Petition for Rehearing En Banc, filed April 30, 2021, is DENIED.

Appendix C

UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF WASHINGTON

No. 2:18-cv-01188-TSZ

THE ERISA INDUSTRY COMMITTEE,

Plaintiff,

v.

CITY OF SEATTLE,

Defendant.

Filed: May 8, 2020

ORDER

THIS MATTER comes before the Court on Defendant City of Seattle's (the "City") Motion to Dismiss, docket no. 37. Having reviewed all papers filed in support of and in opposition to the motion, the Court enters the following order.

BACKGROUND

The Seattle City Council passed SMC 14.28 ("the Ordinance") on September 12, 2019, and the Ordinance became law on September 24, 2019.[2] Amended Complaint ("AC"), docket no. 36 at ¶23. The Ordinance requires large hotel employers and

[2] SMC 14.28 is the successor to Initiative Measure No. 124, which voters approved in November 2016. AC ¶2.

ancillary hotel businesses to make "healthcare expenditures" on behalf of covered employees. SMC 14.28.060. The Ordinance's stated 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." SMC 14.28.025.

To achieve this goal, the Ordinance requires that a "Covered Employer"[2] make monthly expenditures[3] of $420 for each employee, $714 for each employee with only dependents, $840 for each employee with only a spouse or domestic partner, and $1,260 for each employee with a spouse or domestic partner and dependents. SMC 14.28.060.A.

Covered employers may satisfy their payment obligation 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 tax favored health programs to provide healthcare services,

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[2] Covered employers are those who own, control, or operate a hotel or motel with more than 100 guest rooms in Seattle, or who own, control, or operate an ancillary hotel business in Seattle with 50 or more employees. SMC 14.28.020; SMC 14.28.040.

[3] SMC 14.28 merely ensures that employees have access to minimum healthcare benefits in the amounts set forth in SMC 14.28.060.A. Indeed, employers who are already spending the minimum amounts in one of the forms outlined in SMC 14.28.060.B are deemed to have satisfied the requirements of the Ordinance.

> for the purpose of providing healthcare services to the employee or the spouse, domestic partner, or dependents of the covered employee; 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 by the employer's self-insured and/or self-funded insurance program.

SMC 14.28.060.B.

The Ordinance requires the Covered Employer to retain records documenting compliance with SMC 14.28, and it contains enforcement provisions permitting the City to levy civil fines and penalties as well as pay compensation, liquidated damages, and other penalties to aggrieved parties. SMC 14.28.110; SMC 14.28.170. An employer is exempt from making monthly expenditures under SMC 14.28 on behalf of employees that (1) explicitly waive benefits or repeatedly decline monthly expenditures; (2) indicate that they already have access to health coverage from another source; or (3) are covered by a collective bargaining agreement that expressly waives SMC 14.28 benefits. SMC 14.28.030; SMC 14.28.060; SMC 14.28.235. SMC 14.28 is scheduled to go into effect on July 1, 2020 or on the earliest annual open enrollment period for health coverage thereafter. SMC 14.28.260.B.[4]

The ERISA Industry Committee (the "Committee" or "Plaintiff") is a nonprofit trade association that

[4] Ancillary hotel businesses with 50 to 250 employees have until 2025 to comply with the Ordinance. SMC 14.28.260.A.

advocates for nationally uniform laws regarding employee benefits through lobbying and litigation. The Committee seeks to enjoin the enforcement of SMC 14.28 on the basis that it is preempted under federal law by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001, et seq. The Committee asserts preemption on three grounds: (1) SMC 14.28 requires the creation of ERISA plans because each option for compliance requires the maintenance of "on-going, discretion-laden program[s] and administrative process[es]" for the purpose of employee healthcare, and these programs are effectively ERISA plans; (2) SMC 14.28 makes impermissible "references to" ERISA plans because its operation turns on "the value or nature of the benefits available to ERISA plan participants"; and (3) SMC 14.28 has an impermissible "connection with" an ERISA plan because it "force[s] an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict[s] its choice of insurers." AC ¶5.

The City of Seattle moves to dismiss the Plaintiff's complaint on the grounds that federal law does not preempt the Ordinance.

DISCUSSION

A complaint challenged by a Rule 12(b)(6) motion to dismiss must offer "more than labels and conclusions" and contain more than a "formulaic recitation of the elements of a cause of action." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). The complaint must indicate more than mere speculation of a right to relief. *Id.* When a complaint fails to adequately state a claim, such deficiency should be "exposed at the point of minimum expenditure of time

and money by the parties and the court." *Id.* at 558. A complaint may be lacking for one of two reasons: (i) absence of a cognizable legal theory, or (ii) insufficient facts under a cognizable legal claim. *Robertson v. Dean Witter Reynolds, Inc.*, 749 F.2d 530, 534 (9th Cir. 1984). In ruling on a motion to dismiss, the Court must assume the truth of the plaintiff's allegations and draw all reasonable inferences in the plaintiff's favor. *Usher v. City of Los Angeles*, 828 F.2d 556, 561 (9th Cir. 1987). The question for the Court is whether the facts in the Amended Complaint sufficiently state a "plausible" ground for relief. *Twombly*, 550 U.S. at 570.

I. ERISA

ERISA is a comprehensive legislative scheme enacted with two primary purposes: (1) to safeguard against the mismanagement of funds to pay employee benefits, *Massachusetts v. Morash*, 490 U.S. 107, 112 (1989); and (2) to ease the administrative burdens and costs on employers and plan administrators by eliminating the threat of conflicting or inconsistent state and local regulation of employee benefit plans, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 n.25 (1983). To accomplish these dual purposes, ERISA established reporting, disclosure, and fiduciary duty requirements and set forth a broad preemption clause "establish[ing] as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). Whether a state law or local ordinance is preempted by ERISA is a question of law. *Farr v. U.S. W. Commc'ns, Inc.*, 151 F.3d 908, 913 (9th Cir. 1998). This is the question

presented by the Defendant's Motion to Dismiss in this case.

II. *Golden Gate* Opinion

In 2008, in *Golden Gate Rest. Ass'n v. City & Cty. of San Francisco* ("*Golden Gate*"), the Ninth Circuit held that a San Francisco ordinance requiring businesses to make certain minimum health care expenditures on behalf of covered employees was not preempted by ERISA. 546 F.3d 639 (9th Cir. 2008). The San Francisco ordinance at issue in *Golden Gate* is similar to the Seattle Ordinance, and both parties address the Ninth Circuit's opinion in *Golden Gate* and its applicability to this case at length in their briefs. As a result, the Court also starts with an analysis of the *Golden Gate* opinion.

The ordinance in *Golden Gate* required covered employers to make contributions on behalf of certain employees at rates of $1.17 to $1.76 per hour worked for the purpose of providing "required health care expenditures to … employees." *Id.* at 643-44. San Francisco employers had the discretion to make the required expenditures either by paying employee costs associated with health care expenses in various ways or by making payments to the city (the "City-payment option"). *Id.* at 644-45. If the employer chose the City-payment option, its employees would either be eligible for enrollment in a city health access program for uninsured San Francisco residents or enrollment in a reimbursement account. *Id.* The ordinance required covered employers to keep records of compliance, and it set out various exemptions and deductions for employers already making health care expenditures. *Id.* at 645.

The *Golden Gate* court held that the ordinance did not establish an ERISA plan or require an employer to make any changes to an existing ERISA plan. *Id.* at 646. The *Golden Gate* court noted that the ordinance was "not concerned with the nature of the healthcare benefits an employer provides its employees." *Id.* at 647. Rather, the ordinance merely mandated the amounts of dollar payments on a periodic basis, which the court concluded would be similar to wages paid directly to employees. *Id.* at 649-50.

The *Golden Gate* court also found that the employer's administrative responsibilities under the ordinance, which included retaining records showing and determining which employees were eligible for payments, were not enough to convert the City-payment option into an ERISA plan because these responsibilities merely involved "mechanical record-keeping" and did not reserve discretion for the employer to engage in mismanagement of funds. *Id.* at 651. The court further noted that other federal, state, and local laws, such as income tax withholding, social security, and minimum wage laws, impose similar administrative obligations on employers yet do not constitute ERISA plans. *Id.* at 650.

The *Golden Gate* court also found that the ordinance had no impermissible "reference to" or "connection with" an ERISA plan because it was "functional even in the absence of a single ERISA plan." *Id.* at 659. The ordinance's "only influence" was on the employer who, because of the ordinance, could choose to make its required health care expenditures to an ERISA plan rather than to a non-ERISA entity. *Id.* at 656.

III. Presumption Against ERISA Preemption

State and local laws enjoy a presumption against ERISA preemption when they "clearly operate[] in a field that has been traditionally occupied by the States." *De Buono v. NYSA–ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997) (internal quotations omitted). "[N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995); *see also Operating Eng'rs Health & Welfare Trust Fund v. JWJ Contracting Co.*, 135 F.3d 671, 677 (9th Cir. 1998). The Seattle Ordinance "clearly operates" to ensure health benefits for covered Seattle employees. SMC 14.28.025. Thus, the Ordinance is entitled to a presumption against preemption by federal law.

IV. Whether SMC 14.28 Requires the Creation of an ERISA Plan

The Committee contends that SMC 14.28 "impermissibly requires, under any of its options for compliance, the creation of ERISA plans" because it requires that employers establish and maintain "at a minimum, an on-going, discretion-laden program and administrative process for the purpose of defraying, through the purchase o[f] insurance or 'otherwise,' its employees' costs for healthcare, thereby satisfying the definition for the existence of an ERISA plan." AC ¶5(a) (citing 29 U.S.C. §1002(1)). The Committee contends that the Ordinance is preempted by ERISA

because the existence of an ERISA plan is essential to its operation. Plaintiff's Opposition to Defendant's Motion to Dismiss, docket no. 38 at 17.

The Committee focuses its challenge on the direct payment option set forth in SMC 14.28. Under this direct payment option, employers pay workers a dollar amount directly. The Committee contends that, "[b]y its terms, [this direct payment] option for compliance constitutes an employer-based regimen of repeated payments to employees to defray the employees' medical costs which—on its face—satisfies ERISA's welfare plan definition of a program established or maintained by the employer for the purpose of providing benefits in the event of sickness or medical need." *Id.* at 17-18.

An ERISA plan is "[a]ny plan, fund, or program … established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants … through the purchase of insurance or otherwise … medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment." 29 U.S.C. §1002(1).

Here, SMC 14.28 does not require the creation of an ERISA plan because the direct to employee payment option is not an ERISA plan. There is little to differentiate the payments under this option from regular wages, and they can be coordinated with

employees' regular pay periods.[5] Moreover, the Ninth Circuit explicitly rejected this exact challenge in *Golden Gate*. *See Golden Gate*, 546 F.3d at 650 ("[I]f employers made the payments directly to the employees … those payments would not be enough to create an ERISA plan."). *See also Morash*, 490 U.S. at 115; *California Div. of Labor Standards Enf't v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 326 (1997) (employee benefits paid through the regular assets of an employer did not constitute an ERISA plan).

In enacting ERISA, Congress did not intend to regulate payments made directly to employees. *Morash*, 490 U.S. at 115. ERISA was enacted primarily over concerns of employers' mismanagement of employee benefit programs. *Id.* ERISA regulates benefit *plans* because *plans*—not dollar payments to employees—implicate ERISA's concern regarding an employer's potential mismanagement and abuse of funds. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987).

Despite the Committee's attempt to portray SMC 14.28's direct payment option as a "discretion-laden program" involving complicated webs of administrative processes,[6] the employer actually has

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[5] Notably, while the admirable goal of SMC 14.28 is to improve employee access to medical care, the direct payments need not be used for medical care at all. Though this policy might seem questionable, the Court's only role is to ensure that it is not preempted by ERISA.

[6] The Committee contends that unlike the San Francisco ordinance, the Seattle Ordinance contains a waiver system which creates additional administrative burdens on employers sufficient to create an ERISA plan. The Committee is mistaken in this regard. The San Francisco ordinance at issue did include

no responsibility other than to retain records that it would maintain in its normal course of business. Those minimal record keeping and administrative requirements do not give employers discretion to deny or limit benefits under the Ordinance. Therefore, the direct payment option does not "run the risk of mismanagement of funds or other abuse." *Golden Gate*, 546 F.3d at 651. As the *Golden Gate* court noted, there are many other laws that impose similar de minimis administrative obligations, but which do not constitute ERISA plans.[7] *Id.* at 650.

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exemption provisions similar to the waiver system in this case. *See* S.F. Admin. Code § 14.1 (providing various exclusions to the ordinance including employees who already receive health care services from other sources "provided that the Employer obtains from those persons a voluntary written waiver").

[7] The Committee primarily relies on two Ninth Circuit cases decided prior to *Golden Gate* which held that certain direct-to-employee payments constituted ERISA plans. In *Aloha Airlines, Inc. v. Ahue*, the court held that a Hawaiian state law requiring employers to pay for pilot medical examinations was preempted by ERISA because it required employers to modify existing ERISA plans to comply with the law. 12 F.3d 1498, 1504-05 (9th Cir. 1993). Unlike the payment scheme here, however, the payment scheme in *Aloha Airlines* involved discretionary decision-making on behalf of the employer regarding pilot rank and therefore who qualified for the program. *Id.* at 1503. The discretionary employer decision-making in *Aloha Airlines* therefore implicated ERISA concerns regarding abuse and mismanagement of funds. The other case the Committee relies upon—*Bogue v. Ampex Corp.*—involved similar employer discretionary decision making because the law at issue required employers to engage in "particularized" analysis to determine employee eligibility for benefits. 976 F.2d 1319, 1323-24 (9th Cir. 1992). The direct payment to employee option in SMC 14.28

V. Whether SMC 14.28 is Preempted Because It Has a "Connection with" or "Reference to" an ERISA Plan

Section 514(a) provides that ERISA supersedes state and local laws insofar as they relate to any employee benefits plan. 29 U.S.C. §1144(a). A state or local law relates to an ERISA employee benefit plan "if it has a connection with or reference to such a plan." *Shaw*, 463 U.S. at 96-97. "A state law that 'relates to' an ERISA plan is preempted by ERISA 'even if the law is not specifically designed to affect such [a] plan … or the effect is only indirect.'" *Aloha Airlines v. Ahue*, 12 F.3d 1498, 1504 (9th Cir.1993) (citing *Ingersoll–Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990)).

a. SMC 14.28 Lacks a "Connection with" an ERISA Plan

The Committee contends that SMC 14.28 has an impermissible "connection with" an ERISA plan because it "force[s] an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict[s] its choice of insurers." AC ¶5(c) (internal quotations omitted). The Committee further contends that SMC 14.28 effectively compels employers to alter their current insured or self-funded coverage to include employees covered by the Ordinance for consistency and because direct payments are "financially more onerous and therefore not a realistic and legitimate alternative" to the other options. *Id.*

A state or local law has a "connection with" an ERISA plan if it binds, regulates, or dictates the

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requires no such particularized analysis or discretionary decision-making.

administration of the plan. *Golden Gate*, 546 F.3d at 655-56. SMC 14.28 lacks a "connection with" an ERISA plan. Where an ordinance's "only influence is on the employer who, because of the [o]rdinance, may choose to make its required health care expenditures to an ERISA plan rather than" directly to the employee, there is no impermissible "connection with" an ERISA plan. *Id.* at 656. Here, employers subject to SMC 14.28 have multiple options to comply with the Ordinance. They may choose to make those expenditures in "connection with" an existing ERISA plan, establish a new ERISA plan, or make those expenditures directly to the employee. The direct to employee payments are not, in themselves, ERISA plans. Therefore, SMC 14.28 does not contain an impermissible "connection with" an ERISA plan.[8]

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[8] The Court also rejects the Committee's argument that the direct to employee option is not a realistic choice for covered employers because it is "financially more onerous and otherwise problematic, so as not to make it a reasonable choice over the other options." Plaintiff's Opposition to Defendant's Motion to Dismiss, docket no. 38 at 26-27. The Committee contends that some employers have already altered their ERISA plans to bring them into compliance with the Ordinance's predecessor. *Id.* at 27. The Committee accuses the City of "legislative maneuvering" to prevent employers from choosing the direct payment option. *Id.* An employer's decision to prematurely comply with the ordinance before it goes into effect does not change the Court's analysis. Moreover, the Committee has not shown that the Ordinance effectively binds employers to any particular choice. *See N.Y. State Conference of Blue Cross & Blue Shield Plans*, 514 U.S. at 650, 659 (surcharge of 9-24% on non-ERISA plans was an "indirect economic influence" that did not "bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself").

b. SMC 14.28 Lacks a "Reference to" an ERISA Plan

The Committee also contends that SMC 14.28 is preempted by ERISA because it makes a "reference to" an ERISA plan by (1) mentioning ERISA plans and (2) turning on the value or nature of the benefits available to ERISA plan participants. AC ¶5(b).

To determine whether a law has a forbidden "reference to" an ERISA plan, the Court asks whether (1) the law "acts immediately and exclusively upon ERISA plans," or (2) "the existence of ERISA plans is essential to the law's operation." *Dillingham*, 519 U.S. at 325. SMC 14.28 does not require the existence of an ERISA plan. As in *Golden Gate*, the Seattle Ordinance is therefore "fully functional" in the absence of a single ERISA plan. *Golden Gate*, 546 F.3d at 659.

The Committee contends, however, that SMC 14.28 has an impermissible reference to an ERISA plan because its obligations are measured by the level of benefits provided by the ERISA plan to the employee. Citing the Ninth Circuit's analysis in *Golden Gate* regarding *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992) ("*Greater Washington*"), the Committee further contends that SMC 14.28 requires employers to calculate payments based on the value or nature of benefits rather than hours worked by employees and therefore the Ordinance has an impermissible "reference to" an ERISA plan. Plaintiff's Opposition to Defendant's Motion to Dismiss, docket no. 38 at 22-24. The Committee misconstrues the *Golden Gate* court's analysis. In *Golden Gate*, the court noted that the ordinance in *Greater Washington* impermissibly

premised required payments on "existing health insurance coverage." *Golden Gate*, 546 F.3d at 658. The coverage required under the *Greater Washington* ordinance was the same benefit "level" as the existing ERISA coverage. *Id.* However, the *Greater Washington* plan incorporated a reference to an ERISA plan in determining the amount of coverage under that ordinance. *Id.* In contrast, neither the *Golden Gate* ordinance nor SMC 14.28 measure the required level of payments based on an ERISA plan. In particular, SMC 14.28 sets payments on dollar amounts determined by the employee's status. SMC 14.28.060.A.

Finally, the Court notes that the task before it is exceedingly narrow. The Committee does not ask the Court to opine on the wisdom of the Ordinance but rather whether ERISA preempts SMC 14.28. The Court finds that it does not. The dollar amount spending requirements in SMC 14.28 do not establish an ERISA plan and do not create impermissible connections with or reference to ERISA plans. Moreover, this Court is bound by the Ninth Circuit precedent set more than a decade ago in *Golden Gate* determining that a nearly identical local ordinance was not preempted by ERISA.

c. Denial of Leave to Amend

If the Court dismisses the complaint or portions thereof, it must consider whether to grant leave to amend. *Lopez v. Smith*, 203 F.3d 1122, 1130 (9th Cir. 2000). Federal Rule of Civil Procedure 15(a) provides that the trial court shall grant leave to amend freely "when justice so requires." "[A] district court should grant leave to amend … unless it determines that the

pleading could not possibly be cured by the allegation of other facts." *Cook, Perkiss & Liehe, Inc. v. N. California Collection Serv. Inc.*, 911 F.2d 242, 247 (9th Cir. 1990). Here, the Court is bound by the Ninth Circuit's precedent in *Golden Gate* and its application to the Ordinance. Any amendment to Plaintiff's complaint would not change the legal conclusion that the Ordinance is not preempted by ERISA.

CONCLUSION

For the foregoing reasons, the Court ORDERS:

(1) Defendant City of Seattle's Motion to Dismiss, docket no. 37, is GRANTED. Plaintiff's Amended Complaint, docket no. 36, is DISMISSED with prejudice.

(2) The Clerk is directed to enter judgment consistent with this Order, send a copy of the Judgment and this Order to all counsel of record, and CLOSE the case.

IT IS SO ORDERED.

Dated this 8th day of May, 2020.

[handwritten: signature]

Thomas S. Zilly
United States District Judge

Appendix D

RELEVANT STATUTORY PROVISION

Seattle Municipal Code Ch. 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.

(Ord. 125930 , §1, 2019.)

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;

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)

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.

(Ord. 125930 , §1, 2019.)