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No. 652711

COURT OF APPEALS, DIVISION ONE
OF THE STATE OF WASHINGTON

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,

Appellant,

v.

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.,

Respondent.

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BRIEF OF RESPONDENT

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TABLE OF CONTENTS

	<u>PAGE</u>
I. INTRODUCTION.....	1
II. STATEMENT OF THE CASE.....	2
III. ARGUMENT	5
A. Summary of Argument.....	5
B. Standard of Review	7
C. Argument	7
1. ERISA Preempts the Trust’s claim for Alleged Improper Processing of Plan Benefits.....	7
a. Standards for ERISA Preemption	7
(1) <i>Courts Routinely Find that Claims for Improper Processing of Benefits Against Third-Party Administrators Are Preempted.</i>	<i>8</i>
(2) <i>Claims for Improper Processing of Benefits By Plans or Plan Sponsors Against Third-Party Administrators Are Preempted.</i>	<i>9</i>
(3) <i>Washington Law Recognizes the Doctrine of ERISA Preemption of Claims Based on Improper Processing of Claims for Benefits. .</i>	<i>12</i>
(4) <i>The Trust Overstates the Impact of Travelers to this Case.</i>	<i>14</i>
b. The Trust’s Claim Against HMA Is Based Solely on Alleged Improper Processing of Benefits and Interferes with Uniform Plan Administration	18
c. The “Stop-Loss” Cases Relied upon by the Trust Support Preemption in This Case.....	23

2.	HMA’s Fiduciary Status is Irrelevant and the Trust’s Claim Affects the Relationship Between ERISA Entities.	31
3.	Whether a Damages Remedy is Available Under ERISA Does Not Impact the Preemption Analysis.	35
4.	The Choice of Law Provision Cannot Avoid Preemption.	38
IV.	CONCLUSION	40

TABLE OF AUTHORITIES

	<u>PAGE</u>
CASES	
<i>Aetna Health v. Davila</i> , 542 U.S. 200, 159 L. Ed. 2d 312, 124 S. Ct. 2488 (2004)	8, 18
<i>Airparts Co. v. Custom Ben. Serv. of Austin, Inc.</i> , 28 F.3d 1062 (9 th Cir. 1994).....	25
<i>Allstate Ins. Co. v. My Choice Medical Plan for LDM Tech., Inc.</i> , 298 F. Supp. 2d 651 (D. Mich. 2004)	38
<i>American Med. Sec. v. Bartlett</i> , 111 F.3d 358 (4th Cir. 1997)	12
<i>Arizona State Carpenters Pension Trust Fund v. Citibank</i> , 125 F.3d 715 (9th Cir. 1997)	16, 17, 23
<i>Bast v. Prudential Ins. Co. of Am.</i> , 150 F.3d 1003 (9 th Cir. 1998)	9
<i>Behavioral Sciences Inst. v. Great-West Life</i> , 84 Wn. App. 863 (Div. I 1997)	6, 12, 13, 18, 19, 20, 23, 24, 26
<i>Best Int'l USA v. Tucker & Clark</i> , No. 3:9: (V-1556-BC, 2000 U.S. Dist. LEXIS 8799 (D. Tex. June 12, 2000)	11
<i>Blau v. Del Monte Corp.</i> , 748 F.2d 1348 (9 th Cir. 1984).....	7
<i>Cannon v. Group Health Serv.</i> , 77 F.3d 1270 (10 th Cir. 1996).....	37
<i>Carbajal v. Dorn</i> , No. CV-09-283-PHX-DGC, 2009 U.S. Dist. LEXIS 32688, at *6-7 (D. Ariz. April 14, 2009).....	34
<i>Casper Air Service v. Sun Life Assur. Co.</i> , 752 F. Supp. 1005 (D. Wyo. 1990)	10, 32, 33
<i>Collins v. Ralston Purina Co.</i> , 147 F.3d 592 (7th Cir. 1998)	19
<i>Consolidated Beef Indus., Inc. v. New York Life Ins. Co.</i> , 949 F.2d 960 (8 th Cir. 1991)	31
<i>Corcoran v. United Healthcare, Inc.</i> , 965 F.2d 1321 (5th Cir. 1992)	31, 37
<i>Culter v. Phillips Petroleum Co.</i> , 124 Wn.2d 749, 881 P.2d 216 (1994).....	7, 12

<i>Custer v. Pan American Life Ins. Co.</i> , 12 F.3d 410 (4 th Cir. 1993).....	9, 33
<i>Electrical Workers v. Trig Electric</i> , 142 Wn.2d 431, 13 P.3d 622 (2000).....	15
<i>Faulman v. Security Mutual Fin. Life Ins. Co.</i> , No. 08-4152, 2009 U.S. App. LEXIS 26302, at * 6-7 (3rd Cir. 2009).....	34
<i>Fox, Curtis & Assocs., Inc. v. Employee Benefit Plans, Inc.</i> , No. 92-C-5828, 1993 U.S. Dist. LEXIS 9456, at *2 (N.D. Ill. July 13, 1993).....	29
<i>Galen v. McAllister</i> , 833 F. Supp. 761 (N.D. Ca. 1992).....	25
<i>Geweke Ford v. St. Joseph's Omni Preferred Care Inc.</i> , 130 F.3d 1355 (9 th Cir. 1997).....	6, 23, 24, 25, 26, 28
<i>Gibson v. Prudential Ins. Co.</i> , 915 F.2d 414 (9 th Cir. 1990).....	32, 33, 36
<i>Great-West Life & Annuity Ins. Co. v. Knudson</i> , 534 U.S. 204, 122 S. Ct. 708, 151 L.Ed. 2d 635 (2002).....	37, 38
<i>Hospice of Metro Denver, Inc. v. Group Health Ins.</i> , 944 F.2d 752 (10 th Cir. 1991).....	37
<i>Howard v. Parisian, Inc.</i> , 807 F.2d 1560 (11 th Cir. 1987).....	9, 32, 34
<i>Info Systems & Networks Corp. v. Principal Life Ins. Co.</i> , 101 Fed. Appx. 383 (4 th Cir. 2004).....	11
<i>Ingersoll-Rand Co. v. McClendon</i> , 498 U.S. 133, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990).....	15
<i>Jones v. LMR Int'l, Inc.</i> , 457 F.3d 1174 (11 th Cir. 2006).....	34
<i>K.F. v. Blueshield</i> , C08-0890 RSL, 2008 U.S. Dist. LEXIS 71314, at *11-14 (Sep. 19, 2008 W.D. Wash.).....	22
<i>Kahn v. Salerno</i> , 90 Wn. App. 110 (1998).....	36
<i>Ky. Laborers Dist. Council Health & Wel. v. Hope</i> , 861 F.2d 1003 (6 th Cir. 1988).....	19
<i>Lake City Employers' Health & Welfare v. Fiduciary Sec. Life Ins. Co.</i> , 90 Ohio App. 3d 809, 630 N.E. 2d 781, 782 (Ohio App. 1993).....	13
<i>Mass. Mutual Life Ins. Co. v. Russell</i> , 473 U.S. 134, 87 L. Ed. 2d 96, 105 S. Ct. 3085 (1985).....	36

<i>Meadows v. Employers Health Ins.</i> , 47 F.3d 1006 (9 th Cir. 1995)	25
<i>Metropolitan Life Insurance Co. v. Taylor</i> , 481 U.S. 58, 107 S. Ct. 1542, 95 L. Ed. 2d 55 (1987)	30
<i>Michigan Affiliated Healthcare System, Inc. v. CC Systems Co. of Michigan</i> , 139 F.3d 546 (6 th Cir. 1998)	30
<i>Munoz v. Prudential Ins. Co. of America</i> , 633 F. Supp. 564 (D. Colo. 1986)	32
<i>New York State Conference of Blue Cross & Blue Shield Plans v. Travelers, Ins. Co.</i> , 514 U.S. 645, 115 S. Ct. 1671 (1995)	6, 13, 14, 15, 16, 17, 23, 26
<i>New York State Conference of Blue Cross & Blue Shield Plans v. Travelers, Ins. Co.</i> , 514 U.S. at 655	14, 15
<i>Operating Eng'rs Health & Welfare Trust Fund v. JWJ Contracting Co.</i> , 135 F.3d 671 (9 th Cir. 1998)	16
<i>Peralta v. Hispanic Bus., Inc.</i> , 419 F.3d 1064 (9 th Cir. 2005)	19
<i>Pilot Life v. Dedeaux</i> , 481 U.S. 41, 95 L.Ed. 2d 39, 107 S. Ct. 1549 (1987)	7, 8, 15, 16, 36
<i>Pizlo v. Bethlehem Steel Corp.</i> , 884 F.2d 116 (4 th Cir. 1989)	28
<i>Prudential Ins. Co. of Am. v. Doe</i> , 140 F.3d 785 (8 th Cir. 1998)	39
<i>Puget Sound Elect. Worker's Health & Welfare Trust Fund v. Merit Co.</i> , 123 Wn.2d 565 (1994)	16
<i>Rutledge v. Seyfarth et al.</i> , 201 F.3d 1212 (9 th Cir. 2000)	16, 34
<i>Shaw v. Delta Air Lines, Inc.</i> , 463 U.S. 85, 98, 77 L. Ed 2d 490, 103 S. Ct. 2890 (1983)	15, 17
<i>Skilstaf, Inc. v. Adminitron, Inc.</i> , 66 F. Supp. 2d 1210 (M.D. Ala. 1999)	30
<i>Southern Cal. Meat Cutters Unions v. Investors Research</i> , 687 F. Supp. 506 (C.D. Cal. 1988)	32
<i>Spain v. Aetna Life Ins. Co.</i> , 11 F.3d 129 (9 th Cir. 1993)	37
<i>Strategic Outsourcing, Inc. v. Commerce Benefits Group Agency, Inc.</i> , 54 F. Supp. 2d 566 (W.D. N.C. 1999)	11
<i>Strategic Outsourcing, Inc. v. Commerce Benefits Group Agency, Inc.</i> , 54 F. Supp. 2d 566 (W.D.N.C. 1999)	27

<i>Tie Communications, Inc. v. First Health Strategies, Inc.</i> , No. Civ. A. 97-2597-EEO, 1998 WL 171126 , at *2 (D. Kan. Mar. 3, 1998)	28
<i>Tri-State v. Machine, Inc. v. Nationwide Life Ins. Co.</i> , 33 F.3d 309 (4th Cir. 1994).....	9
<i>Union Health Care v. John Alden life Ins. Co.</i> , 908 F. Supp. 429 (S.D. Miss. 1995).....	25, 29
<i>Vantage Health Plan, Inc. v. ACMG, Inc.</i> , 830 So.2d 398 (La. App. 2002)	11
<i>Washington Nat'l Ins. Co. v. Hendricks</i> , 855 F. Supp. 1542 (W.D. Wis. 1994).....	13
<i>Washington State Auto Dealers Ins. Trust v. Aon Consulting, Inc.</i> , No. C07-1182 MJP, 2008 WL 4889206 (W.D. Wash. Nov. 11, 2008)	26

STATUTES

29 U.S.C. § 1001 <i>et. seq.</i>	1
29 U.S.C. § 1132(a)(3).....	33, 34, 35, 36, 37
29 U.S.C. § 1132(a)(3)(A)	35
29 U.S.C. § 1144.....	33
29 U.S.C. § 1144(a)	7, 30, 40
29 U.S.C. § 1144(c)(1).....	7
ERISA 502(a).....	30, 36
U.S.C. § 514(a)	8

RULES

CR 12(b)(6).....	4, 7
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I. INTRODUCTION

This case involves a claim for overpayment and improper payment of medical benefits under an employee welfare benefit plan regulated by the Employment Retirement Income Security Act (“ERISA”), 29 U.S.C. § 1001 *et. seq.* The Associated General Contractors—International Union of Operating Engineers Local 701 Health and Welfare Trust Fund (the “Plan” or the “Trust”) is a medical benefit plan for eligible employees, their spouses and dependents (“Plan Participants”). Healthcare Management Administrators, Inc. (“HMA”) was the third-party administrator responsible for processing medical claims under the Plan.

The Trustees of the Plan sought damages in a common law breach of contract claim against HMA for alleged “failure to pay the benefits in accordance with the Plan documents.” Clerk’s Papers (“CP”) 150.¹

The trial court correctly determined that the Trust’s breach of contract claim was pre-empted by ERISA because the Trust’s claim interferes with uniform administration of an ERISA plan by directly challenging the correctness of benefit decisions made by HMA on medical claims by Plan Participants under the Plan. The Trust’s claim also affects the relationships between ERISA-regulated entities, including those between the Plan and the Plan Participants and HMA and the Trust, by

¹ Opposition to Motion to Dismiss, p. 11 (CP 150).

seeking to have Participants' claims second-guessed in a breach of contract action which is focused on application and interpretation of the Plan terms.

The remedy available to the Trust is found under ERISA. Whether that remedy is acceptable to the Trust is irrelevant to the preemption analysis. The decision of the trial court should be upheld.

II. STATEMENT OF THE CASE

The Trustees established an employee health benefit plan (the "Plan") for eligible employees, their spouses, and dependents. CP 37-43. The Plan is self-funded, meaning that the Trust funds payment of the benefits under the Plan. CP 38. There is no dispute that the Plan is governed by ERISA. CP 132.

Effective July 1, 2005, the Trust and HMA entered into an Administrative Services Agreement ("Agreement"). CP 5-19. Under the Agreement, HMA agreed to administer medical benefit claims made by Plan Participants under the Plan. CP 5-7. In particular, HMA agreed to:

(b) Receive claims and process for payment of covered benefits for Participants in accordance with the provisions of the Plan

. . . .

(d) Process all claims for benefits, calculate amounts due and payable in accordance with the terms of the Plan, and adjust claims accordingly.

. . . .

(f) Coordinate, as necessary, with other payors to determine the amount of benefits payable under the Plan.

.....
(j) Provide for the coordination of benefits, subrogation collection activities, collection of overpayments or improper payments made to any Participants, as reasonably possible. In the event that additional recovery services are needed, HMA, subject to the written approval of the Plan Sponsor, shall arrange for the purchase of such recovery services.

.....
CP 17.

The Plan sets forth when a participant is eligible for benefits (CP 44), when services are medically necessary (CP 74, 118), what charges and benefits are allowed under the Plan (CP 74), when and how to coordinate benefits with other plans or insurers (CP 105), and provides for recovery of benefits against Plan Participants (CP 122).

In October 2009, the Trust filed a complaint against HMA for “overpayment and improper payment” of claims under the Plan. CP 3. The Trust alleged that HMA breached its obligation of “making benefit payments as required by the Plan” by issuing benefits to ineligible dependents, failing to coordinate benefits correctly, incorrectly determining the allowable amount for certain physicians, failing to screen for medical necessity before issuing benefits, incorrectly determining the allowable amount, failing to apply discounts for services at network facilities, and other miscellaneous errors, including incorrect adjustment of

previous payments, data input errors, duplicate payments, and applying copayments in error. CP 3. The Trust “seeks damages for HMA’s failure to pay benefits in accordance with the Plan documents.” (Brief of Appellant, p. 11).

On February 4, 2010, HMA filed a motion to dismiss the Complaint pursuant to Civil Rule 12(b)(6). CP 20-33. The motion was supported by a declaration of Susan Smith, attaching a copy of the Summary Plan Description for the Plan provided by the Trust to HMA. CP 34-139. HMA asked the court to dismiss the Trust’s breach of contract claim because the claim related to a Plan governed by ERISA and was therefore preempted.

At the hearing on the motion, the trial court inquired of HMA’s counsel what remedies were available to the Trust under ERISA. The actual statement from the record is as follows:

MS. MARISSEAU: A civil action may be brought by a participant beneficiary or fiduciary, such as the trust here, to (inaudible) any act or practice which violates the terms of the plan The cases support the notion that against a non fiduciary administrator, there is a cause of action under 1132(A)(3).

There can’t be two causes of action. There can’t be one for state law and one under ERISA. ERISA is exclusive

. . . .
THE COURT: Can I just ask you a very practical question?

MS. MARISSEAU: Sure.

THE COURT: Are you saying then it's preempted, so it's not that they are not without a remedy, but their remedy is under ERISA?

MS. MARISSEAU: Correct.

VR 15:13-25, 16:1; VR 16:18-24.

HMA's counsel also quoted the trial court Ninth Circuit authority which expressly ruled that "The lack of ERISA remedy does not affect a preemption analysis." VR 32:1-35:9.

The court, after taking the matter under advisement, determined that the breach of contract claim was preempted by ERISA and dismissed the Trust's Complaint. CP 160-161. This appeal followed.

III. ARGUMENT

A. Summary of Argument

The Trust's breach of contract claim "relates to" an ERISA plan and is preempted because, at its core, it is a claim for the improper administration and overpayment of benefits under the Plan. The Trust's claim requires an in-depth analysis and interpretation of Plan terms and re-evaluation of each benefit decision under the Plan made by HMA while administering the Plan.

The Trust's claim also impacts the relationship between ERISA-regulated entities. Unlike the stop-loss cases relied upon by the Trust where there is no disagreement about the proper administration of claims under the Plan, the breach of contract claim here directly challenges HMA's administration of benefits under the Plan. The Trust's depiction of *Geweke* and *Behavioral Sciences*² creates a false impression that those cases were based on improper claims processing. Both involved claims for stop-loss insurance coverage. The Trust also overstates the impact of *Travelers*³ to this case and ignores the many authorities which have ruled that a claim relating to the improper processing of plan benefits "relates to" an ERISA plan and is preempted.

As a matter of law, the Trust also cannot avoid preemption on grounds that HMA is not a fiduciary. Appellate courts uniformly hold that ERISA preempts claims against non-fiduciaries. Similarly, under Washington and federal law, the lack of a damages remedy under ERISA has no impact on ERISA preemption and the choice of law provision in the Agreement cannot trump federal law.

² *Geweke Ford v. St. Joseph's Omni Preferred Care Inc.*, 130 F.3d 1355 (9th Cir. 1997); *Behavioral Sciences Inst. v. Great-West Life*, 84 Wn. App. 863 (1997).

³ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers, Ins. Co.*, 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995).

B. Standard of Review

“A trial court’s ruling on a motion to dismiss for failure to state a claim upon which relief can be granted under CR 12(b)(6) is a question of law and is reviewed *de novo* by an appellate court.” *Culter v. Phillips Petroleum Co.*, 124 Wn.2d 749, 755, 881 P.2d 216 (1994) (reviewing CR 12(b)(6) dismissal of state law claim under ERISA preemption *de novo*). Courts should dismiss a claim under CR 12(b)(6) only if it appears beyond a reasonable doubt that no facts exist that would justify recovery. *Id.*

C. Argument

1. ERISA Preempts the Trust’s claim for Alleged Improper Processing of Plan Benefits.

a. Standards for ERISA Preemption

ERISA expressly “supersedes any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan . . . ” 29 U.S.C. § 1144(a) (emphasis added). The term “State law” includes “all laws, decisions, rules, regulations, and other State action having the effect of law of any State.” 29 U.S.C. § 1144(c)(1). Common law claims for breach of contract fall within the definition of the term “State law.” *Pilot Life v. Dedeaux*, 481 U.S. 41, 48, 95 L.Ed. 2d 39, 107 S. Ct. 1549 (1987) (overruled on other grounds). *See also Blau v. Del Monte Corp.*, 748 F.2d 1348, 1356-57 (9th Cir. 1984); *Culter*, 124 Wn.2d at 763.

(1) *Courts Routinely Find that Claims for Improper Processing of Benefits Against Third-Party Administrators Are Preempted.*

The U.S. Supreme Court has long held that claims related to the improper processing or administration of benefit claims are preempted by ERISA. For example in *Pilot Life v. Dedeaux*, 481 U.S. 41, 47-48, 95 L.Ed.2d 39, 107 S. Ct. 1549 (1987), the Court ruled a breach of contract claim and related tort claims were preempted by ERISA: “The common law causes of action raised in [the] complaint, *each based on alleged improper processing of a claim for benefits* under an employee benefit plan, undoubtedly meet the criteria for preemption under § 514(a).” *Id.* (emphasis in original).

More recently, in *Aetna Health v. Davila*, 542 U.S. 200, 213, 159 L. Ed. 2d 312, 124 S. Ct. 2488 (2004), the Court ruled that state law claims against a third-party administrator were preempted, noting that the “interpretation of the terms of respondents’ benefit plans form an essential part of their Texas Health Care Liability Act claim, and THCLA liability would exist here only because of petitioners’ administration of ERISA-regulated benefit plans.” *Davila*, 542 U.S. at 213.

The Ninth Circuit and other appellate courts routinely find claims relating to improper processing of benefits “relate to” an ERISA plan and are preempted. *See Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003 (9th

Cir. 1998) (finding state law claims brought under Washington common law relating to alleged improper benefit processing were preempted against third-party administrator); *Custer v. Pan Am. Life Ins. Co.*, 12 F.3d 410 (4th Cir. 1993) (state law claim against non-fiduciary third-party administrator for improper benefit administration was preempted); *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1564-65 (11th Cir. 1987) (holding that ERISA preempts the assertion of claims against non-fiduciary administrators of self-funded employee benefits plans relating to improper processing of benefits).

(2) *Claims for Improper Processing of Benefits By Plans or Plan Sponsors Against Third-Party Administrators Are Preempted.*

Applying these principles, courts often hold that breach of contract claims by plans or plan sponsors, such as the Trust, against third-party administrators, such as HMA, based on the administrator's alleged improper processing of benefits are preempted by ERISA. In *Tri-State v. Machine, Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309 (4th Cir. 1994), the plan sponsor sued the claims administrator for breach of contract and other state law claims, alleging that the administrator had paid claims to the wrong medical providers, issued coverage to ineligible persons, charged claims to accounts of individuals who had not submitted claims, paid claims that were not covered, denied covered claims, and delayed

processing of claims. *Id.* at 311. The parties had entered into a separate agreement, under which the plan sponsor asserted its claim for breach of contract. *Id.*

The court easily disposed of the preemption issue:

[T]here can be little doubt that the claims relate to the plan. Tri-State's complaint particularizes a list of wrongs committed by Nationwide Life, including paying claims to wrong medical providers, issuing coverage cards in the names of employees never associated with Tri-State, charging claims to accounts of individuals who had not submitted claims, paying claims not covered, denying claims that were covered *All of these allegations are essentially complaints about the processing of claims under an employee benefit plan* and, therefore, *relate to the plan* in the common sense meaning of that phrase.

Id. at 313 (emphasis in original).

In *Casper Air Service v. Sun Life Assur. Co.*, 752 F. Supp. 1005, 1009 (D. Wyo. 1990), the employer and trustees of an ERISA self-funded plan brought a state law breach of contract claim against the non-fiduciary claims administrator for failing to comply with the terms of their administration agreement. The plaintiffs alleged the administrator inaccurately calculated benefits for terminated employees, failed to properly administer plan assets and failed to terminate the plan upon notice from plaintiffs. The court noted that "these certainly appear to be the type of actions which 'relate to' the plan's administration and type of benefits provided." *Id.* at 1007. The court went on to rule the breach of

contract claim was preempted. *See also Vantage Health Plan, Inc. v. ACMG, Inc.*, 830 So.2d 398 (La. App. 2002) (plan's state law contract claim against third-party administrator alleging improper payment for in-patient services as out-patient services, improper authorization of hospital services, and improper overpayment of claims were preempted); *Strategic Outsourcing, Inc. v. Commerce Benefits Group Agency, Inc.*, 54 F. Supp. 2d 566 (W.D. N.C. 1999); *Info Systems & Networks Corp. v. Principal Life Ins. Co.*, 101 Fed. Appx. 383, 384 (4th Cir. 2004) (unpublished) (where the gravamen of the plaintiff's complaint is that certain distributions made by the defendant were erroneous because beneficiaries were not entitled to benefits under the plan, the state law claims were preempted under ERISA); *Best Int'l USA v. Tucker & Clark*, No. 3:9: (V-1556-BC, 2000 U.S. Dist. LEXIS 8799 (D. Tex. June 12, 2000) (unpublished) (finding ERISA preempted claim against third-party administrator).

The Trust has cited no authority supporting its proposition that contract claims against an administrator such as HMA for improper processing of benefits are not preempted.

(3) *Washington Law Recognizes the Doctrine of ERISA Preemption of Claims Based on Improper Processing of Claims for Benefits.*

These preemption principles have been applied by the Washington courts. *See Culter*, 124 Wn.2d at 763; *Behavioral Sciences*, 84 Wn. App. at 863.

In *Culter*, the issue was whether the plaintiffs' claims for negligence, outrage, breach of contract and negligent misrepresentation and fraud "related to an employee benefit plan." 124 Wn. 2d at 755. The *Culter* court noted the "essence of the claims is the Respondents' perceived loss of benefits under the special separation [ERISA-governed] plan." *Id.* at 762. The court ruled, citing *Ingersoll-Rand Co.*, 498 U.S. at 140, that the remaining tort and contract claims "relate to" an ERISA plan. *Id.* at 763.

In *Behavioral Sciences*, this Court examined these principles in the context of a dispute involving the denial of coverage under a stop-loss insurance policy.⁴ Behavioral Sciences Institute (BSI), which self-funded an ERISA plan for its employees, paid benefits under the plan on behalf of the participant. 84 Wn. App. at 865. BSI sought recovery for the benefits

⁴ Stop loss or excess loss insurance provides coverage to self-funded plans above a certain level of risk absorbed by the plan. *American Med. Sec. v. Bartlett*, 111 F.3d 358, 361 (4th Cir. 1997). It provides protection to the plan, not to the plan's participants or beneficiaries, against benefits payments over a specified level. *Id.* Regulation of stop loss insurance is clearly reserved to the states. *Id.* at 365.

paid under the stop-loss insurance policy issued by Great-West Life (GW), the re-insurer. *Id.* GW refused to provide stop-loss coverage, claiming there was no coverage under the stop-loss policy because it argued the participant's claim should not have been paid under the plan. *Id.* BSI sued GW, alleging breach of contract and bad faith. *Id.*

This Court applied a “holistic approach to ERISA preemption, emphasizing congressional intent and the purpose of ERISA.” *Id.* at 872 (citing *Travelers Ins. Co.*, 115 S. Ct. at 1676-77).

Behavioral Sciences contrasted the stop-loss insurance dispute before it from cases where the claims were brought against an entity who directly administered benefits under the plan, as HMA did here. The court also noted that where claims require state courts “to rule on whether a plan participant should be covered under plan guidelines” such state law claims would impact uniform plan administration and would be preempted. *Id.* at 874. The court also noted another distinguishing factor from the stop-loss dispute before it was that “this case does not involve interpreting ambiguous ERISA provisions the disputes here are those of fact, not complex plan interpretations.” *Id.* at 873-74 (citing *Lake City Employers' Health & Welfare v. Fiduciary Sec. Life Ins. Co.*, 90 Ohio App. 3d 809, 630 N.E. 2d 781, 782 (Ohio App. 1993) and *Washington Nat'l Ins. Co. v. Hendricks*, 855 F. Supp. 1542, 1551 (W.D. Wis. 1994)).

This Court went on to state the most important factor for the ERISA preemption analysis: “More importantly, resolution of this case does not implicate whether the Plan participant should have been covered under the Plan.” *Id.* Because the stop-loss insurance claim did not relate to improper processing of benefits under the plan, the court ruled the claim was not preempted.

(4) *The Trust Overstates the Impact of Travelers to this Case.*

The Trust asserted that its claim for breach of contract is peripheral and incidental to the ERISA-governed plan, relying on *Travelers*, 514 U.S. at 645. *Travelers* does not support the Trust’s argument.

In 1995, the U.S. Supreme Court attempted to clarify the phrase “relates to” in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers, Ins. Co.*, 514 U.S. at 655 (“[W]e have to recognize that our prior attempt to construe the phrase ‘relate to’ does not give us much help drawing the line here.”). The Court instructed that the objective of the ERISA statute must be used as a guide to determine the scope of ERISA preemption. *Id.* at 655-56. The Court described the goal of ERISA preemption was to eliminate the threat of inconsistent State and local regulation of plans so as to permit a uniform administration of employee benefit plans. *Id.* at 657-58. The court went on to analyze whether a New York law (which imposed surcharges on HMOs depending

on the number of Medicaid recipients enrolled) “related to” an ERISA plan. *Id.* at 658-59. The Court ruled that the indirect economic effect imposed by the law had only a peripheral connection to an ERISA plan and was therefore not preempted. *Id.* at 659-60.

The Court, however, also ruled “we do not hold today that ERISA pre-empts only direct regulation of ERISA plans, nor could we do that with fidelity to the views expressed in our prior opinions on the matter.” *Id.* at 667 (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990); *Pilot Life v. Dedeaux*, 481 U.S. 41, 47-48, 95 L.Ed.2d 39, 107 S. Ct. 1549 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98, 77 L. Ed 2d 490, 103 S. Ct. 2890 (1983))

The Trust overstates the impact of *Travelers* to this case. The Washington Supreme Court rejected an argument similar to what the Trust asserts here in *Electrical Workers v. Trig Electric*, 142 Wn.2d 431, 437, 13 P.3d 622 (2000). In *Trig Electric*, the court examined whether claims under the public works lien statutes “related to” an ERISA plan.

The appellant argued the decision in *Travelers* represented a retreat from a broad interpretation of ERISA preemption and required the court to overrule its prior decision⁵ finding ERISA preemption. The court rejected

⁵ The decision at issue was *Puget Sound Elect. Worker’s Health & Welfare Trust Fund v. Merit Co.*, 123 Wn.2d 565 (1994).

the argument, ruling: “Nothing in substantive ERISA law has changed in the intervening years between *Merit* and this case that alters our conclusion.” *Id.* at 440. Further, *Travelers* expressly re-affirmed the ruling in *Pilot Life. Travelers*, 514 U.S. at 667.

The Trust’s reliance on *Arizona State Carpenters Pension Trust Fund v. Citibank*, 125 F.3d 715, 723 (9th Cir. 1997) is also misplaced. Following the *Travelers* decision, courts within the Ninth Circuit further clarified the scope of ERISA preemption and adopted various, non-exclusive tests. *See, e.g., Operating Eng’rs Health & Welfare Trust Fund v. JWJ Contracting Co.*, 135 F.3d 671 (9th Cir. 1998) (emphasizing continued viability of factors developed in earlier case law); *Rutledge v. Seyfarth*, 201 F.3d 1212, 1219 (9th Cir. 2000) (ruling that *Arizona State Carpenters* was not an exclusive test for ERISA preemption, and declining to synthesize tests, but holding that a “core factor” leading to preemption is “that the claim bears on an ERISA-regulated relationship.”).

Arizona State Carpenters also did not involve claims relating to the improper processing of benefits under an ERISA plan. There, the plaintiff/trust asserted the defendant/bank breached a custodial agreement by failing to notify the trust (the custodial account holder) of defaults on payments for investments made by the trust fund’s investment managers. The Ninth Circuit reaffirmed the rule that there “can be little doubt that

Congress intended to sweep away any state law whose administration might interfere with or complicate the administration of ERISA.” *Id.* at 722. The court then examined the *Travelers* decision, noting the “Supreme Court recognized at least three areas in which ERISA was intended to preempt state law claims” *Id.* at 723 (emphasis added). Those three areas include state laws: (a) that mandate employee benefit structures or their administration; (b) 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 (c) provide alternate enforcement mechanisms for employees to obtain ERISA plan benefits. *Id.*

The court ruled that the claim against the bank for breach of the custodial agreement “does not depend on ERISA in any way” and “does not affect relations among the principal ERISA entities.” *Id.* at 723-24. Accordingly, “[i]n the circumstances of this case, the connection between the state common law principles and ERISA’s regulation of employee benefit plans is simply too ‘tenuous, remote, or peripheral’ to trigger preemption.” *Id.* at 724 (quoting *Shaw*, 463 U.S. at 100 n.21).

Arizona State Carpenters is distinguished from this case because the Trust’s claim here is a front and center challenge to HMA’s administration of benefits under the Plan.

b. The Trust's Claim Against HMA Is Based Solely on Alleged Improper Processing of Benefits and Interferes with Uniform Plan Administration

Here, the Trust asserts HMA, as claims administrator, paid too much in benefits under the Plan, thereby breaching the Agreement. The Trust's claim directly impacts administration of the Plan because it squarely challenges HMA's administration of Plan benefits. The Agreement creates no obligation by HMA separate and apart from administration of claims under the Plan.

Unlike the stop-loss coverage purchased for the benefit of the employer in *Behavioral Sciences*, resolution of this case *does* "implicate whether the Plan participant should have been covered under the Plan." *Behavioral Sciences*, 84 Wn. 2d at 874. Moreover, liability for the contract claim "would exist here only because of [HMA's] administration of an ERISA-regulated benefit plan[s]." *Davila*, 542 U.S. at 213. The connection between the Trust's claim and regulation of employee benefit plans is not remote, tenuous, or peripheral. It is front and center.

The Trust's contract claim also requires the Court to interpret the ERISA plan provisions and decide whether the Participants' claims paid under the Plan were correctly determined. *Cf. Behavioral Sciences*, 84 Wn. App. at 874 ("More importantly, resolution of this case does not implicate whether the plan participant should have been covered under the

Plan.”). Courts have repeatedly stated: “[a]n action based on state law is considered to relate to an ERISA plan for pre-emption purposes if it requires the court to interpret the terms of the plan.” *Ky. Laborers Dist. Council Health & Wel. v. Hope*, 861 F.2d 1003, 1005 (6th Cir. 1988); *Collins v. Ralston Purina Co.*, 147 F.3d 592, 595 (7th Cir. 1998) (Because Congress enabled ERISA to preempt state law claims so that employers would have a uniform set of procedures and regulations when establishing and maintaining such plans, ERISA “preempts a state law claim if the claim requires the court to interpret or apply the terms of an employee benefit plan[.]”); *Peralta v. Hispanic Bus., Inc.*, 419 F.3d 1064, 1069 (9th Cir. 2005) (finding that claims do not relate to a plan when adjudication of the claim requires no interpretation of the plan, no distribution of benefits, and no dispute regarding any benefits previously paid). Where the dispute involves “complex plan interpretations,” the dispute does not have a tenuous or remote connection to the Plan and is preempted. *Cf. Behavioral Sciences*, 84 Wn. App. at 874 (finding that mere reference to the plan in deciding the reinsurance dispute was tenuous and remote because “the disputes here are those of fact, not complex plan interpretations.”).

Each allegation set forth in the Complaint requires an examination of the Plan set up by the Trustees. Nothing in the Agreement between

HMA and the Trust, pursuant to which HMA administered the Plan, has any parameters for whether a benefit claim should be paid, whom is covered, the amounts to be paid, or whether a claim is “medically necessary.” The Agreement simply requires that claims be processed and benefits determined “in accordance with the terms of the Plan.” CP 5.

If the Trust’s claims are allowed to proceed, the trial court would be required to review all the claims that the Trust asserts were improperly paid and interpret and apply the Plan provisions to determine whether HMA “overpaid” a Participant’s claim. This is contrary to ERISA preemption principles. *See Behavioral Sciences*, 84 Wn. App. at 874 (“ERISA’s purpose would be defeated if state courts were to rule on whether a plan participant should be covered under the plan guidelines.”).

For example, the Trust alleges that HMA approved benefits to ineligible dependents. “Participant” is defined in the Agreement as “those employees and former employees contributing to Plan Sponsor, and their spouses and dependents, who have met the eligibility requirements of the Plan, and satisfied all other conditions to participate in the Plan.” CP 5.

The Plan provides as follows:

To be eligible for benefits, you must have worked a certain minimum number of hours in previous months and your employer must have contributed and reported the hours for you to the plan You will be eligible on the first day of the second month following accumulation of 150 or more working hours (reported

and paid to the plan) within a three consecutive month calendar period.

CP 44.

The Plan continues on to describe an hour bank system, when eligibility is terminated⁶ and when an employee's eligibility may be reinstated.⁷ CP 44-46. Dependents (a defined term)⁸ are eligible for benefits when the employee is eligible, with certain noted exceptions. CP 47. The only "yardstick" by which to measure HMA's conduct is the Plan, and interpretation of the Plan is absolutely necessary to the determination of the Trust's claim. These interpretations then must be applied to every allegedly "ineligible" Participant who received benefits.

The Trust also alleges that HMA failed to screen for medical necessity before approving benefits, which is one of the bases of its claim for recovery of alleged overpayments. CP 3. To vet this claim, the trier of fact would have to interpret and apply the Medical Necessity provision of the Plan and determine whether the claims at issue were "medically

⁶"If your hour bank has less than 120 hours on the first of a month, you will not be eligible for that month and your eligibility is terminated."

⁷ "When your coverage has been terminated because your hour bank has less than 120 hours, the balance of your hours, if any, will be carried for six months. If, during the balance of your hours, you work and add hours to your hour bank, your eligibility will be reinstated on the first day of the second month after your hour bank has a total of 120 hours."

⁸ Dependents are defined as a legal spouse, natural or legally adopted children under a certain age, step or foster children under a certain age under certain circumstances, and same sex domestic partners.

necessary” since only “medically necessary” claims are payable under the Plan. CP 74. The phrase “medically necessary” is defined in the Plan (and not defined in the Agreement). CP 74. The term “medically necessary” has been found to be ambiguous and require interpretation, even when defined in a plan. *See, e.g., K.F. v. Blueshield*, C08-0890 RSL, 2008 U.S. Dist. LEXIS 71314, at *11-14 (Sep. 19, 2008 W.D. Wash.).

The Trust’s claims would further require the trier of fact to apply the Plan terms to re-determine whether benefits should have been allowed to the Participants, whether they were eligible for coverage, and whether benefits shall have been coordinated with other plans. These decisions will impact the benefits received by Plan Participants and bind the Trust to interpretations and applications of Plan terms.

For example, the Plan expressly provides that benefits paid by mistake, such as, payments allegedly approved for “ineligible” participants, can be recovered “from the person paid or anyone else who benefits from it” and includes “the right to deduct the amount paid by mistake from future benefits.” CP 122. The contract claim implicates the Plan’s recovery right against the Participants for overpayment. Whether the Plan chooses to pursue recovery rights against the Participants, the decision on the Trust’s breach of contract claim affects the administration of the Plan. Likewise, the court’s interpretation of Plan terms and

decisions on “overpayment” of Participants’ claims will bind the Trust to particular interpretations of the Plan and applications of Plan terms to Participants’ claims, in violation of ERISA preemption. *See Arizona State Carpenters*, 125 F.3d at 723.

The goal of ERISA preemption—to eliminate the impact of state law claims and regulation on plan administration—is served by finding preemption in this case. *Travelers*, 514 U.S. at 656-58. Each scenario set forth by the Trust’s claim for “overpayment” and “improper payment” impacts Plan administration. The Trust’s claim requires the trial court and the trier of fact to delve into multiple complex issues concerning Plan administration. Given this, together with the impact on Plan administration of any decision on the Trust’s claim, the trial court reached the correct result and found the breach of contract claim was preempted by ERISA.

c. The “Stop-Loss” Cases Relied upon by the Trust Support Preemption in This Case.

The Trust relies solely on cases involving claims for failure to provide stop-loss coverage⁹ to assert no preemption should be found here. But those cases demonstrate there is a stark difference between state law claims based on an administrator’s failure to procure or provide

⁹ *Behavioral Sciences*, 84 Wn. App. at 865 and *Geweke Ford v. St. Joseph’s Omni Preferred Care Inc.*, 130 F.3d 1355 (9th Cir. 1997).

reinsurance (or stop-loss) coverage and claims, such as those at issue here, based on the administrator's alleged improper processing of a claim for benefits. Claims made against stop-loss carriers or third-party administrators relating to stop-loss coverage are generally not preempted by ERISA because the claims do not relate to the plan terms, the participants, or the administrator's responsibilities to the plan participants. *Behavioral Sciences*, 84 Wn. App. At 865.

In fact, *Geweke* and *Behavioral Sciences* actually support the application of preemption in this case. In *Geweke*, the employer, Geweke Ford, contracted with St. Joseph's Omni Preferred Care, Inc. ("Omni") to provide administrative services under a self-funded employee benefit plan subject to ERISA. *Geweke Ford*, 130 F.3d at 1357. Geweke also obtained an excess loss insurance policy from Alden, which required Alden to provide excess loss coverage to Geweke if Geweke's payments made under the plan exceeded the deductible in a given year. *Id.* Omni's duties under its contract with Geweke included notifying Alden of excess loss claims under the excess loss insurance policy.

Geweke sued Omni and Alden to recover payments Geweke made under the plan. Omni argued the claims against it were preempted because they related to "non-payment of plan benefits to the employer to reimburse for a claim under the plan." *Id.* at 1359. The court rejected the

argument because “Omni’s alleged failure was to file the claim with Alden properly and in a timely manner, *it was not a failure to administer the Plan.*” *Id.* at 1359 (emphasis added). In short, as the court demonstrated in its subsequent discussion of other case law, a “failure to administer [a] Plan” triggers preemption.

The court pointed to a district court case in which the claims against an excess-loss insurer were not regulated by ERISA. *Id.* at 1360 (citing *Union Health Care, Inc. v. John Alden Life Ins. Co.*, 908 F. Supp. 429, 432-36 (S.D. Miss. 1995)). The *Geweke* court noted that a key factor in the court’s analysis in *Union Health Care* was that the claim “against the third-party administrator was not preempted because the alleged harm did not involve administrative claims processing, but only a failure to seek insurance reimbursement for the employer for a payment made under the plan.” *Id.* at 1360.

The *Geweke* court also relied on case law where the relationship between the state law claims and the plan was found to be tenuous or incidental. *Geweke* noted that in each case, the defendant did not perform any administrative act under the plan. *Id.* (citing *Airparts Co. v. Custom Ben. Serv. of Austin, Inc.*, 28 F.3d 1062, 1065-66 (9th Cir. 1994); *Galen v. McAllister*, 833 F. Supp. 761 (N.D. Ca. 1992); *Meadows v. Employers Health Ins.*, 47 F.3d 1006 (9th Cir. 1995)).

Behavioral Sciences applied the same analysis to distinguish between state law claims for failure to pay the employer under an excess loss policy and those challenging the administration (overpayment) of benefits. The most important distinction noted by this Court in *Behavioral Sciences* was that “resolution of this case does not implicate whether the Plan participant should have been covered under the Plan.” *Behavioral Sciences*, 84 Wn. App. at 874.

Here, the dispute is precisely whether claims for Plan Participants should have been covered under the Plan. The Trust is suing HMA *because of* its administration of benefits under the Plan and because HMA allegedly breached its administrative duties. Both *Geweke* and *Behavioral Sciences* support preemption where, as here, the state law claim relates to the improper processing of benefits and therefore impacts plan administration.¹⁰

¹⁰ In addition to *Geweke* and *Behavioral Sciences*, the Trust also places heavy reliance on *Washington State Auto Dealers Ins. Trust v. Aon Consulting, Inc.*, No. C07-1182 MJP, 2008 WL 4889206 (W.D. Wash. Nov. 11, 2008). *Washington State v. Aon* is an unpublished district court opinion on a motion in limine. The opinion provides no background facts regarding the nature of the allegations at issue or even the roles of the parties. The opinion summarizes the “relationship” test developed in *Arizona State Carpenters, supra*, *Geweke Ford, supra*, and *Travelers, supra*, the court holds, without explanation, that the contract claim against the third-party defendant does not fall within one of the three categories of preempted state law identified in *Travelers*, does not depend on ERISA, and does not affect relations among ERISA entities. *Washington State Auto Dealers v. Aon*, No. C07-1182 MJP, at *2. Because the opinion provides no information or analysis on the relationship of the parties or the nature of the allegations, it provides no support for the Trust’s position.

The different outcomes under ERISA preemption analysis for claims based on failure to provide stop-loss coverage and claims based on failure to properly administer plan benefits is clearly shown in *Strategic Outsourcing, Inc. v. Commerce Benefits Group Agency, Inc.*, 54 F. Supp. 2d 566 (W.D. N.C. 1999). There, the plaintiff-employer, Strategic Outsourcing, provided health benefits for its employees under an ERISA plan. *Id.* at 568. Commerce Benefits Group Inc. (CBG) was hired to act as the third-party administrator for the plan. Under its contract with Strategic, CBG was also required to assist with procuring reinsurance coverage. *Id.* at 569. The South Lorain Merchants Association, Inc. (SLMA) agreed to provide reinsurance coverage for Strategic Outsources, but failed to obtain it. *Id.*

Strategic became dissatisfied with CBG because the health care claims of its employees were not timely processed or paid and improper denials of coverage were routinely made. *Id.* Strategic brought a variety claims, including claims for breach of contract against CBG, as well as claims against SLMA. *Id.*

The court described the ERISA preemption issue as “whether common law claims sounding in contract and tort brought by the corporations who established the plans are preempted when the employers sue the service providers for failing to timely process and pay claims,

overcharging for premiums, refusing to pay valid claims, and failing to obtain reinsurance coverage.” *Id.* at 572.

The court first ruled that the failure-to-procure claims against CBG and SLMA were not preempted. The court explained: “a claim by an employer against the third-party administrator for failure to obtain reinsurance is not preempted ‘because the alleged harm involved not administrative claims processing, but only a failure to [obtain reinsurance] for the employer [.]’” *Id.* at 573 (quoting *Geweke Ford*, 130 F.3d at 1360, and citing cases).

At the same time, however, the court ruled that the claims against CBG for improper processing of benefits were preempted because they could not be resolved without reference to the plans themselves. It also ruled that recovery under the breach of contract claims would impact the administration of the plan. *Id.* at 573-74 (citing *Pizlo v. Bethlehem Steel Corp.*, 884 F.2d 116, 120 (4th Cir. 1989)).

None of the remaining cases cited by the Trust relate to a challenge to an administrator’s processing of benefits under a plan. In *Tie Communications, Inc. v. First Health Strategies, Inc.*, No. Civ. A. 97-2597-EEO, 1998 WL 171126 , at *2 (D. Kan. Mar. 3, 1998) (unpublished), the court held that the state law claim against First Health Strategies for failure to timely provide the excess loss insurer with

information regarding an excess loss claim was not preempted. It noted the state law claim required no “[i]nterpretation of Tie’s benefit plan.” *Id.* at *9. Nor did it involve a dispute between the parties as to whether the participant who submitted the claim was entitled to benefits under the plan or the amount of those benefits. *Id.*

Union Health Care v. John Alden life Ins. Co., 908 F. Supp. 429, 430 (S.D. Miss. 1995), involved a claim against an administrator for failure to give timely notice of stop-loss claims to the stop-loss insurer. *Id.* at 431. The court, finding no preemption, noted there were no allegations that the administrator (MAS) made any payment under the plan in error or violated the plan terms. “Rather, the only claim asserted against MAS is that it failed to timely notify John Alden of excess claims.” *Id.* at 435.

Fox, Curtis & Assocs., Inc. v. Employee Benefit Plans, Inc., No. 92-C-5828, 1993 U.S. Dist. LEXIS 9456, at *2 (N.D. Ill. July 13, 1993) (unpublished) also involved claims relating to excess loss insurance. The court expressly noted “[n]either beneficiary status, scope of coverage, nor amounts of claims covered are at issue here.” *Id.* at *19-*20.

Michigan Affiliated Healthcare System, Inc. v. CC Systems Co. of Michigan, 139 F.3d 546 (6th Cir. 1998),¹¹ was another case involving allegations that the administrator failed to procure stop-loss insurance. There were no allegations relating to the improper processing or overpayment of claims. *Id.* at 549.

Skilstaf, Inc. v. Adminitron, Inc., 66 F. Supp. 2d 1210 (M.D. Ala. 1999) involved an excess loss claim and the claim did not involve interpretation of the plan's terms. *Id.* at 1212, 1217.

As shown above, where the state law claim is based on a failure to provide or pay for stop-loss insurance, the decision whether to pay benefits under the plan has already been made and is not directly challenged. In contrast, here Trust's the breach of contract claim directly challenges whether the Plan Participants' claims should have been paid, alleging that HMA improperly administered claims for benefits and thereby owes the Trust for alleged "overpayments." Under long established ERISA preemption law, the Trust's claims are preempted.

¹¹ *Michigan Affiliated* is further distinguished because it applied a complete preemption analysis, not a conflict preemption analysis, as applies here. *See Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 107 S. Ct. 1542, 95 L. Ed. 2d 55 (1987) (complete preemption is a basis for federal question removal jurisdiction under 28 U.S.C. § 1441(a), under ERISA 502(a)).

2. HMA's Fiduciary Status is Irrelevant and the Trust's Claim Affects the Relationship Between ERISA Entities.

Courts have repeatedly held that claims against non-fiduciaries can affect ERISA-governed relationships and are preempted. The proper inquiry under the ERISA preemption analysis is not whether HMA is a fiduciary. It is whether the state law claim implicates the plan's funding, benefits, reporting or administration (discussed above) or bears on an ERISA-regulated relationship. Here, the Trust's contract claim not only impacts plan administration because it relates to alleged improper processing of benefits. It also impacts the ERISA regulated relationship between the Trust¹² and HMA and the Plan and Plan Participants.

The Trust asserts HMA is not a fiduciary and that claims against non-fiduciary administrators are not preempted by ERISA. The Trust's argument is contrary to the law.

Courts have repeatedly noted: "[A]ll courts of appeal to have considered the issue have held that ERISA may apply regardless of whether the defendant is a plan fiduciary." *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1330 n.13 (5th Cir. 1992) (citing *Consolidated Beef Indus., Inc. v. New York Life Ins. Co.*, 949 F.2d 960, 964 (8th Cir. 1991); *Gibson v. Prudential Ins. Co.*, 915 F.2d 414, 417-18

¹² The Trustees assert it is an ERISA entity. Brief of Appellant, p. 13.

(9th Cir. 1990); *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1564 (11th Cir. 1987)).

This precise issue, under nearly identical facts, was analyzed in *Casper Air Service v. Sun Life Assurance Company of Canada*, 752 F. Supp. 1005 (D. Wyo. 1990). The trustees sued the non-fiduciary, third-party administrator for failing to comply with the terms of their administrative agreement, by inaccurately paying benefits and for failing to properly administer the plan. *Id.* at 1006.

The court analyzed whether ERISA preempted the state causes of action brought by the trustees of the pension trust against “a nonfiduciary administrator of the plan.” *Id.* Casper Air argued that no adequate remedy for non-fiduciary misconduct was provided under ERISA. Therefore, it argued, Congress could not have intended to regulate the conduct of non-fiduciaries such that state laws claims that regulate such misconduct are not preempted. *Id.* at 1007.

The court elected not to follow two district court cases upon which Casper Air relied: *Meat Cutters* and *Munoz*. *Id.* 1007-08 (citing *Cal Meat Cutters Unions v. Investors Research*, 687 F. Supp. 506 (C.D. Cal. 1988); *Munoz v. Prudential Ins. Co. of America*, 633 F. Supp. 564 (D. Colo. 1986)).

The court noted that the reasoning in the cases was “somewhat appealing,” but held “None of the circuit courts which have addressed the issue have landed on its side.” *Id.* at 1008.

In particular the court noted that an ERISA claim for relief under 29 U.S.C. § 1132(a)(3)¹³ allows for an equitable remedy against both fiduciaries and non-fiduciaries, revealing that “Congress did indeed intend to regulate misconduct of non-fiduciaries.” *Id.* Simply put, “the breadth of the preemption in § 1144 includes state actions taken against non-fiduciary plan administrators. If absent ERISA, state common law would provide a cause of action for improper actions taken under a plan, the state law has a direct connection to the benefit plan.” *Id.* at 1009.

The analysis in *Casper Air* has been consistently applied by other courts, including the Ninth Circuit. *See, e.g., Gibson*, 915 F.2d at 418 (9th Cir. 1990) (finding ERISA preempted state law claims against plan’s non-fiduciary claims handling agent); *Custer v. Pan American Life Ins. Co.*, 12 F.3d 410, 419 (4th Cir. 1993) (finding, in case against non-fiduciary administrator, “All other courts that have considered the question agree that state causes of action asserted against non-fiduciaries are preempted

¹³ An enforcement action may be brought “by a participant, beneficiary, or fiduciary (A) to enjoin any act or practices which violated any provision of this title *or the terms of the plan* or (B) to obtain equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan” 29 U.S.C. § 1132(a)(3).

by ERISA.”); *Howard v. Parisian*, 807 F.2d 1560, 1564-65 (11th Cir. 1987) (“ERISA preempts the assertion of such claims [relating to wrongful administration of plan benefits] against non-fiduciary administrators of self-funded plans.”); *Jones v. LMR Int’l, Inc.*, 457 F.3d 1174, 1180 (11th Cir. 2006) (“[E]ven if Great West were not deemed an ERISA fiduciary, the particular claims brought against it by Plaintiffs would be preempted because the state law claims against Great West affect relations among principal ERISA entities, namely LMR [the Plan] and Plaintiffs.”); *Faulman v. Security Mutual Fin. Life Ins. Co.*, No. 08-4152, 2009 U.S. App. LEXIS 26302, at * 6-7 (3rd Cir. 2009) (unpublished) (holding the preemption inquiry does not depend on the non-fiduciary status of the defendant; rather the inquiry depends on whether a state law claim implicates the plan’s funding, benefits, reporting or administration); *Carbajal v. Dorn*, No. CV-09-283-PHX-DGC, 2009 U.S. Dist. LEXIS 32688, at *6-7 (D. Ariz. April 14, 2009) (unpublished) (holding “the Supreme Court’s subsequent decision in *Harris Trust* made clear that status as a fiduciary is not required for claims under section 1132(a)(3)”); *Rutledge v. Seyfarth et al.*, 201 F.3d 1212, 1214 (9th Cir. 1999) (holding claim against non-fiduciary impacted an ERISA-governed relationship and was preempted).

The Trust asserts “HMA’s contractual breaches . . . conflicted with the Plan documents in this case.” (Brief of Appellant, p. 10) Therefore, ERISA regulates this action because it directly relates to an alleged violation of plan terms. *See* 29 U.S.C. § 1132(a)(3)(A).

The Trust’s claim also impacts the relationship between the Plan and Plan Participants. In this state court breach of contract action, the trial court would be required to interpret ambiguous Plan provisions and those interpretations would be applied to each Participants’ claims to determine whether they were “overpaid.” The Plan also has the right to deduct overpayments from future benefits payable to Participants. Under the Agreement, if there is “an overpayment or improper payment with respect to any Participant or with respect to a person who is not a Participant, HMA *shall* make reasonable efforts to recover the payment made to the ineligible person, or the overpayment or improper payment to the Participant. . .” CP 10. The Trust’s claim also encroaches on the relationship between the Plan and Plan Participants. It is therefore preempted by ERISA.

3. Whether a Damages Remedy is Available Under ERISA Does Not Impact the Preemption Analysis.

The Trust argues that it has no remedy under ERISA. Brief of Appellant, p. 7. This assertion is simply inaccurate; the Trust’s remedy would be under 29 U.S.C. § 1132(a)(3). The fact that the Trust seeks a

damages remedy, which is not available under ERISA, has no legal impact upon the preemption analysis.

The lack of a damages remedy under ERISA has been repeatedly denied as a basis to reject preemption. For example, in *Kahn v. Salerno*, 90 Wn. App. 110, 133-34, 951 P.2d 321, 333-34 (1998), Kahn asserted her claim was not preempted by ERISA because otherwise she would be left without a remedy. This Court stated: “[O]ur Supreme Court has explained that ‘[p]roviding an adequate forum for ERISA-related claims is for the Congress and not for the legislatures or courts of individual states. Thus, we reject Kahn’s argument.” *Id.* at 135 n. 6 (internal citation omitted).

In *Gibson v. The Prudential Insurance Co.*, 915 F.2d at 417, the court found that Section 1132(a)(3) provided a remedy against a non-fiduciary. “The fact that Congress did not include a *damage* remedy is not dispositive.” *Id.* (original emphasis). The six “carefully integrated” civil enforcement provisions found in § 502(a) provide “strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly.” *Id.* (citing *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146, 87 L. Ed. 2d 96, 105 S. Ct. 3085 (1985)). *See also Pilot Life*, 481 U.S. at 54 (“The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and

beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.”).

Even if there were no remedy available to the Trust, the “lack of an ERISA remedy does not affect a pre-emption analysis” as a matter of law. *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 132 (9th Cir. 1993). *See also Cannon v. Group Health Serv.*, 77 F.3d 1270, 1274 (10th Cir. 1996) (holding preemption of a state law claim does not mandate that there be an ERISA remedy); *Corcoran v. United Healthcare, Inc.* 965 F.2d 1321, 1333 (5th Cir. 1992) (“While we are not unmindful of the fact that our interpretation of the preemption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans, the lack of an ERISA remedy does not affect a pre-emption analysis.”); *Hospice of Metro Denver, Inc. v. Group Health Ins.*, 944 F.2d 752, 755 (10th Cir. 1991) (“We are aware that preemption normally is not dependent on the availability of ERISA remedies.”).

While the Trust is correct that *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 122 S. Ct. 708, 151 L.Ed. 2d 635 (2002) holds that money damages cannot be recovered under 29 U.S.C. § 1132(a)(3), the Court so held in the context of distinguishing between equitable and legal remedies under the ERISA statute. *Knudson, supra* at 271.

In responding to the insurer’s argument that such an interpretation deprived it of any remedy, the Court found that this consideration did not impact its decision:

We express no opinion as to . . . whether a direct action by petitioners against respondents asserting state-law claims such as breach of contract would have been pre-empted by ERISA. . . . We need not decide these issues because . . . “even assuming . . . that petitioners are correct about the pre-emption of previously available state-court actions” or the lack of other means to obtain relief, “vague notions of a statute’s ‘basic purpose’ are nonetheless inadequate to overcome the words of its text regarding the specific issue under consideration.” . . . **We will not attempt to adjust the “carefully crafted and detailed enforcement scheme” embodied in the text that Congress has adopted.**

Id. at 220-21 (citations omitted).

The Trust’s lack of a damages remedy under ERISA does not preclude preemption.

4. The Choice of Law Provision Cannot Avoid Preemption.

The Trust implies that HMA implicitly waived any argument that ERISA does not preempt the Trust’s state law claim based on the choice of law provision in the Agreement. Brief of Appellants, p. 24. However, the law is clear that choice of law provisions do not waive preemption.

It is well settled that parties cannot contract out of the application of federal law. *Allstate Ins. Co. v. My Choice Medical Plan for LDM Tech., Inc.*, 298 F. Supp. 2d 651, 654 (D. Mich. 2004). In *Allstate*, the

plaintiff argued that a choice-of-law provision in plan documents constituted a waiver of ERISA preemption. *Id.* The plan contained a provision that stated the “coverage provided pursuant to a contract entered into in the state of Michigan shall be construed under the jurisdiction and according to the law of the state of Michigan.” *Id.* The Plaintiff argued that this language constituted a waiver of ERISA preemption and required that the dispute in the case be resolved under Michigan law rather than federal law. *Id.*

Rejecting that argument, the court ruled: “Plaintiff’s waiver argument is flawed, however, because ‘parties may not contract to choose state law as the governing law of an ERISA-governed benefit plan.’” *Id.* Although choice-of-law provisions may be relevant in a diversity action, the court is required to apply federal common law when deciding federal ERISA questions. *Id.* A choice-of-law provision “cannot be used to contract around or out of federal law.” *Id.* at 655. “The broad preemptive effect of ERISA requires such a result.” *Id.*; *see also Prudential Ins. Co. of Am. v. Doe*, 140 F.3d 785, 791 (8th Cir. 1998) (finding that a choice of law provision does not alter the outcome because the parties cannot contract to choose state law as governing an ERISA benefit plan). The choice-of-law provision in the Agreement has no impact on the preemption analysis as a matter of law.

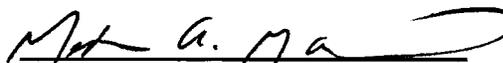
IV. CONCLUSION

The Trust's claim is, at its core, a claim for the improper processing and overpayment of benefits under an ERISA plan. HMA was hired under the Agreement to administer Plan benefits in accordance with the Plan terms, and the Trust alleges that HMA improperly administered those Plan benefits. Such a claim has been held by both Washington and federal courts alike to "relate to" ERISA and should therefore be preempted. The Trust's claim requires complex Plan interpretation, affects relationships between ERISA entities, and impacts the uniform administration of Plan benefits. This is exactly the type of claim that Congress intended to preempt when it adopted 29 U.S.C. § 1144(a).

The Trust has failed to show why its claim for recovery of allegedly overpaid and improperly processed benefits should not be preempted by ERISA. None of the bases asserted by the Trust to reject preemption are consistent with the law, including the fiduciary status of HMA or the lack of a damages remedy under ERISA. HMA respectfully requests that this Court uphold the trial court's decision to dismiss the Complaint.

Respectfully submitted this 27th day of October, 2010.

KARR TUTTLE CAMPBELL

A handwritten signature in black ink, appearing to read "Medora Marisseau", written over a horizontal line.

By: Medora Marisseau

WSBA # 23114

Attorneys for Respondent

No. 652711

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

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,

Appellant,

v.

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.,

Respondent.

CERTIFICATE OF SERVICE

I hereby certify that on the 27th day of October, 2010, I caused to be served a copy of *Respondent's Brief* by electronic mail and U.S. Mail on the following:

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COURT OF APPEALS, DIVISION ONE
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MARK HOLLIDAY, DAVE ALEXANDER, JAMES D. ANDERSON,
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Trustees of Associated General Contractors—international Union of
Operating Engineers Local 701 Health and Welfare Trust Fund,

Appellant,

v.

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.,

Respondent.

UNPUBLISHED CASES CITED IN BRIEF OF RESPONDENT

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COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

MARK HOLLIDAY, DAVE ALEXANDER, JAMES D. ANDERSON,
STEVE BRADLEY, TONY STEELMAN, CHARLES VALENTINE,
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Appellant,

v.

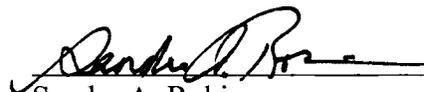
HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.,

Respondent.

CERTIFICATE OF SERVICE

I hereby certify that on the 27th day of October, 2010, I caused to be served a copy of the *Unpublished Cases Cited in Respondent's Brief* by electronic mail and U.S. Mail on the following:

Bruce A. Rubin
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Portland, OR 97204-3699


Sandra A. Robinson

Service: Get by LEXSEE®
Citation: 2000 u.s. dist. lexis 8799

2000 U.S. Dist. LEXIS 8799, *

BEST INTERNATIONAL U.S.A., Plaintiff, v. TUCKER AND CLARK, Defendant.

Civil No. 3:99-CV-1556-BC

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS, DALLAS DIVISION

2000 U.S. Dist. LEXIS 8799

June 12, 2000, Decided
June 12, 2000, Filed; June 13, 2000, Entered on Docket

DISPOSITION: [*1] Plaintiff's motion to remand DENIED and Defendant's motion to dismiss the state law claims for breach of contract, fraud, and breach of fiduciary duty GRANTED.

CASE SUMMARY

PROCEDURAL POSTURE: Plaintiff moved to remand, and defendant moved to dismiss, plaintiff's state law claims for breach of contract, fraud, and breach of fiduciary duty.

OVERVIEW: Plaintiff and defendant entered into a contract whereby defendant agreed to secure and annually renew group health and life insurance coverage for plaintiff, and to administer the insurance coverage pursuant to the Employee Retirement Income Security Act (ERISA), 29 U.S.C.S. § 1001 et seq., as a plan administrator. Defendant subsequently failed to renew insurance coverage, and charged plaintiff for coverage that was not provided. Plaintiff filed an action in state court alleging breach of contract, common law fraud, and breach of fiduciary duty. Defendant removed the case to federal court. The court denied plaintiff's motion to remand, and granted defendant's motion to dismiss. The court found that plaintiff's contract with defendant related to an area of exclusive federal concern, and its claims were subject to ordinary preemption under 29 U.S.C.S. § 1144(a). Also, the court had jurisdiction since plaintiff's breach of fiduciary duty claim fell within ERISA's civil enforcement provisions, and the court could exercise pendent jurisdiction over plaintiff's other claims pursuant to 28 U.S.C.S. § 1367.

OUTCOME: Plaintiff's motion to remand denied, and defendant's motion to dismiss the state law claims for breach of contract, fraud, and breach of fiduciary duty granted; plaintiff's contract with defendant related to an area of exclusive federal concern, and its claims were subject to ordinary preemption.

CORE TERMS: preemption, preempted, state law claims, breach of fiduciary duty, insurance coverage, benefit plan, enforcement provisions, subject matter jurisdiction, breach of contract, removal, state law claims, causes of action, federal question, relinquished, fiduciary, dental, renew, federal law, state cause of action, original petition, administrator, administering, prescription, well-pleaded, coverage, preempt, factual allegations, citation omitted, disability benefits, accrued benefits

LEXISNEXIS® HEADNOTES

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[Civil Procedure](#) > [Pleading & Practice](#) > [Defenses, Demurrers & Objections](#) > [Motions to Dismiss](#)

HN1 For purposes of analyzing a defendant's Fed. R. Civ. P. 12(b)(6) motion, the court must presume all factual allegations in the complaint to be true. [More Like This Headnote](#)

[Civil Procedure](#) > [Pleading & Practice](#) > [Defenses, Demurrers & Objections](#) > [Motions to Dismiss](#)

HN2 In construing a motion to dismiss, the court must presume all factual allegations in the complaint to be true and resolve any ambiguities or doubts regarding the sufficiency of the claim in favor of the plaintiff. The complaint should not be dismissed unless it appears beyond doubt that the plaintiff can prove no set of facts which would entitle him to relief. A court should therefore dismiss a case only if an affirmative defense or other bar to relief appears on the face of the complaint. [More Like This Headnote](#)

[Civil Procedure](#) > [Removal](#) > [Postremoval Remands](#) > [Jurisdictional Defects](#)

HN3 With respect to motions to remand, the removing party bears the burden of establishing that federal jurisdiction exists. Additionally, whether jurisdiction exists for a removed action is determined by looking at the complaint at the time the notice of removal is filed. [More Like This Headnote](#)

[Civil Procedure](#) > [Jurisdiction](#) > [Subject Matter Jurisdiction](#) > [Federal Questions](#) > [General Overview](#)

HN4 A plaintiff's cause of action may confer federal question jurisdiction only when the well-pleaded complaint raises issues of federal law. [More Like This Headnote](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Civil Claims & Remedies](#) > [Federal Jurisdiction & Removal](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Federal Preemption](#) > [General Overview](#)

HN5 The United States Court of Appeals for the Fifth Circuit recognizes two types of preemption under the Employee Retirement Income Security Act, [29 U.S.C.S. § 1001 et seq.](#), complete preemption and conflict preemption. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Civil Procedure](#) > [Jurisdiction](#) > [Subject Matter Jurisdiction](#) > [General Overview](#)

[Civil Procedure](#) > [Removal](#) > [Basis](#) > [Federal Questions](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Civil Claims & Remedies](#) > [Federal Jurisdiction & Removal](#)

HN6 Complete preemption serves as an exception to the well-pleaded complaint rule in that Employee Retirement Income Security Act (ERISA), [29 U.S.C.S. § 1001 et seq.](#), may occupy a particular area such that any civil complaint raising this select group of claims is necessarily federal in character. ERISA's civil enforcement provisions, [29 U.S.C.S. § 1132\(a\)](#), completely preempts any state cause of action seeking the same relief. Thus a claim falling within [29 U.S.C.S. § 1132\(a\)](#), regardless of how artfully pled as a state claim, will be treated as a federal claim. Because such a claim raises a federal question, it will provide a basis for the court's exercise of removal jurisdiction from state court. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Civil Procedure](#) > [Jurisdiction](#) > [Subject Matter Jurisdiction](#) > [General Overview](#)

[Insurance Law](#) > [Industry Regulation](#) > [Federal Regulations](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [ERISA Preemption](#)

[Bad Faith & Misrepresentation](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Federal Preemption](#) > [State Laws](#)

HN7 Conflict preemption, also known as ordinary preemption, arises under [29 U.S.C.S. § 1144\(a\)](#) and applies to state law claims which fall outside the scope of the civil enforcement provisions of the Employee Retirement Income Security Act, [29 U.S.C.S. § 1001 et seq.](#) Such claims are governed by the well-pleaded complaint rule and, therefore, conflict preemption, in and of itself, fails to establish federal question jurisdiction over those claims. [More Like This Headnote](#)

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[Civil Procedure](#) > [Jurisdiction](#) > [Subject Matter Jurisdiction](#) > [Jurisdiction Over Actions](#) > [General Overview](#)

[Insurance Law](#) > [Industry Regulation](#) > [Federal Regulations](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [ERISA Preemption](#)

[Bad Faith & Misrepresentation](#)

HN8 In the context of the Employee Retirement Income Security Act, [29 U.S.C.S. § 1001 et seq.](#), when a complaint raises state causes of action that are completely preempted, the district court may exercise removal jurisdiction, but when a complaint contains only state causes of action that the defendant argues are merely conflict preempted, the court must remand for want of subject matter jurisdiction. When a complaint raises both completely preempted claims and arguably conflict preempted claims, the district court may exercise removal jurisdiction over the completely preempted claims and supplemental jurisdiction under [28 U.S.C.S. § 1367](#) over the remaining claims. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Civil Claims & Remedies](#) > [General Overview](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Federal Preemption](#) > [State Laws](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Judicial Review](#) > [General Overview](#)

HN9 To determine whether a plaintiff's claim is completely preempted under the Employee Retirement Income Security Act, [29 U.S.C.S. § 1001 et seq.](#) (ERISA), the United States Court of Appeal for the Fifth Circuit uses a two-pronged approach. The first step is to determine whether the claim is subject to ordinary preemption under [29 U.S.C.S. § 1144\(a\)](#). Ordinary preemption is a necessary, but obviously not a sufficient, precondition to complete preemption in the context of ERISA. Therefore, a claim that is not subject to ordinary preemption cannot be completely preempted. The second step, then, assuming the claim is subject to ordinary preemption, is to determine whether it is completely preempted; i.e. whether the claim seeks the same relief as provided for in ERISA's civil enforcement provisions in [29 U.S.C.S. § 1132\(a\)](#). [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Federal Preemption](#) > [State Laws](#)

HN10 [29 U.S.C.S. § 1144\(a\)](#) states that the Employee Retirement Income Security Act, [29 U.S.C.S. § 1001 et seq.](#), preempts any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. [29 U.S.C.S. § 1144\(a\)](#). [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Federal Preemption](#) > [State Laws](#)

HN11 If a state law relates to a benefit plan, then Employee Retirement Income Security Act, [29 U.S.C.S. § 1001 et seq.](#), preempts it. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Governments](#) > [Fiduciary Responsibilities](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Federal Preemption](#) > [State Laws](#)

HN12 Two characteristics unify those state law causes of action which have been preempted by the Employee Retirement Income Security Act (ERISA), 29 U.S.C.S. § 1001 et seq.; (1) these claims address areas of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) they directly affect the association among traditional ERISA participants, the employer, the plan and its fiduciaries, and the participants and beneficiaries. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Insurance Law](#) > [Industry Regulation](#) > [Federal Regulations](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [ERISA Preemption](#) > [Bad Faith & Misrepresentation](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Civil Claims & Remedies](#) > [General Overview](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Federal Preemption](#) > [General Overview](#)

HN13 A state law claim seeking the same relief as provided for in Employee Retirement Income Security Act's civil enforcement provisions, 29 U.S.C.S. § 1132(a), is completely preempted. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Governments](#) > [Fiduciary Responsibilities](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Civil Claims & Remedies](#) > [General Overview](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Fiduciaries](#) > [General Overview](#)

HN14 The civil enforcement provisions of the Employee Retirement Income Security Act authorize a participant, beneficiary or fiduciary to bring a civil action for breach of fiduciary duties under 29 U.S.C.S. § 1109; 29 U.S.C.S. § 1132(a)(2). In turn, 29 U.S.C.S. § 1109 imposes liability on any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter. 29 U.S.C.S. § 1109(a). [More Like This Headnote](#)

COUNSEL: For BEST INTERNATIONAL USA, plaintiff: C Timothy Reynolds, Attorney at Law, Law Office of Joel J Steed, Dallas, TX USA.

For TUCKER AND CLARK, defendant: Bennee B Jones, Wade A Forsman, J Price Collins, Attorneys at Law, Wilson Elser Moskowitz Edelman & Dicker, Dallas, TX USA.

For TUCKER AND CLARK, counter-claimant: Bennee B Jones, Wade A Forsman, J Price Collins, Attorneys at Law, Wilson Elser Moskowitz Edelman & Dicker, Dallas, TX USA.

For BEST INTERNATIONAL USA, counter-defendant: C Timothy Reynolds, Attorney at Law, Law Office of Joel J Steed, Dallas, TX USA.

For TUCKER AND CLARK, third-party plaintiff: Bennee B Jones, Wade A Forsman, J Price Collins, Attorneys at Law, Wilson Elser Moskowitz Edelman & Dicker, Dallas, TX USA.

JUDGES: JANE J. BOYLE, UNITED STATES MAGISTRATE JUDGE.

OPINION BY: JANE J. BOYLE

OPINION

MEMORANDUM OPINION AND ORDER

Before the Court are **Defendant Tucker and Clark's Motion to Dismiss, Brought Under Fed. R. Civ. P. 12(b)(6), or Alternatively, Under Rule 12(c)**, filed February 7, 2000, and **[*2] Plaintiff's Motion for Remand (No Subject Matter Jurisdiction)**, filed February 25, 2000. ¹ At issue is whether Plaintiff Best International U.S.A.'s ("Best") state law claims for breach of contract, fraud, and breach of fiduciary duty are preempted by the Employee Retirement Income Security Act ("ERISA"), as amended 29 U.S.C. § 1001 et seq., and whether this Court may exercise subject matter jurisdiction over those claims. Having considered the pertinent pleadings, the Court **DENIES** the plaintiff's motion to remand and **GRANTS** the defendant's motion to dismiss for the reasons that follow

FOOTNOTES

¹ Plaintiff's motion to remand is contained in its response to Defendant's motion to dismiss.

I. Background ²

FOOTNOTES

² **HN1** For purposes of analyzing Defendant's Rule 12(b)(6) motion, the Court must presume all factual allegations in

the complaint to be true ***Fernandez-Montes v. Allied Pilots Ass'n*, 987 F.2d 278, 284 (5th Cir. 1993)**. Accordingly, the background facts giving rise to Best's claims are taken directly from its original petition filed in Texas state court.

[*3] In 1995, Best and Defendant Tucker and Clark ("Tucker & Clark") entered into a contract whereby Tucker & Clark agreed to secure and annually renew *inter alia* group health and group life insurance coverage for Best, and to administer the insurance coverage pursuant to ERISA as a plan administrator for Best's Benefit Plan. Tucker & Clark further represented to Best that the insurance coverage included benefits for dental and prescription expenses.

Tucker & Clark subsequently failed to renew the insurance coverage and failed to inform Best of the non-renewal. In addition, Tucker & Clark charged Best for the dental and prescription coverage despite the fact that such coverage was not provided. Best filed this action on June 10, 1999, in Texas state court alleging state law causes of action for breach of contract, common law fraud, and breach of fiduciary duty. Tucker & Clark removed the case to this Court on July 8, 1999, contending that Best's state law claims are completely preempted by ERISA, thus providing this Court with removal jurisdiction for claims arising under federal law **See 28 U.S.C. §§ 1331 and 1441**.

On February 7, 2000, Tucker & Clark filed [*4] the instant motion to dismiss pursuant to **Rule 12(b)(6)** claiming that because Best's state law claims are preempted by ERISA, it has failed to state a claim for which relief may be granted. **Def.'s Mot. at 1**. Best filed its response on February 25, 2000 and moved the Court to remand this case for lack of subject matter jurisdiction, asserting that its claims are not preempted by ERISA but even assuming they are, preemption alone does not confer jurisdiction on this Court. **Pl.'s Resp. at PP 5-6**. Before turning to address the merits of the parties' arguments, the Court will discuss the standards governing motions to dismiss and motions to remand.

II. Legal Standards

The standard for dismissal under **Rule 12(b)(6)** is a familiar one. ^{HN2} In construing the motion to dismiss, the court must presume all factual allegations in the complaint to be true and resolve any ambiguities or doubts regarding the sufficiency of the claim in favor of the plaintiff. ***Fernandez-Montes v. Allied Pilots Ass'n*, 987 F.2d 278, 284 (5th Cir. 1993)**. The complaint should not be dismissed "unless it appears beyond doubt that the plaintiff can prove no set of facts which would [*5] entitle him to relief." ***Conley v. Gibson*, 355 U.S. 41, 45, 78 S. Ct. 99, 102, 2 L. Ed. 2d 80 (1957)**. A court should therefore dismiss a case only if an affirmative defense or other bar to relief appears on the face of the complaint. ***Garrett v. Commonwealth Mortgage Co.*, 938 F.2d 591, 594 (5th Cir. 1991); *McGaskey v. Hospital Housekeeping Systems of Houston, Inc.*, 942 F. Supp. 1118, 1123 (S.D. Tex. 1996)**.

^{HN3} With respect to motions to remand, the removing party bears the burden of establishing that federal jurisdiction exists. ***De Aquilar v. Boeing Co.*, 47 F.3d 1404, 1408 (5th Cir.), cert. denied, 516 U.S. 865, 116 S. Ct. 180, 133 L. Ed. 2d 119 (1995)(citation omitted)**. Additionally, whether jurisdiction exists for a removed action is determined by looking at the complaint at the time the notice of removal is filed. ***Brown v. Southwestern Bell Telephone Co.*, 901 F.2d 1250, 1254 (5th Cir. 1990)**. As a general rule, ^{HN4} a plaintiff's cause of action may confer federal question jurisdiction only when the well-pleaded complaint raises issues of federal law. ***Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63, 107 S. Ct. 1542, 1546, 95 L. Ed. 2d 55 (1987)**. [*6] The Court now turns to address the parties' arguments regarding these two motions.

III. Analysis

As noted, the instant motions raise the two issues of ERISA preemption and this Court's subject matter jurisdiction. ^{HN5} The Fifth Circuit has recognized two types of preemption under ERISA complete preemption and conflict preemption. ***McClelland v. Gronwaldt*, 155 F.3d 507, 516-17 (5th Cir. 1998)**. ^{HN6} Complete preemption serves as an exception to the well-pleaded complaint rule in that ERISA may occupy a particular area such that "any civil complaint raising this select group of claims is necessarily federal in character." ***Giles v. Nylcare Health Plans, Inc.*, 172 F.3d 332, 336-37 (5th Cir. 1999)(quoting *Metro. Life*, 481 U.S. at 64-65, 107 S. Ct. at 1542)(internal quotations omitted)**. ERISA's civil enforcement provisions, 29 U.S.C. § 1132(a), completely preempt any state cause of action seeking the same relief, thus a claim falling within § 1132(a), regardless of how artfully pled as a state claim, will be treated as a federal claim. ***Id.* at 337 & n.7 (citations omitted)**. Because such a [*7] claim raises a federal question, it will provide a basis for the Court's exercise of removal jurisdiction from state court. ***Id.* at 337**.

On the other hand, ^{HN7} conflict preemption, also known as ordinary preemption, arises under 29 U.S.C. § 1144(a) and applies to state law claims which fall outside the scope of ERISA's civil enforcement provisions. ***Copling v. The Container Store*, 174 F.3d 590, 595 (5th Cir. 1999)**. Such claims are governed by the well-pleaded complaint rule and, therefore, conflict preemption, in and of itself, fails to establish federal question jurisdiction over those claims. ***Id.***

The Fifth Circuit recently summarized the interplay between the issues of preemption and jurisdiction as follows:

^{HN8} When a complaint raises state causes of action that are completely preempted, the district court may exercise removal jurisdiction, but when a complaint contains only state causes of action that the defendant argues are merely conflict preempted, the court must remand for want of subject matter jurisdiction. When a complaint raises both completely preempted claims and arguably conflict preempted claims, the [*8] district court may exercise removal jurisdiction over the completely preempted claims and supplemental jurisdiction [under 28 U.S.C. § 1367] over the remaining claims.

Id. Thus, the issue here with respect to Best's motion to remand is whether any of its state law claims are completely preempted under ERISA. If so, the Court may exercise removal jurisdiction over all of the claims in this case.

^{HN9} To determine whether a plaintiff's claim is completely preempted under ERISA, the Fifth Circuit uses a two-pronged approach. See McClelland, 155 F.3d 507, 517. The first step is to determine whether the claim is subject to ordinary preemption under 29 U.S.C. § 1144(a). **Id.** "Ordinary preemption is a necessary -- but obviously not a sufficient -- precondition to complete preemption in the context of ERISA." **Id.** Therefore, a claim that is not subject to ordinary preemption cannot be completely preempted. The second step, then, assuming the claim is subject to ordinary preemption, is to determine whether it is completely preempted; i.e. whether the claim seeks the same relief as provided [*9] for in ERISA's civil enforcement provisions in § 1132(a). See *id.*; See also Giles, 172 F.3d at 337. The Court now turns to step one of this analysis.

A. Ordinary Preemption Under 29 U.S.C. § 1144(a)

^{HN10} 29 U.S.C. § 1144(a) states that ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan ..." ³ 29 U.S.C. § 1144(a). The Supreme Court defines the phrase "relate to" very broadly. It is to be "given its broad common-sense meaning, such that a state law 'relates to' a benefit plan, 'in the normal sense of the phrase, if it has a connection with or reference to such a plan.'" Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739, 105 S. Ct. 2380, 2389, 85 L. Ed. 2d 728 (1985) (quoting Shaw v. Delta Airlines, 463 U.S. 85, 97, 103 S. Ct. 2890, 2900, 77 L. Ed. 2d 490 (1983)). ^{HN11} If a state law relates to a benefit plan, then ERISA preempts it. Hogan v. Kraft Foods, 969 F.2d 142, 144 (5th Cir. 1992).

FOOTNOTES

³ ERISA preemption is also governed by 29 U.S.C. § 1144(b)(2)(A) and (b)(2)(B), but these provisions are inapplicable to this case.

[*10] ^{HN12}

Two characteristics unify those state law causes of action which have been preempted by ERISA; (1) these claims address areas of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) they directly affect the association among traditional ERISA participants -- the employer, the plan and its fiduciaries, and the participants and beneficiaries. Mem'l Hosp. Sys. v. Northbrook Life Ins., 904 F.2d 236, 245 (5th Cir. 1990); Smith v. Texas Children's Hosp., 84 F.3d 152, 155 (5th Cir.), *reh'g denied*, 95 F.3d 56 (5th Cir. 1996).

Viewing Best's state law claims for breach of contract, fraud, and breach of fiduciary duty in conjunction with these characteristics, the Court finds that those claims are preempted. Best acknowledges in its response that its contract with Tucker & Clark concerning the insurance coverage related to an area of exclusive federal concern, namely the administration of ERISA benefit plans. **Pl.'s Resp. at 3**; See 29 U.S.C. § 1001; See also Cate v. Blue Cross & Blue Shield, 434 F. Supp. 1187, 1190 (E.D. Tenn. 1997) ("It is [*11] clear from [its] declaration of policy, and from the structure of [ERISA], that the focus of Congress was on the 'conduct, responsibility and obligation' of those who were responsible for administering employee benefit plans."). Indeed, Best hired Tucker & Clark as a third-party administrator for the express purpose of administering its Benefit Plan under ERISA, ⁴ and each of its claims pertains to Tucker & Clark's alleged wrongful conduct in connection with performing that job. Such claims unquestionably address areas of exclusive federal concern.

FOOTNOTES

⁴ Pl.'s Original Petition at 2.

As to the second characteristic, Best's claims clearly affect the association among traditional ERISA entities -- the employer and the plan administrator. Since Best's claims involve the two characteristics that are common to other preempted state law claims, the Court concludes that its claims are also subject to ordinary preemption under 29 U.S.C. § 1144(a).

Nevertheless, Best contends that its claims [*12] do not "relate to" an ERISA plan because its allegations do not "concern and/or effect the substantive portions of that plan," but rather they pertain to Tucker & Clark's breach of its contractual obligations and its "improper and derelict actions ... which caused Plaintiff to basically be uninsured." **Pl.'s Resp. at PP 8, 11-12.** This argument is without merit.

As just explained, Best's claims are directly related to Tucker & Clark's conduct in administering an ERISA plan, which is an area that is expressly designed to be governed by federal law. See 29 U.S.C. § 1001. Moreover, Best has cited no authority, and the Court has found none, suggesting that a state law claim does not "relate to" an ERISA plan unless it "concern[s] and/or effect[s] the substantive portions of that plan." All that is required is that the state law claims "relate to" the plan, a term which has been deliberately construed to have a broad, expansive meaning to give effect to the remedial purposes of ERISA. See Cefalu v. B.F. Goodrich Co., 871 F.2d 1290, 1293-95 (5th Cir. 1989) (citing legislative history pertaining to ERISA); Smith, 84 F.3d at 155; [*13] Degan v. Ford Motor Co., 869 F.2d 889, 894 n.7 (5th Cir. 1989) (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 46, 107 S. Ct. 1549, 1552, 95

L. Ed. 2d 39 (1987)). Furthermore, arguments that are virtually identical to those asserted by Best have already been presented to and rejected by the Fifth Circuit. **See Cefalu, 871 F.2d at 1292-95 (finding preemption for breach of contract claim and rejecting plaintiff's claim that preemption was avoided because he was not seeking recovery from the plan, but only from his employer); See also Lee v. E.I. DuPont de Nemours and Co., 894 F.2d 755, 756-58 (5th Cir. 1990)(rejecting plaintiff's argument that preemption under § 1144(a) was avoided because his claim was not cognizable under the ERISA civil enforcement provisions in § 1132(a)).**

Best also relies on **Smith v. Texas Children's Hosp., 84 F.3d 152 (5th Cir. 1996)**, in alleging that its fraud claim is not preempted. **Pl.'s Resp. at PP 10-11.** In **Smith**, the plaintiff sued Texas Children's Hospital based on a fraudulent inducement theory alleging that they had lured her away **[*14]** from her previous job at St. Luke's Hospital on the promise that she would be eligible for certain disability benefits with Texas Children's. In transferring jobs, the plaintiff relinquished her claim to accrued benefits from St. Luke's. After developing multiple sclerosis, the plaintiff applied for disability benefits from Texas Children's but her claim was denied. She sued, and the Fifth Circuit held on appeal that her claim against Texas Children's for denied benefits under their ERISA plan was preempted. **Smith, 84 F.3d at 155.** The Court also stated, however, that the plaintiff may have a separate claim against Texas Children's for the accrued benefits that she relinquished in transferring from St. Luke's, and that such a claim would not be preempted. **Id. at 155-56.** The Court of Appeals reasoned that plaintiff's claim for the relinquished benefits did not necessarily depend on the scope of her rights under Texas Children's ERISA plan. **Id.** Nor was she suing Texas Children's for benefits that they allegedly owed her under its ERISA plan. **Id. at 156-57.**

Here, by contrast, Best International makes no allegation **[*15]** that it relinquished anything unrelated to its own Benefit Plan. Rather, it alleges that Tucker & Clark committed fraud by inducing Best to renew the insurance coverage and to pay for dental and prescription coverage, knowing that the insurance would not be provided. **Pl.'s Original Petition at 4.** Clearly, Best is seeking a recovery against Tucker & Clark for alleged misrepresentations directly related to its administration of Best's ERISA plan. Accordingly, Best's reliance on **Smith** is misplaced.

Having found that each of Best's state law claims are subject to ordinary preemption under **29 U.S.C. § 1144(a)**, the Court now turns to step two to determine whether any of these claims are completely preempted under ERISA.

B. Complete Preemption Under ERISA

As previously explained, **HN13** a state law claim seeking the same relief as provided for in ERISA's civil enforcement provisions, **29 U.S.C. § 1132(a)**, is completely preempted. **Giles, 172 F.3d at 337; McClelland, 155 F.3d at 517.** **HN14** The civil enforcement provisions authorize a "participant, beneficiary or fiduciary" to bring a civil action **[*16]** for breach of fiduciary duties under **29 U.S.C. § 1109**. **29 U.S.C. § 1132(a)(2); See Kramer v. Smith Barney, 80 F.3d 1080, 1084 (5th Cir. 1996).** In turn, **§ 1109** imposes liability on "any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter." **29 U.S.C. § 1109(a); See Kramer, 80 F.3d at 1084.**

In this case, Best has asserted a claim for breach of fiduciary duty. **Pl.'s Original Petition at 4.** More specifically, it alleges that Tucker & Clark breached its duty by failing to inform Best that it did not renew the group insurance coverage, "thereby allowing Plaintiff to incur medical, dental and other claims that would have been covered had Defendant communicated the non-renewal." **5 Id.** Based on these allegations, the Court finds that Best's breach of fiduciary duty claim falls within ERISA's civil enforcement provisions and, therefore, is completely preempted. **See Kramer, 80 F.3d at 1084.** The Court, consequently, may exercise original **[*17]** federal question jurisdiction over that claim and pendent jurisdiction over Best's other claims for breach of contract and fraud pursuant to **28 U.S.C. § 1367.** **See Giles, 172 F.3d at 337-38.** Accordingly, Best's motion to remand is **DENIED.** Furthermore, because the Court has concluded that each of Best's state law claims is preempted by ERISA, Tucker & Clark's motion to dismiss those claims pursuant to **Rule 12(b)(6)** is **GRANTED.** **6**

FOOTNOTES

5 Regardless of the merits of the breach of fiduciary duty claim, the allegations in Best's complaint control for purposes of determining the Court's subject matter jurisdiction. **See Kramer, 80 F.3d at 1083 n.2.**

6 On April 26, 2000, Best filed its First Amended Original Complaint asserting an additional cause of action under ERISA. **Pl.'s First Am. Compl. at 5.** The amended complaint was filed subject to Best's motion to remand, and now that the motion has been denied, this amended complaint becomes the operative complaint in this case. While the state law claims for breach of contract, fraud, and breach of fiduciary duty are dismissed, the ERISA claim, and this case, remain pending for disposition.

[*18] IV. Conclusion

For the foregoing reasons, the Court **DENIES** Plaintiff's motion to remand and **GRANTS** Defendant's motion to dismiss the state law claims for breach of contract, fraud, and breach of fiduciary duty

SO ORDERED,

June 12, 2000.

JANE J. BOYLE

UNITED STATES MAGISTRATE JUDGE

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2009 U.S. Dist. LEXIS 32688, *

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Michael E. Carbajal, a single man; and Mary E. Carbajal, a widow, Plaintiffs, vs. David A. Dorn and Jane Doe Dorn, husband and wife; Dorn Agency, Inc., an Arizona corporation; and Liberty Life Insurance Co., a South Carolina corporation, Defendants.

No. CV-09-283-PHX-DGC

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF ARIZONA

2009 U.S. Dist. LEXIS 32688

April 14, 2009, Decided
April 14, 2009, Filed

SUBSEQUENT HISTORY: Motion granted by, in part, Motion denied by, in part, Motion denied by [Carbajal v. Dorn, 2009 U.S. Dist. LEXIS 103378 \(D. Ariz., Nov. 5, 2009\)](#)

CASE SUMMARY

PROCEDURAL POSTURE: Plaintiffs, purchasers of life insurance policies through an employee benefit plan, sued defendants, an insurer, an insurance agent, and an agency, alleging breach of fiduciary duty and negligence and seeking reformation of the policies. Plaintiffs claimed that the ownership and beneficiaries on the policies were fraudulently changed. The insurer removed the case and moved to dismiss.

OVERVIEW: The case was removed based on federal question jurisdiction under the Employee Retirement Income Security Act of 1974 (ERISA). The insurer argued that plaintiffs' claims arose under [29 U.S.C.S. § 1132\(a\)\(1\)\(B\)](#) and that such a claim could not be brought against an insurer. Plaintiffs responded that because they were not seeking damages from the insurer, but only equitable reformation of the policies, and if ERISA preemption applied to their claims, the preemption would have converted their equitable state claims to claims under [§ 1132\(a\)\(3\)](#), not claims arising under [§ 1132\(a\)\(1\)\(B\)](#). Because reformation was a remedy that could only be characterized as arising under [§ 1132\(a\)\(3\)](#), plaintiffs' claims against the insurer sought equitable relief within the scope of [§ 1132\(a\)\(3\)](#). The insurer next argued that even assuming plaintiffs' claims were for equitable relief under [§ 1132\(a\)\(3\)](#), the insurer had to be an ERISA fiduciary to establish relief, and it was not. The court disagreed. Liability under [§ 1132\(a\)\(3\)](#) was not limited to the plan itself or its fiduciary.

OUTCOME: The court denied the insurer's motion to dismiss.

CORE TERMS: fiduciary, equitable relief, reformation, beneficiary, reply, insurance policies, equitable, failure to state a claim, oral argument, legal theory, civil action, equitable remedies, non-fiduciaries, cognizable, preemption

LEXISNEXIS® HEADNOTES

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HN1 When analyzing a complaint for failure to state a claim under [Fed. R. Civ. P. 12\(b\)\(6\)](#), all allegations of material fact are taken as true and construed in the light most favorable to the non-moving party. [More Like This Headnote](#)

[Civil Procedure](#) > [Pleading & Practice](#) > [Defenses, Demurrers & Objections](#) > [Failures to State Claims](#)

HN2 To avoid a [Fed. R. Civ. P. 12\(b\)\(6\)](#) dismissal, the complaint must plead enough facts to state a claim to relief that is plausible on its face. [More Like This Headnote](#)

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HN3 Dismissal is appropriate where a complaint lacks a cognizable legal theory, lacks sufficient facts alleged under a cognizable legal theory, or contains allegations disclosing some absolute defense or bar to recovery. [More Like This Headnote](#)

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[Suits to Recover Plan Benefits](#)

HN4 ↓ [29 U.S.C.S. § 1132\(a\)\(1\)\(B\)](#) permits a plan participant or beneficiary under the Employee Retirement Income Security Act of 1974 to bring a civil action to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. [More Like This Headnote](#)

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[Suits to Recover Plan Benefits](#)

HN5 ↓ Actions brought under [29 U.S.C.S. § 1132\(a\)\(1\)\(B\)](#) may be enforced only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity. [More Like This Headnote](#)

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[General Overview](#)

HN6 ↓ [29 U.S.C.S. § 1132\(a\)\(3\)](#) provides that a participant, beneficiary, or fiduciary of a plan governed by the Employee Retirement Income Security Act of 1974 may bring a civil action (A) to enjoin any act or practice which violates any provision of the subchapter 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 subchapter or the terms of the plan. [29 U.S.C.S. § 1132\(a\)\(3\)](#). Liability under [§ 1132\(a\)\(3\)](#) is not limited to the plan itself or its fiduciary. [More Like This Headnote](#)

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[General Overview](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Fiduciaries](#) > [General Overview](#)

HN7 ↓ According to the U.S. Court of Appeals for the Ninth Circuit's opinion in Everhart, liability under [29 U.S.C.S. § 1132\(a\)\(3\)](#) is not limited to the plan itself or its fiduciary. [More Like This Headnote](#)

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HN8 ↓ The U.S. District Court for the District of Arizona does not believe the U.S. Supreme Court's 1996 decision in Varsity Corp. v. Howe can fairly be read to stand for the proposition that equitable relief may only be had against fiduciaries under the Employee Retirement Income Security Act of 1974. [More Like This Headnote](#)

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HN9 ↓ The U.S. Supreme Court's decision in Harris Trust makes clear that status as a fiduciary is not required for claims under [29 U.S.C.S. § 1132\(a\)\(3\)](#). [More Like This Headnote](#)

[Administrative Law](#) > [Judicial Review](#) > [Reviewability](#) > [Preservation for Review](#)

HN10 ↓ It is well established that issues cannot be raised for the first time in a reply brief. [More Like This Headnote](#)

Available Briefs and Other Documents Related to this Case:

[U.S. District Court Motion\(s\)](#)

[U.S. District Court Pleading\(s\)](#)

COUNSEL: [*1] For Michael E. Carbajal, a single man, Mary E. Carbajal, a widow, Plaintiffs: [J Tyrrell Taber](#), Taber Law Firm PC, Phoenix, AZ; [Rosemary Joy Shockman](#), Shockman Law Office PC, Phoenix, AZ.

For Liberty Life Insurance Co., a South Carolina corporation also known as Liberty Life Insurance Company, Defendant: [Mary Michelle Kranzow](#), [William Francis Auther](#), Bowman & Brooke LLP, Phoenix, AZ.

For David A. Dorn, husband, Jane Doe Dorn, wife, Dorn Agency, Inc., an Arizona corporation, Defendants: [Randy Lee Kingery](#), [Steven G Mesaros](#), LEAD ATTORNEYS, Renaud Cook Drury Mesaros PA, Phoenix, AZ.

JUDGES: [David G. Campbell](#), United States District Judge.

OPINION BY: [David G. Campbell](#)

OPINION

ORDER

Defendant [Liberty Life Insurance Co.](#) ("Liberty") has filed a motion to dismiss for failure to state a claim pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. For reasons stated below, the Court will deny the motion. ¹

FOOTNOTES

¹ Liberty's request for oral argument is denied because the parties have fully briefed the issues (Dkt. # 5, 12, 13) and oral argument will not aid the Court's decision. See *Fed. R. Civ. P. 78*; *Lake at Las Vegas Investors Group, Inc. v. Pac. Dev. Malibu Corp.*, 933 F.2d 724, 729 (9th Cir. 1991); *Partridge v. Reich*, 141 F.3d 920, 926 (9th Cir. 1998).

I. [*2] Background.

Plaintiffs' claims concern life insurance policies issued by Liberty under the terms of an employee benefit plan operated by Plaintiffs' employer, D.M.C. Boxing, Inc., which insure the lives of Plaintiffs Michael and Mary Carbajal (the "Liberty policies"). Dkt. # 1 at 10-19, 25-42. David Dorn and the Dorn Agency were Plaintiffs' agents for purchase of the life insurance policies. *Id.* at 10-19, P 44. Plaintiffs allege that the Dorn defendants conspired with Danny Carbajal (Michael's brother and Mary's son) to fraudulently change the ownership of and beneficiary designations on the Liberty policies. *Id.* Plaintiffs filed suit in Arizona state court on January 9, 2009, alleging breach of fiduciary duty and negligence against the Dorn defendants, and seeking judicial reformation of the Liberty policies to reflect Michael and Mary Carbajal as owners of the policies with their choice of beneficiaries. *Id.* PP 43-56. Liberty removed the case to this Court on February 11, 2009, alleging federal question jurisdiction under the Employee Retirement Income Security Act of 1974 (ERISA). Dkt. # 1 at 1-4. Liberty simultaneously moved to dismiss Plaintiffs' claims against it, arguing that [*3] it is not a proper party to the action. Dkt. # 5.

II. Legal Standard.

^{HN1} When analyzing a complaint for failure to state a claim under *Rule 12(b)(6)*, "[a]ll allegations of material fact are taken as true and construed in the light most favorable to the non-moving party." *Smith v. Jackson*, 84 F.3d 1213, 1217 (9th Cir. 1996). ^{HN2} To avoid a *Rule 12(b)(6)* dismissal, the complaint "must plead 'enough facts to state a claim to relief that is plausible on its face.'" *Clemens v. Daimler Chrysler Corp.*, 534 F.3d 1017, 1022 (9th Cir. 2008) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 127 S. Ct. 1955, 1974, 167 L. Ed. 2d 929 (2007)). ^{HN3} Dismissal is appropriate where the complaint lacks a cognizable legal theory, lacks sufficient facts alleged under a cognizable legal theory, or contains allegations disclosing some absolute defense or bar to recovery. See *Balistreri v. Pacifica Police Dept.*, 901 F.2d 696, 699 (9th Cir. 1988); *Weisbuch v. County of L.A.*, 119 F.3d 778, 783, n.1 (9th Cir. 1997).

III. Discussion.**A. Plaintiffs' Claim for Reformation Under ERISA.**

Liberty argues that Plaintiffs' claims arise under ^{HN4} 29 U.S.C. § 1132(a)(1)(B), which permits an ERISA plan participant or beneficiary to bring a civil action "to recover benefits [*4] due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." ^{HN5} Actions brought under § 1132(a)(1)(B) "may be enforced 'only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity.'" *Everhart v. Allmerica Fin. Life Ins. Co.*, 275 F.3d 751, 753 (9th Cir. 2001); see also *Ford v. MCI Commc'ns Corp. Health and Welfare Plan*, 399 F.3d 1076, 1081 (9th Cir. 2005) (noting that under section 1132(a)(1)(B), a claimant "may not sue the plan's insurer for additional ERISA plan benefits" (emphasis in original)).

Plaintiffs respond that because they are not seeking damages from Liberty, but only equitable reformation of the insurance policies, "if ERISA preemption applies to [their] claims, the preemption would convert their equitable state claims to claims pursuant to 29 U.S.C. § 1132(a)(3)," not claims arising under 1132(a)(1)(B). Dkt. # 12 at 4. ^{HN6} Section 1132(a)(3) provides that a participant, beneficiary, or fiduciary of an ERISA plan may bring a civil action "(A) to enjoin any act or practice [*5] which violates any provision of this subchapter 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 subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3). "Liability under § 1132(a)(3) is not limited to the plan itself or its fiduciary." *Everhart*, 275 F.3d at 753 (citing *Harris Trust & Savings Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 247, 120 S. Ct. 2180, 147 L. Ed. 2d 187 (2000)).

The question, then, is whether Plaintiffs' claim for reformation of the policies falls within section 1132(a)(1)(B) or 1132(a)(3). The Court finds both *Everhart* and *Ford* distinguishable. In both those cases, plaintiff beneficiaries brought suit under section 1132(a)(1)(B) seeking recovery of benefits under their ERISA plans. See *Everhart*, 275 F.3d at 753; *Ford*, 399 F.3d at 1078. ² That is not the case here. Reformation is a remedy that "can only be characterized as arising under 29 U.S.C. § 1132(a)(3)." *Ross v. Rail Car America Group Disability Income Plan*, 285 F.3d 735, 740-41 (8th Cir. 2002) (stating that Plaintiff's request to reform his employer disability plan was not one for benefits under section 1132(a)(1)). Plaintiffs' [*6] claims against Liberty seek equitable relief within the scope of section 1132(a)(3).

FOOTNOTES

² Ford asserted claims under sections 1132(a)(1)(B) and 1132(a)(2), as well as a claim for "general equitable relief" under section 1132(a)(3). 399 F.3d at 1078. The court found that "[b]ecause Ford asserted specific claims under 29 U.S.C. §§ 1132(a)(1)(B) and 1132(a)(2), she cannot obtain relief under 29 U.S.C. § 1132(a)(3), ERISA's 'catchall' provision." *Id.* at 1083.

B. Section 1132(a)(3) Claims Against Non-Fiduciaries.

Defendant argues that, even assuming Plaintiffs' claims are for equitable relief under § 1132(a)(3), "the defendant must be an ERISA fiduciary" to establish a claim for relief. Dkt. # 13 at 4, quoting *Ford*, 399 F.3d at 1082. The Court declines to follow *Ford* on this point, for several reasons. First, *Ford's* statement that section 1132(a)(3) relief may only be had against an ERISA fiduciary is in direct conflict with the ^{HN7} Ninth Circuit's opinion in *Everhart*, which held that "[l]iability under § 1132(a)(3) is not limited to the plan itself or its fiduciary." *Everhart*, 275 F.3d at 753 (citing *Harris Trust*, 530 U.S. at 247). Until an *en banc* panel reverses course, this Court must follow the [*7] Ninth Circuit's earlier decision in *Everhart*. See *Miller v. Gammie*, 335 F.3d 889, 899 (9th Cir. 2003) (holding that neither a district court nor a three-judge panel may overrule a prior decision of the court unless it has been "undercut by higher authority to such an extent that it has been effectively overruled").

Ford also relies for the quoted proposition on *Mathews v. Chevron Corp.*, 362 F.3d 1172 (9th Cir. 2004), which in turn relies on the United States Supreme Court's 1996 decision in *Varity Corp. v. Howe* in stating that "[t]o establish an action for equitable relief under ERISA section . . . 1132(a)(3), the defendant must be an ERISA fiduciary acting in its fiduciary capacity [internal citation omitted], and must 'violate [] ERISA-imposed fiduciary obligations.'" *Mathews*, 362 F.3d at 1178 (citing *Varity Corp.*, 516 U.S. at 498, 506). ^{HN8} This Court does not believe *Varity Corp.* can fairly be read to stand for the proposition that equitable relief may only be had against ERISA fiduciaries.

Even if *Mathews* contains a fair reading of *Varity Corp.*, ^{HN9} the Supreme Court's subsequent decision in *Harris Trust* made clear that status as a fiduciary is not required for claims under section 1132(a)(3). [*8] See *Harris Trust*, 530 U.S. at 241 (finding that section 1132(a)(3) "admits of no limit . . . on the universe of possible defendants"). This Court is persuaded that *Everhart* correctly followed current Supreme Court precedent in finding that section 1132(a)(3) does not limit the reach of equitable remedies to the plan or its fiduciary.

C. Issues Raised for the First Time in Reply.

Defendant argues in its reply that if section 1132(a)(3) claims may be brought against non-fiduciaries, "[t]he Ninth Circuit has held that a 'party in interest' may only be a proper party to an equitable claim if that party has engaged in certain transactions prohibited by ERISA." Dkt. # 13 at 4 (citing *Rutledge v. Seyfarth*, 201 F.3d 1212, 1221 (9th Cir. 2000)). Liberty also argues in its reply that reformation is not available as an equitable remedy without joinder of Danny Carbajal as a "necessary and indispensable party to this action." Dkt. # 13 at 3. ^{HN10} "It is well established that issues cannot be raised for the first time in a reply brief." *Gadda v. State Bar of Cal.*, 511 F.3d 933, 937 n.2 (9th Cir. 2007). The Court will not consider these issues.

IT IS ORDERED that Liberty's motion to dismiss (Dkt. # 5) is [*9] denied.

DATED this 14th day of April, 2009.

/s/ David G. Campbell

David G. Campbell

United States District Judge

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353 Fed. Appx. 699, *; 2009 U.S. App. LEXIS 26302, **;
48 Employee Benefits Cas. (BNA) 1356

WILLIAM FAULMAN; MICHAEL FAULMAN; U.S. INVESTMENT ADVISORS, INC., on behalf of themselves and others
similarly situated, Appellants v. SECURITY MUTUAL FINANCIAL LIFE INSURANCE COMPANY

No. 08-4152

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

353 Fed. Appx. 699; 2009 U.S. App. LEXIS 26302; 48 Employee Benefits Cas. (BNA) 1356

November 17, 2009, Submitted Under Third Circuit LAR 34.1(a)
December 3, 2009, Filed

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OPINIONS.

PRIOR HISTORY: [1]**

Appeal from the United States District Court for the District of New Jersey. (D.C. Civil No. 04-cv-05083). District Judge:
Honorable Anne E. Thompson.

Faulman v. Sec. Mut. Fin. Life Ins. Co., 2008 U.S. Dist. LEXIS 71227 (D.N.J., Sept. 12, 2008)

Faulman v. Sec. Mut. Fin. Life Ins. Co., 2007 U.S. Dist. LEXIS 76222 (D.N.J., Oct. 12, 2007)

CASE SUMMARY

PROCEDURAL POSTURE: Plaintiffs sued defendant insurer, alleging, inter alia, breach of fiduciary duty under the
Employee Retirement Income Security Act of 1974 (ERISA) and violations of state law. The U.S. District Court for the
District of New Jersey granted summary judgment to the insurer on a number of claims, and a jury found for the
insurer on the remaining ERISA claims. Plaintiffs' motion for a new trial was denied, and plaintiffs appealed.

OVERVIEW: Although the district court did not consider whether the insurer was a fiduciary when determining that
plaintiffs' state law claims related to an ERISA claim and were therefore preempted, none of the cases cited by
plaintiffs supported their position that such an analysis was required. Also, even assuming that the district court
should have considered certain documents to be part of the ERISA plan, they did nothing to substantiate plaintiffs'
claims, and the district court did not err when it concluded that the insurer had not misappropriated the funds in the
reserve. Additionally, because plaintiffs' contributions were deposited in defendant insurer's general account, rather
than in the plan itself, the funds were an asset of the insurer and were not plan assets under 29 U.S.C.S. § 1101(b)
(2). Thus, the fiduciary duties contained in 29 U.S.C.S. § 1106 did not apply to plaintiffs' contributions, but instead
applied only to the life insurance policy. The insurer did not breach its fiduciary duties. Finally, the court found no
abuse of discretion in the court's rulings, and the jury instructions were not erroneous in any of the respects urged by
plaintiffs.

OUTCOME: The order of the district court was affirmed.

CORE TERMS: fiduciary duties, fiduciary, summary judgment, premium, insurance policy, conversion, law claims, jury
instructions, partial, plenary, life insurance, abuse of discretion, preemption, converted, tax-free, breached, insurer,
jury trials, reserve funds, misrepresented, plan assets, fraud claim, evidentiary rulings, indemnification, common-law,
guaranteed, preempted, exemptions, assess, paying

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[Civil Procedure](#) > [Summary Judgment](#) > [Appellate Review](#) > [Standards of Review](#) 

[Civil Procedure](#) > [Summary Judgment](#) > [Standards](#) > [Legal Entitlement](#) 

HN1  An appellate court's review of a grant of summary judgment is plenary. Appellate courts assess the record
using the same summary judgment standard that guides the district courts. Thus, defendant must
demonstrate that there is no genuine issue as to any material fact and that it is entitled to judgment as a

matter of law. [Fed. R. Civ. P. 56\(c\)\(2\)](#). [More Like This Headnote](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Federal Preemption](#) > [Applicability](#)
 HN2 [+](#) The preemption inquiry depends on whether a state law claim implicates the plan's funding, benefits, reporting or administration. Fiduciary status is only one of several factors used to assess whether the claims were actually related to an Employee Retirement Income Security Act of 1974 (ERISA) plan, rather than to duties arising outside of the ERISA context. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Fiduciaries](#) > [Fiduciary Responsibilities](#) > [Loyalty](#)
 HN3 [+](#) 29 U.S.C.S. § 1106(b) provides that a fiduciary may not deal with the assets of the plan in his own interest or receive consideration in connection with a transaction involving the assets of the plan. [More Like This Headnote](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Fiduciaries](#) > [General Overview](#)
 HN4 [+](#) See 29 U.S.C.S. § 1101(b)(2).

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Fiduciaries](#) > [General Overview](#)
 HN5 [+](#) 29 U.S.C.S. § 1108 and Department of Labor guidance known as Prohibited Transaction Exemption 84-24 both provide exceptions to the prohibitions contained in 29 U.S.C.S. § 1106(b). [More Like This Headnote](#)

[Civil Procedure](#) > [Judgments](#) > [Relief From Judgment](#) > [Motions for New Trials](#)
[Civil Procedure](#) > [Appeals](#) > [Standards of Review](#) > [Abuse of Discretion](#)
[Civil Procedure](#) > [Appeals](#) > [Standards of Review](#) > [De Novo Review](#)
[Civil Procedure](#) > [Appeals](#) > [Standards of Review](#) > [Fact & Law Issues](#)
 HN6 [+](#) Appellate courts review a district court's evidentiary rulings for abuse of discretion. Appellate courts also review the denial of a motion for a new trial for abuse of discretion, but they exercise plenary review over that denial to the extent that it is based on a question of law. [More Like This Headnote](#)

[Civil Procedure](#) > [Trials](#) > [Jury Trials](#) > [Jury Instructions](#) > [General Overview](#)
[Civil Procedure](#) > [Appeals](#) > [Standards of Review](#) > [De Novo Review](#)
 HN7 [+](#) Appellate courts' review of jury instructions is plenary, and appellate courts reverse if the instructions, as a whole, were capable of confusing and misleading the jury. [More Like This Headnote](#)

COUNSEL: For WILLIAM FAULMAN, MICHAEL FAULMAN, US INV ADVISORS INC, Plaintiffs - Appellants: Kerri E. Chewning, Esq. -, Steven J. Fram, Esq. -✓, Mark J. Oberstaedt, Esq. -, Archer & Greiner, Haddonfield, NJ.

For SECURITY MUTL FIN LIFE INS CO, Defendant - Appellee: Robert E. Campbell, Esq. -, Christopher P. Leise, Esq. -, White & Williams, Cherry Hill, NJ; Mark J. Crandley, Esq. -, Bart A. Karwath, Esq. -✓, Howard E. Kochell, Esq. -✓, Barnes & Thornburg, Indianapolis, IN.

JUDGES: Before: [RENDELL](#) -, [BARRY](#) - and [CHAGARES](#) -, Circuit Judges.

OPINION BY: [RENDELL](#) -

OPINION

[*700] OPINION OF THE COURT

[RENDELL](#) -, Circuit Judge.

Plaintiffs William and Michael Faulman urge on appeal that the District Court [*701] made a variety of errors in ruling on a motion for partial summary judgment and in its conduct of the bench and jury trials that occurred thereafter in this ERISA case. We disagree and will affirm the order of the District Court.

Background

This case concerns an employer-purchased term life insurance policy called the Group Entry Age Reserve ("GEAR"), which was marketed by defendant [Security Financial Life Insurance Company](#) - [**2] ("Security"). Upon termination or retirement, employees could convert the term coverage to a whole life insurance policy. After conversion, employees were charged a discounted premium, which was based on the employee's age when he was first issued the GEAR policy, rather than his age when he converted the term policy to the whole policy. According to Security, this feature was made possible by allocating part of the pre-conversion premium to a "Rate Stabilization Reserve." The funds in that reserve then offset the cost of premiums after conversion.

The Employer's Participating Insurance Cooperative ("EPIC") plan was a life insurance plan, which provided life insurance through the GEAR product. Initially, a company called Tri-Core, which was an affiliate of Security, administered the EPIC plan. After various changes, Security administered the successor to the EPIC plan that is relevant here.

Plaintiffs William Faulman and Michael Faulman were the only employees of U.S. Investment Advisors ("USIA"), a holding company created to manage several other corporations formed by the Faulmans. In 1992, the late Frank Speer, who was the Faulmans' insurance agent and an agent for Security, suggested **[**3]** that plaintiffs purchase EPIC and GEAR. Although the brochures about these products principally described them as life insurance products, plaintiffs claim that Speer characterized them as an investment vehicle, much like a retirement plan, that would allow the Faulmans to contribute to the Rate Stabilization Reserve and, ultimately, cash out their contributions for a profit. Plaintiffs also claim that Speer stated that contributions to the GEAR product would be tax-free. After considering the products for two years, and having their attorney and accountant review them, plaintiffs purchased the EPIC and GEAR products in 1994. USIA joined the EPIC plan, the Faulmans submitted life insurance applications, and USIA made contributions of \$ 420,000 to the plan over the next seven years.

In 2001, plaintiffs were informed that their premiums had increased. After subsequent inquiries, they were told (for the first time, according to them) that they could not cash out their contributions to the Rate Stabilization Reserve; rather, they could only use those contributions to defray the cost of converting the term life insurance policy to a whole policy, as described above. Plaintiffs ultimately **[**4]** converted their term policies to whole policies. William Faulman's premium for the whole policy was reduced by over 50% as a result of the GEAR conversion benefit.

Plaintiffs claim that Security misrepresented the nature of the Rate Stabilization Reserve and the tax-deductibility of their contributions in order to induce them to purchase the GEAR product. In particular, plaintiffs claim that Security was aware of an Internal Revenue Service ruling that the GEAR contributions were not tax-free, but that Security never notified plaintiffs of this fact. Plaintiffs also claim that Security improperly used plaintiffs' contributions to the plan to pay commissions to Tri-Core and to purchase the GEAR product.

Plaintiffs alleged that Security breached its fiduciary duties under ERISA, violated **[*702]** the Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. §§ 1961-68, violated Florida's Unfair Insurance Trade Practices Act, Fla. Stat. §§ 626.951-626.99, and committed common-law fraud, conversion, breach of contract, and breach of the duty of good faith and fair dealing. The District Court granted partial summary judgment to Security, finding that all of plaintiffs' state law claims **[**5]** except the fraud claim were preempted by ERISA. One year later, the District Court granted a second motion filed by Security for partial summary judgment, rejecting certain of plaintiffs' ERISA and RICO theories.

The case was then brought to trial. The RICO and fraud claims were tried to a jury, which found for defendant on both claims. The ERISA claims were tried to the Court, which also found for defendant. Specifically, the Court found that Security did not owe plaintiffs any fiduciary duties with respect to the disclosure of the plan's tax status or the payment of commissions to Tri-Core, and that Security did not breach its fiduciary duties when it purchased the GEAR product for the USIA plan.

Plaintiffs moved for a new jury trial. They argued that the Court had erred when it limited the length of plaintiffs' opening statements, interrupted their examination of a witness named David Wallman, excluded certain evidence, and instructed the jury. The Court denied the motion.

This appeal followed.

The District Court had jurisdiction under 28 U.S.C. § 1331. We have jurisdiction under 28 U.S.C. § 1291.

The District Court's Summary Judgment Decisions

Plaintiffs challenge various rulings made **[**6]** by the District Court in granting partial summary judgment to defendant. **HN1** Our review of a grant of summary judgment is plenary. Gardner v. State Farm Fire & Cas. Co., 544 F.3d 553, 557 (3d Cir. 2008). "[W]e assess the record using the same summary judgment standard that guides the district courts." *Id.* Thus, defendant must demonstrate that "there is no genuine issue as to any material fact and that [it] is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c)(2).

First, plaintiffs contend that a court must always consider fiduciary status in determining whether ERISA preemption applies. Plaintiffs correctly state that the District Court did not consider whether Security was a fiduciary when determining that plaintiffs' state law claims "relate to" an ERISA claim and were therefore preempted. See 29 U.S.C. § 1144. However, none of the cases cited by plaintiffs support their position that such an analysis is required. To the contrary, in Kollman v. Hewitt Associates, LLC, 487 F.3d 139, 148 (3d Cir. 2007), we rejected the plaintiff's contention that his state law claim was "not subject to preemption because [the defendant] is supposedly a nonfiduciary." Instead, we emphasized, **[**7]** **HN2** the preemption inquiry depends on whether a state law claim implicates the plan's "funding, benefits, reporting or administration." *Id.* at 149-50. Similarly, the court in Findern Management Co. v. Barrett, 355 N.J. Super. 170, 809 A.2d 842, 856 (N.J. Super. Ct. App. Div. 2002), referred to fiduciary status only as one of several factors used to assess whether the claims were actually related to an ERISA plan, rather than to duties arising "outside of the ERISA context." The courts in the other cases cited by plaintiffs either did not consider fiduciary status at all or considered it only because such an analysis was required by the specific facts of those cases.

[*703] Second, plaintiffs argue that when the District Court was evaluating the terms of the USIA Plan, it improperly confined its analysis to the terms of a single document that the court referred to as the "EPIC Plan Document." JA0025. However, plaintiffs do not identify what other documents the Court should have considered. Nonetheless, we have examined other documents in the record that describe the USIA Plan, including a rider to the Group Life Insurance Policy contract called the "Employers' Rate Stabilization Reserve Endorsement" and brochures regarding **[**8]** the EPIC and

GEAR products. Even assuming that the District Court should have considered these documents to be part of the ERISA plan, they do nothing to substantiate plaintiffs' claims.

Third, plaintiffs argue that the District Court erred when it concluded that Security had not misappropriated the funds in the reserve. We disagree. The Court properly determined that plaintiffs had no right to the funds in the Rate Stabilization Reserve, except to have the funds used to reduce their insurance premiums after conversion. Section 5.2 of the Plan clearly provides that "[t]he Employer shall have no right, title, or interest in and to the contributions made by it to the Trust; and, no part of the Trust property . . . ever shall revert to the Employer." JA0984. Thus, USIA had no right to the reserve funds, and Security's actions could not have constituted misappropriation or conversion.

Fourth, plaintiffs contend that the District Court erred in finding that the EPIC plan did not involve a reserve fund. We are unable to locate such a finding in the record. To the contrary, the Court repeatedly referred to the reserve, both in its summary judgment decisions and when it announced its findings **[**9]** after the bench trial.

Breach of Fiduciary Duties

Plaintiffs argue that the District Court erred in finding, after the bench trial, that Security had not breached its fiduciary duties. "In an appeal from an ERISA bench trial, we review findings of fact for clear error but have plenary review over the District Court's conclusions of law." *Vitale v. Latrobe Area Hosp.*, 420 F.3d 278, 281 (3d Cir. 2005).

Three sections of ERISA are relevant to this issue. ^{HN3} 29 U.S.C. § 1106(b) provides that a fiduciary may not "deal with the assets of the plan in his own interest" or receive consideration "in connection with a transaction involving the assets of the plan." Under § 1101(b)(2), however, only certain assets are covered by § 1106. ^{HN4} "In the case of a plan to which a guaranteed benefit policy is issued by an insurer, the assets of such plan shall be deemed to include such policy, but shall not . . . be deemed to include any assets of such insurer." Finally, ^{HN5} § 1108 and Department of Labor guidance known as Prohibited Transaction Exemption 84-24 ("PTE 84-24") both provide exceptions to the prohibitions contained in § 1106(b).

The District Court found that Security was a fiduciary with respect to the **[**10]** life insurance policy owned by the USIA Plan, but not with respect to the contributions made to the plan by plaintiffs. The distinction, according to the Court, lies in § 1101(b)(2). The District Court found that plaintiffs' contributions were deposited in Security's general account, rather than in the USIA Plan itself. Thus, according to the Court, these funds were an asset of the insurer (i.e., Security), and were not plan assets under § 1101(b)(2). Thus, the fiduciary duties contained in § 1106 did not apply to plaintiffs' contributions, but instead applied only to the life insurance policy.

[*704] On appeal, plaintiffs challenge the District Court's legal and factual determinations. They argue that Security engaged in self-dealing by arranging for the USIA Plan to purchase GEAR, and then converted plan assets by misappropriating the funds in the Rate Stabilization Reserve. Plaintiffs also argue that Security breached its fiduciary duties by misrepresenting the tax-free status of contributions to GEAR. Plaintiffs further claim that Security violated PTE 84-24 by paying commissions to Tri-Core and Speer and violated § 1108(b)(2) by paying itself excessive compensation. Finally, they argue **[**11]** that the USIA Plan was not a "guaranteed benefit policy," and therefore is not covered by § 1101(b)(2). Thus, according to plaintiffs, the distinction drawn by the District Court between the plan's assets and Security's assets cannot hold.

We see no reason to disturb the District Court's determination that Security did not breach its fiduciary duties. The Court properly found that it was plaintiffs, not Security, who decided that the USIA Plan should purchase the GEAR product. Indeed, the USIA Plan was created with the specific purpose of purchasing GEAR. Plaintiffs made this decision after evaluating EPIC and GEAR for two years, and after consulting their attorney and accountant. Thus, contrary to plaintiffs' contention, it was not Security that "arranged for" the GEAR product to be purchased. Nor is there any merit to plaintiffs' claim that Security misappropriated the funds in the Rate Stabilization Reserve. Once plaintiffs decided to stop participating in the plan, they were able to use the funds in the Rate Stabilization Reserve to reduce their premiums, as Security had advertised. Finally, we are not persuaded that we should disturb the District Court's finding that Security did **[**12]** not violate its fiduciary duties with respect to its representations regarding the tax status of the GEAR contributions.

We therefore agree with the District Court that Security did not violate § 1106. As a result, we need not reach plaintiffs' arguments with respect to PTE 84-24, § 1108, or § 1101(b)(2), all of which provide exemptions to the prohibitions contained in § 1106.

Rulings at Trial

Plaintiffs challenge several evidentiary rulings made by the Court during trial, and the Court's refusal to grant a new trial based on these same issues.

^{HN6} We review a district court's evidentiary rulings for abuse of discretion. *Acumed LLC v. Advanced Surgical Servs., Inc.*, 561 F.3d 199, 211 (3d Cir. 2009). We also review the denial of a motion for a new trial for abuse of discretion, but we exercise plenary review over that denial to the extent that it is based on a question of law. *Curley v. Klem*, 499 F.3d 199, 205-06 (3d Cir. 2007).

Plaintiffs argue that the District Court improperly interfered with their questioning of David Wallman, Security's chief actuary. Plaintiffs complain that the Court inappropriately interrupted and limited their examination when they tried to

impeach Wallman with purportedly **[**13]** contradictory testimony given eight years earlier. We disagree. Plaintiffs' questions appeared to be of little relevance, and the Court was properly concerned that they could unduly prejudice jurors' interpretation of Wallman's testimony. The Court's attempts to limit this portion of this examination were well within its discretion to manage the trial.

Plaintiffs also argue that the Court erred in refusing to admit certain documents into evidence: a magazine article, letters from former EPIC participants, notes by Security employees, and correspondence between the Internal Revenue **[*705]** Service and Security. The Court properly concluded that these documents contained information that was either hearsay, irrelevant, or unduly prejudicial, especially in light of the fact that defendant had already stipulated to the facts that plaintiffs were attempting to prove using these documents. We find no abuse of discretion in the Court's rulings.

Jury Instructions

Plaintiffs argue that the District Court's jury instructions were flawed in several respects.

HN7 Our review of jury instructions is plenary, and we reverse if the instructions, as a whole, were capable of confusing and misleading the jury. *Mosley v. Wilson*, 102 F.3d 85, 94 (3d Cir. 1996).

First, **[**14]** plaintiffs argue that the Court should have instructed the jury that Security was a fiduciary under ERISA, and that it therefore had certain disclosure obligations under ERISA. However, at the close of the jury trial, the Court had not yet determined whether Security was an ERISA fiduciary. Since that determination was irrelevant to the common-law fraud and RICO claims that the jury was asked to decide, and since the determination had not even been made, the Court did not error in refusing to give such an instruction.

Second, plaintiffs argue that the Court should have informed the jury that the GEAR policy contained an indemnification clause that was invalid under 29 U.S.C. § 1110(a), which provides that "any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability . . . shall be void as against public policy." The indemnification clause was not even being relied on by Security in this litigation, however, and was therefore irrelevant to the case. An instruction to this effect would have only served to confuse the jury.

Finally, plaintiffs argue that the Court improperly failed to instruct the jury that plaintiffs could prevail on **[**15]** their misrepresentation claim on either of two theories: that Security misrepresented how the reserve funds would be used, or that Security misrepresented the tax-deductible nature of plaintiffs' contributions. The Court was not required to give such a specific instruction. The Court did instruct the jury that the misrepresentation had to be of a material "statement of fact." JA2042-43. This instruction was broad enough to encompass both of plaintiffs' theories.

We therefore conclude that the jury instructions were not erroneous in any of the respects urged by plaintiffs.

Conclusion

We will AFFIRM the order of the District Court.

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1993 U.S. Dist. LEXIS 9456, *

FOX, CURTIS & ASSOCIATES, INC. d/b/a EBTEK, Plaintiff, v. EMPLOYEE BENEFIT PLANS, INC. and NORTH AMERICAN LIFE AND CASUALTY COMPANY, Defendants.

No. 92 C 5828

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

1993 U.S. Dist. LEXIS 9456

July 12, 1993, Decided
July 13, 1993, Docketed

CASE SUMMARY

PROCEDURAL POSTURE: Defendants, insurer and administrator, filed a motion pursuant to Fed. R. Civ. P. 12(b)(1) to dismiss plaintiff employer's breach of contract and statutory fraud action as preempted by § 514(a) of the Employee Retirement Income Security Act (ERISA) § 514(a), 29 U.S.C.S. § 1144(a).

OVERVIEW: The employer filed an action against the insurer and the administrator for violating an agreement regarding an employee benefits plan. The insurer and the administrator filed a motion to dismiss the employer's complaint as preempted by ERISA § 514(a). The court denied the motion. The court found that the plan was an employee benefit plan within the meaning of ERISA § 3(1), 29 U.S.C.S. § 1002(1), and that ERISA § 514 preempted common law actions brought by ERISA plan participants or beneficiaries seeking benefits or alleging improper processing of claims under ERISA. However, the court found that the employer's action did not directly involve the rights of plan beneficiaries established under ERISA. The court held that any effect that the breaches by the insurer and the administrator of their obligations could have had on plan beneficiaries was incidental to the employer's claims. The court held that a conclusion that the employer's complaint was preempted would impair rather than preserve the integrity of employee benefit plans and jeopardize the very protections that Congress sought to secure for beneficiaries.

OUTCOME: The court denied the motion by the insurer and the administrator to dismiss the employer's breach of contract and statutory fraud action as preempted by ERISA.

CORE TERMS: beneficiary, preempted, fiduciary, benefits plan, preempt, law claims, preemption, insurer, aggregate, coverage, entity, plan's administrator, administrator, discretionary, administer, state law, insurance coverage, health care provider, causes of action, self-funded, calculation, contractual, incidental, premium, law causes of action, declaration, deceptive, lawsuit, law claims, preemption provision

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HN1 ↓ When considering a motion to dismiss, the court must assume that all well-pleaded factual allegations are true and draw all reasonable inferences possible therefrom in a light most favorable to plaintiff. The court is called upon to consider whether relief is possible under any set of facts that could be established consistent with the allegations of the complaint. [More Like This Headnote](#)

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[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Federal Preemption](#) > [State Laws](#)

HN2 ↓ State law claims by plan beneficiaries against plan fiduciaries are ordinarily preempted by the Employee Retirement Income Security Act. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

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[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Fiduciaries](#) > [General Overview](#)

Section 3(21)(A) of the Employee Retirement Income Security Act provides that a person is a fiduciary with

HN3 ↓ respect to a plan to the extent (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, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. 29 U.S.C.S. § 1002(21)
(A). [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

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[Pensions & Benefits Law > Employee Retirement Income Security Act \(ERISA\) > Federal Preemption > General Overview](#)

[Pensions & Benefits Law > Employee Retirement Income Security Act \(ERISA\) > Fiduciaries > General Overview](#)

HN4 ↓ Under some circumstances the Employee Retirement Income Security Act does preempt claims against entities that are not statutory fiduciaries. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

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HN5 ↓ Section 514(a) of the Employee Retirement Income Security Act (ERISA) provides that ERISA shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan covered by the statute. 29 U.S.C.S. § 1144(a). In enacting § 514(a), Congress sought a uniform body of benefit law to avoid the inefficiencies that would arise as a result of conflicts between state and federal laws in this arena and that could work to the detriment of plan beneficiaries. The court interprets the words "relate to" very broadly, and repeatedly states that a law "relates to" a covered employee benefit plan for purposes of § 514(a) if it has a connection with or reference to such a plan. Under a "common-sense" interpretation, a state law may "relate to" a plan even if it is not specifically designed to affect such plans, or the effect is only indirect. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Insurance Law > Industry Regulation > Federal Regulations > Employee Retirement Income Security Act \(ERISA\) > ERISA Preemption >](#)

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[Torts > Procedure > Preemption > General Overview](#)

HN6 ↓ Section 514 of the Employee Retirement Income Security Act (ERISA) preempts common law causes of action brought by ERISA plan participants or beneficiaries seeking benefits or alleging improper processing of claims under ERISA. Moreover, preemption is appropriate even where the state law claims are not brought by plan beneficiaries, if such claims nevertheless interfere with plan administration. Thus, the Seventh Circuit concludes that ERISA preempts Illinois statutory provisions dealing with personal liability of corporate officers and bars a lawsuit brought under those provisions to hold the officers of a corporate employer personally liable for delinquent pension contributions. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

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[Suits to Recover Plan Benefits](#)

[Pensions & Benefits Law > Employee Retirement Income Security Act \(ERISA\) > Federal Preemption > State Laws](#)

HN7 ↓ The federal preemption provision of the Employee Retirement Income Security Act does not apply to state causes of action that affect employee benefit plans in too tenuous, remote, or peripheral a manner. State law claims brought by plan beneficiaries for recovery of benefits are preempted. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Governments > Fiduciary Responsibilities](#)

[Insurance Law > Industry Regulation > Federal Regulations > Employee Retirement Income Security Act \(ERISA\) > ERISA Preemption >](#)

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[Pensions & Benefits Law > Employee Retirement Income Security Act \(ERISA\) > Federal Preemption > State Laws](#)

HN8 ↓ Preemption of state law claims against Employee Retirement Income Security Act (ERISA) fiduciaries serves the statute's goal of preserving the financial integrity of employee benefit plans and prohibiting interference with plan administration. The goal of preservation of plan assets does not require, however, the preemption of any lawsuit in which an ERISA fiduciary is a party. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Contracts Law > Types of Contracts > Lease Agreements > General Overview](#)

[Insurance Law > Industry Regulation > Federal Regulations > Employee Retirement Income Security Act \(ERISA\) > General Overview](#)

[Torts > Procedure > Preemption > General Overview](#)

HN9 ↓ State statutes that are preempted include those that provide an alternative cause of action to employees to collect benefits protected by the Employee Retirement Income Security Act (ERISA), refer specifically to ERISA plans and apply solely to them, or interfere with the calculation of benefits owed to an employee. Those that have not been preempted are laws of general application, often traditional exercises of state power or regulatory authority, whose effect on ERISA plans is incidental. Much of state tort and contract law is not preempted. State law governing relationships in which an ERISA plan operates like any other commercial entity as, for example, the relationship between the plan and its own employees, or the plan and its insurers or creditors, or the plan and the landlords from whom it leases office space, should withstand the broad reach of preemption. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Insurance Law > Industry Regulation > Federal Regulations > Employee Retirement Income Security Act \(ERISA\) > ERISA Preemption >](#)

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HN10 Lawsuits by beneficiaries to recover benefits clearly do sufficiently "relate to" the administration of Employee Retirement Income Security Act (ERISA) plans and are preempted. On the other hand, lawsuits by a health care provider against insurers to recover benefits due under the terms of an insurance plan are not sufficiently "related to" an ERISA plan to warrant preemption. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Insurance Law](#) > [Industry Regulation](#) > [Federal Regulations](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [ERISA Preemption](#) > [Bad Faith & Misrepresentation](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Civil Claims & Remedies](#) > [Standing](#)

[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Federal Preemption](#) > [General Overview](#)

HN11 State law claims brought by parties other than plan beneficiaries (or health care providers standing in the shoes of beneficiaries) that do not directly involve the adjudication of beneficiaries' rights under the plan are not preempted. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

JUDGES: [*1] PALLMEYER

OPINION BY: REBECCA R. PALLMEYER

OPINION

MEMORANDUM OPINION AND ORDER

This case presents the question of whether ERISA's broad preemption provision bars state law claims brought by an ERISA plan fiduciary against the plan's administrator and insurer. Plaintiff Fox, Curtis & Associates, Inc. d/b/a EBTEK ("EBTEK") charges Defendants [Employee Benefit Plans, Inc.](#) ("EBP") and [North American Life and Casualty Company](#) ("NALAC") with violating the terms of an agreement pursuant to which EBP allegedly agreed to administer, and NALAC agreed to insure, EBTEK's employee benefits plan. Count I of EBTEK's three-count complaint seeks a declaration of the rights and liabilities of the parties and an order directing EBP to administer, and EBP and NALAC to pay, all claims in accordance with the agreement. In Count II, Plaintiff charges Defendants with breach of contract, and in Count III, with violation of the Illinois Consumer Fraud and Deceptive Practices Act, [815 ILCS 505/1](#). Defendants EBP and NALAC now move pursuant to [FED. R. Civ. P. 12\(b\)\(1\)](#) to dismiss the complaint as preempted by section 514(a) of the Employee Retirement Income Security Act ("ERISA"), [29 U.S.C. § 1144](#) [*2] (a). For reasons discussed below, Defendants' motion is denied.

ALLEGATIONS OF THE COMPLAINT

Factual Background

For purposes of this motion, the following allegations are presumed true. EBTEK is an Illinois corporation with its principal place of business in DuPage County, Illinois. (Complaint, P 1.) Defendants EBP and NALAC are both Minnesota corporations with their principal places of business in Minneapolis, Minnesota. (Id. PP 2, 3.) EBP maintains an office and conducts business in Cook County, Illinois. (Id.) Pursuant to [28 U.S.C. § 1332](#), Plaintiff invokes diversity of citizenship as the basis of this court's jurisdiction over this action. (Id. P 6.)

On July 30, 1991, S. Michael Rummel, acting as agent for EBP and NALAC, presented a written proposal to EBTEK in which EBP offered to act as third-party administrator of EBTEK's self-funded employee benefits program for one year beginning on August 1, 1991 and ending on July 31, 1992. (Complaint, P 7; Ex. A.) Under the proposal, EBP would administer EBTEK's plan on a "15/12 incurred/paid basis" ¹ with a yearly self-funded aggregate of \$ 618,000, and NALAC would provide [*3] specific and aggregate stop-loss insurance coverage. ² (Id.) In a telecopy transmittal from Rummel to EBTEK dated August 1, 1991, EBP and NALAC memorialized the parties' agreement to certain premium amounts to be paid by EBTEK for the proposed coverage. (Id. P 8.)

FOOTNOTES

¹ Neither the complaint nor any of the materials submitted by the parties in connection with this motion explains this phrase.

² Again, the parties have not defined this term. The court understands stop-loss insurance to be "excess insurance designed to protect a selfinsured plan against unexpectedly large claims and catastrophic health costs for covered employees." See [Rockline, Inc. v. Wisconsin Physicians Serv. Ins.](#), [175 Wis. 2d 583, 587, 499 N.W.2d 292, 294 \(Ct. App. Wis. 1993\)](#).

EBTEK accepted the offer from EBP and paid an initial sum of \$ 38,533.67 in consideration. (Id. PP 8, 10.) EBTEK also paid a premium to NALAC in consideration for the issuance of NALAC's insurance coverage to EBP. (Id. P 11.) [*4] Subsequently, EBTEK paid the full contract price of \$ 552,176 for the one-year program on a pro-rated basis through June 1992, and continued paying NALAC premiums through June 1992. (Id. P 12.)

During October 1991, Plaintiff alleges, EBP "unilaterally requested a recalculation of the self-funded aggregate." (Id. P 13.) EBTEK rejected this proposal. (Id.) Later, in June 1992, EBP allegedly demanded an additional \$ 295,388.42 from EBTEK based upon EBP's own calculations of the cost to "fund the aggregate." ³ (Id. P 14.) This request was contrary to the terms of the contract, EBTEK alleges, and EBTEK refused to pay it. (Id.) Consequently, EBP terminated its contract with EBTEK on July 6, 1992, twenty-five days before the contract termination date, and stopped administering the plan. (Id. P 15.) NALAC similarly cancelled its contract with EBTEK and has refused to pay claims owing under its policy. (Id.) At the time of the complaint, EBTEK's outstanding claims under the benefit plan totalled more than \$ 295,000. (Id. P 16.) In addition, EBTEK contends that it has had to pay \$ 59,389.10 more than the aggregate established in the contract with EBP, and the sum continues to grow as additional [*5] claims are presented to EBTEK. (Id.) EBTEK filed this complaint against EBP and NALAC on September 22, 1992.

FOOTNOTES

³ The nature of EBP's calculations is not explained in the pleadings.

Claims Asserted

Plaintiff's complaint alleges causes of action under state law. Count I seeks a declaration of the parties' contractual rights and obligation. In Count II, EBTEK seeks damages in excess of \$ 350,000 against EBP and NALAC for breach of contract. In Count III, EBTEK alleges that Defendants violated the Illinois Consumer Fraud and Deceptive Practices Act, 815 ILCS 505/1. As its basis for this claim, EBTEK alleges that EBP, in an effort to extract additional sums of money from EBTEK, refused to administer all claims made by EBTEK plan participants promptly and fairly. (Id. PP 54-56.) EBTEK alleges, further, that Defendants concealed the fact that EBP itself, or one of its subsidiaries, reinsured the excess risk coverage NALAC provided EBTEK, with the result that EBP became responsible for excess claims. (Id. P [*6] 57.) EBTEK argues that EBP's dual position as plan administrator and reinsurer of EBTEK's self-insured plan motivated EBP to increase the yearly self-funded aggregate limits thus limiting EBP's own reinsurance obligation -- and to intentionally delay or deny payment of claims under the plan. (Id. PP 57, 58.)

Defendants EBP and NALAC now move to dismiss the complaint in its entirety on the grounds that section 514(a) of ERISA preempts these state law causes of action.

DISCUSSION

^{HN1} When considering a motion to dismiss, the court must assume that all well-pleaded factual allegations are true and draw all reasonable inferences possible therefrom in a light most favorable to plaintiff. Belmont Community Hosp. v. Local Union No. 9, I.B.E.W. & Outside Contractors Health & Welfare Fund, 737 F. Supp. 1034, 1038 (N.D. Ill. 1990). The court is called upon to consider "whether relief is possible under any set of facts that could be established consistent with the allegations [of the complaint]." Bartholet v. Reishauer A.G. (Zurich), 953 F.2d 1073, 1078 (7th Cir. 1992) (reversing dismissal of state law claims; fact that such claims [*7] were preempted by ERISA did not require dismissal for failure to state a claim). ⁴

FOOTNOTES

⁴ As Bartholet demonstrates, Defendants in this case err in assuming that a conclusion that ERISA preempts the state law claims will require dismissal of this case with prejudice. See also Shannon v. Shannon, 965 F.2d 542, 553 (7th Cir. 1992) (vacating dismissal with prejudice of beneficiary's state-law claim against plan fiduciary and remanding to permit beneficiary to pursue claim under ERISA), cert. denied, 121 L. Ed. 2d 599, 113 S. Ct. 677 (1992); Ampere Automotive Corp. v. Employee Benefit Plans, Inc., No. 92 C 2580, 1992 U.S. Dist. LEXIS 13097 (N.D. Ill. Aug. 31, 1992) (state law causes of action between two fiduciaries preempted by ERISA but cognizable under ERISA's provisions authorizing civil action by fiduciary for breach of another fiduciary's duty).

The parties do not dispute that the plan administered by EBP and NALAC is an employee benefit plan within the [*8] meaning of § 3(1) of ERISA. 29 U.S.C. § 1002(1). As discussed further below, ^{HN2} state law claims by plan beneficiaries against plan fiduciaries are ordinarily preempted by ERISA. Defendants have not, however, disputed Plaintiff's assertion that Defendant EBP is not a fiduciary ⁵ under the plan. (Plaintiff's Response to Defendants' Motion to Dismiss, at 2.) Defendants do, however, contend that even though EBTEK's complaint alludes neither to the Master Plan Document nor to the Plan Booklet which set forth the terms of EBTEK's benefits plan, the court will be requested to examine these documents to adjudicate EBTEK's claims. Therefore, Defendants argue, § 514(a) of ERISA preempts the state law claims because they "relate to" an employee benefit plan under ERISA. 29 U.S.C. § 1144(a).

FOOTNOTES

⁵ **HN3** Section 3(21)(A) of ERISA provides:

[A] person is a fiduciary with respect to a plan to the extent (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 . . . , or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002 (21)(A). Section 5.04 of the Administration Agreement between EBP and EBTEK acknowledges that EBP "is not a fiduciary to the Plan" and that "any delegation of authority or duties pursuant to this Agreement construed by a court of law or governmental agency to make the Contract Administrator [EBP] a fiduciary shall be null and void, and such duties are hereby retained by the Plan Sponsor [EBTEK]." Administration Agreement, App. B to Memorandum in Support of Defendants' Motion to Dismiss, P 5.04.

Relying exclusively on three cases decided in other districts, EBTEK argues that it is "well-established" that ERISA does not preempt state law claims against entities who are not "fiduciaries" under ERISA. (Plaintiff's Response to Defendants' Motion to Dismiss, P 1). See Kelly v. Pan-American Life Ins. Co., 765 F. Supp. 1406, 1410 (W.D. Mo. 1991); Munoz v. Prudential Ins. Co. of America, 633 F. Supp. 564, 570-71 (D. Colo. 1986); Southern California Meat Cutters Unions and Food Employers Pension Trust Fund v. Investors Research Co., 687 F. Supp. 506, 508-09 (C.D. Cal. 1988). As Defendants point out, however, several appellate courts have held that **HN4** under some circumstances ERISA does preempt claims against entities that are not statutory fiduciaries. Because this court concludes for other reasons that Plaintiff's claims are not preempted, the court will not reach the question whether Defendants' non-fiduciary status by itself requires such a conclusion.

[*9] Preemption

HN5 Section 514(a) of ERISA provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. 29 U.S.C. § 1144(a). In enacting § 514(a), Congress sought "a uniform body of benefit law" to avoid the inefficiencies which would arise as a result of conflicts between state and federal laws in this arena and which "could work to the detriment of plan beneficiaries." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990) (citing FMC Corp. v. Holliday, 498 U.S. 52, 60, 112 L. Ed. 2d 356, 111 S. Ct. 403 (1990), and Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 105, 77 L. Ed. 2d 490, 103 S. Ct. 2890 n.25 (1983)). The Court has interpreted the words "relate to" very broadly, and has "repeatedly stated that a law 'relates to' a covered employee benefit plan for purposes of § 514(a) 'if it has a connection with or reference to such a plan.'" District of Columbia v. Greater Washington Bd. of Trade, 121 L. Ed. 2d 513, 113 S. Ct. 580, 583 (1992) (quoting Show, 463 U.S. at 97). ⁶ Under a "common-sense" interpretation, **[*10]** a state law may "relate to" a plan even if it is "not specifically designed to affect such plans, or the effect is only indirect." Ingersoll-Rand, 498 U.S. at 139 (citing Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987)).

FOOTNOTES

⁶ In Greater Washington Bd. of Trade, the Court held that ERISA preempted that portion of the District of Columbia worker's compensation statute which required employers providing health insurance coverage for employees to provide equivalent health insurance coverage while the employee is eligible to receive worker's compensation benefits. The Court reasoned that ERISA's exemption of plans "maintained solely for the purpose of complying with applicable workmen's compensation laws" under § 4(b) (29 U.S.C. § 1003(b)) does not limit the "preemptive sweep of § 514 once it is determined that the law in question relates to a covered plan." 113 S. Ct. at 582, 584 (citations omitted).

[*11] It is well-established that Congress intended **HN6** § 514 to preempt common law causes of action brought by ERISA plan participants or beneficiaries seeking benefits or alleging improper processing of claims under ERISA. See Pilot Life, 481 U.S. at 48; see also, e.g., Gibson v. Prudential Ins. Co. of America, 915 F.2d 414, 416-18 (9th Cir. 1990) (ERISA preempts plan beneficiary's state law claims against nonfiduciary insurer/administrator of employer's disability benefits plan); Howard v. Parisian, Inc., 807 F.2d 1560 (11th Cir. 1987) (ERISA preempts plan beneficiary's contract and tort claims against plan administrator which independently contracted with employer).

Moreover, preemption is appropriate even where the state law claims are not brought by plan beneficiaries, if such claims nevertheless interfere with plan administration. Thus, in Plumbers' Pension Fund, Local 130 v. Niedrich, 891 F.2d 1297 (7th Cir. 1989), cert. denied, 495 U.S. 930, 109 L. Ed. 2d 499, 110 S. Ct. 2169 (1990), the Seventh Circuit concluded that ERISA preempts Illinois statutory provisions dealing with personal **[*12]** liability of corporate officers and bars a lawsuit brought under those provisions to hold the officers of a corporate employer personally liable for delinquent pension contributions. Likewise, in General American Life Ins. Co. v. Castonquay, 984 F.2d 1518 (9th Cir. 1993), the Ninth Circuit concluded that an insurer's effort to invoke California law imposing personal liability on ERISA plan trustees was preempted because "the state law here regulates one of the relationships [the relationship between the plan and its trustees] regulated by ERISA." Id. at 1522. See also First Nat'l Life Ins. Co. v. Sunshine-Jr. Food Stores, Inc., 960 F.2d 1546 (11th Cir. 1992) (claims brought by insurer charging employer with failure to adhere to its obligations under group policy which funded ERISA plan held preempted), cert. denied, 122 L. Ed. 2d 354, 113 S. Ct. 1045 (1993).

Despite these broad interpretations, the "relate to" clause and the preemption doctrine are not without limits. As the Supreme Court has recognized, ^{HN7} the federal preemption provision does not apply to state causes of action that affect employee [*13] benefit plans in "too tenuous, remote, or peripheral a manner." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 97, 100, 77 L. Ed. 2d 490, 103 S. Ct. 2890 n.21 (1983). As noted, it is clear that state law claims brought by plan beneficiaries for recovery of benefits are preempted. It is less clear, however, that Congress intended to preempt state law claims which involve ERISA plans but which concern relationships among parties peripheral to the central goal of ERISA -- that is, relationships incidental to the administration of the rights of beneficiaries under an ERISA plan.

The Seventh Circuit has not directly addressed this question. In Pohl v. National Benefits Consultants, Inc., 956 F.2d 126 (7th Cir. 1992), the court endorsed a broad reading of the "relate to" language, holding that ERISA preempted a beneficiary's state law claim charging the plan administrator with orally misrepresenting the scope of the plan's coverage. More recently, in Decatur Memorial Hosp. v. Connecticut General Life Ins. Co., 990 F.2d 925 (7th Cir. 1993), the court refused to determine whether a similar "negligent misrepresentation claim" by the health care [*14] provider was preempted. The court concluded it need not reach the preemption question because state law did not recognize such a cause of action at all.

Other Courts of Appeals have concluded, however, that ERISA need not preempt suits involving relationships between ERISA entities (employer, plan fiduciary, or plan beneficiary) and third parties. In Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990), for example, plaintiff hospital sought recovery of the cost of health care provided to an individual for whom delendant plan fiduciaries had earlier confirmed coverage. On appeal from an order dismissing the complaint as preempted, the Fifth Circuit suggested that preemption is more appropriate where a claim "affects relations among the principal ERISA entities -- the employer, the plan, the plan fiduciaries, and the beneficiaries -- than if it affects relations between one of these entities and an outside party, or between two outside parties with only an incidental effect on the plan." Id. at 249 (quoting Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters., Inc., 793 F.2d 1456, 1467 (5th Cir. 1986), [*15] cert. denied, 479 U.S. 1034, 93 L. Ed. 2d 837, 107 S. Ct. 884 (1987)). The court reasoned that Congress struck a "bargain" by granting broad protections to plan beneficiaries in exchange for forfeiture of state remedies, but that this bargain did not necessarily involve tangential relationships. 904 F.2d at 249. The court concluded that plaintiff hospital's breach of contract claims against plan administrators and insurers were preempted because the hospital's claim was derivative of the beneficiary's. The court did not, however, reach the same conclusion with respect to the hospital's claim that the insurers had engaged in deceptive and unfair trade practices by misrepresenting the coverage status of the beneficiary. Such a claim, the court observed, is "independent of the plan's actual obligations under the terms of the insurance policy and in no way seeks to modify those obligations." Id. at 250. The court concluded that Congress had not intended that ERISA would regulate these commercial interactions. (Id.)

As both parties here recognize, ^{HN8} preemption of state law claims against ERISA fiduciaries serves the statute's goal of preserving [*16] the financial integrity of employee benefit plans and prohibiting interference with plan administration. The goal of preservation of plan assets does not require, however, the preemption of any lawsuit in which an ERISA fiduciary is a party. For example, in Aetna Life Ins. Co. v. Borges, 869 F.2d 142 (2d Cir.), cert. denied, 493 U.S. 811, 107 L. Ed. 2d 25, 110 S. Ct. 57 (1989), the Second Circuit held that ERISA did not preempt the State of Connecticut's claims under the state escheat statute for recovery of uncashed benefit checks. Aetna concluded that preemption is triggered not by "just any indirect effect on administrative procedures" but rather by an effect on "the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit." 869 F.2d at 146-47. Thus, ^{HN9} state statutes held preempted include

those that provide an alternative cause of action to employees to collect benefits protected by ERISA, refer specifically to ERISA plans and apply solely to them, or interfere with the calculation of benefits owed to an employee. Those that have not been preempted [*17] are laws of general application -- often traditional exercises of state power or regulatory authority -- whose effect on ERISA plans is incidental.

Id. at 146. Similarly, according to the General American Life court, the Supreme Court has explained that "much of state tort and contract law isn't preempted." 984 F.2d at 1521. State law governing relationships in which an ERISA plan operates like "any other commercial entity" as, for example, "the relationship between the plan and its own employees, or the plan and its insurers or creditors or the plan and the landlords from whom it leases office space," should withstand the broad reach of preemption. Id. at 1522 (emphasis supplied).

The Tenth Circuit drew a similar distinction in Monarch Cement Co. v. Lone Star Indus., Inc., 982 F.2d 1448 (10th Cir. 1992). In Monarch Cement, an employer which shut down one of its plants brought an equitable action against a successor-in-interest and administrator of the benefits plan created by the employer for its former employees. The employer sought a declaration of liabilities against [*18] the successor company, which had failed to pay its share of "shutdown benefits" to the former employees of the plant. The Tenth Circuit concluded that ERISA did not preempt the cause of action. Relying on the Shaw Court's conclusion that some state claims are too remote or tenuous to "relate to" an ERISA plan for preemption purposes, the court noted that "a line has emerged between the kinds of state law claims which generally are and are not preempted by ERISA." Id. at 1452. ^{HN10} Suits by beneficiaries to recover benefits clearly do sufficiently "relate to" the administration of ERISA plans and are preempted. On the other hand, suits by a health care provider against insurers to recover benefits due under the terms of an insurance plan are not sufficiently "related to" an ERISA plan to warrant preemption. Id. at 1453. The purpose of ERISA preemption is to protect the interests of plan beneficiaries and to ensure uniformity of benefit law; accordingly, the court concluded that ERISA did not preempt the employer's claim as it did "not disturb the administration of a pension plan, calculation of benefits, or determination of entitlement [*19] to benefits." Id.

The case before this court, similarly, does not directly involve the rights of plan beneficiaries established under ERISA. Plaintiff here alleges that Defendants breached their contractual obligations to administer the plan and make payments to Plaintiff pursuant to an administration-insurance agreement negotiated between the parties. Assuming, as is required, the truth of EBTEK's allegations, EBP unilaterally demanded that EBTEK pay more premium money than the contract required. When EBTEK refused these extra-contractual demands, Defendants allegedly refused to meet their contractual obligations. Such allegations present a "garden variety" commercial dispute which bears no apparent relationship to plan interpretation.

Defendants complain that Plaintiff failed to attach to its complaint a copy of the Administration Agreement between EBTEK and EBP -- a copy which would demonstrate, Defendants argue, that this court cannot adjudicate this dispute without interpretation of EBTEK's employee benefits plan. In fact, however, the parties appeared to take pains in negotiating the Administration Agreement to place on EBTEK (the Plan Sponsor) alone all responsibility [*20] for plan interpretation; determination of eligibility of claims; collection of contributions; and payment of plan benefits. (Administration Agreement, App. B to Memorandum in Support of Defendants' Motion to Dismiss, P 2.01-.04.) The Agreement provided, further, that EBP (the Contract Administrator) was not to be deemed a fiduciary to the Plan and that any plan provision construed by a court to render EBP a fiduciary "shall be null and void. . . ." (Id. P 5.04.) In light of these efforts on the part of the drafters of the Administration Agreement, this court concludes that any effect that Defendants' breach of their obligations may have on plan beneficiaries is incidental to EBTEK's claims. The extent to which the plan documents will have to be reviewed in adjudicating the merits of EBTEK's claims, if at all, is merely ancillary to an examination of the terms of the agreement between EBTEK and Defendants. Neither beneficiary status, scope of coverage, nor amounts of claims covered are at issue here.

So far as the complaint alleges, this case does not involve the adjudication of any discretionary administrative decision-making on the part of Defendants regarding the rights of plan [*21] beneficiaries. Rather than seeking an award to be recovered against plan assets, EBTEK's lawsuit constitutes an attempt to secure assets on behalf of its plan. Under these circumstances, a conclusion that Plaintiff's complaint is preempted would impair rather than preserve the integrity of employee benefit plans and thus jeopardize the very protections that Congress sought to secure for beneficiaries in establishing ERISA legislation.

CONCLUSION

While Congress intended to place the regulation of benefit plans squarely within the purview of ERISA, it did not intend to regulate all aspects of contractual relationships tangential to an ERISA plan. ^{HN11} State law claims brought by parties other than plan beneficiaries (or health care providers standing in the shoes of beneficiaries) that do not directly involve the adjudication of beneficiaries' rights under the plan are not preempted. Defendants' motion to dismiss the complaint is denied.

ENTER:

REBECCA R. PALLMEYER

United States Magistrate Judge

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101 Fed. Appx. 383, *; 2004 U.S. App. LEXIS 11226, **;
32 Employee Benefits Cas. (BNA) 2859

INFORMATION SYSTEMS & NETWORKS CORPORATION, Plaintiff-Appellant, v. PRINCIPAL LIFE INSURANCE COMPANY,
Defendant-Appellee.

No. 03-1948

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

101 Fed. Appx. 383; 2004 U.S. App. LEXIS 11226; 32 Employee Benefits Cas. (BNA) 2859

May 5, 2004, Argued
June 8, 2004, Decided

NOTICE: [1]** RULES OF THE FOURTH CIRCUIT COURT OF APPEALS MAY LIMIT CITATION TO UNPUBLISHED OPINIONS. PLEASE REFER TO THE RULES OF THE UNITED STATES COURT OF APPEALS FOR THIS CIRCUIT.

PRIOR HISTORY: Appeal from the United States District Court for the District of Maryland, at Greenbelt. (CA-03-303-PJM). Peter J. Messitte, District Judge.

DISPOSITION: Affirmed.

CASE SUMMARY

PROCEDURAL POSTURE: Appellant employer challenged a judgment of the United States District Court for the District of Maryland, at Greenbelt, dismissing its complaint against appellee employee pension plan administrator raising claims for breach of contract and professional negligence regarding the administration of the plan. The district court found that the Employee Retirement Income Security Act (ERISA), 29 U.S.C.S. § 1144(a), preempted the employer's claims.

OVERVIEW: The employer sponsored an employee pension plan within the meaning of § 3(3) of ERISA. The employer retained the administrator to assist in the administration of the plan. The employer brought an action alleging that the administrator had committed claim administration errors and, thus, made improper distributions and that but for those errors, the funds at issue would have been forfeited to the plan where they might have been credited to or returned to the employer as plan sponsor. The district court granted the administrator's motion to dismiss. On appeal, the court affirmed. The district court correctly determined that the employer's claims boiled down to allegations of "improper administration of the plan." Accordingly, the district court also correctly held that the claims were pre-empted by ERISA. It was clear that the employer's claims fell squarely within the recognized rule that when a cause of action under state law was "premised on" the existence of an employee benefit plan so that in order to prevail, a plaintiff must plead, and the court must find, that an ERISA plan existed, ERISA preemption would apply.

OUTCOME: The court affirmed the district court's judgment.

CORE TERMS: employee benefit plan, pre-empted, breach of contract, professional negligence, beneficiaries, correctly, raising, sponsor, issuing

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[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Federal Preemption](#) > [State Laws](#)

HN1 [29 U.S.C.S. § 1144\(a\)](#) provides that the Employee Retirement Income Security Act preempts any and all state laws insofar as they relate to any employee benefit plan. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

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HN2 When a cause of action under state law is "premised on" the existence of an employee benefit plan so that in order to prevail, a plaintiff must plead, and the court must find, that an Employee Retirement Income Security Act (ERISA) plan exists, ERISA preemption will apply. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

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HN3 Common-law tort and contract actions which are based on alleged improper processing of a claim for benefits

under an employee benefit plan are preempted by the Employee Retirement Income Security Act. [More Like This Headnote](#)

COUNSEL: Norman Henry Singer, SINGER & ASSOCIATES, P.C., Bethesda, Maryland, for Appellant.

Jacqueline Elizabeth Bennett, REED SMITH, L.L.P., Washington, D.C., for Appellee.

ON BRIEF: Benjamin M. Kahrl, SINGER & ASSOCIATES, P.C., Bethesda, Maryland, for Appellant.

Andrew C. Bernasconi, REED SMITH, L.L.P., Washington, D.C., for Appellee.

JUDGES: Before LUTTIG, MOTZ, and SHEDD, Circuit Judges.

OPINION

[*384] PER CURIAM:

Appellant, Information Systems & Networks Corp. ("ISN"), appeals from the dismissal of its complaint raising claims for breach of contract and professional negligence against appellee, *Principal Life Insurance Co.* ("Principal"). ISN sponsors an employee pension plan within the meaning of Section 3(3) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1002(3) (the "Plan"). ISN had retained Principal **[**2]** to assist in the administration of the Plan, with the duties of maintaining Plan records, issuing required distributions to Plan beneficiaries upon ISN's approval, collecting contributions made by ISN to the Plan, and issuing statements regarding Plan participation.

Alleging that Principal had committed claim administration errors and thus made improper distributions totaling at least \$ 300,000, and that but for these errors the funds at issue would have been forfeited to the Plan where they might have been credited to or returned to ISN as Plan sponsor, ISN sued Principal in federal district court, raising claims of breach of contract and professional negligence. Principal then moved for dismissal under Federal Rule of Civil Procedure 12(b)(6), asserting that ERISA pre-empted all of ISN's claims. Ruling from the bench after a hearing, the district court granted Principal's motion to dismiss, holding that because ISN's claims essentially asserted "improper administration of the plan," they were pre-empted under ERISA. See 29 U.S.C. § 1144(a) (providing that ERISA ^{HN1} preempts "any and all State laws insofar as they . **[**3]** ..relate to any employee benefit plan"). ISN timely appealed.

Having considered the contentions raised in the parties' briefs and at oral argument, we now affirm. The gravamen of ISN's complaint is that certain distributions made by Principal were erroneous because the beneficiaries were not entitled to those distributions *under the terms of the Plan*. In light of this, the district court correctly determined that ISN's claims boil down to allegations of "improper administration of the plan." Accordingly, the district court also correctly held these claims to be pre-empted by ERISA. Indeed, given the foregoing description, it is clear that ISN's claims fall squarely within the recognized rule that ^{HN2} "when a cause of action under state law is 'premised on' the existence of an employee benefit plan so that 'in order to prevail, a plaintiff must plead, and the court must find, that an ERISA plan exists, ERISA preemption will apply.'" *Griqqs v. E.I. Dupont de Nemours & Co.*, 237 F.3d 371, 378 (4th Cir. 2001) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990)); see also **[*385]** *Stiltner v. Beretta U.S.A. Corp.*, 74 F.3d 1473, 1480 (4th Cir. 1996) **[**4]** (noting that state ^{HN3} common-law tort and contract actions which are 'based on alleged improper processing of a claim for benefits under an employee benefit plan' are preempted by ERISA") (citations omitted).

For the foregoing reasons, we affirm the judgment of the district court.

AFFIRMED

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Citation: 2008 u.s. dist. lexis 71314

2008 U.S. Dist. LEXIS 71314, *

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K.F. by and through her parents and guardians, JOHN AND EMBER FRY, Plaintiff, v. REGENCE BLUESHIELD, et al., Defendants.

Case No. C08-0890RSL

UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF WASHINGTON, SEATTLE DIVISION

2008 U.S. Dist. LEXIS 71314

September 19, 2008, Decided
September 19, 2008, Filed

PRIOR HISTORY: [K.F. v. Regence BlueShield, 2008 U.S. Dist. LEXIS 69150 \(W.D. Wash., Sept. 10, 2008\)](#)

CORE TERMS: inpatient, nursing, hospitalization, coverage, in-home, home health, substituted, skilled, administrator, medical necessity, standard of review, insured, contractual, insurer, hourly, airway, tracheostomy, constant, survive, medically necessary, administrative record, de novo, independent review, substitution, reevaluate, utilizing, authorize, external, medical care, obligation to provide

⚡ **Available Briefs and Other Documents Related to this Case:**

[U.S. District Court Motion\(s\)](#)

COUNSEL: **[*1]** For KF, by and through her parents and guardians, JOHN AND EMBER FRY, Plaintiff: [Eleanor Hamburger](#) ✓, [Richard E Spoonemore](#) ✓, LEAD ATTORNEYS, SIRIANNI YOUTZ MEIER & SPOONEMORE, SEATTLE, WA.

For Regence BlueShield, MBA Group Insurance Trust Health and Welfare Plan, Defendants: [Medora A Marisseau](#) ✓, KARR TUTTLE CAMPBELL, SEATTLE, WA.

For Office of the Insurance Commissioner, Amicus: Elizabeth Christina Beusch, ATTORNEY GENERAL OF WASHINGTON (40100-OLY), OLYMPIA, WA.

JUDGES: [Robert S. Lasnik](#) ✓, United States District Judge.

OPINION BY: [Robert S. Lasnik](#) ✓

OPINION

MEMORANDUM OF DECISION

INTRODUCTION

This matter was heard by the Court on September 11, 2008. Plaintiff alleges that she is entitled to sixteen (16) hours per day of in-home nursing services under a medical benefits plan governed by the Employee Retirement Security Act of 1974 ("ERISA"), [29 U.S.C. § 1001 et seq.](#) Complaint at P 1. Defendants argue that because inpatient hospitalization is not warranted under the plan, in-home nursing services are not available as a substituted benefit. Even if inpatient hospitalization were warranted, defendants maintain that there is no coverage for hourly nursing services under the terms of the plan and that there is no evidence that more **[*2]** than 9 hours of in-home nursing care is medically necessary. The Court has considered the administrative record, the arguments of counsel, and the remainder of the record and, being fully advised, finds as follows:

DISCUSSION

A. STANDARD OF REVIEW

Regence's May 23, 2008, denial of benefits will be reviewed *de novo* for the reasons stated in the Court's "Order Granting in Part Defendants' Motion for Partial Summary Judgment." Dkt. # 59 at 3-5.

Defendants have filed a motion for reconsideration of that decision. They assert that the Court's order forces the claims administrator to substantively evaluate the decision of the third-party independent review organization, in violation of state law. That is not the case. State laws mandating insurance policy terms apply to insurance contracts purchased for plans subject to ERISA. See, e.g., UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 375-76, 119 S. Ct. 1380, 143 L. Ed. 2d 462 (1999); 29 U.S.C. § 1144(b)(2)(A). Washington has created an external appeal procedure for participants who disagree with the administrator's denial of benefits: the statute compels insurers to implement the independent review organization's determination. RCW 48.43.535. The Court's decision in no way calls [***3**] into doubt or alters that imperative. Regence had no authority or discretion to reevaluate the decision of the independent review organization ("IRO"). It was, by law, required to implement the IRO's determination, which it did on May 23, 2008.

It is the effect that the mandatory implementation of the IRO's decision has on the standard of review in this case that troubles defendants. Defendants argue that utilizing a *de novo* standard would be "a drastic departure from the procedures under ERISA for reviewing benefits decisions . . ." Dkt. # 61 at 4. The default standard of review under ERISA is *de novo*, however. A deferential standard of review is not guaranteed by ERISA (Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 385-86, 122 S. Ct. 2151, 153 L. Ed. 2d 375 (2002)), and any grant of discretion must be unambiguously set forth in the plan (Kearney v. Standard Ins. Co., 175 F.3d 1084, 1090 (9th Cir. 1999)). Because the requirements of RCW 48.43.535 are incorporated into the plan, the scope and nature of the administrator's discretion are far from clear when the participant exercises her right to an external appeal. The Supreme Court recognized that state statutes creating independent appeal procedures, such as RCW 48.43.535, [***4**] could subject the plan to different standards of review depending on whether the participant appealed directly from the internal process or waited until after the external review was completed. Rush Prudential, 536 U.S. at 384. This dichotomy is neither unfair nor unexpected. Even when the plan unambiguously grants discretion to the administrator, only those decisions that actually involve the exercise of discretion are entitled to deference from the judiciary. Lamantia v. Voluntary Plan Adm'rs, Inc., 401 F.3d 1114, 1122 (9th Cir. 2005). The implementation of the IRO's decision on May 23, 2008, did not involve the interpretation of the plan or a determination of eligibility for benefits. Because no discretion was or could be exercised, deference is not appropriate. The Court will, therefore, review the administrative record to determine whether Regence's final coverage decision was correct or incorrect. Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 963 (9th Cir. 2006).

B. MEDICAL NECESSITY

It is undisputed that K.F. requires skilled nursing care to survive. At the time of this decision, K.F. is an eleven month old child diagnosed with diastrophic dysplasia. Diastrophic dysplasia [***5**] is a form of dwarfism associated with short limbs, micrognathia (abnormally small lower jaw), cleft palate, severe spinal curvature, hand and feet abnormalities, and tracheobronchomalacia (collapsible airway). K.F. has been tracheostomy dependent since she left the hospital in December 2007. The record shows that without supervision from adequately-trained personnel, secretions would build up in K.F.'s tracheostomy, her oxygen saturation levels would drop, and she would die from acute airway obstruction. Even with constant medical care, K.F. suffers episodes of hypoxia that require training to identify and treat. In addition, the cartilaginous rings of K.F.'s trachea are poorly formed, giving rise to a constant risk that her trachea will collapse. She is, in short, unable to protect her airway and must rely on a combination of mechanical and medical assistance to continue breathing throughout the day.

Pursuant to Section 5.9.2 of the plan, Regence will pay for in-home services as an alternative to hospitalization if such care can be provided at equal or lesser cost. ¹ Benefits under Section 5.9.2 "will only be provided when the Member's condition is serious enough to require Inpatient [***6**] care and the Member could qualify for the Inpatient Benefits of this Contract . . ." The question then becomes whether K.F.'s condition is serious enough to require inpatient care, *i.e.*, whether admission to the hospital is medically necessary.

FOOTNOTES

¹ Defendants argue that the coverage afforded by Section 5.9.2 is far more limited than this summary suggests. Plan interpretation issues are discussed in section C of this Order.

Medical necessity is defined by the plan as a service that meets all of the following criteria:

- . It is required to diagnose or treat the Member's condition.
- . It is consistent with the symptom or diagnosis and treatment of the condition.
- . It is the most appropriate supply or level of service that is essential to the Member's needs.
- . When applied to an Inpatient, it cannot be safely provided to the Member as an outpatient, including diagnostic studies.
- . It is not an Investigational Service or Supply.
- . It is not primarily for the convenience of the Member or provider.

Regence argues that K.F. does not satisfy the first criteria of "medical necessity." As noted above, however, K.F. would not survive without round-the-clock skilled care: suctioning and constant monitoring/intervention [*7] are necessary to treat her condition. Regence argues that hospitalization is not necessary to treat K.F.'s condition because she has not been hospitalized since she was discharged in November 2007. The only reason K.F. has stayed out of the hospital, however, is because her parents have stepped forward to provide or obtain medical services for her when Regence declined to do so. Regence's simplistic analysis would force parents to stand by and watch as their child's health deteriorates to the point where acute medical intervention becomes necessary just so they could prove that her condition is serious enough to require hospitalization. This cannot be right. There is no dispute regarding K.F.'s need for skilled nursing care: Regence would simply prefer to have her parents provide those services since they have shown an ability to do so. The fact that K.F.'s parents have cobbled together twenty-four hours of care for their child through extraordinary efforts does not mean that skilled nursing services are not required to treat K.F.'s condition. The Court finds that K.F.'s condition is serious enough to require inpatient care, and Regence cannot escape its contractual obligation to provide [*8] substituted healthcare services under Section 5.9.2 simply because others have stepped forward to provide the necessary care.²

FOOTNOTES

² K.F. needs skilled care to survive. Defense counsel acknowledged as much at trial, and the administrative record contains multiple references to K.F.'s need for tracheostomy care throughout the day. Rao Decl. at 192-94, 279, 282, 746-48, 1035-36, 1151-52, 1206-07, 1247, and 1266-67. Instead of focusing on K.F.'s needs when determining whether inpatient care was necessary to treat her condition, Regence improperly relied on the fact that her parents had been trained to provide suctioning, tracheostomy tube maintenance/replacement, and emergent interventions when determining medical necessity. Rao Decl. at 1247 and 1266-67. Regence's analysis, if adopted, would effectively abrogate its contractual obligation to provide medical care if any third party proved capable of providing such care. Even under an abuse of discretion standard, the Court would conclude that Regence's coverage determination was unreasonable.

Earlier in the litigation, defendants also argued that K.F. had to meet the so-called Milliman criteria³ in order to show that she qualified for inpatient [*9] care. There is no evidence that the Milliman criteria are part of, or were incorporated into, the plan. They cannot, therefore, impose coverage limitations or restrictions that are inconsistent with those set forth in the plan or that were not disclosed to participants. Saltarelli v. Bob Baker Group Med. Trust, 35 F.3d 382, 386-87 (9th Cir. 1994). Even if Regence were entitled to rely on the Milliman criteria when determining whether K.F.'s condition was serious enough to require inpatient care, the record shows that K.F. is unable to protect her airway. Because she exhibits one of the clinical indications for admission to the hospital, the Milliman criteria are satisfied.

FOOTNOTES

³ Milliman, Inc., produces care guidelines for hospitals, health plans, and physicians. According to Milliman's website, its products are updated annually by a team of healthcare professionals and provide authorization criteria, care pathways, and case management tools to its customers. Defendants rely on a section of these guidelines entitled "Clinical Indications for Admission to Inpatient Care."

At trial, defendants took the position that substitution of home health care services under Section 5.9.2 is not appropriate [*10] because such care would not, in fact, be less expensive than hospitalization. There is no evidence in the record to support this assertion, and reasonable assumptions regarding the comparative costs of inpatient services versus home health care services suggest otherwise. See AR 1035. Defendants seem to assert that it would be cheaper to pay for multiple hospitalizations to stabilize K.F. whenever she had an acute medical emergency and her parents had to call 911 or drive her to a hospital emergency room than to provide ongoing treatment to keep her out of distress in the first place. This argument does not withstand scrutiny. Under the Milliman criteria, discharge would be appropriate only when the respiratory treatments are no longer needed or could be provided at a lower level of care. Given her ongoing need for mechanical and medical interventions, the next level of care, such as in-home health services, would be a viable option only if Regence substitutes benefits so that K.F. can receive the medical care she continues to need. There is no evidence from which one could conclude that K.F.'s doctors would release her without some assurance that the home was a medically-appropriate [*11] option. In fact, the record supports the opposite conclusion: when K.F. was originally discharged from the hospital, it was with the understanding that Regence would provide 16 hours of in-home care to supplement the eight hours the parents could provide. K.F.'s doctors have consistently objected to every reduction in the services provided by Regence below this 16 hour threshold. Defendants' comparative cost argument is unpersuasive and unsupported.

C. PLAN INTERPRETATION

Defendants argue that, even if K.F. could qualify for inpatient care, there is no coverage for hourly nursing services under the plan. Although Section 5.9.2 appears to promise that home health care can, at the option of the insured, be substituted for inpatient services, defendants rely on the reference to "Benefits of this Contract" in the first sentence of Section 5.9.2 to limit this promise. Defendants argue that the phrase incorporates into Section 5.9.2 all of the limitations and exclusions set forth in Sections 6 and 8.15, including exclusions for hourly nursing services.

ERISA plans "are to be interpreted in an ordinary and popular sense as would a [person] of average intelligence and

experience." *Simkins v. Nevada Care, Inc.*, 229 F.3d 729, 734-35 (9th Cir. 2000) [*12] (internal quotation marks omitted) (alteration in original). Coverage should be liberally construed to protect the interests of beneficiaries (1 ERISA Leg. History 604, S. Rep. No. 93-127, 93d Cong., 1st Sess. 18 (1973), reprinted in 1974 U.S. Code Cong. & Admin. News 4838, 4854) and to ensure that their reasonable expectations are met (*Winters v. Costco Wholesale Corp.*, 49 F.3d 550, 554 (9th Cir. 1995)). "[A]mbiguous language is construed against the insurer and in favor of the insured." *McClure v. Life Ins. Co. of N. Am.*, 84 F.3d 1129, 1134 (9th Cir. 1996).

Section 5.9.2 states that "[a]n alternative to hospitalization or other Inpatient care, the Benefits of this Contract . . . will be provided for substitution of home health care when provided in lieu of hospitalization or other Inpatient care" The term "Benefits" is defined as "payment by [Regence] for services and supplies covered under the Contract." Ignoring certain syntactical problems, the first sentence of Section 5.9.2 promises that, as an alternative to hospitalization, payment for services covered under the plan will be provided for home health care. The sentence could be interpreted to mean, as defendants suggest, [*13] that only services authorized by the plan and not subject to any exclusion will be provided at home. Thus, even though hospitals provide nursing to inpatients, those services would be unavailable if home care were substituted for hospitalization under Section 5.9.2 because Section 6.1.22 and Section 8.15.4 expressly exclude payment for hourly nursing services. This reading would make Section 5.9.2 redundant: if the section does no more than authorize the provision of services that are already provided elsewhere in the contract, no additional benefit is granted. It would also make Section 5.9.2's promise of substituted home care illusory in most circumstances: if nursing services will never be provided in the home, very few inpatients would be able to take advantage of the repeated promises of substituted services.

More importantly, defendants' interpretation relies on a bare reference to "Benefits of this Contract" to import critical limitations into an otherwise broad benefit provision. The doctrine of reasonable expectations prevents such slight of hand:

[a]n insurer wishing to avoid liability on a policy purporting to give general or comprehensive coverage must make exclusionary clauses [*14] conspicuous, plain, and clear, placing them in such a fashion as to make obvious their relationship to other policy terms, and must bring such provisions to the attention of the insured.

Saltarelli, 35 F.3d at 386. The bare reference to "Benefits of this Contract" is insufficient to alert a reasonable insured that limitations on those benefits are intended. Nor is it clear that the reference to "Benefits of this Contract" actually affects the meaning of Section 5.9.2 as defendants suggest. Utilizing the plan definitions, Section 5.9.2 promises that payment for services under the contract will be provided for substitution of home health care. The most natural reading of Section 5.9.2 is that Regence will pay for in-home services as an alternative or substitute to the covered hospitalization or inpatient care benefits offered under the Contract. This interpretation construes any ambiguities in favor of the insured, comports with her reasonable expectations, and prevents plaintiff from expanding the scope of hospitalization coverage beyond what the plan allows, while giving substance to the promise of substituted health benefits.

D. HOURS OF HOME CARE

Having determined that K.F. has a contractual [*15] right to substitute home health care for the hospitalization benefits provided by the plan, the Court finds no contractual or record support for defendants' contention that Regence has to provide only nine hours of in-home care per day. As discussed above, K.F.'s condition is constant: without round-the-clock mechanical and medical support, she will not survive. Twenty-four hours of skilled nursing care is medically necessary, and Regence is contractually obligated to provide it. The parents' willingness to relieve Regence of this obligation for eight hours every day is not a waiver of the coverage and does not justify Regence's attempt to foist upon them the duty to provide skilled nursing care for longer than they feel capable. ⁴

FOOTNOTES

⁴ At trial, defendants repeatedly asserted that the skills and abilities of K.F.'s parents somehow abrogate the coverage that might otherwise exist under the plan. In attempting to explain this theory, defendants pointed out that an insurer would not have to provide in-home food service for a child simply because its parents had failed to feed it. If, however, the child became critically malnourished/ dehydrated and required inpatient care to stabilize her [*16] condition, the hospitalization benefit of the plan would likely be implicated. More importantly, K.F. is not asking Regence to provide basic necessities for which parents are generally held responsible. The care K.F. needs is beyond that which an unskilled layperson can provide and falls within the coverage provisions of the plan. K.F.'s parents, who are not medically-trained, have learned certain skills which they are willing to use, and have been using, to care for their child. Their skills do not, however, impact the coverage analysis. Unlike the obligation to feed a child, which falls on the parents, the obligation to provide nursing services falls on Regence under the terms of the plan, making the analogy inapposite.

E. AWARD OF BENEFITS

As of May 7, 2008, the date on which Regence terminated K.F.'s in-home nursing services, she was entitled to the requested sixteen hours of in-home nursing care in lieu of hospitalization under Section 5.9.2 of the plan. There is no evidence that K.F.'s situation has changed: in fact, the declarations submitted during the preliminary injunction proceeding show that K.F. continues to need around-the-clock support and that her parents have been compelled

[*17] to retain a nursing agency, New Care Concepts, to provide care. Defendant Board of Trustees of the MBA Group Insurance Trust is therefore ORDERED to reimburse plaintiff for the hours of care K.F. has received from the nursing agency since May 7, 2008. Regence, as the claim administrator, shall continue to provide sixteen hours of in-home nursing care per day until K.F.'s condition is no longer serious enough to require inpatient care (or the lifetime benefit under the plan is exhausted). Under the terms of the plan, Regence is entitled to reevaluate K.F.'s medical condition in the future and to make eligibility determinations based on then-existing facts. Regence must, however, make medical necessity determinations in keeping with the analysis set forth above: the fact that K.F.'s parents can provide certain nursing services does not and will not relieve Regence of its contractual obligation to provide care. ⁵

FOOTNOTES

⁵ Defendants argue that the record cannot support an award of future benefits because K.F.'s medical needs will likely change as she grows. Section 1132(a)(1)(B) of ERISA specifically authorizes the Court to clarify rights to future benefits under the plan, while Section 1132(a)(3) **[*18]** authorizes actions against the claim administrator to enjoin conduct that violates the terms of the plan. The Court is not declaring an immutable right to coverage or otherwise abrogating Regence's ability to reevaluate K.F.'s needs in the future. It is simply clarifying K.F.'s right to benefits under the facts presented here and precluding Regence from utilizing the parent-centric analysis of medical necessity that resulted in its incorrect and unreasonable coverage denial.

CONCLUSION

For all of the foregoing reasons, defendants' motion for reconsideration (Dkt. # 61) is DENIED and the Clerk of Court is directed to enter judgment in favor of plaintiff and against defendants.

Dated this 19th day of September, 2008.

/s/ Robert S. Lasnik

Robert S. Lasnik

United States District Judge

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1998 U.S. Dist. LEXIS 5022, *

TIE COMMUNICATIONS, INC., Plaintiff, v. FIRST HEALTH STRATEGIES, INC., Defendant.

CIVIL ACTION No. **97-2597-EEO**

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF KANSAS

1998 U.S. Dist. LEXIS 5022

March 3, 1998, Decided

March 3, 1998, Filed; March 4, 1998, Entered on the Docket

DISPOSITION: [*1] Plaintiff's motion to remand (Doc. # 8) granted.

CASE SUMMARY

PROCEDURAL POSTURE: Plaintiff employer filed a motion to remand to state court its breach of contract action against defendant health plan administrator (administrator).

OVERVIEW: The employer formed a self-insurance program to provide medical benefits for its employees, and obtained an excess insurance policy. The employer entered into an agreement with the administrator to operate the plan. The employer remained the plan's fiduciary. An employee became severely ill and incurred substantial medical bills. The employer filed suit in state court against the administrator, and alleged that it had breached the agreement by failing to provide the excess insurer with information in a timely manner and failing to provide run-out claims services. The administrator removed the action to federal court claiming that the Employment Retirement Income Security Act (ERISA), preempted the employer's state law claims. The employer filed a motion to remand. The court held that the employer's state law claims were not preempted by ERISA because the administrator was not a fiduciary and because the claims involved interpretation of the administration agreement, not interpretation of the employee benefit plan. The court held that federal law did not provide a replacement cause of action for the state law claims. The court granted the motion to remand.

OUTCOME: The court granted the employer's motion to remand the cause of action to state court.

CORE TERMS: preempted, preemption, benefits plan, beneficiary, state laws, law claims, cause of action, replacement, administrator, plan administrators, employee benefits, fiduciary, provider, federal law, plan participants, administrative services, excess insurer, preemption provision, particular choice, removal, entity, bind, laws of general application, law provides, excess loss, timely manner, state cause of action, contractual claims, equitable relief, self-insured

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HN1 A civil action is removable only if plaintiff could have brought the action in federal court originally. See [28 U.S.C.S. § 1441\(a\)](#). The court is required to remand an action to state court if at any time before final judgment it appears that the district court lacks subject matter jurisdiction. [28 U.S.C.S. § 1447\(c\)](#). Defendant has the burden of demonstrating that removal was proper and the court has original jurisdiction. Because the courts of the United States are courts of limited jurisdiction, there is a general presumption against federal jurisdiction. Accordingly, the court must strictly construe the federal removal statute. Any doubts concerning removability must be resolved in favor of remanding the case to state court. [More Like This Headnote](#)

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HN2 A defendant may remove a state court action to federal court based on preemption if (1) the state law claims are preempted by federal law and (2) congress has provided for a replacement of the state law cause of action with a federal cause of action. [More Like This Headnote](#)

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HN3 The Employee Retirement Income Security Act (ERISA), supersedes any and all state laws insofar as they relate to any employee benefit plan. 29 U.S.C.S. § 1144(a). It is well established that the scope of ERISA preemption is very broad. The express preemption provisions of ERISA are deliberately expansive, and designed to establish pension plan regulation as exclusively a federal concern. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

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HN4 The threshold issue in determining whether the Employee Retirement Income Security Act (ERISA) preempts a state cause of action is whether plaintiff's claims "relate to" its employee benefit plan. A law "relates to" an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan. Although the term "relates to" is quite broad, it is not unlimited. Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law "relates to" the plan. What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

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HN5 To determine the scope of the Employee Retirement Income Security Act (ERISA), preemption, courts must look at the purposes of ERISA and ascertain whether congress intended for a particular cause of action to survive. The purpose of ERISA is to protect participants in employee benefit plans and their beneficiaries. In passing the ERISA preemption clause, congress intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among states or between states and the federal government, and to prevent the potential for conflict in substantive law requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. At least three categories of state laws are preempted by ERISA: (1) state laws that mandate employee benefit structures or their administration, (2) state laws that provide alternate enforcement mechanisms for employees to obtain plan benefits, and (3) state laws that bind plan administrators to a particular choice or preclude uniform administrative practice of benefit plans. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

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HN6 When a plaintiff's state contractual claims will not bind plan administrators to a particular choice or preclude the uniform administration of benefit plans and when the claims fit into the category of state laws of general application, the claims ordinarily are not preempted by the Employee Retirement Income Security Act (ERISA). Claims which involve traditional areas of state law, e.g., contract law, which do not remotely conflict with or implicate the underlying purposes of ERISA -- to -- protect plan participants and their beneficiaries and to provide a uniform body of employee benefit law are not preempted by ERISA. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

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[Insurance Law](#) > [Industry Regulation](#) > [Federal Regulations](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [ERISA Preemption](#)

[Bad Faith & Misrepresentation](#)

HN7 For federal preemption of state law claims, the federal replacement cause of action does not have to be identical to the state cause of action or provide the same remedies. [More Like This Headnote](#)

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[Pensions & Benefits Law](#) > [Employee Retirement Income Security Act \(ERISA\)](#) > [Civil Claims & Remedies](#) > [Equitable Relief](#)

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HN8 29 U.S.C.S. § 1132(a)(3) provides a cause of action by a participant, beneficiary, or fiduciary: (A) to enjoin any act or practice which violates any provision of § 1132(a) 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 § 1132(a) or the terms of the plan. While a non-fiduciary administrator may be sued under § 1132(a)(3), a plaintiff must allege a violation of the Employee Retirement Income Security Act (ERISA) or a plan to recover under the statute. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

COUNSEL: For TIE COMMUNICATION, INC., plaintiff: Patrick L. Dunn, Dunn & Keller, L.C., Kansas City, MO.

For FIRST HEALTH STRATEGIES, INC., defendant: Heather Suzanne Woodson, Stinson, Mag & Fizzell, P.C., Overland Park, KS.

For FIRST HEALTH STRATEGIES, INC., defendant: Mark M. Iba, Stinson, Mag & Fizzell, P.C., Kansas City, MO.

For FIRST HEALTH STRATEGIES, INC., defendant: Bentley J Tolk, Gary A Dodge, Salt Lake City, UT.

JUDGES: EARL E. O'CONNOR, United States District Judge.

OPINION BY: EARL E. O'CONNOR

OPINION

MEMORANDUM AND ORDER

This matter is before the court on plaintiff's motion to remand (Doc. # 8). After careful consideration of the parties' briefs, the court is prepared to rule. As an initial matter, the court finds that oral argument will not be of material assistance in resolving plaintiff's motion and, therefore, defendant's request for oral argument is denied. For the reasons set forth below, plaintiff's motion to remand will be granted.

Factual Background

On October 9, 1997, plaintiff Tie Communications, Inc. ("Tie") filed this action against First Health Strategies, Inc. ("First Health") in the District Court of [*2] Johnson County, Kansas. Tie sponsored and funded a self-insured medical benefits plan (the "Plan") for its participating employees and beneficiaries. Tie entered into a Master Services Agreement with First Health under which First Health was obligated to perform administrative services which included, in part, the handling of the medical bills and disbursement of the Plan's funds for the benefit of the Plan's beneficiaries. Tie remained the Plan fiduciary and retained all discretionary authority and control over plan administration. To protect the Plan against catastrophically large claims, Tie purchased an Excess Loss Insurance Policy from the Insurance Company of North America ("INA").

Emily Riggatieri, a beneficiary of the Plan, became severely ill in 1996. Ms. Riggatieri incurred \$ 366,373.84 in medical expenses covered by the Plan. Tie alleges that First Health breached the Administrative Services Agreement by failing to provide INA with information regarding Ms. Riggatieri's expenses under the Plan in a timely manner. Tie also alleges that First Health failed to provide run-out claims service for the benefit of the Plan.

On November 21, 1997, First Health removed the state [*3] court action to this court claiming that Tie's state law claims relate to the Plan within the meaning of the preemption provision of the Employment Retirement Income Security Act ("ERISA").

Standards For Remand

HN1 A civil action is removable only if plaintiff could have brought the action in federal court originally. See 28 U.S.C. § 1441(a). The court is required to remand an action to state court "if at any time before final judgment it appears that the district court lacks subject matter jurisdiction...." 28 U.S.C. § 1447(c). Defendant has the burden of demonstrating that removal was proper and the court has original jurisdiction. See McNutt v. General Motors Acceptance Corp., 298 U.S. 178, 189, 80 L. Ed. 1135, 56 S. Ct. 780 (1936). Because the courts of the United States are courts of limited jurisdiction, there is a general presumption against federal jurisdiction. See Basso v. Utah Power & Light Co., 495 F.2d 906, 909 (10th Cir. 1974). Accordingly, the court must strictly construe the federal removal statute. See Merrell Dow Pharmaceuticals, Inc. v. Thompson, 478 U.S. 804, 814, 92 L. Ed. 2d 650, 106 S. Ct. 3229 (1986); [*4] Fajen v. Foundation Reserve Ins. Co., Inc., 683 F.2d 331, 333 (10th Cir. 1982); Henderson v. Holmes, 920 F. Supp. 1184, 1186 (D. Kan. 1996); J.W. Petroleum, Inc. v. R.W. Lange, 787 F. Supp. 975, 977 (D. Kan. 1992). Any doubts concerning removability must be resolved in favor of remanding the case to state court. See Henderson, 920 F. Supp. at 1186; J.W. Petroleum, Inc., 787 F. Supp. at 977.

Analysis

HN2 A defendant may remove a state court action to federal court based on preemption if (1) the state law claims are preempted by federal law and (2) Congress has provided for a replacement of the state law cause of action with a federal cause of action. See Schmeling v. NORDAM, 97 F.3d 1336, 1342 (10th Cir. 1996).

I. Preemption Of Plaintiff's State Law Claims.

Section 514(a) states that **HN3** ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan ..." 29 U.S.C. § 1144(a). It is well established that the scope of ERISA preemption is very broad. See, e.g., Straub v. Western Union Telegraph Co., 851 F.2d 1262, 1263 (10th Cir. 1988). The Supreme Court noted in [*5] Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 45, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987), that the "express preemption provisions of ERISA are deliberately expansive, and designed to establish pension plan regulation as exclusively a federal concern."

HN4 The threshold issue is whether plaintiff's claims "relate to" its employee benefit plan. A "law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97, 77 L. Ed. 2d 490, 103 S. Ct. 2890 (1983). Although the term "relates to" is quite broad, it is not unlimited. See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655, 131 L. Ed. 2d 695, 115 S. Ct. 1671 (1995) ("If 'relate to' were taken to extend to the furthest stretch of its

indeterminacy, then for all practical purposes pre-emption would never run its course, for 'really, universally, relations stop nowhere.'" (internal quotation omitted); *Airparts Co., Inc. v. Custom Benefit Services of Austin, Inc.*, 28 F.3d 1062, 1065 (10th Cir. 1994) (ERISA preemption is not unlimited). "Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral [***6**] a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21. "What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit." *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146-47 (2d Cir.), cert. denied, 493 U.S. 811, 107 L. Ed. 2d 25, 110 S. Ct. 57 (1989); see *Travelers*, 514 U.S. at 659 (finding that indirect economic influences do not bind plan administrators to any particular choice and therefore do not function as a regulation of an ERISA plan itself); *Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc.*, 944 F.2d 752, 754 (10th Cir. 1991) ("The mere fact that the [law] has some economic impact on the plan does not require that the [law] be invalidated") (quoting *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2d Cir. 1984), cert. denied, 472 U.S. 1008, 86 L. Ed. 2d 718, 105 S. Ct. 2702 (1985)).

The Supreme Court emphasizes ^{HN5} that to determine the scope of ERISA preemption, courts must look at the purposes of ERISA and [***7**] ascertain whether Congress intended for a particular cause of action to survive. See *Travelers*, 514 U.S. at 655-56. The purpose of ERISA is to protect participants in employee benefit plans and their beneficiaries. See *id.* at 656; *Massachusetts v. Morash*, 490 U.S. 107, 115, 104 L. Ed. 2d 98, 109 S. Ct. 1668 (1989) ("In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds."). In passing the ERISA preemption clause, Congress intended

to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government ..., [and to prevent] the potential for conflict in substantive law ... requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

Travelers, 514 U.S. at 656-57 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990)). In light of the Congressional [***8**] intent behind the ERISA preemption provision, the Supreme Court has held that at least three categories of state laws are preempted by ERISA: (1) state laws that "mandate employee benefit structures or their administration," (2) state laws that provide "alternate enforcement mechanisms" for employees to obtain plan benefits, and (3) state laws that bind plan administrators to a particular choice or preclude uniform administrative practice of benefit plans. 514 U.S. at 658-59. Other courts have drawn similar boundaries for ERISA preemption. "Laws that have been ruled preempted are those that provide an alternative cause of action to employees to collect benefits protected by ERISA, refer specifically to ERISA plans and apply solely to them, or interfere with the calculation of benefits owed to an employee. Those that have not been preempted are laws of general application -- often traditional exercises of state power or regulatory authority -- whose effect on ERISA plans is incidental." *Monarch Cement Co. v. Lone Star Indus., Inc.*, 982 F.2d 1448, 1452 (10th Cir. 1992) (quoting *Aetna*, 869 F.2d at 146).

Applying the above principles, we find that Tie's state law claims against [***9**] First Health are not preempted by ERISA. Tie's claims involve First Health's alleged failure to timely submit a benefits claim to INA pursuant to the Administrative Services Agreement. Interpretation of Tie's benefit plan is not involved, or is at most tenuously connected to the central dispute, which involves the Administrative Agreement between Tie and First Health and the Excess Insurance Agreement between Tie and INA. There is no dispute between the parties as to whether Ms. Riggatieri, the participant who submitted a claim, was entitled to benefits under the plan or the amount of those benefits. See *Monarch*, 982 F.2d at 1453 (finding no preemption in part because the participants' entitlement to benefits was undisputed, parties only disputed the proportion each party was required to pay pursuant to a sales agreement). Only one ERISA-related entity, Tie, is involved in this dispute. See *Airparts*, 28 F.3d at 1065 ("Ultimately, if there is no effect on the relations among the principal ERISA entities -- the employer, the plan, the plan fiduciaries, and the beneficiaries -- there is no preemption. As a corollary, actions that affect the relations between one or more of these [***10**] plan entities and an outside party similarly escape preemption.").

We note that Tie's claims do not fall into any of the categories of claims that the Supreme Court and the Tenth Circuit have held are preempted. In particular, ^{HN6} Tie's contractual claims will not bind plan administrators to a particular choice or preclude the uniform administration of benefit plans. On the other hand, Tie's claims fit into the category of state laws of general application which ordinarily are not preempted by ERISA. Tie's claims involve traditional areas of state law, e.g., contract law, which do not remotely conflict with or implicate the underlying purposes of ERISA -- to -- protect plan participants and their beneficiaries and to provide a uniform body of employee benefit law. See *Airparts*, 28 F.3d at 1066 ("no Congressional purpose [is] furthered by denying an ERISA plan a state cause of action against allegedly negligent third-party service providers"); *Monarch*, 982 F.2d at 1452 (claim which does not impose "conflicting directives" or threaten an employee's entitlement to benefits does not implicate the purposes of ERISA); *Hospice of Metro Denver*, 944 F.2d at 756 ("Denying a third-party [***11**] provider a state law action based upon misrepresentation by the plan's insurer in no way furthers the purposes of ERISA."). Indeed, the protection of plan participants may be impaired if the plan or plan administrator cannot contract with third party providers, such as First Health or even a copier service, with an expectation that traditional contractual remedies will be available.

Several courts have held that state law actions by an employer against a third party administrator who is not a plan fiduciary, such as First Health, are not preempted by ERISA. See *Geweke Ford v. St. Joseph's Omni Preferred Care Inc.*, 130 F.3d 1355 (9th Cir. 1997); *Jefferson Parish Hosp. Serv. Dist. v. Ruby Tuesday's Inc.*, 1998 U.S. Dist. LEXIS 767, No. Civ. A. 97-2722, 1998 WL 24422, at *5-6 (E.D. La. Jan. 23, 1998) (employer's contractual claim for indemnification against administrator pursuant to administration agreement is not preempted by ERISA); *Union Health Care, Inc. v. John*

Alden Life Ins. Co., 908 F. Supp. 429 (S.D. Miss. 1995) (claim against administrator alleging that it failed to timely notify excess insurer of claims is not preempted by ERISA); see also [*12] *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 833, 100 L. Ed. 2d 836, 108 S. Ct. 2182 (1988) (run-of-the-mill state law contract claims, "although obviously affecting and involving ERISA plans and their trustees," are not preempted by ERISA). In *Geweke*, a self-insured employer sued Omni, a company that provided ministerial administrative services for the employer's plan, and Alden, an insurance company that contracted with the employer to provide excess loss coverage. 130 F.3d at 1357, 1361. The employer brought its claims for breach of contract and declaratory relief in state court to recover sums paid by the employer for a plan beneficiary's claim. 130 F.3d at 1357. The employer alleged that Omni failed to administer and process benefit claims covered under the employer's plan. *Id.* Omni and Alden removed the case to federal court, arguing that ERISA preempted the employer's state law claims. *Id.* The Ninth Circuit, relying on the Supreme Court's reasoning in *Travelers*, held that the employer's state law claims against Omni were not preempted by ERISA. *Id.* at 1359. The court emphasized that the employer's claims against Omni were based on Omni's alleged failure to file a claim with the excess insurer [*13] properly and in a timely manner, there was no alleged failure to administer the employer's plan. *Id.*

First Health's reliance on *Tri-State Machine, Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309 (4th Cir. 1994), cert. denied, 513 U.S. 1183, 130 L. Ed. 2d 1128, 115 S. Ct. 1175 (1995), is misplaced. In *Tri-State*, a plan sponsor sued a third party administrator who also was an excess insurer for "paying claims to wrong medical providers, issuing coverage cards in the names of employees never associated with Tri-State, charging claims to accounts of individuals who had not submitted claims, paying claims not covered, denying claims that were covered, and delaying processing of claims in a year when the stop-loss limit had been reached in order to deflect them into a new policy year to be charged against Tri-State under its self-funding obligations." *Id.* at 313-14. The court found that all of these claims essentially involved the improper processing of benefit claims and therefore were preempted under ERISA. *Id.* at 314. In *Tri-State*, protection of plan participants and their beneficiaries clearly was involved and therefore ERISA preemption may have been appropriate. [*14] In addition, the Fourth Circuit decided *Tri-State* prior to the Supreme Court's decision in *Travelers*, which more clearly defined the scope of ERISA preemption. Several of the other authorities cited by First Health also predate the Supreme Court's decision in *Travelers* or are inconsistent with the decision.

For the above reasons, the court finds that plaintiff's claims are not preempted by federal law.

II. Replacement Cause Of Action Under ERISA.

We also will analyze whether defendant has met the second requirement for removal to federal court, *i.e.*, whether federal law provides a replacement cause of action for plaintiff's state law claims. See *Schmeling*, 97 F.3d at 1342. The Tenth Circuit has noted that ^{HNS} the federal replacement cause of action does not have to be identical to the state cause of action or provide the same remedies. *Id.* at 1343.

First Health argues that section 502(a)(3) of ERISA provides Tie with a replacement cause of action for its state law claims. ^{HNS} Section 502(a)(3) provides a cause of action "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the [*15] 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 subchapter or the terms of the plan." See 29 U.S.C. § 1132. While a nonfiduciary administrator may be sued under section 502(a)(3), a plaintiff must allege a violation of ERISA or a plan to recover under the statute. See *Varity Corp. v. Howe*, 516 U.S. 489, 116 S. Ct. 1065, 1077-78, 134 L. Ed. 2d 130 (1996) (section 502(a)(3) is a catchall provision that offers appropriate equitable relief for injuries caused by violations that § 502 does not elsewhere adequately remedy") (emphasis added). Here, Tie has not alleged that First Health violated the Plan or any of the statutory provisions of ERISA and First Health has not established under what legal theory Tie could pursue its claims pursuant to section 502(a)(3).

In sum, defendant has failed to meet its burden to establish either that federal law preempts plaintiff's state law claims or that federal law provides a replacement cause of action. Accordingly, remand of this action to state court is appropriate.

IT IS THEREFORE ORDERED that plaintiff's motion to remand (Doc. # 8) is [*16] granted. This case is remanded to the District Court for Johnson County, Kansas.

Dated this 3rd day of March, 1998, at Kansas City, Kansas.

EARL E. O'CONNOR

United States District Judge

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2008 U.S. Dist. LEXIS 114755, *

WASHINGTON STATE AUTO DEALERS INSURANCE TRUST, Plaintiff/Cross-Claimant, v. AON CONSULTING, INC.,
Defendant/Third-Party Plaintiff, v. LUMENOS, INC., Third-Party Defendant.Case No. **C07-1182** MJP

UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF WASHINGTON

2008 U.S. Dist. LEXIS 114755

November 11, 2008, Decided
November 11, 2008, Filed**PRIOR HISTORY:** [Wash. State Auto Dealers Ins. Trust v. Aon Consulting, Inc., 2008 U.S. Dist. LEXIS 86488 \(W.D. Wash., Oct. 22, 2008\)](#)**CORE TERMS:** preempted, state laws, limine, contract claim, preemption, law claim, enforcement mechanisms, interfere, unopposed, benefits plan, citation omitted, fiduciary, holistic, entity, disclosure, ambiguous**COUNSEL:** [*1] For Washington State Auto Dealers Insurance Trust, an employee benefits trust, Plaintiff: [Charles H. Thulin](#), LEAD ATTORNEY, EKMAN BOHRER & THULIN, SEATTLE, WA; [Richard E Spoonemore](#), LEAD ATTORNEY, SIRIANNI YOUTZ MEIER & SPOONEMORE, SEATTLE, WA.For Aon Consulting Inc, a New Jersey corporation, Defendant: [Maria E Sotirhos](#), [Robert Craig Levin](#), [Scott M Stickney](#), WILSON SMITH COCHRAN & DICKERSON, SEATTLE, WA.For Lumenos, Inc., ThirdParty Defendant: [Gwendolyn C. Payton](#), [John R Neeleman](#), LANE POWELL PC (SEA), SEATTLE, WA.For Aon Consulting Inc, a New Jersey corporation, Counter Claimant: [Maria E Sotirhos](#), [Scott M Stickney](#), WILSON SMITH COCHRAN & DICKERSON, SEATTLE, WA.For Washington State Auto Dealers Insurance Trust, an employee benefits trust, Counter Defendant: [Charles H. Thulin](#), LEAD ATTORNEY, EKMAN BOHRER & THULIN, SEATTLE, WA; [Richard E Spoonemore](#), LEAD ATTORNEY, SIRIANNI YOUTZ MEIER & SPOONEMORE, SEATTLE, WA.For Aon Consulting Inc, a New Jersey corporation, ThirdParty Plaintiff: [Maria E Sotirhos](#), [Scott M Stickney](#), WILSON SMITH COCHRAN & DICKERSON, SEATTLE, WA.For Washington State Auto Dealers Insurance Trust, an employee benefits trust, Cross Claimant: [Charles H. Thulin](#), LEAD ATTORNEY, [*2] EKMAN BOHRER & THULIN, SEATTLE, WA; [Richard E Spoonemore](#), LEAD ATTORNEY, SIRIANNI YOUTZ MEIER & SPOONEMORE, SEATTLE, WA.For Lumenos, Inc., Cross Defendant: [Gwendolyn C. Payton](#), [John R Neeleman](#), LANE POWELL PC (SEA), SEATTLE, WA.**JUDGES:** [Marsha J. Pechman](#), U.S. District Judge.**OPINION BY:** [Marsha J. Pechman](#)**OPINION**

ORDER ON PARTIES' MOTIONS IN LIMINE

This matter comes before the Court on motions in limine brought by Lumenos, Inc. ("Lumenos") and

Aon Consulting, Inc. ("Aon"). (Dkt. Nos. 83, 84, 86, 88 & 89.) All parties, including Plaintiff Washington State Auto Dealers Insurance Trust ("WSADIT"), have responded to the motions as required. After reviewing the briefing submitted and the balance of the record, the Court orders as follows:

I. Lumenos's Motions in Limine

1. Motion to Exclude Reference to Wellpoint (Dkt. No. 83)

This motion is DENIED. Lumenos has not shown that its affiliation with Wellpoint, Inc. is prejudicial.

2. Motion to Exclude Bruce Carlson (Dkt. No. 84)

This motion is DEFERRED. The Court will preview Mr. Carlson's testimony before it is offered to the jury and will evaluate its admissibility under the *Daubert* standard.

3. ERISA Preemption (Dkt. No. 86)

This motion is DENIED. Lumenos errs in asserting that **[*3]** Tri-State Mach., Inc. v Nationwide Life Ins. Co., 33 F.3d 309 (1994) "controls the outcome of Lumenos' motion and dictates that the Court grant Lumenos' motion in limine." (Reply at 2.) This Court looks to the Ninth Circuit for guidance on ERISA preemption analysis. After the Supreme Court decision in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995), the Ninth Circuit modified its preemption analysis and created a new framework for determining whether a state law claim is preempted by ERISA. See Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson, 201 F.3d 1212, 1217-1219 (9th Cir. 2000) (collecting cases and summarizing history of preemption analysis in the Ninth Circuit).

The Ninth Circuit formulated the "relationship test" ¹ in General Am. Life Ins. Co. v. Castonguay, 984 F.2d 1518, 1522 (9th Cir. 1993) and Arizona State Carpenters Pension Trust Fund v. Citibank, 125 F.3d 715, 722 (9th Cir. 1997). This test emphasizes:

three traditional areas identified as preempted by the Supreme Court in *Travelers*: (1) "state laws that mandate ... employee benefit structures or their administration"; (2) "state laws that bind employers or plan **[*4]** 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." Arizona State Carpenters, 125 F.3d at 723 (quoting Coyne & Delany Co. v. Selman, 98 F.3d 1457 (4th Cir.1996)) (citations and internal quotation marks omitted). [The Ninth Circuit] concluded that "[1] where state law claims fall outside [these] 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[,] the state law claims are not preempted." *Id.* at 724.

Rutledge, 201 F.3d at 1217. The court emphasized a similar "relationship" approach in *Geweke Ford*, reiterating that "[a] state law claim is preempted if it 'encroaches on the relationships regulated by ERISA.'" Geweke Ford v. St. Joseph's Omni Preferred Care, Inc., 130 F.3d 1355, 1358 (9th Cir. 1997) (quoting Castonguay, 984 F.2d at 1522). The court went on to state:

ERISA does not preempt regulation of those relationships 'where a plan **[*5]** operates just like any other commercial entity [-] for instance the relationship between the plan and its own employees, or the plan and its insurers or creditors.' Under *Castonguay*, the key issue is whether the parties' relationships are ERISA-governed relationships.

Geweke Ford, 130 F.3d at 1358 (citation omitted).

FOOTNOTES

¹ Later, the court "made clear that the multi-pronged test in *Arizona State Carpenters* was not the exclusive guide for the Circuit." Rutledge, 201 F.3d at 1218 (citing Operating Eng'rs Health & Welfare Trust Fund v. JWJ Contracting Co., 135 F.3d 671 (1998)). Because WSADIT brings only a common law contract claim, the factors test developed in *Aloha Airlines* and *Operating Eng'rs* is inapplicable.

The Ninth Circuit expanded the "relationship" test in Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Group, Inc., 187 F.3d 1045 (9th Cir.1999), but:

analyzed the issue from the perspective of ERISA's purposes, concluding that the purposes of ERISA preemption, as explained by *Travelers*, did not apply because "[t]he state law ... does not create an alternative enforcement mechanism for securing benefits under the terms of ERISA-covered plans" and "the economic effects that the ... claims **[*6]** might have on the plans does not imply that the claims interfere with the field of benefits law that Congress sought to occupy with ERISA."

Rutledge, 201 F.3d at 1219 (citations omitted).

In 2001, the Ninth Circuit observed that Supreme Court decisions issued after *Travelers* "have eschewed ... multi-factor tests in favor of a more holistic analysis guided by congressional intent." *Dishman v. UNUM Life Ins. Co. of America*, 269 F.3d 974, 981 (9th Cir. 2001) (citing *Egelhoff v. Egelhoff*, 532 U.S. 141, 121 S. Ct. 1322, 149 L. Ed. 2d 264 (2001)). Applying a holistic analysis, the Ninth Circuit determined that a state law tort did not relate to an ERISA plan because the tort remedy did not "interfere with nationally uniform plan administration" or provide an "alternative enforcement mechanism." *Id.*

Keeping the *Dishman* approach in mind, this Court applies the "relationship" test developed in *Castonquay* and *Arizona State Carpenters* and expanded by *Geweke Ford, Blue Cross of Cal.*. Under this analysis, 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 [*7] 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*, 269 F.3d at 981. 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 U.S. Dist. LEXIS 5022, 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 ... [*8] and the Excess Insurance Agreement[.]"

Because WSADIT's contract claim is not preempted by ERISA, Lumenos's motion in limine is DENIED.

II. Aon's Motions in Limine (Dkt. No. 88)

1. Reference to Fiduciary Duties

The Court GRANTS this unopposed motion.

2. Reference to Negligent Actions

The only remaining claims at issue are for breach of contract. Because no tort claims remain, the legal negligence standard is not at issue and will not be presented to the jury. This motion is DENIED -- the Court will not disallow any party from using the word "negligent" in its common usage.

3. Lumenos's Rebuttal Witness

The Court GRANTS this unopposed motion.

4. Item No. 3 on AIG Disclosure List

This motion is DENIED. The parties contest whether the plain language of AIG's disclosure request encompassed information about R.A.P.'s claim. This is a question for the jury.

5. Renewal Clause

This motion is DENIED. The Court found the clause ambiguous as it relates to a limitation on damages and construed the ambiguous language against the drafter. (Dkt. No. 74 at 5.) Having ruled on the legal issue, nothing remains for a jury to decide.

6. Testimony Regarding Damages Limitation Clause

The Court GRANTS this unopposed [*9] motion.

The Clerk is directed to send a copy of this order to all counsel of record.

Dated: November 11, 2008.

/s/ Marsha J. Pechman ▾

Marsha J. Pechman ▾

U.S. District Judge

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