

No. 652711

**COURT OF APPEALS, DIVISION I  
STATE OF WASHINGTON**

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MARK HOLLIDAY, DAVE ALEXANDER, JAMES D.  
ANDERSON, STEVE BRADLEY, TONY STEELMAN,  
CHARLES VALENTINE, NELDA WILSON, and JAMES M.  
WRIGHT, in their capacity as the Trustees of Associated General  
Contractors—International Union of Operating Engineers Local 701  
Health and Welfare Trust Fund,

Plaintiffs-Appellants,

v.

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.,  
Defendant-Respondent.

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**BRIEF OF APPELLANTS**

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MILLER NASH LLP  
Bruce A. Rubin (WSBA No. 37384)  
Adam G. Hughes (WSBA No. 34438)  
4400 Two Union Square  
601 Union Street  
Seattle, Washington 98101-2351  
Telephone: (206) 622-8484  
Fax: (206) 622-7485

Attorneys for Plaintiffs-Appellants

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COURT OF APPEALS DIVISION I  
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## **I. INTRODUCTION**

The complaint seeks money damages for breach of a written contract, namely, an Administrative Services Agreement (the "Contract") attached to the complaint. The Contract provides that it is governed by Washington state law and expressly consents to jurisdiction in King County, Washington. The trial court nevertheless granted a motion by respondent, Healthcare Management Administrators, Inc. ("HMA"), to dismiss the case on the ground that the breach-of-contract claim is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq.

This court must decide whether that decision was correct. As discussed herein, there is no remedy under ERISA for appellant trustees of Associated General Contractors—International Union of Operating Engineers Local 701 Health and Welfare Trust Fund (the "Trust") for the damages caused by HMA's breach of contract. Thus, unless this court reverses the trial court, the Trust will have no remedy at all for HMA's misconduct.

## **II. ASSIGNMENT OF ERROR**

The Superior Court for King County erred when it dismissed the complaint on the ground that it was preempted by ERISA.

## **III. STATEMENT OF THE CASE**

Appellants are members of the board of trustees of the Trust. CP 2 (Compl. ¶ 1.1). In July 2005, the Trust entered into the Contract<sup>1</sup> in which HMA agreed to act as a ministerial service provider, with no fiduciary or discretionary responsibilities, for the employee health benefit plan sponsored by the Trust (the "Plan"). CP 2 (Compl. ¶¶ 3.1, 3.2); CP 5-7 (Contract ¶¶ B, 2, 3).

The complaint has one claim for relief, alleging that HMA breached the Contract by incorrectly determining health care providers' allowable amounts, failing to apply discounts for services at network facilities, issuing benefits to ineligible dependents, failing to coordinate benefits correctly, incorrectly determining the allowable amount for certain physicians, failing to refer claims to determine medical

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<sup>1</sup> A copy of the Contract is attached as Exhibit 1 to the complaint.

necessity before issuing benefits, and making other miscellaneous errors. CP 3 (Compl. ¶ 4.5).

Paragraph 18(m) of the Contract expressly provides as follows:

(m) **Governing Law.** This Agreement shall be deemed to have been executed and entered into in Bellevue, Washington, and shall be governed, construed, performed and enforced in accordance with the laws of the State of Washington, without regard to its conflict of law principles. In the event of litigation with respect to this Agreement or the obligations of the parties hereunder, the parties hereto expressly consent to the jurisdiction of King County, Washington.

CP 13.

HMA filed a motion to dismiss under CR 12(b)(6), asserting that the Trust's common-law contract claim must be dismissed because it is preempted by ERISA. CP 20-33. The motion was supported by the Declaration of Susan Smith attaching a copy of the Summary Plan Description of the Plan sponsored by the Trust.

CP 34-139.

At oral argument on the motion, HMA's attorney first stated that the Trust could pursue a remedy for contract damages under an

ERISA provision that allows for equitable relief. RP 15:9-23, 16:18-24.<sup>2</sup> When the Trust's attorney explained that there are United States Supreme Court decisions to the contrary (RP 17:12-19:5), the trial court asked HMA's attorney what remedy, if any, would be available to the Trust under ERISA (RP 31:22-25), and she responded that there might not be one, concluding, "The lack of ERISA remedy does not affect a preemption analysis." RP 35:3-4.

The trial court then issued its Order Granting Defendant's Motion to Dismiss Plaintiffs' Complaint entered on March 22, 2010. The Notice of Appeal was timely filed within the period allowed by RAP 2.2, 5.1, and 5.3 on April 20, 2010.

#### **IV. ARGUMENT**

##### **A. Summary of Argument**

The ERISA preemption clause uses generalized language to preempt claims that "relate to" an employee benefit plan. Although early United States Supreme Court cases broadly construed that

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<sup>2</sup> All references to the RP are citations to the Amended Verbatim Report of Proceedings of March 19, 2010, filed with the trial court on August 25, 2010.

term, its modern cases explain that when the relationship to the employee benefit plan is peripheral, state-law claims are not preempted.

In particular, after *New York Blue Cross v. Travelers Ins. Co.*, 514 U.S. 645, 655, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995), the analysis changed. The Court recognized that the term "relate to" cannot be taken "to extend to the furthest stretch of its indeterminacy," or else "for all practical purposes pre-emption would never run its course." *Id.* After *Travelers*, preemption under ERISA has been limited to:

- (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 alternative enforcement mechanisms for employees to obtain ERISA plan benefits.

None of those factors exist in this case. Put simply, proof of the allegations in the complaint that HMA breached its Contract with the Trust does not create a conflict with ERISA, so there is not preemption.

In *Behavioral Sciences Inst. v. Great-West Life*, 84 Wn. App. 863, 872, 930 P.2d 933 (1997), a case similar to this one, this court followed and cited *Travelers*, to hold that there was no preemption merely because the contract alleged in the complaint, between a provider of employee benefits and an administrative services provider, referenced an ERISA plan. The court noted that the relationship between the parties was not one that ERISA purports to govern. *Id.* at 874. Here, too, the relationship between the Trust and HMA, a nonfiduciary plan administrator, is not one governed by ERISA.

The Trust has no remedy under ERISA, so an affirmance will leave it with no remedy at all. The civil-enforcement provision of ERISA in 29 U.S.C. § 1132(a)(3) permits a fiduciary such as the Trust to recover "appropriate equitable relief"; but in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 122 S. Ct. 708, 151 L. Ed. 2d 635 (2002), the Supreme Court held that an action to obtain monetary relief for breach of contract is an action for damages not within the scope of that provision.

**B. Standard of Review**

This controversy hinges on the interpretation of a federal statute and case law interpreting that statute. The issue presented, therefore, is a pure issue of law: there are no disputes as to the facts, only as to the application of the law to the undisputed facts. When an appeal raises pure issues of law, a de novo standard of review applies: "The construction of a statute is a question of law that this court reviews de novo." *Tenino Aerie v. Grand Aerie*, 148 Wn.2d 224, 239, 59 P.3d 655 (2002); *see also State v. Keller*, 143 Wn.2d

267, 276, 19 P.3d 1030 (2001); *Rettkowski v. Dep't of Ecology*,  
128 Wn.2d 508, 514-15, 910 P.2d 462 (1996).

**C. Argument**

**1. As a matter of law, ERISA does not preempt the Trust's breach-of-contract claim.**

**a. ERISA preemption standard.**

Here is the ERISA preemption provision in question:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall 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 and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

29 U.S.C. § 1144(a).

In early cases such as *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97, 100, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (1983), the Court expansively stated that a state law relates to an ERISA plan "if it has a connection with or reference to such a plan." But even that case recognized that there was no preemption if the state law has only a "tenuous, remote, or peripheral" connection to the plan. *Id.* at 100 n.21. Thereafter, the Court issued several opinions as it

searched for the congressional intent that led to the preemption clause. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 111 S. Ct. 478, 112 L. Ed. 2d 474 (1990).

The turning point came in *Travelers*. The Court returned to basic principles, and the first was "the starting presumption that Congress does not intend to supplant state law." 514 U.S. at 654. In that decision, the Court explained that the term "relate to" cannot be taken "to extend to the furthest stretch of its indeterminacy" or else "for all practical purposes pre-emption would never run its course." 514 U.S. at 655. *Accord Egelhoff v. Egelhoff*, 532 U.S. 141, 146, 121 S. Ct. 1322, 149 L. Ed. 2d 264 (2001). Rather, *Travelers* held that to determine whether a state law has the forbidden connection to an ERISA plan, courts "look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Egelhoff*, 532 U.S. at 147 (internal

quotation marks and citation omitted). A state law that "directly conflicts with ERISA's requirements that plans be administered, and benefits be paid, in accordance with plan documents" has the forbidden "'connection with' ERISA plans and is therefore pre-empted." *Id.* at 150.

The Trust's lawsuit seeking damages for HMA's breach of the Contract in no way "directly conflicts with ERISA's requirements that plans be administered, and benefits be paid, in accordance with plan documents." *Id.* Instead, it was HMA's contractual breaches that conflicted with the Plan documents in this case. The Trust's lawsuit seeks only to hold HMA accountable for breaching its Contract with the Trust—the outcome of which would have no effect on the Plan.

**b. There is no ERISA preemption if a complaint merely mentions an ERISA plan.**

In *Behavioral Sciences*, 84 Wn. App. at 872, this court relied on *Travelers* and held that there was no preemption merely because the complaint referenced an ERISA plan. There, as here, a self-insured provider of employee health benefits (BSI) entered into

a contract with a company to provide administrative services (GW). There, as here, the self-insured provider retained the discretion to make the ultimate benefit decisions and the administrative services provider was not a fiduciary. A dispute arose as to the amounts that GW should have paid under the contract as a result of treatment for a blood disorder of a plan participant (Sonntag-Johnston). That, of course, required interpretation of the plan coverage language, to see how it affected GW's contract obligations to provide reinsurance.

In rejecting GW's ERISA preemption argument, this court noted that the relationship between the parties was not one that ERISA purports to govern. *Behavioral Sciences*, 84 Wn. App. at 872-74. In particular, this court explained that "GW's ability to challenge the determination is limited to its own agreement with BSI and in no way affects Sonntag-Johnson's right to receive benefits under the Plan." *Id.* at 875. In short, whether a plan participant might have an ERISA claim for benefits under the plan (something that the parties agree would be preempted) differs from whether a contract claim with a service provider is preempted.

**c. The Trust's breach-of-contract claim falls outside the three areas of ERISA preemption.**

The Supreme Court has identified three traditional areas as preempted by ERISA:

(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 alternative enforcement mechanisms for employees to obtain ERISA plan benefits.

*Travelers*, 514 U.S. at 658. See also *Ariz. State Carpenters Pension Trust v. Citibank*, 125 F.3d 715, 723 (9<sup>th</sup> Cir. 1997) (quoting *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1468 (4<sup>th</sup> Cir. 1996)).

The Ninth Circuit holds that state-law claims are not preempted "where state law claims [1] fall outside the three areas of concern identified in *Travelers*, [2] arise from state laws of general application, [3] do not depend upon ERISA, and [4] do not affect the relationships between the principal ERISA participants." *Ariz. State Carpenters*, 125 F.3d at 724.

The Trust's breach-of-contract claim does not fall within any of the three categories of preempted state law identified in *Travelers*. In no way does the claim seek to mandate employee benefit structures, regulate an ERISA plan, or provide an alternate enforcement mechanism for employees to obtain ERISA plan benefits.

In addition, the breach-of-contract claim arises from state laws of general application, does not depend on ERISA, and does not affect the relationships between the principal ERISA participants. *Ariz. State Carpenters*, 125 F.3d at 724. The principal ERISA participants are employers, plans, plan fiduciaries, and plan beneficiaries. *Rutledge v. Seyfarth, Shaw, Fairweather*, 201 F.3d 1212, 1219-20 (9<sup>th</sup> Cir. 2000). Although the Trust is an ERISA participant, HMA is not. Accordingly, the relationship between the Trust and HMA is governed by the Contract, not ERISA. Moreover, the breach-of-contract claim does not interfere with the administration of an ERISA plan. *See Wash. State Auto Dealers Ins. Trust v. Aon Consulting, Inc.*, No. C07-1182 MJP, 2008 WL 4889206, at \*2 (W.D. Wash. Nov. 11, 2008).

The facts of *Geweke Ford v. St. Joseph's Omni Preferred Care Inc.*, 130 F.3d 1355 (9<sup>th</sup> Cir. 1997), are similar to the facts in this case. Geweke was a private employer that sponsored an ERISA plan. Geweke contracted with Omni to provide administrative services for the plan by managing the day-to-day operations of the plan, including claims processing. *Id.* at 1357. Geweke brought a state-law breach-of-contract claim against Omni for failure to administer and process benefit claims covered under the ERISA plan. Omni, like HMA, argued that "because the claim against it arose from an alleged failure of its duties as administrator of the Plan, it 'related to' the Plan." *Id.* at 1359. The Ninth Circuit, however, held that the breach-of-contract claim was *not* preempted by ERISA:

Geweke's state law claims fall outside the three areas of concern identified in *Travelers*: the state contract law upon which Geweke relies does not mandate employee benefit structures or their administration; does not bind employers or plan administrators to particular choices or preclude uniform administrative practice; and does not provide alternate enforcement mechanisms for employees to obtain ERISA plan benefits. *See Coyne & Delaney Co. v. Selman*, 98 F.3d 1457, 1468 (4th Cir. 1996)

(summarizing the three areas recognized by the Supreme Court in which ERISA was intended to preempt state law claims). Moreover, Geweke's claims arise from state laws of general application, do not depend upon ERISA, and do not affect the relationships between the principal ERISA participants. Thus, under *Arizona State Carpenters*, Geweke's state law claims are not preempted by ERISA.

*Id.* at 1360. The same reasoning applies to the Trust's breach-of-contract claim in this case.

This case is also like *Wash. State Auto Dealers*, where the court held that ERISA did not preempt WSADIT's breach-of-contract claim:

WSADIT's breach of contract claim against Lumenos is not preempted by ERISA. Lumenos is not an ERISA fiduciary and the parties' relationship is governed by their services contract, not by ERISA. *See Geweke Ford*, 130 F.3d at 1359. The contract claim against Lumenos does not fall within one of the three categories of preempted state law identified in *Travelers*. Further, the claim arises from a state law doctrine of general application (contract law), it does not depend on ERISA, and does not affect relations among principal ERISA entities. The contract remedy sought provides no alternative ERISA enforcement mechanism and does not interfere with the administration of an ERISA plan. *See Dishman [v. UNUM Life Ins. Co. of Am.]*, 269 F.3d [974] at 981 [(9<sup>th</sup> Cir. 2001)]. The claim is not preempted because any connection to a benefits plan is "tenuous, remote,

or peripheral . . . as is the case with many laws of general applicability." *Travelers*, 514 U.S. at 661. See also *Tie Communications, Inc. v. First Health Strategies, Inc.*, No. Civ. A. 97-2597-EEO, 1998 WL 171126, at \*3 (D.Kan. Mar.3, 1998) (holding that a contract claim involving "failure to timely submit a benefits claim . . . pursuant to the Administrative Services Agreement" was not preempted by ERISA, in part because "[i]nterpretation of [the plaintiff's] benefit plan is not involved, or is at most tenuously connected to the central dispute, which involves the Administrative Agreement . . . and the Excess Insurance Agreement[.]").

2008 WL 4889206, at \*2.

**d. HMA is not an ERISA fiduciary.**

In the breach-of-contract context, many courts hold that ERISA preempts breach-of-contract actions against only those plan administrators that act as fiduciaries. ERISA does not, however, preempt claims involving plan administrators that perform only ministerial functions of administration and are not vested with discretion or authority over the administration of the plan. In that context, the administrative services providers merely refer to the plan insofar as appropriate to perform the ministerial duties they agree to perform. *Geweke*, 130 F.3d 1355. Summaries of cases so holding follow:

- *Tie Comm'cns, Inc. v. First Health Strategies, Inc.*,  
No. CIV. A. 97-2597-EEO, 1998 WL 171126, at \*1  
(D. Kan. Mar. 3, 1998): plan sponsor's claims against  
third-party administrator held not preempted because  
plan sponsor remained the plan fiduciary and retained  
"all discretionary authority and control over plan  
administration" and third-party administrator was not a  
fiduciary, but merely handled medical bills and  
disbursement of plan funds to beneficiaries.
- *Union Health Care, Inc. v. John Alden Life Ins. Co.*,  
908 F. Supp. 429, 435 (S.D. Miss. 1995): plan sponsor's  
claim against insurer not preempted because insurer was  
not a plan fiduciary and claim against administrator  
alleging that it had failed to timely notify excess insurer  
of claims was not preempted because the claim "d[id] not  
relate to [the administrator's] responsibilities to the plan  
or its participants, with respect to which duties it has a  
fiduciary relationship. Rather, the claims asserted . . .

relate solely to [the administrator's] duties vis-à-vis the reinsurance contract."

- *Fox, Curtis & Assocs., Inc. v. Employee Benefit Plans, Inc.*, No. 92 C 5828, 1993 WL 265474, at \*6 (N.D. Ill. July 13, 1993): claim against third-party administrator and stop-loss insurer alleging breach of contract not preempted in case that did not involve "the adjudication of any discretionary administrative decision-making on the part of Defendants regarding the rights of plan beneficiaries" and "any effect that Defendants' breach of their obligations may have on plan beneficiaries is incidental to [employer's] claims."
- *Mich. Affiliated Healthcare Sys. v. CC Sys.*, 139 F.3d 546 (6<sup>th</sup> Cir. 1998): plan sponsor's claim against third-party administrator was not preempted because third-party administrator was not a fiduciary of plan under the terms of the plan and did not have discretion or decision-making authority.

- *Skilstaf, Inc. v. Adminitron, Inc.*, 66 F. Supp. 2d 1210, 1215 (M.D. Ala. 1999): distinguishing many cases cited in this opinion, stating that an administrator that "merely performs administrative functions and claims processing within a framework of rules established by an employer" is not a fiduciary, as opposed to an administrator that "has . . . been granted the authority to review benefits denials and make the ultimate decisions regarding eligibility." (Internal quotation marks and citation omitted.)

As stated above, HMA is not a fiduciary. The Contract expressly states that "HMA is not a fiduciary." CP 6 (Contract ¶ 2(b)). Further, HMA expressly "acknowledge[s] and agree[s] that HMA is acting solely in a ministerial capacity in performing its duties and obligations under this Agreement and shall have no authority or discretionary responsibility with respect to the administration of the Plan." CP 6 (Contract ¶ 2(a)). Moreover, paragraph 2(b) of the Contract again states that "HMA shall limit its

activities to carrying out ministerial acts of notifying Plan Participants and making benefit payments as required by the Plan." CP 6. A copy of the Summary Plan Description is attached as Exhibit A to the Declaration of Susan Smith in Support of Defendant's Motion to Dismiss. CP 36-139. It further confirms that HMA is not the administrator acting in a fiduciary capacity. Rather, it states that the Plan Administrator is the Board of Trustees. CP 132 (Smith Decl., Ex. A at 94). Under ERISA, 29 U.S.C. § 1002(16), "administrator" is defined as "the person specifically so designated by the terms of the instrument under which the plan is operated" or, if there is no such designation, the Plan sponsor. Again, the Plan sponsor is the Board of Trustees. CP 132 (Smith Decl., Ex. A at 94).

In addition to the express language of the Contract, HMA is not a fiduciary as defined by ERISA. ERISA defines "fiduciary" as anyone who exercises discretionary authority or control respecting the management or administration of an employee benefit plan.

29 U.S.C. § 1002(21)(A).<sup>3</sup> Performance of ministerial duties or processing claims does not make a party a fiduciary under ERISA. *Kyle Rys. v. Pac. Admin. Servs.*, 990 F.2d 513, 516 (9<sup>th</sup> Cir. 1993).

According to the Code of Federal Regulations:

a person who performs purely ministerial functions . . . for an employee benefit plan within a framework of policies, interpretations, rules, practices and procedures made by other persons is not a fiduciary because such person does not have discretionary authority or discretionary control respecting management of the plan, does not exercise any authority or control respecting management or disposition of the assets of the plan, and does not render investment advice with respect to any money or other property of the plan and has no authority or responsibility to do so.

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<sup>3</sup> A person or an entity is considered a fiduciary with respect to a plan to the extent that

(i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A).

29 CFR § 2509.75-8(D-2).<sup>4</sup>

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<sup>4</sup> 29 CFR § 2509.75-8(D-2) sets forth the following question and answer regarding whether persons who perform ministerial functions for an employee benefit plan are fiduciaries:

Q: Are persons who have no power to make any decisions as to plan policy, interpretations, practices or procedures, but who perform the following administrative functions for an employee benefit plan, within a framework of policies, interpretations, rules, practices and procedures made by other persons, fiduciaries with respect to the plan:

- (1) Application of rules determining eligibility for participation or benefits;
- (2) Calculation of services and compensation credits for benefits;
- (3) Preparation of employee communications material;
- (4) Maintenance of participants' service and employment records;
- (5) Preparation of reports required by government agencies;
- (6) Calculation of benefits;
- (7) Orientation of new participants and advising participants of their rights and options under the plan;
- (8) Collection of contributions and application of contributions as provided in the plan;
- (9) Preparation of reports concerning participants' benefits;
- (10) Processing of claims; and
- (11) Making recommendations to others for decisions with respect to plan administration?

A: No. . . . [A] person who performs purely ministerial functions such as the types described above for an employee benefit plan within a framework of policies, interpretations, rules, practices and procedures made by other persons is not a fiduciary because such person does not have discretionary authority or discretionary control respecting management of the plan, does not exercise any authority or control respecting management or disposition of the assets of the plan, and does not render investment advice with respect to any money or other property of the plan and has no authority or responsibility to do so.

In the trial court, HMA relied heavily on *Vantage Health Plan, Inc. v. ACMG, Inc.*, 830 So. 2d 398 (La. Ct. App. 2002). That decision, however, actually supports the Trust's position that ERISA does not preempt this breach-of-contract claim. The court in *Vantage* held that "[t]he resolution of claims that involve whether, when and how much beneficiaries are paid on claims under an employee benefit plan, as determined by an administrator *acting in a fiduciary capacity*, clearly 'relate to' the administration of the plan and, therefore, to the protection of the beneficiaries of the plan." *Id.* at 407-08 (emphasis added). The court specifically distinguished cases in which claims were asserted against defendants who were not fiduciaries:

This is not a case where the defendant is a third party insurer or service provider who is **not** an ERISA entity, i.e., plan, employer, participant, beneficiary, fiduciary; nor is this a case where a defendant performed only ministerial functions of administration and was not vested with discretion or authority over the administration of the plan. In addition, this is not a case where the resolution of the claims asserted have no effect on the relationship between ERISA entities.

*Id.* at 406.

Here, because the resolution of the Trust's claim does not involve determination by an administrator acting in a fiduciary capacity, the claim does not relate to the Plan and is not preempted by ERISA. HMA implicitly recognized these facts when it expressly agreed in paragraph 18(m) of the Contract that King County Superior Court is the appropriate jurisdiction for litigation of disputes arising under the Contract and that Washington law applies. CP 13.

**2. Because the Trust has no claim under ERISA, affirming the trial court will leave the Trust without a remedy for HMA's misconduct.**

HMA urged the trial court to find preemption by initially stating that the Trust could pursue recovery for its damages under 29 U.S.C. § 1132(a)(3). RP 15:9-23; 16:18-24. That portion of the ERISA civil-enforcement statute does permit a fiduciary such as a trust to recover "appropriate equitable relief," stating as follows:

A civil action may be brought—

....

(3) by a participant, beneficiary, or fiduciary

(A) to enjoin any act or practice which violates any provision of this [title] or the terms of the plan, or

(B) to obtain other *appropriate equitable relief*

(i) to redress such violations or

(ii) to enforce any provisions of this [title] or the terms of the plan[.]

(Emphasis added.)

But that provision has been eliminated as a basis for seeking to recover contract damages. In *Knudson*, 534 U.S. 204, the Supreme Court held that an action to obtain monetary relief for breach of contract was an action for damages not within the scope of that provision.

When Supreme Court authority was brought to the attention of the trial court, HMA backtracked, revealing its true game plan by asserting that preemption should take place even when there is no remedy under ERISA. [reference]. Here, HMA is correct as to the law—as explained in cases such as *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 107 S. Ct. 1542, 95 L. Ed. 2d 55 (1987), and *Dedeaux*, 481 U.S. 41, when ERISA preemption applies, the scheme

of including certain remedies and excluding others under ERISA would be undermined if litigants were free to obtain remedies under state law that Congress did not include in ERISA.

**V. CONCLUSION**

This court should reverse the trial court's order dismissing the complaint and remand the case to the King County Superior Court for trial.

Respectfully submitted this 17<sup>th</sup> day of August, 2010.

MILLER NASH LLP

By: 

Bruce A. Rubin, P.C., WSBA No. 37384

Adam G. Hughes, WSBA No. 34438

4400 Two Union Square

601 Union Street

Seattle, Washington 98101

Telephone: (206) 622-8484

Fax: (206) 622-7485

Attorneys for Plaintiffs-Appellants

**CERTIFICATE OF FILING AND SERVICE**

I hereby certify that on the date set forth below, I filed the original and one copy of this BRIEF OF APPELLANTS with the Washington Court of Appeals, Division I, by hand-delivery to:

Mr. Richard D. Johnson  
Court Administrator/Clerk  
Washington Court of Appeals, Division I  
One Union Square  
600 University Street  
Seattle, Washington 98101-1176

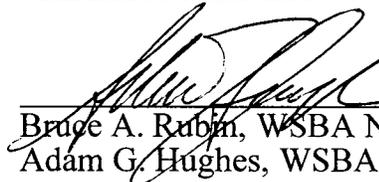
I further certify that on the date set forth below, I served a true copy of this BRIEF OF APPELLANTS by hand-delivery to the last-known office address for Respondent's counsel as follows:

Ms. Medora A. Marisseau  
Karr Tuttle Campbell  
1201 Third Avenue, Suite 2900  
Seattle, Washington 98101-3028

Attorney for Respondent

DATED this 27<sup>th</sup> day of August, 2010.

MILLER NASH LLP

  
\_\_\_\_\_  
Bruce A. Rubin, WSBA No. 37384  
Adam G. Hughes, WSBA No. 34438

Attorneys for Plaintiffs-Appellants