

ERISA BASICS: PREEMPTION

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I. ERISA PREEMPTION

A. Statutory Framework

1. Section 514 of ERISA provides that ERISA supersedes any and all state laws insofar as they relate to any employee benefit plan. ERISA § 514(a).
2. The breadth of this provision is clear in the definition of “state laws” which includes “all laws, decisions, rules, regulations, or other state actions having the effect of law, of any state.” ERISA § 514(c)(1).

“State” is defined as “a state, any political subdivision thereof, or any agency or instrumentality of either which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by ERISA.” ERISA § 514(c)(2).
3. Section 514(b)(2)(A) contains a “savings clause” which provides that nothing in ERISA “shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking or securities.”
4. Section 514(b)(2)(B) -- the “deemer clause” -- qualifies the savings clause by providing that no employee benefit plan shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company for the purpose of state regulation.

B. What is a Plan?

If there is no employee benefit plan, there can be no preemption.

1. Definition of Employee Benefit Plan

An "employee benefit plan" is defined as including an "employee welfare benefit plan" and an "employee pension benefit plan." ERISA § 3(3), 29 U.S.C. § 1002(3). An "employee welfare benefit plan" is any "plan, fund or program" which is "established or maintained" by an "employer" or an "employee organization" (union, etc.) or both for the purpose of providing, either directly or through the purchase of insurance, benefits such as medical, dental, disability, vacation, apprenticeship, etc. ERISA § 3(1), 29 U.S.C. § 1002(1). By regulation, severance pay arrangements may also constitute welfare benefit plans (rather than pension benefit plans). ERISA § 3(2)(b)(i), 29 U.S.C. § 1002(2)(b)(i).

An "employer" includes an individual employer and a group or association of employers. ERISA § 3(5), 29 U.S.C. § 1002(5). A plan must cover employees. *E.g., Matinchek v. John Alden Life Ins. Co.*, 93 F.3d 96 (3d Cir. 1996) (plan covering sole proprietor and spouse not covered by ERISA).

2. A Plan May Exist Absent Formalities

In *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982), the Court held that the test was whether a reasonable person could ascertain from the surrounding circumstances: (1) intended benefits, (2) intended beneficiaries, (3) the source of financing, and (4) a procedure for obtaining benefits. Some of these essentials may be provided by or adopted from outside the employer; *e.g.*, through an insurance company. Although the mere purchase of insurance does not necessarily establish a plan, it is evidence of a plan. The fact that fiduciaries fail to carry out their duties to enact a written instrument does not indicate that no plan exists. (On the other hand, *Donovan* held that a mere decision to extend benefits does not constitute a plan, fund, or program.) In *Donovan*, a group insurance trust (multiple employer trusts or METs) created to enable small employers to obtain group health insurance at favorable rates had purchased a group policy from Occidental Insurance Company. Employers and employee groups had then "subscribed" to the MET to receive Occidental coverage. The employers and unions had done so pursuant to either collective bargaining agreements or practices which were expected to continue. The benefits were spelled out in the policies, and the beneficiaries were a substantial percentage of the employees of the subscribing employers and members of the subscribing unions. The Court held that the employer and union subscribers to the MET had established employee benefit plans. (The MET was held not to be a plan.)

3. On-Going Plan Administration

In *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), the Supreme Court held that a Maine law requiring employers who closed their plants to pay a one-time severance payment to employees was not preempted because there was no on-going administrative responsibility to determine eligibility, calculate benefit levels, or monitor funding for benefit payments, and thus there was no plan.

There has been a good deal of litigation over two questions: (1) whether or not employer promises to individuals constitute plans; *see, e.g., Williams v. Wright*, 927 F.2d 1540 (11th Cir. 1991); and (2) whether there must be an ongoing scheme and/or an administrative structure in order for a plan to exist. *Compare Velarde v. Pace Membership Warehouse, Inc.*, 105 F.3d 1313 (9th Cir. 1997) (agreement to pay bonus and severance

pay if employees worked through a certain date not a plan because no requirement of administrative scheme; single mathematical calculation only); *Sherrod v. General Motors Corp.*, 33 F.3d 636 (6th Cir. 1994) (collectively bargained General Motors severance payments not ERISA-covered plan because payments to each group of affected employees were one-time payments with amounts predetermined through bargaining, creating no need for continuing administration); *Angst v. Mack Trucks*, 969 F.2d 1530 (3rd Cir. 1992) (collectively bargained buy-out plan not an ERISA plan because no new administrative scheme and no new administrative requirements imposed on existing scheme) *with Bogue v. Ampex Corp.*, 976 F.2d 1319 (9th Cir. 1992), *cert. denied*, 507 U.S. 1031 (1993) (severance plan covered by ERISA because administrator had to make discretionary determinations as to whether new job duties similar to old ones, which constituted ongoing administration).

4. Vacation Pay

Employer practices of paying vacation pay out of general assets, rather than through funded trusts, do not constitute employee benefit plans covered by ERISA. As a result, state laws regulating vacation pay are not preempted insofar as they apply to such practices. *Massachusetts v. Morash*, 490 U.S. 107 (1989).

Query when and whether a managed care organization (MCO) is acting as a plan, as a business or as insurance. See *Bauman v. U.S. Healthcare*, 23 EBC 1681 (3d Cir., 1999), *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), *cert. denied*, 523 U.S. 1141 (1999); *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997) ("the organization and offering of restricted . . . networks should be seen as part of the carrier's own administration rather than its administration of ERISA plans). Compare with *Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998), *cert. granted*, 120 S. Ct. 10 (1999) (court's total confusion over what is the plan); *Nealy v. US Healthcare HMO*, 1999 WL 161533, at *n.3 (N.Y. March 25, 1999) (court does not reach argument that MCO is not a plan). See generally *Zavora v. Paul Revere Life Ins. Co.*, 145 F.3d 1118 (9th Cir. 1998) (no plan because employer acts as conduit for insurer's product).

C. Exceptions To Preemption

1. Statutory Exceptions

Statutory exemptions to preemption are set forth in ERISA § 514(b), 29 U.S.C. § 1144(b). The following is only a partial list:

a. Insurance, Banking and Securities Laws

Section 514(b)(2)(A) provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

- (1) However, § 514(b)(2)(B), the so-called "deemer" clause provides that neither employee benefit plans nor trusts established under such plans "shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."
- (2) The interpretation and application of the insurance "savings" clause and the "deemer" clause have been the subject of extensive case law. See *UNUM v. Ward*, 526 U.S. 358 (1999),

b. Other Federal Laws

Such laws (e.g., Title VII, Railway Labor Act, Taft-Hartley Act, RICO) are not preempted if preemption would "alter, amend, modify, invalidate, impair or supersede" them. ERISA § 514(d), 29 U.S.C. § 1144(d). See, e.g., *Murphy v. Heppenstall Co.*, 635 F.2d 233 (3rd Cir. 1980), *cert. denied*, 454 U.S. 1142 (1982) (NLRA and federal common law of labor relations not preempted); *Airline Pilots Ass'n International v. Northwest Airlines*, 627 F.2d 272 (D.C.Cir. 1980) (mandatory arbitration provision of the RLA not preempted); *Nemeth v. Clark*, 677 F.Supp. 899 (W.D.Mich. 1987) (ADEA); See *Shaw v. Delta Airlines*, 463 U.S. 85, 96-97 (1983);

c. State laws applicable to "multi-employer welfare arrangements" MEWA's)

ERISA § 514(b)(6), 29 U.S.C. § 1144(b)(6). This provision was added to ERISA in 1980 because certain individuals and companies had sought to avoid state insurance laws requiring specified reserve levels, etc. by marketing so-called "multiple employer trusts" or "METS," then claiming that the METS were employee welfare benefit plans and that state regulation of those METS was preempted by ERISA, which does not impose funding requirements on welfare benefit plans. ERISA now provides that, whether or not the MEWA is a "plan," it is still subject to state laws; however, a fully insured MEWA is subject only to certain state insurance laws, while a non-fully insured MEWA is subject to all

state insurance laws that are not inconsistent with Title I of ERISA. See, e.g., *Fuller v. Norton*, 86 F.3d 1016 (10th Cir. 1996) (state regulation of non-fully insured MEWA not in conflict with Title I of ERISA).

D. Court Decisions and Open Issues

1. While state laws mandating that health care plans include certain coverage are generally preempted insofar as they apply to employee benefit plans, such statutes may be saved from preemption insofar as they are applied to insurance companies, as opposed to self-funded and self-administered plans. In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the Court held that insured plans are subject to indirect regulation by the state such as mandated benefits, but self-insured plans are protected from such regulation by the deemer clause. In so holding, the Court recognized that this created an anomaly between insured and self-funded plans, but stated that this was inherent in ERISA. Accord, *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (ERISA's deemer clause prohibits the application of state insurance laws such as subrogation to self-insured plans).
2. Courts have been left with the question as to what is an insured plan
 - a. Performance of administrative services only does not convert self-insured plan into an insured plan. E.g., *Tri State Mach., Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309 (4th Cir. 1994), cert. denied, 513 U.S. 1183 (1995); *O'Reilly v. Ceuleers*, 912 F.2d 1383 (11th Cir. 1990); *Insurance Board Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987).
 - b. Purchase of stop-loss insurance does not convert a self-insured employee benefit plan into a fully insured one. *Tri State Mach., Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309 (4th Cir. 1994); *American Medical Sec., Inc. v. Bartlett*, 111 F.3d 358 (4th Cir. 1997), cert. denied, 524 U.S. 936 (1998).
3. Notice Prejudice Rule and What is the Business of Insurance?

In *UNUM v. Ward*, 526 U.S. 358 (1999), the Court looked at the breadth of the savings clause. Mr. Ward notified his employer concerning his disability in order to receive certain benefits (such as COBRA health rights), but failed to timely file for long-term disability benefits with UNUM, whom his employer had designated as the claims administrator. UNUM denied Mr. Ward's claim. Mr. Ward

argued that his claim should be allowed for two reasons. First, the employer's knowledge of Mr. Ward's disability should be imputed to UNUM. Second, Mr. Ward's claim should be considered timely filed under California's notice-prejudice rule which requires that the claim be deemed timely filed unless UNUM can show actual prejudice.

In *Pilot Life*, the Supreme Court identified three factors to determine whether an activity comes within the meaning of the business of insurance: (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry. The Ward Court held that a common sense view of what constitutes the business of insurance governs and the three factors are guidelines to make that determination. Thus all three factors need not be met to meet the definition of business of insurance. The Court held that the notice prejudice rule is a rule of decision limited to the insurance industry, and thus saved from ERISA preemption. The Court also held however that California's law of agency was not saved from preemption; and thus, there was no imputation of the employer's knowledge to the plan administrator as provided by state law.

The impact of this decision is that more state laws will be saved from preemption and thus fewer of them will be preempted. In the health care arena, there may be more state legislation to attempt to regulate managed care entities. With regard to benefit claims, the fight over imputation of knowledge will now shift to the DOL's regulatory process.

- E. A Law Must "Relate To" an Employee Benefit Plan in Order for It To Be Preempted
 - 1. The Supremacy Clause of the Constitution may entail preemption of state law either by express provision, by implication, or by a conflict between federal and state law.
 - 2. ERISA preemption analysis is no different than any other preemption analysis. *John Hancock Mutual Life Ins. Co. v. Harris Trust and Savings Bank*, 510 U.S. 86, 99 (1993) ("we discern no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis").

3. Conflict Preemption

Where a state law directly conflicts with ERISA, the state law is preempted by ERISA. See, e.g., *Boggs v. Boggs*, 520 U.S. 833 (1997) (the Court affirmatively said it was only applying ordinary conflict preemption analysis); *District of Columbia v. Greater Washington Board of Trade*, (“*Board of Trade*”), 506 U.S. 125 (1992); *Alessi v. Raybestos- Manhattan, Inc.*, 451 U.S. 504 (1981).

If a claim can be brought under ERISA § 502(a), then the state law action is completely preempted by ERISA § 514(a). See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (a common law wrongful discharge claim that an employer terminated or otherwise discriminated against an employee to prevent the employee from vesting in a benefit or to prevent accrual or receipt of a benefit is preempted by ERISA § 510); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (“*Pilot Life*”). *Accord, Painter v. Golden Rule Ins. Co.*, 121 F.3d 436 (8th Cir. 1997), *cert. denied*, 523 U.S. 1074 (1998) (allegation of wrongful denial of conversion policy benefits is specifically governed by ERISA, and tortious interference claims are conflict preempted). For an impassioned plea for ERISA reform, see *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997).

When considering the removal of a case from state court, defendants must consider whether the cause of action is subject to “complete” or simply “conflict” preemption. Courts have looked to the “well-pleaded complaint rule” which applies unless the claim has the characteristics of a 502(a)(1)(B) action. See *Warner v. Ford Motor Co.*, 46 F.3d 531 (6th Cir. 1995). If preemption is only a defense to the claim it is not removable. See *Franklin H. Williams v. Travelers Ins. Inc.*, 50 F.3d 144 (2d Cir. 1995); *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332.

4. The Meaning of “Relates To” (a/k/a Field Preemption)

Beginning with the *Travelers* case, the Supreme Court announced a remarkable change regarding its preemption analysis. Prior to *Travelers*, the Court had started its analysis with the observation that Congress intended to preempt to state laws broadly. In *Travelers* the Court began its analysis with the “presumption that Congress does not intend to supplant state laws.” *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654 (1995) (“*Travelers*”). Moreover, the Court stated that the “basic thrust of the pre-emption . . . clause was to avoid a multiplicity of regulation in order to permit nationally uniform administration of employee benefit plans.” *Id.* at 657.

- a. A law “relates to” an ERISA plan if it has a connection with or reference to such a plan. *California Div. of Labor Standards*

Enforcement v. Dillingham Construction, 519 U.S. 316 (1997) (“*Dillingham*”) (in order to “relate to” a plan, a statute must necessarily refer only to ERISA plans. Since not all apprenticeship plans are ERISA plans, the statute does not “relate to” ERISA plans and thus are not preempted on that basis); *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997) (“*DeBuono*”).

- b. After *Dillingham*, the circuit courts are split concerning whether a state statute should be preempted if all it does is specifically refer to an ERISA plan. Compare *Dillingham*, 519 U.S. at 327 (if a state law functions irrespective of the existence of an ERISA plan, the law does not reference an ERISA plan); *Community Health Partners v. Commonwealth of Kentucky*, 14 F. Supp. 2d 991 (W.D.Ky. 1998) (even though Kentucky’s “any willing provider” statute specifically references ERISA plans, the court held that “mere reference alone” was not enough to trigger preemption because ERISA plans were not the only plans affected and the law did not act “immediately and exclusively” upon employee benefit plans with *Shaw v. Delta Airlines*, 463 U.S. 85, 96-97 (1983); *Board of Trade*, 506 U.S. 125, 130 (1992) (striking down District of Columbia law that “specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is preempted”); *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825 (1988) (a garnishment statute singling out ERISA plans for special treatment was held preempted, but the general garnishment statute was not preempted as applied to ERISA plans); *Prudential Ins. Co. v. National Park Med. Ctr.*, 154 F.3d 812 (8th Cir. 1998) (because *Travelers* had no effect on the “reference to” prong of the analysis ERISA preempts the Arkansas Patient Protection Act because it specifically excludes ERISA plans).
- c. If a law has a connection with an ERISA plan, it may be preempted. However, “relates to” must have some limitation; otherwise it “would never run its course.” *Travelers*, 514 U.S. at 655.
- d. There is a presumption against preemption absent a clear indication of Congressional intent to do so, in order that state law is given the fullest effect possible. *Travelers*, 514 U.S. at 653-58. Starting with this presumption in *Dillingham*, the Court noted that apprenticeship standards have been long regulated by the states, and there was nothing in ERISA to indicate Congressional intent to preempt this traditional area

of state regulation. Because the statute merely changed the economic conditions under which the ERISA plan must operate, there was no connection and therefore no preemption. [Of particular note is the concurrence of Justices Scalia and Ginsburg suggesting that the Court had gotten ERISA preemption wrong by using the “relates to” clause; instead the Court should use just traditional field and conflict preemption analysis.]

- e. In *DeBuono*, the Court, again applying its *Travelers*’ analysis, held that the states traditionally regulated matters of health and safety and therefore the presumption was against preemption. The tax’s effect on benefits was an indirect economic effect and therefore there was no relation to an ERISA plan.

F. Preemption Applied to Selected Issues

1. In General

State laws dealing with those areas with which ERISA is expressly concerned -- funding, reporting and disclosure, vesting, fiduciary responsibility -- are clearly preempted. *Travelers*, 514 U.S. at 651; *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978) (state law regulating funding and disclosure requirements of ERISA plans is preempted). Thus, state laws that (1) mandate benefits, structures and/or their administration; (2) bind employers or administrators to particular choices or preclude uniform administrative practice, thereby regulating ERISA plans; or (3) provide alternate enforcement mechanisms, are preempted.

Conversely, ERISA generally should not have any preemptive effect on areas that states have historically regulated concerning the protection of the lives, limbs, health, comfort, and quiet of all persons. *Travelers*; *Dillingham*; *DeBuono*.

Thus, regulation of health and hospital costs, including taxation of health care facility owned by ERISA plan; medical quality control standards; hospital workplace regulations; general health care regulation will generally not be preempted. *Travelers*, 514 U.S. at 659-65; *Dillingham*, 117 S.Ct. at 840; *DeBuono*, 117 S.Ct. at 1747.

2. Wrongful Discharge

A common law wrongful discharge claim that an employer terminated or otherwise discriminated against an employee to prevent the employee

from vesting in a benefit or to prevent accrual or receipt of a benefit is preempted by ERISA § 510. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). However, the mere fact that the relief to be afforded an employee or former employee under state law may involve an employee benefit plan (e.g., an order for "back" contributions or an award of damages for loss of employee benefits arising out of a termination) will not result in ERISA preemption. E.g., *Forbus v. Sears Roebuck & Co.*, 30 F.3d 1402, 1406-1407 (11th Cir. 1994), *cert. denied*, 513 U.S. 1113 (1995).

3. Employment Discrimination

State law claims of employment discrimination may not be preempted if they have a basis independent of the plan in question. Even if they directly implicate plans, such claims may not be preempted if the portion of the state statute at issue tracks a federal employment discrimination statute. *Compare Shaw v. Delta Air Lines*, 463 U.S. 85, 97 (1983) (ERISA preempts a state law barring pregnancy discrimination because Title VII had not yet been amended to bar such discrimination; state laws play a "significant role" in the enforcement of Title VII and stated that "to the extent that the Human Rights Law provides a means of enforcing Title VII's commands," ERISA preemption would impair Title VII. Consequently, such state laws would not be preempted because of ERISA § 514(d)) *with Warner v. Ford Motor Co.*, 46 F.3d 531 (6th Cir. 1995) (state age discrimination law not preempted); *Clark v. Coats & Clark, Inc.*, 865 F.2d 1237 (11th Cir. 1989) (same); *Le v. Applied Biosystems*, 886 F.Supp. 717 (N.D.Cal. 1995) (state disability discrimination claim not preempted).

4. State Laws Regulating Benefits

a. Types of benefits or terms of a plan

E.g., *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (required provision of pregnancy benefits is preempted); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (state "mandated benefit" statute requiring ERISA plans to provide mental health benefits is related to ERISA plans); *Board of Trade*, 506 U.S. 125 (1992) (workers' compensation law prohibiting termination of health benefits of workers receiving workers' compensation benefits is preempted); *Air Transport Ass'n of America v. City and County of San Francisco*, 992 F. Supp. 1149 (N.D. Cal. 1998) (ERISA preempts city ordinance requiring airlines to provide ERISA-covered domestic partner benefits because ordinance mandated benefit structure; however recognizes a narrow marketplace

participant exception to ERISA preemption but finds that the City's monopoly position as Airport proprietor requires preemption).

b. Rules for the calculation of benefits

E.g., FMC Corp. v. Holliday, 498 U.S. 52 (1990) (state anti-subrogation statute interferes with calculation of benefits and is thus preempted); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (state prohibition of offset of workers' compensation benefits against retirement benefits is preempted).

5. Promises of Benefits and Misrepresentations

Where an employer promises an employee certain benefits which are not reflected in the terms of an employee benefit plan or makes representations regarding the plan, are the employee's claims of breach of contract, bad faith, and intentional or negligent misrepresentation preempted? This question is often inter-related with questions of whether or not a plan exists and/or whether the plaintiff is a "participant" in an employee benefit plan.

a. Historically, where claims have been held preempted, employees and former employees frequently have found that ERISA affords no remedy. Thus, if the employer is acting in its capacity as such, rather than as a fiduciary, it owes no fiduciary duty to the employee. Prior to the Supreme Court's recent decision in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), some circuits did not allow participants to sue for breaches of fiduciary duty based on misrepresentations. Although the Supreme Court held in *Varity* that individuals may bring such claims, they are limited to "equitable relief." Some circuits do not recognize estoppel claims against plans, or do so in very limited circumstances. In an oft-quoted phrase, the Fifth Circuit has characterized this situation as "betrayal without a remedy." *Degan v. Ford Motor Co.*, 869 F.2d 889 [10 Employee Benefits Cas. 2438] (5th Cir. 1989).

b. Cases holding claims preempted include: *Smith v. Dunham-Bush*, 959 F.2d 6 (2d Cir. 1992); *Sanson v. General Motors*, 966 F.2d 618 [15 Employee Benefits Cas. 1943] (11th Cir. 1992), cert. denied, 507 U.S. 984 (1993); *Christopher v. Mobil Oil Corp.*, 950 F.2d 1209 (5th Cir. 1992); *Bartholet v. Reishauer A.G. (Zurich)*, 953 F.2d 1073 (7th Cir. 1992); *Olson v. General Dynamics*, 960 F.2d 1418 (9th Cir. 1991), cert. denied, 504 U.S. 986 (1992); *Anderson v. John Morrell*

& Co., 830 F.2d 872 [8 Employee Benefits Cas. 2657] (8th Cir. 1987); *Pane v. RCA Corp.*, 667 F. Supp. 168 [8 Employee Benefits Cas. 2663] (D.N.J. 1987), *aff'd*, 10 Employee Benefits Cas. 2079 (3d Cir. 1989); *Lister v. Stark*, 890 F.2d 941 [11 Employee Benefits Cas. 2362] (7th Cir. 1989); *Degan v. Ford Motor Co.*, 869 F.2d 889 [10 Employee Benefits Cas. 2438] (5th Cir. 1989); *Straub v. Western Union Telegraph Co.*, 851 F.2d 1262 (10th Cir. 1988); *Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290 (5th Cir. 1990); *Degnan v. Publiker Industries*, 83 F.3d 27 (1st Cir. 1996); *Farr v. U.S. West*, 151 F.3d 908 (9th Cir. 1998), *amended*, 179 F.3d 1252 (9th Cir. 1999), *cert. denied*, 120 S. Ct. 935 (2000). In virtually all of these cases, plan participants were left with no cause of action or no remedy.

- c. Cases holding no preemption include *Deller v. Portland General Electric Co.*, 734 F. Supp. 916 [12 Employee Benefits Cas. 1488] (D.Ore. 1990) (state law claims of unfair dealing and negligent misrepresentation based on an employer's delay in implementing pension plan amendments until after plaintiffs were terminated not preempted because plaintiffs were not plan participants and therefore could not bring a claim under ERISA); *Forbus v. Sears Roebuck & Co.*, 30 F.3d 1402 (11th Cir. 1994), *cert. denied*, 115 S. Ct. 906 (1995) (plaintiffs accepted early retirement packages based on representation that jobs would be eliminated; misrepresentation was as to existence of jobs, not benefits under plan); *Smith v. Texas Children's Hospital*, 84 F.3d 157 (5th Cir. 1996) (fraud claim based on misrepresentation by new employer where remedy sought was damages for loss of benefits from former employer); *Greenblatt v. The Budd Co.*, 666 F. Supp. 735 [8 Employee Benefits Cas. 2673] (E.D. Pa. 1987); *Johnson v. Antioch University*, 1992 WL 88028, 15 Employee Benefits Cas. 1402 (D.D.C. 1992); *McNamee v. Bethlehem Steel Corp.*, 692 F. Supp. 1477 (E.D.N.Y. 1988), and *Welsh v. Northern Telecom*, 354 S.E.2d 746 (N. Carolina Ct. of Apps. 1987).
- d. In *Scott v. Gulf Oil Corporation*, *supra*, 754 F.2d 1499, the Ninth Circuit held that plaintiffs' state law claims of violation of public policy, bad faith, and fraud were not preempted insofar as they claimed that Gulf's conduct "prevented the existence of an employee benefit plan." *Id.* at 1505-1506. *Scott* arguably supports the type of analysis discussed in No. 1, above, but other courts have interpreted *Scott* as a "no plan" case.

6. Fraud in the Inducement.

- a. A growing number of courts have held that claims of fraud in the inducement to join employee benefit plans are not preempted by ERISA. *Perry v. P.I.E. Nationwide, Inc.*, 872 F.2d 157 [10 Employee Benefits Cas. 2503] (6th Cir. 1989), *cert. denied*, 493 U.S. 1093 [11 Employee Benefits Cas. 2680] (1990); *Perkins v. Time Insurance Co.*, 898 F.2d 470 [12 Employee Benefits Cas. 1281] (5th Cir. 1990); *Hubbard v. Blue Cross & Blue Shield Association*, 42 F.3d 942 [18 Employee Benefits Cas. 2825] (5th Cir. 1995); *Morstein v. National Insurance Services*, 93 F.3d 715 (11th Cir. 1996) (*en banc*) (overruling *Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (4th Cir. 1989)); *Wilson v. Zoellner*, 114 F.3d 713 [21 Employee Benefits Cas. 1222] (8th Cir. 1997); *Martin v. Pate*, 749 F. Supp. 242 [12 Employee Benefits Cas. 2676] (S.D. Ala. 1990); *Isaac v. Life Investors Insurance Co.*, 749 F. Supp. 855 [12 Employee Benefits Cas. 2523] (E.D. Tenn. 1990); *Health America v. Menton*, 551 So. 2d 235 [11 Employee Benefits Cas. 1751] (Ala. Supreme Court 1989); *Miller v. Lay Trucking Co.*, 606 F. Supp. 1326 (N.D. Ind. 1985); *Smith v. Texas Children's Hospital*, 84 F.3d 152 (5th Cir. 1996); *Smith v. Cohen Benefit Group*, 851 F. Supp. 210 (M.D.N.C. 1993); *Johnson v. Antioch University*, 1992 WL 88028, 15 Employee Benefits Cas. 1402 (D.D.C. 1992) (fraud claims against plan preempted, but not against third parties); *MNVA R.R. v. John Alden Life Ins. Co.*, 507 N.W.2d 15, [17 Employee Benefits Cas. 2089] (Minn. Ct. App. 1993).
- b. Other courts have not allowed such state law claims to proceed. *Anderson v. Humana, Inc.*, 24 F.3d 889 [18 Employee Benefits Cas. 1565] (7th Cir. 1994); *Massachusetts Cas. Ins. Co. v. Reynolds*, 113 F.3d 1450 (6th Cir. 1997); *Carlo v. Reed Rolled Thread Die Co.*, 49 F.3d 790 (1st Cir. 1995); *Franklin v. QHG of Gadsden, Inc.*, 127 F.3d 1024 (11th Cir. 1997); *Maez v. Mountain States Tel. & Tel., Inc.*, 54 F.3d 1488 (10th Cir. 1995); *Hall v. Blue Cross/Blue Shield of Ala.*, 134 F.3d 1063 (11th Cir. 1998). *See also, Butero v. Royal MacCabees Life Ins. Co.*, 174 F.3d 1207 (11th Cir. 1999) (although not analyzing claim as such).

7. State Law Claims Relating to Plan Administration Are Preempted

- a. *Pilot Life*, 481 U.S. 41 (1987) (allegations of improper handling of benefit claims conflict with ERISA's comprehensive enforcement scheme and are, therefore, preempted).
- b. *Bast v. Prudential Ins. Co.*, 150 F.3d 1003 (9th Cir. 1998), *cert. denied*, 120 S. Ct. 170 (1999). ERISA preempts a survivor's allegations for breach of contract for a health plan's delayed coverage of benefits for autologous bone marrow transplant.
- c. *But see, Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825, 833 (1988) (run-of-the-mill state law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan are against the plan in a capacity other than as a plan -- *i.e.*, as a commercial entity -- and are not preempted); *Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc.*, 944 F.2d 752, 753 (10th Cir. 1991) (a law affecting the relations between an ERISA entity and an outside party is not preempted). *See, e.g., Coyne & Delany Co. v. Selman*, 98 F.3d 1457 (4th Cir. 1996) (professional malpractice claim by an employer against consultants and plan administrator is not preempted because it was based on traditional state laws that do not implicate the relations among ERISA plan entities; court relied on *Travelers'* presumption); *Geweke Ford v. St. Joseph's Omni Preferred Care Inc.*, 130 F.3d 1355 (9th Cir. 1997) (no preemption of contractual dispute between administrator and plan sponsor).

8. State Law Tort Claims By Participants

a. Cases Holding Preemption

State law tort claims arising out of denials of care or delivery of inadequate care have frequently been held preempted. The following is not a complete list. *Corcoran v. United HealthCare*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 113 S. Ct. 812 (1992) (wrongful death action against entity which provided utilization review services for a plan and denied full-time nursing care); *Rodriguez v. Pacificare of Texas*, 980 F.2d 1014 (5th Cir. 1993), *cert. denied*, 113 S. Ct. 2456 (1993) (state law claim against HMO and doctor for failing to provide prompt and adequate care and

coverage); *Kuhl v. Lincoln National Health Plan*, 999 F.2d 298 (8th Cir. 1993), *cert. denied*, 114 S. Ct. 694 (1994) (malpractice and other claims based on denial of treatment at non-HMO hospital); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993), *cert. denied*, 114 S. Ct. 1612 (1994) (wrongful death claim based on plan's delay in approving treatment); *Cannon v. Group Health Service of Oklahoma*, 77 F.3d 1270 (10th Cir. 1996); *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997) (claims of fraudulent non-disclosure and misrepresentation arising from HMO's compensation agreement with doctor); *Elsesser v. Philadelphia College of Osteopathic Medicine*, 802 F. Supp. 1286 (E.D. Pa. 1992) (action challenging HMO's decision not to pay for heart monitor); *Dearmas v. Av-Medi*, 814 F. Supp. 1103 (S.D. Fla. 1993); *Ricci v. Googerman*, 840 F. Supp. 316 (D.N.J. 1993) (malpractice claim against HMO based on doctor's error); *Anderson v. Humana, Inc.*, 24 F.3d 889 (7th Cir. 1994) (consumer fraud action against HMO for failing to disclose incentive structure under which it operated); *Jass v. Prudential Health Care Plan*, 88 F.3d 1482 (7th Cir. 1996) (vicarious liability and loss of consortium claims against managed care entity based on physician's failure to treat not preempted, but fraud claim preempted); *Nealy v. U.S. Health Care HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994) (various claims vs. HMO arising out of participant's death); *Tolton v. American Biodyne*, 48 F.3d 937 (6th Cir. 1995) (wrongful death and other tort claims against insurer and contract provider of managed care mental health services); *Visconti By Visconti v. U.S. Health Care*, 857 F. Supp. 1097 (E.D. Pa. 1994) (medical malpractice claims against HMO based on direct and vicarious liability), *rev'd on other grounds sub nom Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995); *Danca v. Emerson Hosp.*, 9 F. Supp. 2d 27 (D. Mass. 1998), *aff'd*, 185 F.3d 1 (1st Cir. 1999) (utilization review entity's wrongful denial of a request for placement in a particular psychiatric facility).

b. Cases Holding No Preemption

In some cases, state law claims have been held not preempted. The following is not a complete list. *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995) (vicarious liability claims against HMO based on malpractice of one of its treating physicians in treating patient); *Pappas v. Asbel*, 724 A.2d 889, 1998 WL 892074 (Pa. Dec. 23, 1998) (vicarious liability malpractice claim against HMO based on delay in transferring patient to an authorized facility equipped to handle his medical problem); *Kohn v. Delaware Valley HMO*, 14 E.B.C. 2336 (E.D. Pa. 1991) (medical malpractice action against HMO which denied therapy recommended by its own doctors; claims based on HMO's

responsibility for actions of health care providers alleged to be its agents not preempted; claims based on direct negligence preempted); *Chaghervand v. Carefirst*, 909 F. Supp. 304 (D. Md. 1995) (vicarious liability claim against HMO not preempted; direct negligence claim preempted); *Kearney v. U.S. Healthcare*, 859 F. Supp. 182 (E.D. Pa. 1994) (vicarious liability claim against HMO which allegedly held out physician as its employee and lead patient reasonably to believe being treated by an employee not preempted; other claims preempted); *Roessert v. Health Net*, 929 F. Supp. 343 (N.D. Cal. 1996) (claims against HMO, participating medical group and doctors based on various alleged acts of negligence by doctors attempting to commit patient); *Burke v. Smithkline Bio-Science Laboratories*, 858 F. Supp. 1181 (M.D. Fla. 1994) (claims based on vicarious liability for acts of doctors); *Decker v. Saini*, 14 E.B.C. 1556 (Mich. Cir. Ct. 1991) (action against HMO for vicarious liability based on malpractice of physicians); *Independence HMO v. Smith*, 733 F. Supp. 983, 988 (E.D. Pa. 1990) (malpractice action against HMO based on doctor's treatment); *Elsesser, supra* (malpractice claim against HMO for alleged malpractice of physician); *Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994) (malpractice action vs. HMO); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994) (medical malpractice claim against HMO based on vicarious liability for acts of doctor as its agent, where HMO directly provides medical services or leads participant to reasonably believe that it has, rather than simply arranging and paying for treatment); *Schacter v. Pacificare of Oklahoma*, 923 F. Supp. 1448 (N.D. Okl. 1995) (action v. HMO, based on vicarious liability for doctor's negligence). See also *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) (claims against administrator of plan under theory of respondeat superior based on malpractice of provider on list designated by plan, not on negligent selection of that provider, improperly removed to federal court -- not subject to "complete preemption"); *Lupo v. Human Affairs International Inc.*, 28 F.3d 269 (2d Cir. 1994) (malpractice, breach of fiduciary duty based on doctor-patient relationship, and infliction of emotional distress against managed psychotherapy care entity based on actions of its psychotherapist-employee improperly removed); *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995), *cert. denied*, 116 S. Ct. 1876 (1996) (medical negligence claims against HMO's improperly removed, court leaves preemption issue open).

To review the Secretary of Labor's position and amicus briefs on this issue, go to <http://www.dol.gov/pwba/public/pubs>.

9. Professional Malpractice

Coyne & Delany Co. v. Selman, 98 F.3d 1457 (4th Cir. 1996). Relying on the *Travelers*' presumption, the court found that a professional malpractice claim by an employer against consultants and plan administrator is not preempted because it was based on traditional state laws that do not implicate the relations among ERISA plan entities. *But see, LeBlanc v. Cahill*, 153 F.3d 134 (4th Cir. 1998) (§ 502(a)(3) provides a cause of action against non-fiduciary party in interest for participation in prohibited transactions); *Liss v. Smith*, 991 F.Supp. 278 (S.D.N.Y. 1998) (attorney who exercises discretionary authority over plan assets may be a fiduciary).

10. State Independent Review Procedures

Corporate Health Ins. Inc. v. Texas Dept. of Ins., 12 F. Supp. 2d 597 (S.D.Tex. 1998). The Texas Health Care Liability Act allows an individual to sue a health insurance carrier, HMO, or other managed care entity for damages caused by the entity's failure to exercise ordinary care when making a health care treatment decision. The Act also establishes an independent review process for adverse benefit determinations. Finally, the Act also prevents removal of a physician from its plan for advocating on behalf of a patient and voids any indemnification or hold harmless clause between a physician and a managed care entity.

In an interesting discussion of the *Corcoran* decision, calling into question whether the court would have decided it the same way after *Travelers*. The court held that the statute is distinguishable from the failure to treat claims in *Corcoran* and indeed is more akin to the quality of care claims asserted in the *Dukes* case. Thus the failure to exercise ordinary care provisions were not preempted. However, the court found that the independent review provision mandate the administration of employee benefits and therefore are connected to an ERISA plan. The court also held ERISA plans which offer coverage through any managed care entity would be restricted to using a certain benefit structure -- that is, one which does not remove a physician for advocating for a patient and one that does not include a prohibited hold harmless or indemnification clause. These provisions have a connection with an ERISA plan and are preempted. The court rejected plaintiffs' argument that being able to sue for quality of care claims is an alternative enforcement mechanism. Finally, the court held that those provisions which it held to be preempted may be severed from the remainder of the statute because the Act may still be given effect.

G. Remedies

ERISA § 502(a)(1)(B) provides that a participant may receive the benefits to which s/he is entitled. State law remedies generally are unavailable in the context of benefits litigation. *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) (punitive and extra-contractual damages not available under § 502(a)(2) of ERISA to individual participants); *Degan v. Ford Motor Co.*, 869 F.2d 889 (5th Cir. 1989) (ERISA precludes oral modifications to benefit plans and thus promissory estoppel claims are not cognizable, resulting in “betrayal without a remedy”). *Accord, Nero v. Industrial Molding Corp.*, 167 F.3d 921 (5th Cir. 1999) (any damages which would make person whole is not equitable relief).