ERISA Preemption

ERISA PREEMPTION

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I. Scope of Preemption

Section 514(a) of ERISA, 29 U.S.C. § 1144(a), provides that the statute will "supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title [29 U.S.C. § 1003(a)] and not exempt under section 1003(b) of this title [29 U.S.C. § 1003(b)]."

A. ERISA's Preemption Provision is Broad.

ERISA broadly preempts state law and has been held to "preempt the field."

1. "State laws" are not merely state statutes, but "[all laws, decisions, rules, regulations or other State action having the effect of law. . . .]" ERISA § 514(c)(1), 29 U.S.C. § 1144(c)(1).

2. State includes "a state, any political subdivisions thereof, or any agency or instrumentality of either which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter [of ERISA]." ERISA § 514(c)(2), 29 U.S.C. § 1144(c)(2).

3. Where a state law "conflicts with" ERISA, it will be preempted. Boggs v. Boggs, 521 U.S. 1138, 118 S. Ct. 9 [21 Employee Benefits Cas. 1047] (1997) (state community property law allowing a nonparticipant spouse to transfer by testamentary instrument an interest in undistributed pension plan benefits preempted; Congress, through ERISA's alienation, survivors' annuities, and QDRO provisions, intended to spell out who would and would not have rights to pension benefits; the state law would conflict with Congressional intent); Ingersoll-Rand v. McClendon, 498 U.S. 133, 111 S. Ct. 478 [12 Employee Benefits Cas. 2737] (1990) (state law claim of wrongful termination to prevent vesting of pension benefits in conflict with ERISA, which provides cause of action for same alleged misconduct).

4. Initially, the Supreme Court gave the term "relate to" an expansive interpretation. A state law relates to a plan "if it has a connection with or reference to a plan." Shaw v. Delta Air Lines, 463 U.S. 85, 97, 103 S. Ct. 2890 [4 Employee Benefits Cas. 1593] (1983). See also FMC v. Holliday, 498 U.S. 52, 111 S. Ct. 403 [12 Employee Benefits Cas. 2689] (1990); Ingersoll-Rand v. McClendon, supra. But more recent Supreme Court decisions have rejected the Court's prior focus on the meaning of "relate to." See Section “C,” below.

5. The Supreme Court has held that even state laws which are consistent with ERISA and at least some state laws which indirectly affect employee benefit plans may be preempted. Shaw v. Delta Air Lines, supra, 463 U.S. 85 at 95; Metropolitan Life
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a. In Shaw, the Court found preempted a section of New York’s employment discrimination law which required employers to cover pregnancy disability in their health plans.


c. In Mackey v. Lanier Collections Agency & Service, 486 U.S. 825, 108 S. Ct. 2182 [9 Employee Benefits Cas. 2129] (1988), a Georgia garnishment statute was held preempted to the extent that it purported to exempt from garnishment the assets of an ERISA-covered welfare benefit plan. (However, the Court held that to the extent a creditor merely seeks to take advantage of the state’s general garnishment statute, the state law is not preempted.) In the wake of Mackey, several Circuit courts have held that state mechanic’s lien laws referring to employee benefit plans are preempted, even when the references are merely for the purpose of extending to such plans the same rights to use the lien statute as those afforded to other creditors. See Sturgis v. Herman Miller, Inc., 943 F.2d 1127 (9th Cir. 1991); McCoy v. Massachusetts Institute of Technology, 950 F.2d 13 [13 Employee Benefits Cas. 1937] (1st Cir. 1991); Iron-Workers Mid-South Pension Fund v. Terotechnology Corp., 891 F.2d 548 [11 Employee Benefits Cas. 2481] (5th Cir. 1990), cert. denied, 497 U.S. 1024, 110 S. Ct. 3272 (1990).

6. The Supreme Court has rejected the argument that the term "purports to regulate" (see subsection "2," above) limits the scope of ERISA preemption. Ingersoll-Rand v. McClendon, supra.

B. Claims Arising From Benefit Denials, Fiduciary Breaches Generally Preempted.

1. Claims of breach of contract, fraud, infliction of emotional distress, etc., based on the denial of benefits pursuant to the terms of an employee benefit plan, the administration of such a plan, or the representations of an administrator or fiduciary of such a plan are generally preempted. This is the case whether the plaintiff is seeking payment of benefits or some form of damages. See, e.g., Pilot Life
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2. Claims of fiduciary duty (e.g., by participants or on behalf of the plan) are preempted. See, e.g., Kramer v. Smith Barney, 80 F.3d 1080 (5th Cir. 1996); District 65 v. Prudential Securities, 925 F. Supp. 1551 (N.D. Ga. 1996).

C. Limitations to Preemption.

1. In Mackey v. Lanier Collections Agency & Service, 486 U.S. 825, 108 S. Ct. 2182 [9 Employee Benefits Cas. 2129] (1988), a Georgia garnishment statute which singled out ERISA plans for special protection was held preempted, but the general garnishment statute was held not preempted as applied to ERISA plans. The Court stated that preemption would not apply to "run-of-the-mill" state law claims against ERISA plans, such as for unpaid rent, failure to pay creditors, or torts committed by the plans. The Court's statements in this regard have been much-cited and have been used to allow claims by plans against non-fiduciaries (and visa versa). See, e.g., Section IV-E, below.

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2. In *New York State Conference of Blue Cross and Blue Shield Plan v. Travelers Insurance Co.*, 514 U.S. 645, 115 S. Ct. 1671 (1995), the Supreme Court unanimously rejected a challenge on grounds of ERISA preemption to a New York State statute which required hospitals to collect surcharges from patients covered by certain third-party health providers, but not from patients covered by a Blue Cross/Blue Shield Plan. The reasoning in *Travelers* and subsequent cases (see "3," below) indicates that the Court now is taking a less expansive view of preemption, moving away from its prior focus on the literal meaning of "relate to." 514 U.S. at 656. Thus, in *Travelers*, the Court observed that "relate to" could not be read to "extend to the furthest stretch of its indeterminacy, [or] for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere.' 514 U.S. at 165 (quoting a philosophical treatise). In addition, the Court stated that "where federal law is said to bar state action in fields of traditional state regulation, we have worked on “the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.”" *Id.* at 655.

3. In *California Division of Labor Enforcement v. Dillingham Construction, N.A.*, 519 U.S. 316, 117 S. Ct. 832 [20 Employee Benefits Cas. 2425] (1997), the Court held that a California "prevailing wage" statute which had the effect of regulating an apprenticeship plan (which was an employee welfare benefit plan) was not preempted by ERISA. The Court reiterated its observation in *Travelers* that the text of ERISA's preemption provision was "unhelpful." The Court restated its Shaw analysis that a law "relates to" an employee benefit plan if it (1) "has a connection with," or (2) "reference to" an employee benefit plan. After giving examples of its prior holdings regarding the second of these criteria (not relevant to *Dillingham*), the Court then went on to repeat its *Travelers* observations that "an uncritical literalism" in applying the "connection with" standard "offered scant utility in determining Congress' intent as to the extent of Section 514(a)'s reach." 519 U.S. at 325 [20 Employee Benefits Cas. at 2428]. As in *Travelers*, the Court looked to the objectives of ERISA (i.e., Congressional intent) and the nature and effect of the state law on ERISA plans, again working from the assumption that the historic police powers of the state would not be superseded absent clear indication that it was Congress' intent.

4. In his concurring opinion in *Dillingham*, Justice Scalia, joined by Justice Ginsburg, noted that despite the Court's 14 previous ERISA preemption decisions, the rate of new cases coming to the Court had not diminished, "suggesting that our prior decisions have not succeeded in bringing clarity to the law." 519 U.S. at 335 [20 Employee Benefits Cas. at 2433]. Although joining in the majority opinion, which paid "obeisance" to the Court's previous decisions, he stated his belief that the Court should acknowledge that the criteria set forth in some of them had been abandoned. 519 U.S. at 335 [20 Employee Benefits Cas. at 2434]. Following up on the majority
opinion in *Travelers*, he further noted that "applying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else." *Id.* Finally, he stated that he thought that the Court should acknowledge that the Court's "first take on this statute was wrong" in that the "relate to" clause was not intended as a "test for preemption," but merely an indicator that "ordinary field preemption" applies to law regulating employee benefit plans. *Id.* (Emphasis added.)

5. In *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 117 S. Ct. 1747 [21 Employee Benefits Cas. 1041] (1997), the Court held that ERISA did not preempt New York from imposing a gross receipts tax on medical centers which were owned and operated by an ERISA-covered employee benefit plan. The Court held that the law in question was "one of 'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of [ERISA]. . . ." 520 U.S. at 815 [21 Employee Benefits Cas. at 1045] (quoting *Travelers*), 514 U.S. at 668, 115 S. Ct. at 1683. The Court specifically disavowed the distinction between "indirect" and "direct" impact on the plan on which it had based its *Travelers* decision in part. In a footnote, the Court listed its 13 decisions on ERISA preemption over the 16 years through 1996 and the "avalanche of litigation [over ERISA preemption] in the lower courts." 520 U.S. at 809 [21 Employee Benefits Cas. at 1041] fn 1.

6. 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 Medical Center*, 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).

7. Even before these recent Supreme Court decisions, some courts held that state law claims are not preempted or are less likely to be preempted where they do not affect
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the "relations among the principal ERISA entities -- the employer, the plan, the plan fiduciaries, and the beneficiaries [i.e., participants]" and/or where "the state law involves an exercise of traditional state authority." Sommers Drug Stores v. Corrigan Enterprises, 793 F.2d 1456, 1467-1468 [7 Employee Benefits Cas. 1782] (5th Cir. 1986), cert. denied, 479 U.S. 1034. See also, Memorial Hospital System v. Northbrook Life Ins. Co., 904 F.2d 236 [12 Employee Benefits Cas. 1897] (5th Cir. 1990); Hubbard v. Blue Cross & Blue Shield Ass’n, 42 F.3d 942, 945 (5th Cir.), cert. denied, 515 U.S. 1122 (1995) (ERISA preempts a state law claim only “if (1) the state law claim addresses an area of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) the claim directly affects the relationship between the traditional ERISA entities--the employer, the plan and its fiduciaries, and the participants and beneficiaries”); Hospice of Metro-Denver v. Group Health Insurance of Oklahoma, 944 F.2d 752 (10th Cir. 1991); Aetna Life Ins. Co. v. Borges, 869 F.2d 142 (2d Cir. 1989), cert. denied, 493 U.S. 811 (1989); Arkansas Blue Cross & Blue Shield v. St Mary’s Hosp., Inc., 947 F.2d 1341 (8th Cir. 1992) (six-factor test); Thiokol Corp. v. Roberts, 76 F.3d 751 [19 Employee Benefits Cas. 2871] (6th Cir. 1996) (Michigan value-added tax on all compensation to employees, including payments to employee benefit plans, not preempted); Custer v. Sweeney, 89 F.3d 1156 (4th Cir. 1996).

8. More recently, the courts of appeal have attempted to articulate frameworks for analyzing preemption. For example, in Arizona State Carpenters Pension Trust Fund v. Citibank, 125 F.3d 715 (9th Cir. 1997), the Ninth Circuit first indicated that pursuant to Travelers, three types of state laws are always preempted: (1) state laws that mandate employee benefit structures or their administration; (2) state laws that bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself; and (3) state laws providing alternate enforcement mechanisms for employees to obtain ERISA plan benefits. If it is determined that a state law does not fall within one of these categories, and it is a law of general application, then preempted turns on the question of whether the relationship involved is one which is regulated by ERISA, in which case there is preemption, or not, in which case, there is no preemption. The Ninth Circuit previously had discussed these relationships in General American Life Ins. Co. v. Castonguay, 984 F.2d 1518 (9th Cir. 1993), where it stated that ERISA preempts claims as to those relationships which it regulates comprehensively (e.g., between plan and plan participant, plan and employer, plan and trustee) but not as to those which ERISA doesn’t regulate, but rather where the plan operates like any other commercial entity (e.g., plan and its own employees, plan and its insurers or creditors). The actual holding of the case, however, was that an insurance company’s state law fraud claims against the plan’s trustees, rather than the plan, was preempted. See also, Geweke Ford v. St. Joseph’s Omni Preferred Care Inc., 130 F.3d 1355 (9th Cir. 1997) (employer’s state law breach of
contract claims against its ERISA-governed medical plan’s third-party administrator and its excess insurer were not preempted).

In *Coyne & Delaney Co. v. Selman*, 98 F.3d 1457 (4th Cir. 1996), on which Citibank relied, the 4th Circuit employed a similar post-Travelers analysis. The court held that an employer’s claim against insurance professionals for alleged misrepresentations before the plan came into existence were not preempted, even though defendants ultimately served as fiduciaries of plan.

9. In *Massachusetts v. Morash*, 490 U.S. 107 [10 Employee Benefits Cas. 2233] (1989), the Supreme Court held that a state law regulating vacation pay was not preempted insofar as it was applied to an employer's practice of paying such funds out of its general assets, as opposed to from a separate trust fund. See also, *California Hospital Association v. Henning*, 770 F.2d 856 [6 Employee Benefits Cas. 2065] (9th Cir. 1985) (California law requiring payment to an employee of a pro rata share of vacation pay upon termination was not preempted where the payment was made out of the employer’s general assets); *Fuller v. Norton*, 86 F.3d 1016 (10th Cir. 1996).

II. EXCEPTIONS TO PREEMPTION

A. Statutory Exceptions.

Statutory exemptions to preemption are set forth in ERISA § 514(b), 29 U.S.C. § 1144(b):


2. **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."

   a. **However,** Section 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."
b. The interpretation and application of the insurance "savings" clause and the "deemer" clause are discussed further in Section "B" below.


5. State laws applicable to "multi-employer welfare arrangements" (MEWAs): ERISA § 514(b)(6), 29 U.S.C. § 1144(b)(6). This provision was added to ERISA 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).

B. More on the Statutory Exception to Preemption For Laws Regulating Insurance.

1. While state laws mandating that health care plans include certain coverage are generally preempted insofar as they apply to employee benefit plans (see Section IV-G of this Outline), such statutes may be saved from preemption insofar as they are applied to insurance companies, as opposed to self-funded and self-administered plans. Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 [6 Employee Benefits Cas. 1545] (1985). In Metropolitan Life, the Massachusetts statute mandated that health care plans and insurance policies include specified minimum health care benefits. In holding that it was not preempted insofar as it applied to insured plans, the Court recognized that this created an anomaly between insured and self-funded plans, but stated that this was inherent in ERISA. See also, Washington Physicians Service Association v. Gregoire, 147 F.3d 1039 (9th Cir. 1998) (law requiring HMOs and health care service contractors to cover alternative treatments did not "relate" to employee benefit plans, but even if it did, it would be saved because HMOs and contractors were engaged in the business of insurance); Seymour v. Blue Cross/Blue Shield, 988 F.2d 1020 [16 Employee Benefits Cas. 1757] (10th Cir. 1993). (See Pilot Life Insurance Company v. Dedeaux, discussed in subsection 5, below, which limits the potential scope of Metropolitan Life.)

3. The presence of a stop-loss policy insuring a plan against large claims does not invoke the savings clause. *Moore v. Provident Life Insurance Co.*, 786 F.2d 922 (9th Cir. 1986); *American Medical Security v. Bartlett*, 111 F.3d 358 [20 Employee Benefits Cas. 2761] (4th Cir. 1997), *cert. denied*, 118 S. Ct. 2340 (1998) (state mandated benefits law preempted even though stop-loss policy had low attachment point, notwithstanding state's argument that low attachment point essentially shifted risk from plan to insurer, but enabled the insurer to avoid state regulation; court influenced by fact that one of the stated purposes of the regulation was to reach plan-participant relationship and regulate self-funded plans). *See also, Bone v. Associated Management Services, Inc.*, 632 F. Supp. 493 [7 Employee Benefits Cas. 1419] (S.D. Miss. 1986); *Brown v. Granatelli*, 897 F.2d 135 [12 Employee Benefits Cas. 1241] (5th Cir. 1990).

4. The savings clause can exempt state common law as well as statutory law from preemption. See *Winchester v. Prudential Life Ins. Co.*, 975 F.2d 1479 (10th Cir. 1992). However, decisional law will have a harder time meeting the test of *Pilot Life Ins. Co.* (See below.)

5. Insurance Bad Faith And Similar Claims: State common law claims of breach of the implied covenant of good faith and fair dealing (and other similar common law claims), even as applied to insurance companies (and not just self-funded plans) are preempted by ERISA and are not "saved" from preemption as laws which "regulate" insurance. *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 [8 Employee Benefits Cas. 1409] (1987). Such claims may be removed to federal court despite the fact that the federal question does not appear on the face of the state court complaint. *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 [8 Employee Benefits Cas. 1417] (1987) Both of these cases involved disability insurance claims against insurance companies insuring employee group insurance plans.

   a. In *Pilot Life*, the Court applied a three-factor standard adapted from the McCarran-Ferguson Act to decide whether the "practice" regulated by the state law in question constituted the "business of insurance": (1) does the practice regulated have "the effect of transferring or spreading a policyholder's risk"; (2) is the practice "an integral part of the policy relationship between the insurer and the insured," and (3) "is the practice limited to entities within the insurance industry." (See discussion of *UNUM Life Ins. Co. v. Ward*, infra, regarding whether all three factors must be met.) The Court rejected the argument that the common law bad
faith doctrine at issue in *Pilot Life* regulated an integral part of the policy relationship between insurer and insured, finding the connection too "attenuated."

b. Subsequent cases have applied *Pilot Life* so as to foreclose certain state law statutory claims against insurers involved with employee benefit plans, as well as common law claims. For example, California Insurance Code Section 790.03 requires insurers to acknowledge and act reasonably promptly on communications regarding claims. Courts have held claims under this and similar state statutes preempted. See *Kanne v. Connecticut General Life Insurance Co.*, 859 F.2d 96 [10 Employee Benefits Cas. 1947] (9th Cir. 1989); *Commercial Life Insurance Co. v. Superior Court*, 47 Cal.3d 473 [10 Employee Benefits Cas. 2020] (1988); *In re Life Insurance Co. of North America*, 857 F.2d 1190 [10 Employee Benefits Cas. 1085] (8th Cir. 1988).

c. Other cases holding that state laws were not saved include: *DeBruyne v. Equitable Life Ins. Co.*, 920 F.2d 57 [13 Employee Benefits Cas. 1193] (7th Cir. 1990) (following the "business of insurance test" set forth under the McCarran-Ferguson Act to hold that the saving clause did not apply to a statute prohibiting misrepresentations by insurers); *Davies v. Centennial Life Ins. Co.*, 128 F.3d 934 (6th Cir. 1997) (provision in Ohio Code that permits insurer to rescind policy issued in reliance on applicant's willfully false statement); *Tingle v. Pacific Mutual Ins. Co.*, 996 F.2d 105, 17 Employee Benefits Cas. 1052 (5th Cir. 1993) (Louisiana insurance law barring rescission of policy where applicant made false statement); *Willett v. Blue Cross & Blue Shield*, 953 F.2d 1335, 14 Employee Benefits Cas. 2637 (11th Cir. 1992) (Alabama law requiring insurers to inform insureds that their coverage had lapsed due to employer's failure to pay premium); *Serrato v. John Hancock Life Ins. Co.*, 31 F. 3d 882 (9th Cir. 1994) (state law vesting rule because it did not regulate insurance); *Maciosek v. Blue Cross & Blue Shield United*, 930 F.2d 536 (7th Cir. 1991) (employee's claim under Wisconsin common law prohibiting insurer from recovering payments absent a mistake of fact); *Howard v. Gleason Corp.*, 901 F.2d 1154, 12 Employee Benefits Cas. 1297 (2d Cir. 1990) (New York insurance law requiring employers to give plan participants notice of conversion rights within 15 days after the participants' termination; court reasoned that, because the statute regulated notices given by the employer, rather than by the insurer, it did not regulate insurance within the meaning of the saving clause); *Tingey v. Pixley-Richards West, Inc.*, 953 F.2d 1124, 14 Employee Benefits Cas. 2445 (9th Cir. 1992); *Presley v. Blue Cross-Blue Shield*, 744 F. Supp. 1051 (N.D. Ala. 1990) (Alabama law that required insurers of group employment health plans to notify plan participants of cancellation or modification of policy occasioned by failure of employer to pay premiums); and *Drexelbrook Eng'g Co. v. Travelers Ins. Co.*, 710 F. Supp. 590 (E.D. Pa.) (same), aff'd, 891 F.2d 280 (3d Cir. 1989).
WARNING: To the extent that any of the above cases require that all three McCarran Ferguson Act criteria be met, they may not be good law after UNUM Life Ins. Co. v. Ward, infra.

d. Cases holding state laws saved from preemption, include: Martin v. Pate 749 F. Supp. 242, 12 Employee Benefits Cas. 2676 (S.D. Ala. 1990), aff’d without op., 934 F.2d 1265 (11th Cir. 1991) (Alabama statute permitting an insurer to rescind any contract entered into on the basis of a misrepresentation made by an insured); Henkin v. Northrop Corp., 921 F.2d 864, 13 Employee Benefits Cas. 1409 (9th Cir. 1990) (California statute that mandated conversion rights for terminated plan participants who died before conversion election period expired); DePasquale v. Aetna Life Ins. Co., 743 F. Supp. 364, 12 Employee Benefits Cas. 2293 (E.D. Pa. 1990) (Pennsylvania law that required insurer to give notice of conversion rights after policy cancellation); Ruble v. UNUM Life Ins. Co., 913 F.2d 295 [12 Employee Benefits Cas. 2434] [6th Cir. 1990]; Howard v. Gleason Corp., 901 F.2d 1154 [12 Employee Benefits Cas. 1297] (2d Cir. 1990); United of Omaha v. Business Men’s Assurance Co., 104 F.3d 1034 [20 Employee Benefits Cas. 2353] (8th Cir. 1997) (state statute’s requirement that an insurance carrier provide continuation coverage to a totally disabled participant upon termination of policy); Cellilli v. Cellilli, 939 F. Supp. 72 (D. Mass. 1996) (divorced spouse’s claim for continued coverage under state insurance law); Lewis v. Aetna U.S. Healthcare, 1999 WL 1133761 (N.D. Okla. 1/20/99) (court found that a tort claim alleging insurance company’s failure to pay claim in bad faith, thereby forcing the claimant to hire an attorney and incur unnecessary costs, but ultimately paying all benefits under policy and then invoke ERISA preemption so the insurance company has no accountability (the Christian rule) is not preempted because this rule regulates insurance and is saved).

e. In both Kanne and Commercial Life, the courts held that even if the California Insurance Code section in question did regulate insurance according to the Pilot Life criteria, it would still be preempted because it regulated plan procedures. See also, UNUM Life Ins. Co. v. Ward, infra; Ruocco v. Bateman, Eichler, Hill, Richards, Inc., 903 F.2d 1232 [12 Employee Benefits Cas. 1557] (9th Cir. 1990) (state law governing the distribution of the surplus of insurance plans is preempted because the distribution of surplus is not an integral part of the policy relationship and does not serve a risk spreading function).

6. State Law Interpretive and Similar Doctrines: In UNUM Life Ins. Co. v. Ward, 526 U.S. 358 [22 Employee Benefits Cas. 2745] (1999), the Supreme Court held that California’s “notice-prejudice” rule, which prohibits an insurer from denying a claim based on an insured’s failure to give timely notice under the terms of a policy unless the insurer can demonstrate prejudice from the delay, was saved from preemption. The Court held that the doctrine satisfied the “common sense” test of whether it was a law regulating insurance, and also that it met two of the three McCarran-Ferguson factors. The Court held that the three factors were not a rigid checklist. On the other hand, the Court held that another California law doctrine, which made the employer
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an agent of the insured, was not saved. It was a general doctrine of agency law, and, in any event, it would be preempted, notwithstanding the saving clause, because it would require employers to take on administrative functions with regard to plans. 

Note: Some state law insurance doctrines, such as the interpretive doctrine of “contra proforentum” or the rule of “reasonable expectations” may be adopted as federal common law applicable to ERISA plans. See, e.g., Saltarelli v. Bob Baker Group Medical Trust, 35 F.3d 382, 386-87 (9th Cir. 1994).

7. The Supreme Court held that a Pennsylvania anti-subrogation law was preempted by ERISA because it relates to benefits paid or payable under "[a]ny program, group contract or other arrangement for the payment of benefits." FMC Corp. v. Holliday, supra, 498 U.S. 52 [12 Employee Benefits Cas. 2689] (1990). The Court gave the deemer clause an expansive interpretation. See also Baxter v. Lynn, 886 F.2d 182 [11 Employee Benefits Cas. 1698] (8th Cir. 1989); Travitz v. Northeast Depart. ILGWU Health & Welfare Fund, 13 F.3d 704 (3d Cir. 1994), cert. denied, 511 U.S. 1143 (1994); Electro-Mechanical Corp. v. Ogan, 9 F.3d 445 (6th Cir. 1993); Dees v. Primehealth, 894 F. Supp. 1549 (S.D. Ala. 1995) (state law that insurer not entitled to subrogation until insured made whole for loss preempted by ERISA where it would have barred enforcement of plan’s subrogation provision; state law requiring recovery by HMO from tortfeasor preempted because plan allowed HMO to recover against participant).

8. The Sixth Circuit found that a Michigan no-fault insurance law was a risk-spreading device that met the three Pilot Life criteria and was not preempted. Northern Group Services, Inc. v. Auto Owners Insurance Co., 833 F.2d 85 [9 Employee Benefits Cas. 1038] (6th Cir. 1987).

III. NO PREEMPTION IF NO ERISA PLAN

In order for ERISA to preempt state law, an "employee benefit plan" must be involved in the action.

A. 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).

1. An "employer" includes an individual employer and a group or association of employers. ERISA § 3(5), 29 U.S.C. § 1002(5).
B. Statutorily Exempt Plans
Certain plans are statutorily exempt from ERISA regulation and therefore from preemption. ERISA § 514(a), 29 U.S.C. § 1144(a); ERISA § 4(b), 29 U.S.C. § 1003(b). These include:

   a. Church plans, plans maintained outside the U.S. for the benefit of non-resident aliens, and unfunded excess benefit plans are also excluded from ERISA coverage and preemption. ERISA § 3(33), 29 U.S.C. § 1002(33); § 4(b)(2), 29 U.S.C. § 1003(b)(2); § 3(36), 29 U.S.C. § 1002(36).


3. DoL regulations provide descriptions of the types of funds that do not meet the definition of employee benefit welfare plan in ERISA § 3(3), 29 U.S.C. § 1002(3). See, e.g., Devlin v. Transportation Communications International Union, 175 F.3d 121 (2d Cir. 1999) (death benefit fund which paid $300 to survivors was not an ERISA employee welfare benefit plan because the amount provided was a “small gift” payable on “occasions, such as the . . . death . . . of employees. . . .” and therefore came within the exclusion from ERISA provided by 29 C.F.R. § 2510.3-1(g)).

C. A Plan May Exist Absent Formalities.
A plan may be held to exist even in the absence of a written plan document or compliance with other ERISA requirements. In Donovan v. Dillingham, 688 F.2d 1367 [3 Employee Benefits Cas. 2122] (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
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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.) Donovan has
been widely followed. Wickman v. Northwestern National Life Ins. Co., 908 F.2d 1077,
1082 (1st Cir.), cert. denied, 498 U.S. 1013, 111 S. Ct. 581 (1990); Grimo v. Blue
Cross/Blue Shield of Vermont, 34 F.3d 148, 151, 18 Employee Benefits Cas. 2140 (2d
Cir. 1994); Diebler v. United Food and Commercial Workers’ Local Union 23, 973 F.2d
206, 209 (3d Cir. 1992); Almeria v. Cone Mills Corp., 23 F.3d 855 (4th Cir. 1994) (en
banc); Memorial Hospital System v. Northbrook Life Ins. Co., 904 F.2d 236, 240-241
(n.4) (5th Cir. 1990); Brown v. Amoco-Pittsburgh Corp., 876 F.2d 546, 551 (6th Cir.
1989); Ed Miniata, Inc. v. Globe Life Ins. Group, Inc., 805 F.2d 732, 7 Employee Benefits
Cas. 2414 (7th Cir. 1986), cert. denied, 107 S. Ct. 3188, 8 Employee Benefits Cas. 1848
(1986); Harris v. Arkansas Book Co., 794 F.2d 358 (8th Cir. 1986); Beau v. Del Monte
Corp., 748 F.2d 1348, 5 Employee Benefits Cas. 2744 (9th Cir. 1984), cert. denied, 474
U.S. 865 (1985); Scott v. Gulf Oil Corporation, 754 F.2d 1499 (9th Cir. 1985); Peckham
v. Gem State Mutual of Utah, 964 F.2d 1043, 1047 (10th Cir. 1992); Kenney v. Roland
Parson Contracting Corp., 28 F.3d 1254 (D.C. Cir. 1994).
But see Whitt v. Sherman Int’l Corp., 147 F.3d 1325 (11th Cir. 1998) (no plan based on
letter to employee at time of termination because final form and terms not then settled);
Shaw v. PACC Health Plan, 908 P.2d 308 (Oregon Supreme Ct. 1995) (where employer
and provider never reached agreement, no plan was established and employee’s state
law claims against provider were not preempted).

1. In Donovan, a group insurance trust (MET) 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.)

2. Two circuits have attempted to delineate the types of “surrounding circumstances”
that should be examined in determining when a plan exists under the Dillingham test.
Henglein v. Informal Plan for Plant Shutdown Benefits for Salaried Employees, 974
representations, [3] existence of a fund or account to pay benefits, [4] actual payment
of benefits, [5] a deliberate failure to correct known perceptions of a plan’s existence,
[6] the reasonable understanding of employees, and [7] the intentions of the putative
sponsor); and Kenney v. Roland Parson Contracting Corp., 28 F.3d 1254 (D.C. Cir.
1994) (adopting same).

3. Only a few cases have addressed the language in Dillingham requiring an
“ascertainable class” of beneficiaries. Compare, e.g., Diak v. Dwyer, Costello &
Knox, P.C., 33 F.3d 809 (7th Cir. 1994) (no plan where court unable to ascertain intended beneficiaries despite fact that some individuals had received benefits); and Smith v. Hartford Ins. Group, 6 F.3d 131 (3d Cir. 1993) (no plan where document contained conflicting statements regarding class of beneficiaries) with McDonald v. Provident Indemnity Life Ins. Co., 60 F.3d 234 (5th Cir. 1995), cert. denied, 516 U.S. 1174 (1996) (plan established where insurance policy designated all employees and dependents as beneficiaries); and Randol v. Mid-West Life Ins. Co. of Tennessee, 987 F.2d 1547 (11th Cir.), cert. denied, 510 U.S. 863 (1993) (class composed of two employees who chose to purchase policy offered to all employees)

Only a few cases have addressed whether an arrangement covering one employee can constitute plan. See Williams v. Wright, 927 F.2d 1540, 13 Employee Benefits Cas. 2137 (11th Cir. 1991) (letter from company president to retiring general manager promising various retirement benefits, which were paid for a time, constituted an ERISA-covered plan); Biggers v. Wittek Indus., 4 F.3d 291, 17 Employee Benefits Cas. 1556 (4th Cir. 1993) (preempting state law where court assumed, without deciding, that employment contract covering one employee and promising one year severance pay upon termination constituted plan). Compare Curtiss v. Union Central Life Ins. Co., 823 F. Supp. 851 (D. Colo. 1993) (employer's purchase of insurance policy for one individual not a plan for various reasons); New England Mutual Life Ins. Co. v. Baig, 166 F.3d 1 (1st Cir. 1999) (employer's reimbursement of premiums paid by employee did not create plan); Delaye v. Agripac, Inc., 39 F.3d 235 (9th Cir. 1994) (individual employment contract with severance pay clause held not to create a plan because no ongoing administrative scheme).

4. An arrangement by which an employer contracted with 2 health insurers to offer insurance to its employees, allowed employees to choose between them, and paid the employees’ premiums was an ERISA-covered welfare benefit plan. Brundage-Peterson v. Compcare Health Services Insurance Corp., 877 F.2d 509 [11 Employee Benefits Cas. 1649] (7th Cir. 1989). See also, e.g., Crull v. Gem Insurance Co., 58 F.3d 1386 (9th Cir. 1995) (plan existed where employer paid 25% of premiums, agreed to act as administrator and undertook numerous administrative tasks); Marshall v. Bankers Life and Casualty Co., 832 P.2d 573 [15 Employee Benefits Cas. 2018] (Cal. Sup. Ct. 1992) (although employer did not intend to create ERISA plan and was not involved in plan administration, fact employer paid premiums and retained authority to terminate the policy established existence of ERISA plan for preemption purposes).

5. The lack of employer involvement in ongoing administration does not necessarily establish the absence of a plan.

a. Some courts have held that the purchase of insurance may be enough. See, e.g., Randol v. Mid-West National Life Insurance Co., 987 F.2d 1547 (11th Cir. 1993); Libbey-Owens Ford v. Blue Cross/Blue Shield, 982 F.2d 1031 (6th Cir. 1993); Custer v. Pan American Life Insurance Co., 12 F.3d 410 (4th Cir. 1993); International Resources, Inc. v. New York Life Ins. Co., 950 F.2d 294 (6th Cir. 1991) (plan established where employer contracted with agency and chose plan,
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all employees automatically covered, employer paid premiums); *Marshall v. Bankers Life and Casualty Co.*, 832 P.2d 573 [15 Employee Benefits Cas. 2018] (Cal. Sup. Ct. 1992) (although employer did not intend to create ERISA plan and was not involved in plan administration, facts employer paid premiums and retained authority to terminate the policy established existence of ERISA plan for preemption purposes); *Custer v. Pan American Life Insurance Co.*, 12 F.3d 410 (4th Cir. 1993) (while mere purchase of insurance may not be enough, plan was established where employer determined benefits to be provided, negotiated policy terms, paid for one-half of costs, provided benefits based on employment relationship, and exercised discretion to cancel and replace policy when it became dissatisfied). *See also Demars v. CIGNA Corp.*, 173 F.3d 443 (1st Cir. 1999) (no preemption of claims under an individual long term disability insurance policy obtained after termination of employment through exercise of a conversion rights granted by ERISA plan; conversion policy was not itself an employee welfare benefit plan); *Brundage-Peterson v. CompCare Health Services Insurance Corp.*, 877 F.2d 509, 11 Employee Benefits Cas. 1649 (7th Cir. (1989) (ERISA-covered plan established where employer contracted with two health insurers to offer insurance to its employees, allowed employees to choose between them, and paid the employees' premiums).

b. Other courts have required more employer involvement or found that plans existed based on the purchase of insurance and other factors. *Crull v. Gem Insurance Co.*, 58 F.3d 1386 (9th Cir. 1995) (plan existed where employer paid 25% of premiums, agreed to act as administrator and undertook numerous administrative tasks); *Kidder v. H&B Marine, Inc.*, 932 F.2d 347, 33 (5th Cir. 1991); *Peterson v. American Life & Health Ins. Co.*, 48 F.3d 404, 408 (9th Cir. 1995) (finding plan existed where employer chose insurance, added and deleted individuals from policies, contacted insurance companies for covered individuals, and distributed information relevant to the coverage). *Compare Curtiss v. Union Central Life Ins. Co.*, 823 F. Supp. 851 (D. Colo. 1993) (no plan where mere purchase of insurance for a single employee, no employer representations to owners or employees that a plan existed, no designation of an administrator or fiduciary to oversee a group plan, and no procedure to ensure compliance with ERISA reporting requirements). *See also Donovan v. Dillingham*, supra (“the purchase of insurance does not conclusively establish a plan, fund, or program, but the purchase is evidence of the establishment of a plan, fund, or program”).

6. Under the Secretary of Labor’s “safe-harbor” regulation, 29 U.S.C. § 2510.3-1(j), an employee welfare benefit plan does not include a group insurance program in which (1) the employer does not make contributions, (2) participation by employees is voluntary, (3) the sole functions of the employer are, without endorsing the program, to permit the insurer to publicize the program and to collect premiums by payroll deduction and forward them to the insurer, and (4) the employer receives no remuneration other than reasonable compensation for administrative services actually rendered in connection with the payroll deduction. All four of these criteria
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must be met in order for the “safe harbor” to apply. Qualls v. Blue Cross of California, 22 F.3d 839 (9th Cir. 1994). (On the other hand, failure to meet the criteria is not dispositive, but merely evidence that a plan exists. Zavora v. Paul Revere Life Ins. Co., 145 F.3d 1118 (9th Cir. 1998).) See, e.g., Johnson v. Watts Regulator Co., 63 F.3d 1129 (1st Cir. 1995) (no plan; cover letter merely recommending did not constitute endorsement; activities such as tracking eligibility status were ministerial); Grimo v. Blue Cross/Blue Shield of Vermont, 34 F.3d 148 (2d Cir. 1994) (mere fact that employer paid for coverage at some time in the past does not preclude application of safe-harbor provision in future). Compare Gaylor v. John Hancock Mut. Life Ins. Co., 112 F.3d 460 (10th Cir. 1997) (although employee self-paid for disability coverage giving rise to dispute, that coverage was part of a comprehensive insurance program pursuant to which employer paid for another type of coverage); Hansen v. Continental Insurance Co., 940 F.2d 971 [14 Employee Benefits Cas. 1909] (5th Cir. 1991).

7. Some courts have held that employer or employee organization control or involvement in the operation or administration of a MET is a necessary prerequisite to the existence of a “plan.” See, e.g., Taggart Corp. v. Life & Health Benefits Admin., 617 F.2d 1208 [2 Employee Benefits Cas. 2472] (5th Cir. 1980), cert. denied sub nom, Taggart Corp. v. Efros, 450 U.S. 1030 (1981); Matthew 25 Ministries, Inc. v. Corcoran, 771 F.2d 21 [6 Employee Benefits Cas. 2070] (2d Cir. 1985); MD Physicians & Associates, Inc. v. Texas Board of Insurance, 957 F.2d 178 [15 Employee Benefits Cas. 1007] (5th Cir. 1992). However, these cases and others with similar holdings for the most part involve only the question of whether the MET itself is a “plan.” Even under such an analysis, it could still be held that the individual employer's practice of purchasing insurance from a MET constitutes an ERISA-covered plan. Compare Taggart, supra, with Donovan v. Dillingham, supra. See also, Kanne v. Connecticut General Life Insurance Co., supra (employer involvement necessary for plan existence took place through the MET, which, within meaning of "employer" under ERISA § 3(5), either acted on behalf of the employer or was an association of employers); Crull v. Gem Insurance Co., 58 F.3d 1386 (9th Cir. 1995) (individual employer maintained plan notwithstanding fact that MET, composed of "heterogenous, unrelated employers" would not be a plan). Actions against the METS themselves or insurers might then be preempted because the METS and/or insurers might be considered administrators or fiduciaries of an ERISA-covered plan. Other courts have found that METS are themselves plans. See, e.g., National Business Association Trust v. Morgan, 770 F. Supp. 1168 [13 Employee Benefits Cas. 1716] (W.D. Ky. 1991).
D. *Fort Halifax Packing Co. v. Coyne* -- The Requirement of Ongoing Administration

In *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 8 Employee Benefits Cas. 1729 (1987), the Supreme Court held that a Maine statute requiring employers who closed their plants to pay one-time severance benefits to employees was not preempted because there was no "plan." (See Section IV-B, below, for more on severance pay.) Especially in the wake of this Supreme Court decision, there has been a good deal of litigation over two questions: (1) whether or not employer promises to individuals constitute plans; and (2) whether there must be an ongoing scheme and/or an administrative structure in order for a plan to exist. (These issues are frequently inter-related with the issues addressed in sections IV-C and IV-D, below.)

1. Cases holding that no plan existed include: *Wells v. General Motors Corporation*, 881 F.2d 166 [11 Employee Benefits Cas. 2375] (5th Cir. 1989) and *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); *Rodowicz v. Massachusetts Mutual life Ins. Co.*, 192 F.3d 162 (1st Cir. 1999) (voluntary termination plan offered certain employees a one-time bonus paid over a two month period did not require implementation of on-going administrative structure or long-term financial commitment to any employee); *Kulinski v. Medtronic Bio-Medicus*, 21 F.3d 254 (8th Cir. 1994) (golden parachute payment not a plan where no ongoing administrative scheme); *Fontenot v. NL Industries*, 953 F.2d 960 (5th Cir. 1992) (same); *Angst v. Mack Trucks*, 969 F.2d 1530 (3d 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); *Belanger v. Wyman-Gordon Co.*, 71 F.3d 451 (1st Cir. 1995) (series of early retirement offers did not constitute a plan because no ongoing administration or financial obligation; no claims of employee reliance on promise of future offers); *James v. Fleet/ Norstar Financial Group*, 992 F.2d 401 [16 Employee Benefits Cas. 2153] (10th Cir. 1993) (employer's oral promise to pay employees additional pay if continued to work after corporate consolidation completed); *Delaye v. Agripac, Inc.*, 39 F.3d 235 (9th Cir. 1994) (individual employment contract with severance pay provisions did not constitute plan because no ongoing administrative scheme); *Velarde v. Pace Membership Warehouse, Inc.*, 105 F.3d 1313 [20 Employee Benefits Cas. 2479] (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); *McKinsey v. Sentry Ins.*, 986 F.2d 401 [16 Employee Benefits Cas. 2153] (10th Cir. 1993) (bonus plan allowing withdrawal of benefits at any time not ERISA severance plan); *Harris v. Arkansas Book Co.*, 794 F.2d 358 (8th Cir. 1986) (monthly payments to retiree did not establish a plan); *Smith v. Hartford Insurance Group*, 6 F.3d 131 (3d Cir. 1993); *Tener v. Hoag*, 697 F. Supp. 196 [10 Employee Benefits Cas. 1550] (W.D. Pa. 1988) (one-time payment per agreement not a plan); *Frauer v. North Carolina Farm Bureau Mutual Insurance Co.*, 801 F.2d 675, 677-678 (4th Cir. 1986), cert.
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denied, 480 U.S. 919 (individually negotiated agreement not an ERISA plan); Curtiss v. Union Central Life Insurance Co., 823 F. Supp. 851 (D. Colo. 1993) (employer’s purchase of insurance policy for one individual); Fludgate v. Management Technologies, 885 F. Supp. 645 (S.D.N.Y. 1995) (severance benefits pursuant to individual employment agreement; no administrative scheme -- although payments continued for 2 years, no decision-making necessary during that time); See also, Reliance Ins. Co. v. Zeigler, 938 F.2d 781 (7th Cir. 1991) (annuity purchased by an employee out of a lump-sum payment from an ERISA plan was not a “benefit” of a plan); In Re Tucker Freightline, 789 F. Supp. 884 (W.D. Mich. 1991); Hagel v. United Land Co., 759 F. Supp. 1199 (E.D. Va. 1991); Pritchard v. Rainfair, Inc., 945 F.2d 185 (7th Cir. 1991); Carver v. Westinghouse Hanford Co., 951 F.2d 1083 (9th Cir. 1991); Tischman v. ITT/Sheraton Corp., 882 F. Supp. 1358 (S.D.N.Y. 1995).

2. Cases holding that a plan existed include: Emmenegger v. Bull Moose Tube Co., 1999 U.S. App. LEXIS 30579 (8th Cir. 1999) (plan required a process of determining whether a particular employee was entitled to severance pay and determining the amount of pay due such employee, thus constituting ongoing administrative scheme sufficient to be an ERISA welfare plan); Cvelbar v. CBI Illinois Inc., 106 F.3d 1368 (7th Cir. 1997) (agreement to pay severance benefits to executive for three years after his termination where employer required to process medical claims, pay medical benefits, and make monthly payments); 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); Simas v. Quaker Fabric Corp., 6 F.3d 849 (1st Cir. 1993) (Mass. statute requiring severance benefits to employees with certain seniority who lose jobs within 2 years after corporate takeover and who are not disqualified for benefits under Mass. unemployment laws preempted); Tischmeann v. ITT/Sheraton Corp., 145 F.3d 561 (2d Cir. 1998) (plan existed where employer had limited power to terminate and amend, employer could elect to pay lump sum, employer sho9wed ongoing commitment to pay benefits over time and contemplated case-by-case analysis for each termination); Perdue v. Burger King Corp., 7 F.3d 1251 [17 Employee Benefits Cas. 2032] (5th Cir. 1993) (lump sum separation payment made with no pre-conceived plant closing date); Pane v. RCA Corp., 861 F.2d 631 [10 Employee Benefits Cas. 2079] (3d Cir. 1989); Williams v. Wright, 927 F.2d 1540 (11th Cir. 1991) (promise to one employee); Jervis v. Elerding, 504 F. Supp. 606 (C.D. Cal. 1980); NARDA, Inc. v. Rhode Island Hospital Trust National Bank, 744 F. Supp. 685 (D. Md. 1990); Hollingshead v. Burford Equipment Co., 995 F.2d 74 (3d Cir. 1991); International Resources, Inc. v. New York Life Ins. Co., 950 F.2d 294 (6th Cir. 1991); Smith v. Rochester Telephone Business Marketing, 786 F. Supp. 293 (W.D.N.Y. 1992); Kidder v. H&B Marine, 925 F.2d 857 (5th Cir. 1991); McClelland v. Gronwaldt, 909 F. Supp. 457 (E.D. Tex. 1995) (severance benefits to workers who separate for reasons other than cause -- requires ongoing determinations of reason for separation by administrator and determinations of continuing eligibility).
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E. Plan Must Cover Employees.

In order to be an employee benefit plan covered by ERISA, the plan must cover employees. See, e.g., Meredith v. Time Insurance Co., 980 F.2d 352 (1993) (plan covering only sole proprietor and spouse not covered by ERISA); Matinchek v. John Alden Life Ins. Co., 93 F.3d 96 (3d Cir. 1996) (same); Kennedy v. Allied Mutual Ins. Co., 952 F.2d 262 (9th Cir. 1991) (plan covering only owners of corporation not covered); Agrawal v. Paul Revere Life Ins. Co., 205 F.3d 297, 24 Employee Benefits Cas. 1175 (6th Cir. 2000) (policy covering only sole shareholder not covered). Compare Peterson v. American Life & Health Ins. Co., 48 F.3d 404 (9th Cir. 1995) (health policy previously covering two partners and one employee, but covering only one partner at time of benefit dispute after the other two participants were shifted to a different policy, was an ERISA-covered plan because the policy was only one component of the employer's benefit program which, taken as a whole, constituted a plan). But see, Slamen v. Paul Revere Life Ins. Co., 166 F.3d 1102 (11th Cir. 1999) (policy covering only sole owner of dental practice not an ERISA plan; policy could not be viewed as part of one plan along with separate policy purchased at different time for owner and employees); Hampton v. Provident Life & Accident Co., 1999 U.S. Dist. LEXIS 20677 [23 Employee Benefits Cas. 2870] (E.D.La. 2000) (policy covering only partners not an ERISA plan; not part of one plan with separate health insurance policy purchased at different time from different insurer covering employees).

IV. Frequently Litigated Preemption Issues Which Apply or May Apply to Managed Care-Related Claims

A. Claims Arising Out of Health Care Delivery and Denial.

1. 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 [15 Employee Benefits Cas. 1793] (5th Cir. 1992), cert. denied, 506 U.S. 1033 (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, 508 U.S. 956 (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, 510 U.S. 1045 (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, 511 U.S. 1052 (1994) (wrongful death claim based on plan's delay in approving treatment); Cannon v. Group Health Service of Oklahoma, 77 F.3d 1270, 19 Employee Benefits Cas. 2864 (10th Cir. 1996); Shea v. Esensten, 107 F.3d 625 [20 Employee Benefits Cas. 2561] (8th Cir.) cert. denied, 522 U.S. 914 (1997) (claims of fraudulent non-disclosure and
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misrepresentation arising from HMO's compensation agreement with doctor);  
*Dearmas v. Av-Medi*, 814 F. Supp. 1103 (S.D. Fla. 1993);  
*Anderson v. Humana, Inc.*, 24 F.3d 889 [18 Employee Benefits Cas. 1564] (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);  
*Danca v. Private Health Care Systems, Inc.*, 185 F.3d 1 [23 Employee Benefits Cas. 1505] (1st Cir. 1999) (claims of failure to follow physician’s recommendations, failing to ensure that the evaluation of treatment requests in the course of precertification were made and overseen by capable personnel in a competent manner, negligent supervision and training of precertification personnel, and negligent infliction of emotional distress);  
*Pryzbowski v. U.S. HealthCare, Inc.*, 64 F. Supp. 2d 361 (D.N.J. 1999) (claims against HMO and individual physicians that plaintiffs’ injuries were caused by defendants’ negligence in not getting speedier approval for out-of-network consultations and surgery “relate to” ERISA plan).

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 [19 Employee Benefits Cas. 1572] (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 (Pa. Supreme Ct. 1998), petition for cert. filed, 67 USLW (May 13, 1999)(No. 98-1836) (vicarious liability malpractice claim against HMO based on delay in transferring patient to an authorized facility equipped to handle his medical problem);  
*Nealy v. US HealthCare HMO*, 93 N.Y. 2d 209, 711 N.E.2d 621 (Ct. App. 1999) (medical malpractice, breach of contract, and breach of fiduciary duty claims against primary care physician based on alleged delay in submitting specialist’s referral form);  
*Kohn v. Delaware Valley HMO*, 1991 WL 275609, 14 Employee Benefits Cas. 2336 (E.D. Pa. 1991) (medical malpractice action against HMO which denied therapy recommended by its own doctors; claims based on HMO's...
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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 [18 Employee Benefits Cas. 1887] (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 Employee Benefits Cas. 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 [12 Employee Benefits Cas. 1329] (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. Okla. 1995) (action v. HMO, based on vicarious liability for doctor’s negligence); Harris v. Deaconess Health Services Corp., 61 F. Supp. 2d 889 (E.D. Mo. 1999) (state law action for medical malpractice arising out of diagnostic and treatment decisions relates to “quality,” not “quantity” of benefits under ERISA group health plan, so claims are not completely preempted under ERISA § 502 and should be remanded to state court); Crum v. Health Alliance- Midwest, 47 F. Supp. 2d 1013 (C.D. Ill. 1999) (wrongful death action for negligence and medical malpractice was not action to recover benefits and therefore complete preemption does not apply).

See also Rice v. Panchal, 65 F.3d 637 [19 Employee Benefits Cas. 1841] (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 [18 Employee Benefits Cas. 1759] (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 HMOs improperly removed, court leaves preemption issue open);
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_Giles v. NYLCARE Health Plans, Inc._, 172 F.3d 332 (5th Cir. 1999) (upholding remand of vicarious liability and negligence claims after voluntary dismissal of breach of contract and misrepresentation claims which were preempted; court leaves preemption issue open); _In re U.S. HealthCare_, 193 F.3d 151 (3d Cir 1999) (remanding claims for direct negligence and vicarious liability against HMO based on policy of presumptively discharging mothers and newborns after 24 hours as relating to quality of care; also remanding claims of “reckless indifference” in adopting policy and of negligent selection, supervision and training of physician as not completely preempted).

To review the Secretary of Labor’s position and amicus briefs on this issue, go to [http://www.dol.gov/pwba/public/pubs](http://www.dol.gov/pwba/public/pubs).

c. **Disclosure of Physician Incentives.**

In _Shea v. Esensten_, 208 F.3d 712 [24 Employee Benefits Cas. 1065] (8th Cir. 2000) (“Shea II”), the Eighth Circuit held that a state law claim that a physician failed to disclose a conflict of interest created by his financial relationship with an ERISA entity was not preempted. In an earlier decision, the same court had held that the plaintiff could proceed under ERISA with a claim against the HMO for breach of fiduciary duty for failing to disclose the same incentives. _Shea v. Esensten_, 107 F.3d 625 (8th Cir.), _cert. denied_, 522 U.S. 914 (1997) (“Shea I”). In _Shea II_, the court distinguished the situation from that at issue in _Shea I_ because the defendants in _Shea II_ were not fiduciaries.

Although it is not a case which directly raises a preemption issue, _Herdrich v. Pegram_, 154 F.3d 362 (7th Cir. 1998), as of May 22, 2000, awaiting the decision of the Supreme Court (which granted _certiorari_ and heard argument), may impact preemption in this area. In _Herdrich_, the district court held that plaintiff’s state law claims against physicians and an HMO owned by them for failure to disclose that ownership and failing to disclose financial incentives were preempted. Plaintiff amended and set forth those same claims as breach of fiduciary duty claims under ERISA. The district court dismissed, but the Seventh Circuit reversed, holding that the physicians and HMO could be liable as fiduciaries under ERISA. The forthcoming Supreme Court decision as to that issue may
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bear on the preemption issue in any one of several ways: the Court might say something about preemption in the course of addressing the fiduciary status issue, the Court’s ruling on the fiduciary status issue might have implications for preemption even without any discussion of preemption, or the Court might directly rule on preemption (as urged by amici who have asked the court to rule sua sponte on whether the district court ever had jurisdiction).

2. State Law Claims By Health Care Providers.

a. Health care providers’ claims against plans based on assignments of their patients’ rights against the plans are uniformly held to be preempted by ERISA. See, e.g., Variety Children’s Hosp. v. Century Medical Health Plan, 57 F.3d 1040 [19 Employee Benefits Cas. 1792] (11th Cir. 1995); Memorial Hospital System v. Northbrook Life Insurance Co., 904 F.2d 236 (5th Cir. 1990). However, where the providers’ claims are based on direct dealings with the plan, their claims may not be preempted.

b. In Memorial Hospital System, supra, the plaintiff hospital called the employer to confirm employee coverage under the company health plan, insured and administered by Northbrook. The employer erroneously confirmed coverage and in reliance thereon, the hospital provided medical care. Memorial Hospital also took an assignment of benefits from the employee. When Northbrook denied the employee’s claim, the hospital brought suit against the employer and Northbrook for breach of contract, negligent misrepresentation, equitable estoppel, and deceptive and unfair trade practices under Texas law. The Fifth Circuit ruled that any claims Memorial asserted in its derivative capacity were preempted by ERISA. However, the Court held that Memorial’s claims brought as the health care provider under Texas insurance law were not preempted because they were independent of an ERISA plan’s actual obligations. See also, discussion of 5th Circuit’s decisions in Hermann Hospital and Cypress-Fairbanks, below.

c. Accord Hospice of Metro Denver, Inc. v. Group Health Ins. of Oklahoma, Inc., 944 F.2d 752 (10th Cir. 1991); The Meadows v. Employers Health Insurance, 47 F.3d 1006 (9th Cir. 1995) (ERISA does not preempt a substance abuse treatment facility’s state law misrepresentation and estoppel claims seeking damages caused by medical plan’s misrepresentation about patient’s coverage status); Home Health, Inc. v. The Prudential Ins. Co. of America, 101 F.3d 600 (8th Cir. 1996) (no preemption of provider’s suit based on misrepresentation that patient had not exceeded maximum benefit); Transitional Hospital Corp. v. Blue Cross (THC), 164 F.3d 952 (5th Cir. 1999) (no preemption for alleged misrepresentation
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d. But see Hermann Hosp. v. MEBA Medical & Benefits Plan, 845 F.2d 1286 (5th Cir. 1988) and 959 F.2d 569 (5th Cir. 1992) (explained in note below); Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272 (6th Cir. 1991), cert. dismissed, 505 U.S. 1233 (1992), wherein the court held the health care provider’s state law claims for promissory estoppel, breach of contract, negligent misrepresentation, and breach of good faith claims filed against the administrator of an employee benefit plan for health care services rendered to a plan participant, were preempted by ERISA.

Note: In Cypress-Fairbanks Medical Center, supra, the 5th Circuit attempted to reconcile its Memorial Hospital and Hermann decisions (see above). The court stated that the decisions were consistent because the claim in Hermann derived solely from the rights of the plan participant, whereas those in Memorial were those of an independent third-party provider. See also, Transitional Hospitals Corp. v. Blue Cross and Blue Shield, 164 F.3d 952 [22 Employee Benefits Cas. 2418] (5th Cir. 1999), for a further explanation of Cypress-Fairbanks.

e. In Decatur Memorial Hospital v. Connecticut Gen. Life Ins. Co., 990 F.2d 925 (7th Cir. 1993), the court declined to rule on the split in authority between and Cromwell v. Equicor-Equitable HCA Corp., supra, and Memorial Hosp. Sys. v. Northbrook Life Ins. Co., supra. Faced with claims of negligent misrepresentation by an ERISA plan, the court held it need not resolve whether the alleged state law claims were preempted because the health care provider could not assert a successful state law claim.
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f. In *Central States, Southeast and Southwest Areas Health and Welfare Fund v. Pathology Laboratories*, 71 F.3d 1251 (7th Cir. 1995), *cert. denied*, 517 U.S. 1233 (1996), the court held that ERISA did not preempt medical providers from billing patients directly for services not covered by plans or state from enforcing such payment obligations. Mere fact that this affected price of medical care did not create preemption. However, the plan’s action against provider for restitution of amounts plan had paid “governed by federal common law in the shadow of ERISA.”

g. In *Blue Cross of California v. Anesthesia Care Assocs. Medical Group*, 187 F.3d 1045 (9th Cir. 1999), the court held that ERISA did not preempt providers’ action against plan based on their own agreements with plans, rather than on their assignments from patients.

B. State Attempts to Regulate Health Coverage.

Generally, ERISA’s broad preemption provision has blocked state attempts to regulate health and welfare plans. (ERISA contains no substantive regulation of the terms of "employee welfare benefit plans" such as medical, dental and prescription drug plans, or of the funding of such plans. However, such plans are subject to reporting and disclosure requirements and ERISA’s fiduciary provisions.)


a. Prior to the Supreme Court’s decision in *California Division of Labor Enforcement v. Dillingham Construction, N.A.*, 519 U.S. 316, 117 S. Ct. 832 [20 Employee Benefits Cas. 2425] (1997), applications of state “prevailing wage” laws which require payments of prevailing benefits to employees working for private contractors on public works projects or requiring payments of prevailing wages to employees employed through apprenticeship programs (which are specifically included in ERISA’s definition of employee welfare benefit plans) have been held preempted. See *Dillingham Construction N.A. v. County of Sonoma*, 57 F.3d 712 (9th Cir. 1995); *General Electric Co. v. New York State Dept. of Labor*, 891 F.2d 25 [11 Employee Benefits Cas. 2343] (2d Cir. 1989), *modified*, *General Electric*
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Co. v. New York State Dept. Of Labor, 936 F.2d 1448 (2d Cir. 1991) (provisions regarding non-ERISA benefits such as vacation and holiday pay not preempted); Plumbers & Pipefitters Industry Journeymen & Apprentices Training Fund v. J.A. Jones Construction Co., 846 F.2d 1213 [10 Employee Benefits Cas. 1204] (9th Cir. 1988), aff'd without opinion, 488 U.S. 881 [10 Employee Benefits Cas. 1212]).

2. However, in New York State Conference of Blue Cross and Blue Shield Plan v. Travelers Insurance Co., 115 S. Ct. 1671 (1995) ("Travelers II"), the Supreme Court unanimously rejected a challenge on grounds of ERISA preemption to a New York State statute which required hospitals to collect surcharges from patients covered by certain third-party health providers, but not from patients covered by a Blue Cross/Blue Shield Plan). See also, United Wire Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital, 995 F.2d 1179 (3d Cir. 1993) (N.J. law permitting hospitals to bill paying patients surcharges to cover losses associated with non-paying patients not preempted as applied to self-funded ERISA plans despite the fact that it "took" money from those plans.)

3. On remand in Travelers Insurance Co. v. Pataki, 63 F.3d 89 (2d Cir. 1995) and then in New England Health Care Union, District 1199 v. Mount Sinai Hospital, 65 F.3d 1024 [19 Employee Benefits Cas. 1809] (2d Cir. 1995), the Second Circuit held that New York and Connecticut hospital surcharge statutes were not preempted by ERISA, even as applied to self-funded plans. (The Supreme Court decision in Travelers II, supra, did not address the application of the surcharge to self-funded plans.) The Court held, among other things, that the law did not relate to a self-insured plan any more than to an insured plan, and that even if it did, there was no proof of a substantial economic impact on the plan. Other post-Travelers II surcharge cases include Safeco Life Insurance Co. v. Musser, 65 F.3d 647 (7th Cir. 1995) (Wisconsin law imposing fees upon insurers who sell health insurance in state in order to fund health insurance for uninsurable people not preempted); NYS Health Maintenance Organization Conference v. Curiale, 64 F.3d 794 [19 Employee Benefits Cas. 1777 (2d Cir. 1995) (New York law establishing health insurance pools to spread cost of high-risk claims and stabilize insurance market by rescuing failing non-profits, and imposing surcharges on insurers with relatively few high-risk people covered not preempted); Connecticut Hospital Association v. Weltman, 66 F.3d 413 [19 Employee Benefits Cas. 1928] (2d Cir. 1995) (Connecticut surcharge on hospital bills of all private patients not preempted); Boyle v. Anderson, 68 F.3d 1093 (8th Cir. 1995) (Minnesota statute imposing tax on hospital revenues to fund coverage for uninsured people not preempted).

4. In De Buono v. NYSA-ILA Medical and Clinical Services Fund, 520 U.S. 806, 117 S. Ct. 1747 [21 Employee Benefits Cas. 1041] (1997), the Court held that ERISA did not preempt New York from imposing a gross receipts tax on medical centers which were owned and operated by an ERISA-covered employee benefit plan. The Court held that the law in question was "one of 'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of [ERISA]. . . ." 520 U.S. at 815, 117 S. Ct. at
1752 [21 Employee Benefits Cas. at 1045] (quoting Travelers). The Court specifically disavowed the distinction between "indirect" and "direct" impact on the plan on which it based its Travelers decision in part.

5. In Washington Physicians Service Ass’n v. Gregoire, 147 F.3d 1039 (9th Cir. 1998), the court held that a statute requiring HMOs and health care service contractors to cover alternative medical treatments did not relate to employee benefit plans.

6. State “any willing provider” statutes (requiring inclusion of doctors or other providers in PPO panels, etc.) have been held preempted, unless they are saved under the insurance savings clause. Stuart Circle Hospital Corp. v. Aetna Health Management, 995 F.2d 500 [16 Employee Benefits Cas. 2235] (4th Cir. 1993), cert. denied, 510 U.S. 1003 [18 Employee Benefits Cas. 1224] (1993) (law related to plans, but saved because directed at insurance industry); CIGNA Healthplan of Louisiana v. State of Louisiana, 82 F.3d 642 (5th Cir. 1996) (preempted and not saved because not limited to insurance industry); Prudential Ins. Co. v. National Park Medical Center, 154 F.3d 812 (8th Cir. 1998) (Arkansas statute requiring that patients be allowed to use physicians of their own choice preempted because it made implicit reference to ERISA plans through reference to “health benefit plans” and not saved, because not limited to insurance industry); Blue Cross & Blue Shield of Virginia v. St. Mary’s Hospital, 426 S.E.2d 117 [16 Employee Benefits Cas. 1347] (Va. Sup. Ct. 1993) (same as Stuart Circle); Blue Cross and Blue Shield of Alabama v. Nielsen, 917 F. Supp. 1532 (N.D. Ala. 1996) (same). See also Zuniga v. Blue Cross and Blue Shield of Michigan, 52 F.3d 1395 (6th Cir. 1995) (psychiatrist’s action against Blue Cross for breach of settlement agreement reinstating him as participating physician preempted where Blue Cross acted as administrator of managed care programs for employee benefit plans and excluded plaintiff from panels). But see American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc., 973 F. Supp. 60 [21 Employee Benefits Cas. 1613] (D. Mass. 1997) (law requiring HMOs and other “carriers” to allow non-network pharmacists to provide drug benefits if they entered agreements with carriers which were no more restrictive than those applicable to network pharmacies not preempted because it did not relate to plans; alternatively, saved under insurance saving clause).

In Texas Pharmacy Association v. Prudential Insurance Co. of America, 105 F.3d 1035 (5th Cir. 1997), the 5th Circuit held that a Texas statute prohibiting plans from contracting with pharmacy networks excluding any willing provider related to employee benefit plans and not saved because applies to HMOs, PPOs, etc., which are not in the insurance industry. However, the court also held that the prior statute was not preempted because it was limited to insurance policies and satisfied McCarran-Ferguson criteria.

7. States have attempted to require plans to use independent review procedures. In Corporate Health Insurance Inc. v. Texas Department of Insurance, 12 F. Supp. 2d 597 (S.D. Tex. 1998), on appeal to Fifth Circuit (No. 98-20940), Aetna challenged the

Texas Health Care Liability Act (even though the HMOs had lobbied to obtain passage). The 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.

C. Promises of Benefits and Misrepresentations.

Where an employer or other person (broker, etc.) 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 (see Section III, above) and/or whether the plaintiff is a "participant" in an employee benefit plan (see D, below). Although not all of the cases discussed below pertain to managed care, the cases would be relevant in situations where there have been promises made about such care.

1. 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
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“equitable relief.” Some circuits do not recognize estoppel claims against plans, or do so in very limited circumstances. In an oft-quoted phrase, the Second 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).

2. 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. Publiccker Industries*, 83 F.3d 27 (1st Cir. 1996); *Farr v. U.S. West*, 151 F.3d 908 (9th Cir. 1998). In virtually all of these cases, plan participants were left with no cause of action or no remedy.

3. 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).

4. 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.
5. Fraud in the Inducement.


b. Other courts have not allowed such state law claims to proceed, especially where the claim is made against an ERISA-covered entity. *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); *Engelhardt v. Paul Revere Life Ins. Co.*, 139 F.3d 1346 (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).

D. Interrelationship With Standing to Sue.

1. ERISA § 502, 29 U.S.C. § 1132, grants "participants" the right to sue. A participant is defined as an "employee or former employee of an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan. . . ." ERISA § 3(7), 29 U.S.C. § 1002 (7). Participants include "employees in, or reasonably expected to be in, currently covered employment" and "former employees who have . . . a reasonable expectation of returning to covered employment or who
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3. Other courts have rejected this "no participant/no preemption" analysis. See, e.g., Ogden v. Michigan Bell, 657 F. Supp. 328 [8 Employee Benefits Cas. 1478 and 8 Employee Benefits Cas. 1481] (E.D. Mich. 1987), rev’d on other grounds, Berlin v. Michigan Bell Telephone Co., 858 F.2d 1154 [10 Employee Benefits Cas. 1217] (6th Cir. 1988); Martin v. General Motors Corp., 753 F. Supp. 1347 (E.D. Mich 1991); Smith, Christopher, Bartholet, Olson, and cases cited in Part C-4, above of this Section IV.

4. In Wolk v. UNUM Life Ins. Co., 185 F.3d 352, 23 Employee Benefits Cas. 1377 (3rd Cir. 2000), the Third Circuit seemed to assume that lack of standing would result in a finding of no preemption, but found that a partner-employer had standing as a "beneficiary" where he was designated as such in a plan also covering employees. See also, Engelhardt v. Paul Revere Life Ins. Co., 139 F.3d 1346 (11th Cir. 1998) (partner was beneficiary with standing).

5. Even assuming that lack of standing results in the absence of preemption, this analysis might not necessarily apply to the situation where the employee is undisputedly a participant in a plan, but the employer has promised to improve the plan benefits.
E. Suits v. Non-Fiduciaries.

1. One highly problematic area is that of state law tort and contract actions by plans, their fiduciaries, and/or plan participants against non-fiduciary individuals or entities with which the plan transacts business. This is an especially critical issue, given that ERISA provides virtually no remedies for misdeeds by non-fiduciaries. See *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993).

   a. In *Mertens*, the Supreme Court ruled that money damages against non-fiduciary service providers are not available under ERISA even where such service providers participate in plan fiduciaries’ breaches of duty. Moreover, *Mertens* raises serious doubt as to the existence of such a claim for knowing participation under ERISA. In any event, remedies for such knowing participation and/or for a prohibited party-in-interest transaction would appear to be limited to equitable relief, which, at most would allow restitution of plan assets wrongfully transferred to the non-fiduciary service provider.

   b. As a result, for example, if an actuary’s miscalculation lost millions of dollars for the plan, ERISA would provide no monetary remedy against the actuary for the mistake. If claims by the plan or its participants are preempted, plans will be deprived of remedies which would have been available to them at common law, without comparable ERISA remedies.

   c. The Supreme Court has not directly addressed preemption of claims by plans or their participants against service providers. The *Mertens* majority specifically declined to discuss preemption. However, Justice White’s discuss of preemption in the *Mertens* dissent (as well as some of the language in Justice Scalia’s majority opinion) has raised questions about the availability of state law claims. (See No. 5, below.)

   d. On the other hand, the Court’s approach and analysis in *New York Conf. of Blue Cross Plans v. Travelers Ins.*, supra, 514 U.S. 645 (1995), can be viewed as an indication that such claims may not be preempted. The Court held that a state law which had only an indirect economic effect on, as opposed to a direct regulation of, ERISA plans was not preempted. See, e.g., *Coyne & Delany Co. v. Selman*, 98 F.3d 1457 (4th Cir. 1996).

   e. Finally, the case of *Harris Trust v. Salomon Brothers*, 184 F.3d 646 (7th Cir. 1999), *certiorari granted*, 120 S. Ct. 784 (2000), currently pending (as of May 22, 2000), before the Supreme Court may further complicate this issue. Salomon, a non-fiduciary, sold to a pension plan certain “Fee Agreements” entitling the plan to fees generated by net cash flows from the operation of certain motels and to fees based on the appreciation of properties on which the motels were situated. The Fee Agreements proved nearly worthless, and the plan lost almost $20
million of the nearly $21 million it had paid. Salomon, on the other hand, which had zero basis in the Agreements, made a profit of almost $21 million on the sales to the plan. In contrast to the six other circuits which had considered the issue, the Seventh Circuit held that Salomon, a non-fiduciary party in interest, could not be sued to remedy a prohibited transaction under ERISA. In so holding, the Seventh Circuit focused on the language of ERISA Section 406(a), which provides that “[a] fiduciary . . . shall not cause the plan to engage in a transaction . . .” The court concluded that by this language, Congress intended to prohibit only fiduciaries from entering into prohibited transactions. Other circuits and plaintiff in Salomon rely, instead, on the fact that ERISA Section 502(a)(3) provides a cause of action for equitable or injunctive relief to correct any violation of the statute, and does not, by its terms, limit such claims to claims brought against fiduciaries. The case has been briefed and argued before the Supreme Court, but not decided as of the date these materials have been prepared.

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See also, Memorial Hospital System v. Northbrook Life Insurance Co., 904 F.2d 236 [12 Employee Benefits Cas. 1897] (5th Cir. 1990) (3rd party health care provider's state law claims against plan not preempted); Simon Levi Co. v. Dun & Bradstreet Pension Services, 1997 WL 289852 (Cal. Ct. App. 1997); F.H. Krear & Co. v. 19 Named Trustees, 810 F.2d 1250 [8 Employee Benefits Cas. 1136] (2d Cir. 1987); Schulist v. Blue Cross of Iowa, 553 F. Supp. 248 [4 Employee Benefits Cas. 1193] (N.D. Ill. 1982); Bukoskey v. Shuham, 666 F. Supp. 181 [8 Employee Benefits Cas. 2284] (D. Alaska 1987). Compare Concha v. London, 62 F.3d 1493 (9th Cir. 1995) (where plaintiff fiduciaries alleged that accountants and actuaries were fiduciaries and brought ERISA breach of fiduciary duty claims against them, state law claims were preempted because plaintiffs' claims related to the administration of the plan and plaintiffs had standing under ERISA to bring those claims).

3. For the most part, although not exclusively, the cases cited above involve claims by or on behalf of plans, rather than claims for damages by individual participants. See Smith v. Provident Bank, 170 F.3d 609 (6th Cir. 1999) (claims against non-fiduciaries by plan's sole participant preempted; claims by plan against non-fiduciaries not preempted).

4. Cases in which claims against non-fiduciaries were held preempted include Gibson v. Prudential Ins. Co. of America, 915 F.2d 414 (9th Cir. 1990) (employee's claim against an insurer and various doctors and services alleging that they used an improper disability definition and participated in a sham medical examination);
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See also, American Federation of Unions v. Equitable Life Insurance Society, 841 F.2d 658 [9 Employee Benefits Cas. 1769] (5th Cir. 1988); Howard v. Parision, Inc., 807 F.2d 1560 [8 Employee Benefits Cas. 1033] (11th Cir. 1987) (intentional infliction of emotional distress by plan administrator); Light v. Blue Cross/Blue Shield, 790 F.2d 1347 (5th Cir. 1986); Sturm, Ruger Co. V. Connecticut General Life Insurance Co., 892 F. Supp. 33 (D.N.H. 1993) (employer’s claim against insurer for not properly administering plan by failing to detect fraudulent claims submitted by pharmacist; opinion does not address whether administrator was a fiduciary or not).

5. The only cases to discuss the language in Mertens regarding preemption have been the 4th Circuit’s decisions in Custer, supra, and Tri-State, supra (forming the basis for the court’s preemption holdings) and the Central District of California companion cases of Bourns, supra, and Mertens, supra (rejecting preemption). Note, however, that Custer and Tri-State may be of limited significance in view of the later 4th Circuit decisions in Coyne & Delany Co. v. Selman, supra, and Custer v. Sweeney, supra.
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6. See also, Sections A and C-5, above. The courts’ analyses in these areas often overlap with their analysis in the non-fiduciary cases discussed above.

F. Wrongful Discharge and Employment Discrimination.

1. A common law wrongful discharge claim that an employer terminated or otherwise discriminated against an employee to prevent the employee from vesting a right to a benefit or to prevent accrual or receipt of a benefit would be preempted by ERISA’s prohibition against interference with protected rights. (ERISA § 510, 29 U.S.C. § 1140.) See, e.g., Ingersoll-Rand v. McClendon, 498 U.S. 133, [12 Employee Benefits Cas. 2737] (1990); Heimann v. National Elevator Industry Pension Fund, 187 F.3d 493 (5th Cir. 1999) (state law claims against union and union’s agent, alleging misrepresentation that plan participant was engaging in disqualifying work after retirement, was completely preempted as retaliation claim under ERISA § 510); Felton v. Unisource Corp., 940 F.2d 503 (9th Cir. 1991); Kariotis v. Navistar International Transp. Corp., 131 F.3d 672 (7th Cir. 1997) (claim under state anti-retaliation statute alleging firing in retaliation for seeking medical and disability benefits under employer’s plan); Tolle v. Carroll Touch, Inc., 977 F.2d 1129 (7th Cir. 1992) (claims alleging employee benefit plans constituted part of employment agreement, employer breached agreement by discharging plaintiff, and employer breached implied duty of good faith and fair dealing preempted because termination based on intent to avoid paying plan benefits); Tingey v. Pixley-Richards West, Inc., 953 F.2d 1124, 14 Employee Benefits Cas. 2445 (9th Cir. 1992) (contract and tort wrongful termination claims alleging plaintiff was fired to avoid paying medical benefits to his son); McDonald v. Aircraft Electric Supply Co., 774 F. Supp. 29 (D.D.C. 1991); Anderson v. Electronic Data Systems Corp., 11 F.3d 1311 (5th Cir. 1994) (termination for refusal to commit acts prohibited, inter alia, by ERISA); Dochterman v. First Mississippi Corp., 831 F. Supp. 556 (S.D. W.Va. 1993) (breach of implied covenant of good faith and fair dealing based in part on claim that discharge was to avoid paying "employment benefits, including, but not limited to, moving expenses, vacation, and other benefits due").

2. In addition, state law statutory or common law “whistleblowing” claims have been held preempted by ERISA. Anderson v. Electronic Data Systems Corp., 11 F.3d 1311 (5th Cir. 1994) (state law wrongful termination claim of investment manager/participant who reported ERISA violations); Hashimoto v. Bank of Hawaii, 999 F.2d 408, 16 Employee Benefits Cas. 2751 (9th Cir. 1993) (claim under Hawaii whistleblower statute based upon employee complaints that plan administrator violated ERISA); Authier v. Ginsberg, 757 F.2d 796, 6 Employee Benefits Cas. 1420 (6th Cir.), cert. denied, 474 U.S. 888 [6 Employee Benefits Cas. 2288] (1985) (plaintiff claimed discharge in retaliation for fulfilling ERISA fiduciary obligations by writing letter to plan participants critical of plan administration).
3. However, in *Miller v. Carelink Health Plans, Inc.*, 82 F. Supp. 2d 574 (S.D. W.Va. 2000), the court held that a nurse-employee of an HMO could sue her former employer under state law for wrongful discharge in violation of public policy where she alleged that she was discharged in retaliation for upholding her patients’ rights. See also, *Jorgensen v. Prudential Insurance Co.*, 852 F. Supp. 255 (D.N.J. 1994) (no preemption of state whistleblowing claim brought by insurance company employee with management responsibilities relating to investment accounts in which employee benefit plan assets invested, where employee alleged he was terminated for questioning valuation of properties in accounts; accounts were not themselves ERISA plans, and the court’s rulings would not affect administration of the plans which invested in the accounts).
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