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PREEMPTION "BETWEEN THE POLES:" ERISA'S EFFECT ON STATE COMMON LAW ACTIONS OTHER THAN BENEFIT CLAIMS

Troy A. Price*

I. INTRODUCTION

In the decade since *Pilot Life Insurance Company v. Dedeaux*¹ and *Metropolitan Life Insurance Company v. Taylor*,² the Employee Retirement Income Security Act of 1974 (ERISA)³ has swept with extraordinary force⁴ across the field of state common laws regulating relationships between those who seek to collect health, life, disability, or other job-related benefits and those who either sponsor such benefits or play some role in deciding benefit claims. Congress charted the preemptive effect of this federal law on the basis of a functional landmark, the employee benefit plan.⁵ When a claim for benefits is a part of an employee welfare benefit plan⁶ or pension plan,⁷ it arises

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1. 481 U.S. 41 (1987). The Court held that ERISA preempted an employee's breach of contract and tort claims against the insurance company that issued his employer's group disability policy. *Id.* The opinion by Justice Sandra Day O'Connor acknowledged that a framework for preemption decisions had by then emerged, and that one of its essential features was the breadth of the preemption language in the statute. *Id.*

2. 481 U.S. 58 (1987). Justice O'Connor wrote the opinion holding that plaintiff's contract and wrongful termination claims arising from a disability dispute not only were preempted, but were completely displaced by ERISA remedies so as to authorize removal of a well-pleaded complaint in which only state claims were raised. *Id.*

3. 29 U.S.C. §§ 1001-1461 (1994).

4. In *Metropolitan Life*, the Supreme Court described ERISA as having "unique preemptive force" as well as such "extraordinary" power as to convert purported state law claims into claims that necessarily are federal in character. 481 U.S. at 64-65 (comparing sweep of ERISA preemption to that under § 301 of the Labor Management Relations Act (LMRA), 29 U.S.C. § 185, by which any suit alleging violation of a contract between an employer and a labor union is purely a creature of federal law, despite the fact that state law would otherwise provide a cause of action).

5. As used in ERISA, "[t]he term 'employee benefit plan' or 'plan' means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both." 29 U.S.C. § 1002(3).

6. ERISA § 3(1) provides, in relevant part, as follows:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits,

exclusively under ERISA — which displaces all state law rights and remedies in favor of the comprehensive federal mechanism for defining⁸ and enforcing rights.⁹

The contours of preemption are not as well defined with respect to laws that affect common law actions other than those by which plan participants or beneficiaries seek benefits under plans sponsored by employers. In such cases, mapping the boundaries of the prerogatives reserved to the states in their historic areas of concern has required closer scrutiny of the extent to which the state law "relate[s] to" an employee welfare benefit plan.¹⁰ Generally, when a state common law cause of action merely has some incidental effect, tenuous connection, or minor reference to such a plan, the state law survives; "run-of-the-mill state law claims such as unpaid rent, failure to pay creditors, or even torts committed by ERISA plans . . . although obviously affecting and involving ERISA plans and their trustees, are not preempted by ERISA."¹¹

apprenticeship or other training programs, or day care centers, scholarship funds or prepaid legal services . . .

29 U.S.C. § 1002(1).

7. Section 3(2)(A) of ERISA provides as follows:

[Except as the Secretary of Labor may prescribe certain exemptions,] the terms "employee pension benefit plan" and "pension plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program—

- (i) provides retirement income to employees, or
- (ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond, regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan.

Id. § 1002(2)(A).

8. See, e.g., *Donovan v. Dillingham*, 688 F.2d 1367, 1370 (11th Cir. 1982) ("Broadly stated, ERISA established minimum standards for vesting of benefits, funding of benefits, carrying out fiduciary responsibilities, reporting to the government and making disclosures to participants.") (quoting H.R. REP. NO. 533, 93d Cong., 2d Sess. 3 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639).

9. This is so because "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Pilot Life*, 481 U.S. at 54.

10. See ERISA § 514, which provides as follows:

(a) Supersedure; effective date. Except as provided [by exceptions set out in the statute], the provisions of this subchapter and subchapter III shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described [by the statute].

29 U.S.C. § 1144(a). State laws include "laws, decisions, rules, regulations, or other State action having the effect of law." 29 U.S.C. § 1144(c)(1).

11. *Mackey v. Lanier Collection Agency & Serv. Co.*, 486 U.S. 825 (1988) (ERISA did

When the action adjusts relationships between ERISA entities,¹² or draws on the benefit plan as a source of rights, preemption usually applies.¹³

"Between the poles of those laws that clearly 'relate to' an ERISA plan and those that are clearly too tenuously related are a host of state laws that pose more difficult questions of preemption."¹⁴ This article surveys preemption in this gray area. It includes an overview of ERISA litigation, which is necessary to an appreciation of the effect of preemption in destroying state law causes of action as well as in displacing them with federal remedies.¹⁵ It also suggests that, because of a seemingly heightened focus on the distinction between "super" or "complete" preemption and ordinary preemption, state courts may play a growing role in defining the limits of preemption. Focusing on the Eighth Circuit, the article notes the emergence of a multi-factor test¹⁶ that

not preempt state's general garnishment statute, despite its effect on plan participants; however, state law that singled out ERISA plans for protective treatment as to garnishment had sufficiently strong reference to plan as to be preempted); see *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) (no preemption of state law requiring one time payment of severance benefits, since the law did not require or establish a benefit plan, an essential element of which would be an ongoing administrative program to meet the employer's obligation).

12. See, e.g., *In re Life Ins. Co. of N. Am.*, 857 F.2d 1190 (8th Cir. 1988) (Missouri statute creating damages for an insurance company's vexatious refusal to pay disability benefits was completely preempted by ERISA).

13. Within the sphere of benefit determinations and enforcement of rights stemming from benefit plans, Congress chose a "closely integrated regulatory system" marked by "various safeguards to preclude abuse and 'to completely secure the rights and expectations brought into being by this landmark reform legislation.'" *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990) (quoting S. REP. NO. 127, 93d Cong., 2d Sess. 36 (1974), reprinted in 1974 U.S.C.C.A.N. 4838, 4872). Thus, in *Ingersoll-Rand*, a former employee's state law claim that he was fired so that the employer could avoid contributing to his pension fund was held preempted, as it would have required proof that an ERISA plan existed and that the employer was motivated to avoid the terms of the plan. *Id.* at 140. Otherwise, the Court reasoned, various states might exercise their power to develop different common law standards applicable to the same employer conduct. *Id.* at 142. Inefficiencies arising from conflicting burdens might work to the detriment of beneficiaries. *Id.*

14. *Bannister v. Sorenson*, 103 F.3d 632, 635 (8th Cir. 1996).

15. At least in the Eighth Circuit, when a state law claim is preempted, the district court should examine the complaint to determine whether a cause of action has been stated under ERISA. *Slice v. Sons of Norway*, 978 F.2d 1045 (8th Cir. 1992) (*Slice I*).

16. See, e.g., *Bannister*, 103 F.3d at 635 (setting forth six factors for determining ERISA preemption: (1) whether the state law negates a plan provision; (2) the effect on primary ERISA entities; (3) the impact on plan administration; (4) the economic impact on the plan; (5) whether preemption is consistent with other provisions of ERISA; and (6) whether the state law at issue is an exercise of traditional state power). The factors were initially outlined by the Eighth Circuit in the context of a challenge to state legislation. See *Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341, 1344-45 (8th Cir. 1992); see also *Boyle v. Anderson*, 68 1093, 1101-1110 (8th Cir. 1995), cert. denied, 116 S. Ct. 1266 (1996) (applying factors to state health provider tax). In *Bannister*, the Eighth Circuit adopted this test for application in "both the common law and statutory environment." *Bannister*, 103 F. 3d at 635.

should supply a measure of predictability and regularity¹⁷ to preemption analysis in the wake of the Supreme Court's recent characterization of the once-venerated "relates to" test as merely "unhelpful."¹⁸ Finally, the article examines the way some courts have resolved preemption issues arising from actions falling between the realm of benefit claims (whether of the direct or disguised variety) that are plainly preempted, and that of state common law claims that scarcely have anything to do with employee benefit plans.

The effect of ERISA preemption on state legislation is a subject of great interest and speculation, ripe for further clarification on the basis of signals from the Supreme Court.¹⁹ That topic, however, is beyond the scope of this article. The virtually infinite permutations of possible state legislation bearing on health care and health care providers assures that preemption litigation will continue in that arena for some time, with each new Supreme Court decision further refining the permissible reach of state legislation.²⁰ Indeed, as this article was written an Arkansas federal judge²¹ had issued an order enjoining

17. The Eighth Circuit has disclaimed any view of the test as a "magic formula for determining preemption," but has acknowledged that it "sets forth an analytical structure for ERISA preemption claims that facilitates reasoned decision-making and appellate review." *Bannister*, 103 F.3d at 636.

18. See New York State Conference of Blue Cross/Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) (*New York Blues*). For a thorough and thought-provoking discussion of the background of the Supreme Court's focus on the broad and common meaning of "relates to," and its effect on preemption analysis, see generally Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35 (1996) [hereinafter, *The Last Article*]. Professor Fisk suggests that questionable analytical methodology and unfortunate social policy resulted from the Court's "slavish devotion to literalist textualism in interpreting ERISA's broad preemption provision." *Id.* at 39.

If that were so, it no longer seems to be the case, as Professor Fisk acknowledges. In *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 117 S. Ct. 832 (1997), the court further abandoned the "unhelpful text" of ERISA's preemption provision in favor of a more refined two-part inquiry: whether the law has express reference to a plan, *Id.*, (citing *District of Columbia v. Washington Bd. of Trade*, 506 U.S. 125, 129 (1992) (law imposed by reference to ERISA covered programs is preempted) and *Mackey*, 486 U.S. at 829-30 (preemption applies to law that excluded ERISA plans by reference to them), or a "reference" to be inferred from the fact that the existence of an ERISA plan is essential to the very operation of the law. *E.g.*, *Ingersoll-Rand*, 498 U.S. 133.

19. Nevertheless, the Court seems inclined to allow lower courts some time in which to apply its *New York Blues* framework, and has declined to review an early circuit court decision preempting a state law imposing any willing provider requirements on ERISA plans. See *CIGNA Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642 (5th Cir.), *cert. denied*, 117 S. Ct. 387 (1996).

20. See, *e.g.*, *California Div. of Labor Standards Enforcement*, 117 S. Ct. 832 (holding that state prevailing wage law that neither "made reference to" nor had a connection with ERISA plan was not preempted).

21. The Hon. James M. Moody, United States District Judge for the Eastern District of Arkansas.

the enforcement portions of Arkansas's Patient Protection Act of 1995,²² on the ground that the state statute was preempted by ERISA,²³ by the time the article is published, the Eighth Circuit may have decided the anticipated appeal in the case.

II. ERISA'S COMPREHENSIVE MECHANISM

A. Scope of Statute

The emerging preemption issues might be more easily resolved if, as the title of the statute suggests, Congress had acted only to regulate pension relationships between employers and employees or their beneficiaries. To the contrary, ERISA applies broadly to disputes in which employers play no greater role than facilitating the purchase of insurance by their employees.²⁴ Indeed, an employer who sponsors insurance can escape the reach of ERISA only by carefully structuring that benefit²⁵ so as to minimize its involvement.²⁶

22. ARK. CODE ANN. § 23-99-201 to -209 (Michie Supp. 1995), popularly known as the "Any Willing Provider Act".

23. See *Prudential Ins. Co. v. National Park Medical Ctr.*, No. LR-C-95-514, order, (E.D. Ark. Jan. 31, 1997). Plaintiffs in that case filed a complaint in federal court seeking declaratory and injunctive relief to prevent the enforcement of state legislation designed to ensure "that patients . . . be given the opportunity to see the health care provider of their choice" by allowing providers to participate in health benefit plans. ARK. CODE ANN. § 23-99-202 (Michie Supp. 1995). Under the "Any Willing Provider" clause, health insurers were not to impose monetary advantages or penalties that would affect a beneficiary's choice among providers; insurers were also prohibited from excluding providers who were willing to accept the health benefit plan's terms and conditions. The legislature sought to exempt ERISA plans from the effect of the Act, by providing that it did not apply to "self-funded or other health benefit plans that are exempt from state regulations by virtue of [ERISA]." *Id.* § 23-99-209. The district court noted that preemption applies even when a state's law seeks to single out ERISA plans; in a facially favorable way, for exclusion from laws of general applicability. *Prudential v. Nat'l Park Medical Ctr.*, order at 10-11 (citing *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 829 (1988)). Applying the standard established by the Eighth Circuit, the district court concluded that the Any Willing Provider provisions were too strongly connected to ERISA plans to stand. See also *CIGNA Healthplan*, 82 F.2d 642.

24. It is not necessary that the employer sponsor a detailed or exhaustive plan or program in order for the employee to bring claims for benefits under ERISA. The statute applies even if the plan is not written, since the specific reporting and disclosure requirements contained in the statute impose duties on fiduciaries but do not prevent the *existence of a plan*. See *Donovan*, 688 F.2d at 1372. See also *Robinson v. Linomaz* 58 F.3d 365 (8th Cir. 1995).

25. The Department of Labor has promulgated regulations setting forth a "safe harbor" in the form of a test which, if met in every respect, provides a strong indication that insurance purchased in connection with the workplace is not an employee welfare benefit plan:

The terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employers . . . under which

(1) No contributions are made by an employer or employee organization;

B. Written Plans as Source of Rights

Congress envisioned that every employee benefit plan would be established and maintained pursuant to a written plan.²⁷ This, the Supreme Court has explained, is one of ERISA's "core functional requirements."²⁸ The Congressional emphasis on the written plan has sometimes been regarded as irreconcilable with common law principles such as equitable estoppel, by which parties may negate the express terms of instruments through their conduct.²⁹ Even such well-entrenched legal doctrines as *contra proferentem*

(2) Participation in the program is completely voluntary for employees or members;

(3) The sole functions of the employer or employee organization with respect to the program are . . . to permit the insurer to publicize the program . . . , to collect premiums . . . , and to remit them to the insurer; and

(4) The employer or employee organization receives *no consideration* in the form of cash or otherwise in connection with the program[.]

29 C.F.R. § 2510.3-1(j) (1996). The insurance purchase is not exempt from ERISA unless all four of these standards are met. *See, e.g.,* Gahn v. Allstate Life Ins. Co., 926 F.2d 1449, 1452 (5th Cir. 1991); Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236, 243 (5th Cir. 1990).

26. *See Donovan*, 688 F.2d at 1370. The question of whether the individual seeking benefits is actually an employee may be a critical one, to be resolved under general common law principles. *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318 (1992) (summary judgment in favor of company on ground that agent was an independent contractor, as determined by application of traditional agency principles, including the following: the hiring party's right to control the manner and means by which the project was accomplished; the skill required; the source of the instrumentalities and tools; the location of the work; the duration of the relationship between the parties; whether the hiring party had the right to assign additional projects to the hired party; the extent of the hired party's discretion over when and how long to work; the method of payment; the hired party's role in hiring and paying assistants; whether the work was part of the hiring party's regular business; whether the hiring party was in business; the provision of employee benefits; and the tax treatment).

As new workplace issues emerge from the growing use of leased employees and independent contractors, courts will be called upon to make more determinations about the existence of a benefit plan in the context of nontraditional hiring relationships. *See, e.g.,* *Viscaino v. Microsoft Corp.*, 97 F.3d 1187 (9th Cir. 1996) (holding that plaintiffs were common law employees entitled to participate in benefit plans although their relationship with the plan sponsor had been described in agreements as that of independent contractors).

27. 29 U.S.C. § 1102(a)(1).

28. *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73 (1995). "In the words of the key congressional report, '[a] written plan is to be required in order that every employee may, on examining the plan documents, determine exactly what his rights and obligations are under the plan.'" *Id.* (citation omitted). The statute and the regulations promulgated under it require plan administrators to give every new participant in the plan a Summary Plan Description (SPD) setting forth the terms of the plan. 29 U.S.C. §§ 1024(b)(1)(A), 1021(a)(1), 1022(a)(1). When new employees receive an SPD, it must be accompanied by any summaries of material modifications or changes that have not yet been incorporated into the SPD. 29 C.F.R. § 2520.104b-3(c) (1996).

29. *See, e.g.,* *Weber v. St. Louis Univ.*, 6 F.3d 558, 560 (8th Cir. 1993) (estoppel

may yield to the emphasis on plan language, as shaped by the regulatory scheme requiring use of terms in their ordinary meaning.³⁰ There are many other requirements,³¹ some of which support the view that Congress intended to regulate comprehensively the benefits aspects of private contracts for employment within the states.³²

C. Effect on Litigation

1. *Causes of Action.*

In section 502 of ERISA Congress provided six specific mechanisms for enforcement of the rights created under the Act. Participants and beneficiaries³³ were authorized to sue among other things, to (1) recover benefits due under the terms of a plan, (2) enforce rights under the plan, and (3) clarify their right to future benefits.³⁴ A participant, beneficiary, fiduciary, or the Secretary of Labor can sue for appropriate relief against one who has breached any of the responsibilities, obligations, or duties imposed on fiduciaries by ERISA.³⁵

In section 502(a)(3),³⁶ Congress authorized actions for certain kinds of equitable relief, including an injunction against an act or practice that violates

principles unavailable to contradict express plan terms).

30. *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150 (8th Cir. 1990).

31. For example, under ERISA the SPD must be written in a manner meant to be understood by the average plan participant; it must be accurate and reasonably comprehensive. 29 U.S.C. § 1022(a)(1). Federal regulations prohibit the distribution of an SPD whose format has the effect of misleading, misinforming, or failing to inform participants and beneficiaries. 29 C.F.R. § 2520.102-2(b) (1996). Any exceptions, limitations, reductions and restrictions applicable to benefits may not be minimized or rendered obscure through their description. *Id.*

32. Although Congress elected not to require any particular type of benefit in plans subject to ERISA, it included in the legislation carefully drawn provisions giving plan participants the right to obtain information about their benefits. An administrator who fails to comply with a participant's request for information that must be made available under the statute may be personally liable to the participant or beneficiary for an amount of up to \$100.00 per day. 29 U.S.C. § 1132(c).

33. Only a participant or beneficiary may bring a civil enforcement action under Section 502(a)(1). A participant or beneficiary is someone who "is or may become eligible to receive a benefit of any type from an employee benefit plan": 29 U.S.C. § 1002(7)-(8). The term "participant" covers former employees who reasonably expect to return to covered employment or who have a colorable claim for vested benefits. *Adamson v. Armco, Inc.*, 44 F.3d 650, 654 (8th Cir.), *cert. denied*, 116 S. Ct. 85 (1995) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 117-18 (1989)). Moreover, if the loss of participant status is a result of the fiduciary's alleged ERISA violation, the former participant has standing to challenge the fiduciary violation. *Id.* at 654-55; *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997).

34. 29 U.S.C. § 1132(a)(1)(B).

35. *See* 29 U.S.C. § 1132 (a)(2), 29 U.S.C. § 1109.

36. 29 U.S.C. § 1132(a)(3).

ERISA or the terms of the plan, or for "appropriate equitable relief" to (1) redress violations of the statute or plan or (2) enforce the plan or the provisions of ERISA. An employee benefit plan may be sued, or sue, as an entity.³⁷

Under section 510 of ERISA,³⁸ employers may not discriminate or take other adverse action against individuals³⁹ for exercising their ERISA rights.⁴⁰ The prohibition also applies to interfering with the attainment of ERISA rights, and to retaliation against those who have given information or testified in any proceeding under the statute.

Plan assets such as pension plan funds and employee stock ownership plan funds must be held in trust, and are not to inure to the benefit of the employer.⁴¹ Fiduciaries are charged with adherence to a "[p]rudent man standard of care,"⁴² avoiding participation in or knowing concealment of impropriety by other fiduciaries, and eschewing prohibited transactions, such as those with a party in interest.⁴³

ERISA does not provide employees or their beneficiaries a right to any particular welfare benefits. When an employer acts in its capacity as settlor, or creator of the plan, it may adopt or amend the plan without regard for the best interests of participants.⁴⁴

37. 29 U.S.C. § 1132(d)(1). Any money judgment obtained under Section 502 against the employee benefit plan is enforceable against the plan only, and not against any other person. 29 U.S.C. § 1132(d)(2).

38. 29 U.S.C. § 1140. The section provides as follows: "It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of [a plan, the Act, or certain other provisions of federal law]." *Id.*

39. An interesting aspect of section 510 litigation is the requirement that a person have "standing" in order to bring a claim; that is, he or she must be a participant or beneficiary of a plan. When workers have been discharged, the question arises as to whether they have a reasonable expectation of receiving benefits under the plan. *See, e.g.,* Shahid v. Ford Motor Co., 67 F.3d 1404 (6th Cir. 1996); Fleming v. Ayers & Assocs., 948 F.2d 993 (6th Cir. 1991) (woman hired one day and fired, allegedly in an effort to avoid high medical costs associated with her child, was a participant with standing to sue for discrimination in provision of benefits); Kross v. Western Elec. Co., 701 F.2d 1238 (7th Cir. 1983) (discharge by employer to avoid high costs of benefits for employee's benefits was actionable).

40. The evidentiary framework under section 510 mirrors that applicable to Title VII and Age Discrimination in Employment (ADEA) cases. *Kinkhead v. Southwestern Bell Tel. Co.*, 49 F.3d 454, 456 (8th Cir. 1995) (if claimant can establish prima facie case of violation of section 510, burden shifts to employer to articulate legitimate, nondiscriminatory reason for its action; if this is done, the burden shifts back to plaintiff to show offered reason was pretextual); *accord*, *Dister v. Continental Group, Inc.*, 859 F.2d 1108, 1111 (2d Cir. 1988).

41. 29 U.S.C. § 1103.

42. 29 U.S.C. § 1104(a).

43. 29 U.S.C. § 1106.

44. *Curtiss-Wright Corp.*, 514 U.S. 73. An employer may unilaterally modify or terminate benefits. *John Morrell & Co. v. United Food & Commercial Workers Int'l*, 37 F.3d 1302, 1303-04 (8th Cir. 1994), *cert. denied*, 115 S. Ct. 2251 (1995). *See also* *Ravenscraft v. Hy-Vee*

2. *Equitable Nature of Actions.*

The rights and remedies arising under ERISA are rooted in the equitable law of trusts. Thus, it is widely held that no right to jury trial exists under the statute, and trial of an ERISA case to a jury can constitute reversible error.⁴⁵ Furthermore, the legal remedy of punitive damages does not fit within the equitable scheme chosen by Congress.⁴⁶

3. *Standard of Review.*

The proper standard for judicial review of benefit determinations under ERISA turns on the language of the document establishing the employee benefit plan.⁴⁷ If the plan document gives discretionary authority to the plan administrator or other fiduciary to determine eligibility for benefits or to construe the plan's terms, the fiduciary's decisions must be reviewed under a deferential standard; if there is no language granting discretion, review is *de novo*.⁴⁸ A court may overturn a fiduciary's discretionary decision in such circumstances only if the claimant demonstrates an abuse of that discretion.⁴⁹

Employee Benefit Plan & Trust, 85 F.3d 398 (8th Cir. 1996) (ERISA did not provide continued right to plan benefits formerly available).

45. *Houghton v. SIPCO, Inc.*, 38 F.3d 953, 957 (8th Cir. 1994) (reversing and remanding judgment on jury verdict where district court declined to make precautionary findings and conclusions). "The Supreme Court's decision in *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993) confirms that there is no right to money damages or a jury trial under ERISA." *Id.* ERISA displaces state common law with a comprehensive set of federal remedies, all of which are equitable in nature. See *Kirk v. Provident Life & Accident*, 942 F.2d 504 (8th Cir. 1991) (no Seventh Amendment right to jury trial under ERISA) (citing *In re Vorpahl*, 695 F.2d 318 (8th Cir. 1982)).

46. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) (punitive damages and extracontractual damages not available for benefit denial claims under ERISA).

47. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 108-09 (1989).

48. *Id.* at 115. Appellate courts apply *de novo* review to the district court's application of deferential review. *E.g.*, *Maune v. International Bd. of Elec. Workers*, 83 F.3d 959, 962 (8th Cir. 1996).

49. See *Donaho v. FMC Corp.*, 74 F.3d 894, 898 (8th Cir. 1996); *Cox v. Mid-America Dairymen, Inc.*, 965 F.2d 569, 571 (8th Cir. 1992) (*Cox I*), *aff'd after remand*, 13 F.3d 272 (8th Cir. 1993) (*Cox II*). In *Donaho*, the court surveyed various formulations of the discretionary standard employed by Eighth Circuit panels, noting that the court has looked to a substantial evidence standard, *Donaho*, 74 F.3d at 898 (citing *Short v. Central States, S.E. & S.W. Areas Pension Fund*, 729 F.2d 567, 571 (8th Cir. 1984)), has required that the decision be "reasonable," *Id.* (citing *Cox II*, 13 F.3d at 274), and has upheld decisions that were characterized as not "'extraordinarily imprudent or extremely unreasonable,'" *Id.* (citing *Licktieg v. Business Men's Assurance Co. of Am.*, 61 F.3d 579, 583 (8th Cir. 1995)). Writing for the *Donaho* panel, Senior Circuit Judge Myron H. Bright observed that the last of these formulations should be viewed as an example of abuse of discretion, and not as a threshold for review. *Id.* at 898-99. The proper standard was merely one of reasonableness, as reflected by substantial evidence to support the fiduciary's decision. In determining whether a decisive

This deferential standard "does not permit a reviewing court to reject a discretionary trustee decision with which the court simply disagrees."⁵⁰ Typical insurance policy language, however, does not give rise to deferential review.⁵¹

4. *Unique Evidentiary Rules.*

The applicable standard impacts the admissibility of evidence at trial as well.⁵² When the deferential standard applies, the court ordinarily refuses to consider materials that were not presented to the claim administrator.⁵³

When the plan documents do not support deferential review, the trial court may for good cause shown, "allow the parties to introduce evidence in addition to that presented to the fiduciary" if necessary for adequate de novo review.⁵⁴

interpretation of plan language or terms is reasonable, the Eighth Circuit applies the five-factor test outlined in *Finley v. Special Agents Mut. Benefit Ass'n*, 957 F.2d 617 (8th Cir. 1992) (in determining whether plan decision is reasonable court considers 1) whether fiduciary's interpretation is consistent with the goals of plan; 2) whether the interpretation renders any language in plan meaningless or internally inconsistent; 3) whether fiduciary's interpretation conflicts with substantive or procedural requirements of ERISA; 4) whether fiduciary has interpreted relevant term consistently; and 5) whether interpretation is contrary to the clear language of the plan).

50. *Donaho*, 74 F.3d at 898 (quoting *Cox I*, 965 F.2d at 572). Furthermore, the court is not to substitute its own weighing of conflicting evidence for that of the body given discretion. Faced with a record that supports both parties' positions, the court cannot find the fiduciary's decision arbitrary or capricious. *Collins v. Central States S.E. & S.W. Areas Health & Welfare Fund*, 18 F.3d 556, 560 (8th Cir. 1994).

51. *Ravenscraft*, 85 F.3d 398, 402 n.2. See also *Bounds v. Bell Atl. Enters. Flexible Long-Term Disability Plan*, 32 F.3d 337, 339 (8th Cir. 1994).

52. See *Donatelli v. Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993) (appropriate standard affects evidence admissible and legal analysis applied).

53. *Id.* at 765 n.2.

54. *Id.* at 763. Furthermore, if the fiduciary fails or refuses to decide a claim, the district court may address benefits issues de novo, deciding the case on a "somewhat expanded" factual basis. *Mansker v. TMG*, 54 F.3d 1322 (8th Cir. 1995).

5. *Exhaustion of Remedies.*

Although nothing in the language of the statute requires it,⁵⁵ many courts have interpreted Congressional intent to favor exhaustion of administrative remedies as a prerequisite to bringing a claim for benefits. Failure to exhaust appeal procedures outlined in a plan can result in dismissal of the benefit claim in federal court.⁵⁶

6. *Fee-Shifting.*

Although ERISA preempts state laws regarding fee-shifting, the statute contains its own provisions for award of fees to either party.⁵⁷

III. EVOLUTION OF PREEMPTION ANALYSIS

A. Text of Section 514

In section 514, Congress directed that the statute was to "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."⁵⁸ By means of a saving clause, Congress excepted from the statute's preemptive sweep those laws that regulate insurance, banking, and

55. See *Conley v. Pitney Bowes*, 34 F.3d 714, 718 (8th Cir. 1994) (judicially created exhaustion requirements may advance goals of ERISA, but need not be applied in case where fiduciary has failed to inform beneficiary of procedures for appeal of decision). As the court acknowledged, the doctrine is broadly regarded as serving important purposes in ERISA. *Id.* at 718 (citing *Constantino v. TRW, Inc.*, 13 F.3d 969, 975 (6th Cir. 1994) (exhaustion requirement (1) reduces frivolous lawsuits; (2) promotes consistent treatment of claimants; (3) provides non-adversarial means of claims settlement; (4) minimizes costs of claims resolution for all parties; (5) enhances the ability of fiduciaries efficiently to manage plans by preventing premature judicial intervention; (6) gives fiduciaries a chance to correct their errors, or to convince disappointed benefit seekers that they are incorrect; (7) enhances the ability of the fiduciary to interpret plan provisions; and (8) helps assemble a record that will assist the court in reviewing the fiduciary's actions).

56. *Southwestern Bell*, 111 F.3d 67. See also Kevin D. Hart, Annotation, *Exhaustion of Administrative Remedies as Prerequisite to Suit Under Employee Retirement Income Security Act of 1974* (29 U.S.C.S. §§ 1001 et seq.), 54 A.L.R. FED 364 (1981).

57. See 29 U.S.C. § 1132(g). *International Bd. of Elec. Workers*, 85 F.3d 959, 963 (to determine whether award of fees to prevailing party is warranted, court should consider (1) degree of culpability or bad faith assigned to opposing party; (2) opposing party's ability to pay; (3) potential for deterring others in similar circumstances; (4) whether the moving party sought to benefit all participants and beneficiaries or resolve a significant legal question regarding ERISA; and (5) the relative merits of the parties' positions) (citing *Mansker v. TMG Life Ins. Co.*, 54 F.3d 1322, 1329 (8th Cir. 1995) and *Lawrence v. Westerhaus*, 749 F.2d 494, 495-96 (8th Cir. 1994) (per curiam)).

58. 29 U.S.C. § 1144(a).

securities.⁵⁹ The preemption framework is completed by a deemer clause, in which Congress made clear that state laws purportedly regulating insurance may not deem an employee benefit plan to be an insurance company.⁶⁰

1. *Indicia of Congressional Purpose.*

Although the Supreme Court paused in *New York Blues* to acknowledge the difficulty of applying a true "relates to" test when "'really, universally, relations stop nowhere,'"⁶¹ it is not as if the remarkable breadth of the "relates to" language in ERISA's preemption clause occurred only recently to the Court. Rather, the potentially limitless sweep of the phrase was seen for years as a reflection of Congressional intent to forestall intentional or inadvertent interference by states in a delicately balanced scheme designed to benefit employees by carefully regulating benefit plans while encouraging employers to adopt and maintain fair plans.

Thus, courts have variously explained Congress' adoption of a preemption rule that the Supreme Court has characterized as "deliberatively expansive"⁶² and "conspicuous for its breadth."⁶³ Most commonly, the explanation reflects the Supreme Court's observation that ERISA's comprehensive set of remedies⁶⁴ would make little sense if states could adopt contrary or conflicting remedies.⁶⁵

2. *Effect of Regulatory Scheme.*

The preemption principles emanating from the Supreme Court's pension cases are quite strong and relatively clear, since Congress has supplied its own thorough regulatory mechanism that displaces state attempts to regulate in a concrete way the law of pensions.⁶⁶ There has been little challenge to the view

59. 29 U.S.C. § 1144(b)(2)(A).

60. 29 U.S.C. § 1144(b)(2)(B).

61. 115 S. Ct. at 1677 (quoting H. James, Roderick Hudson xli (New York ed., WORLD CLASSICS (1980)).

62. *See Pilot Life*, 481 U.S. at 46.

63. *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990).

64. "The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985).

65. *See Pilot Life*, 481 U.S. at 54 ("The policy choices reflected in the inclusion of certain remedies and the exclusion of others would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA."); *see also* *Mohamed v. Kerr*, 53 F.3d 911 (8th Cir. 1995).

66. Particularly with respect to pensions, ERISA is a "comprehensive and reticulated statute." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510 (1981) (quoting Nachman

that Congress "meant to establish pension plan regulation as exclusively a federal concern."⁶⁷

As in the case of pension plans, in the context of employee welfare benefit plans, the Supreme Court in *Pilot Life Insurance Co. v. Dedeaux*⁶⁸ had little trouble discerning a clear Congressional intent to preempt the field in favor of federal regulation, thereby completely preventing the possibility of contrary or inconsistent state law regulation.⁶⁹ The claim at issue was brought by a worker whose long term disability benefits were terminated after he received them for two years following a back injury at work. Over the next three years, Pilot Life terminated and reinstated the benefits several times.⁷⁰

Finding the claim preempted, the Court observed that there could be no dispute that the common law causes of action asserted in the complaint "related to" an employee welfare benefit plan so that the plaintiff's claims brought under the Mississippi law of first party bad faith by an insurance company were preempted.⁷¹

Except as to the claims of employees and their beneficiaries for specific benefits,⁷² preemption rules operate with less certainty outside the realm of pension rights, since Congress has not crafted an extensive regulatory scheme with which to displace state law.⁷³ ERISA does impose administrative responsibilities on plan sponsors and others,⁷⁴ but apart from concerns imposed

Corp. v. Pension Benefit Guar. Corp., 446 U.S. 359, 361 (1980)).

67. *Alessi*, 451 U.S. at 523. In *Alessi*, the court held that Congress articulated its reasoning for expansive pension regulation in its statement of findings and declaration of policy: "despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans." 29 U.S.C. § 1001(a). ERISA supplies vesting and accrual standards, *Id.* § § 1053-1054, minimum rules for employee participation, *Id.*, § 1051, fiduciary standards, *id.*, § 1081-1085, fiduciary standards for those who control plan assets, *id.*, § § 1101-1114, and an insurance program in the event of plan termination, *Id.*, § 1341-1348. See *Alessi*, 451 U.S. 510-11 & n.5. In *Alessi* the Court held that a New Jersey statute prohibiting the offset of workers' compensation benefits against pension benefits was preempted by ERISA. Justice Marshall, writing for a unanimous Court, mentioned "respect for the separate spheres of governmental authority preserved in our federalist system," 451 U.S. at 522, but concluded that the state law was an "impermissible intrusion on the federal regulatory scheme," *Id.* at 525, in that it forbade a method of calculating benefits that Congress meant to permit.

68. 481 U.S. 41, 46 (1987).

69. *Id.* (citing 120 CONG. REC. 29,197, 29933 (1974) (remarks of Senator Williams regarding Employee Retirement Income Security Act of 1974)).

70. *Id.*

71. *Id.*

72. In the last decade, courts and counsel have grown accustomed to the fact that ERISA preempts contract claims for benefits brought by employees against the companies that supply insurance. See, e.g., *Anderson v. John Morrell & Co.*, 830 F.2d 872, 875 (1987) (state contract claim to recover benefits under employee welfare plan clearly preempted).

73. See generally, *The Last Article*, *supra* note 18.

74. See *supra* notes 29 & 33.

by other state and federal laws⁷⁵ those who draft plans are free to include or reject various species of benefits and limitations as they please. Moreover, although the statute does impose certain fiduciary duties on those who have particular roles in deciding claims,⁷⁶ it is unclear whether an action for breach of this duty would provide any basis for a claim based on denial of benefits.⁷⁷

B. Species of Preemption

In the context of removal of purported state law claims, the preemption analysis is critically shaped by the "well-pleaded complaint" rule.⁷⁸ If no federal question is presented on the face of the plaintiffs' properly pleaded complaint, removal is proper only if federal law completely displaces the field of state law actions so that any claim of the kind governed by federal law is completely displaced. Unless this is so, the statutory preemption language of section 514 provides a mere affirmative defense that is not present on the face of the complaint. Such defenses are insufficient to warrant removal to federal court.⁷⁹ The removing party must show that "Congress has so completely pre-

75. See, e.g., *Henderson v. Bodine Alum., Inc.*, 70 F.3d 958 (8th Cir. 1995) (per curiam) (enjoining as violation of Americans with Disabilities Act a benefit plan's decision to treat high dose chemotherapy treatment for breast cancer as a procedure that was not accepted for the disease and therefore not covered by the plan, while treating the same procedure as accepted treatment for other kinds of cancer).

76. A person is a fiduciary with respect to a plan to the extent he or she (1) has discretionary authority or control in the management of the plan or disposition of its assets; (2) renders investment advice for a fee; or (3) has any discretionary authority or responsibility for plan administration. ERISA § 3(21), 29 U.S.C. § 1002(21). The test is functional, and one may be a fiduciary for some purposes but not others. E.g., *Kerns v. Benefit Life Ins. Co.*, 992 F.2d 214 (8th Cir. 1993). An insurer is a fiduciary if it has authority to grant, deny, or review claims. *Robinson v. Linomaz*, 58 F.3d 365 n.6 (8th Cir. 1995). Under typical circumstances, third-party administrators are unlikely to be found to be fiduciaries, if they have no power to make the final decision regarding claims. See also, Wesley Kobylak, Annotation, *Who is "Fiduciary" within meaning of 3(21) of Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002(21))*, 67 A.L.R. FED. 186 (1984). The Department of Labor has issued Interpretative Bulletins addressing fiduciary status. See generally 29 C.F.R. 2509, 75-8 (1974).

77. See *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) (noting statutory provisions that fiduciary who breaches duty must make good "to such plan any losses to the plan" and restore "to such plan" any profits made through loss of plan assets). More recently, however, the Supreme Court has held that fiduciary duties may be enforced through Section 502(a)(3), which allows actions for "appropriate equitable relief" to enforce plan terms, and such relief may include reinstatement to coverage under a benefit plan. *Howe v. Varity Corp.*, 116 S. Ct. 1065 (1996), *aff'g* 36 F.3d 746 (8th Cir. 1994).

78. E.g., *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 353 (3d Cir.), *cert. denied, sub nom. U.S. Healthcare, Inc. v. Dukes*, 116 S. Ct. 564 (1995) (citing *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987)). The rule describes the basic boundaries of federal question jurisdiction. *Metropolitan Life*, 481 U.S. at 63.

79. See, e.g., *Metropolitan Life*, 481 U.S. at 63; *Dukes*, 57 F.3d at 353.

empt[ed] a particular area that any civil complaint raising this select group of claims is necessarily federal in character.”⁸⁰

“When the doctrine of complete preemption does not apply, but the plaintiff’s state claim is arguably preempted [by the ‘relates to’ language of 29 U.S.C. § 1144(a)], the district court, being without removal jurisdiction, cannot resolve the dispute regarding preemption.”⁸¹ Thus, the district court lacks power to do anything other than remand to state court, where the preemption issue, if properly raised, can be resolved.⁸²

Generally when the limits of section 514 “relates to” preemption have been raised, federal courts have rejected that provision as grounds for removal unless the claim is one that actually is best characterized as one that would fall within the scope of ERISA’s specific remedies.⁸³

C. Retreat from “Relates to” Analysis

In *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*,⁸⁴ the Supreme Court unanimously rejected a challenge to a New York statute that required hospitals to collect surcharges from patients covered by certain third party health providers, but not from patients covered by a Blue Cross/Blue Shield plan. Seemingly signaling a turn away from a focus on whether the state law merely “relates to” a plan in the sense of having any “connection” or “reference” to an ERISA plan, the Court acknowledged that such considerations do “not give much help in drawing the line” between state laws that survive preemption and those that are displaced.⁸⁵ “If ‘relate to’ were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course, for [r]eally, universally, relations stop nowhere.”⁸⁶ For the first time, the Court read the “relates to” language as Congress’ imposition of a limitation on the sweep of preemption, and looked instead to the scope of state law Congress

80. *Dukes*, 57 F.3d at 354 (quoting *Metropolitan Life*, 481 U.S. at 63-64).

81. *Dukes*, 57 F.3d at 355.

82. *Id.* (citing *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 4 (1983)).

83. *Rice v. Panchal*, 65 F.3d at 639 (Section 514 creates “conflict” preemption and does not support removal); *Warner v. Ford Motor Co.*, 46 F.3d 531, 534 (6th Cir. 1995) (Section 514(a) does not create federal cause of action); *Brown v. Connecticut General Life Ins. Co.*, 934 F.2d 1193, 1996 (11th Cir. 1991) (“super preemption” required in order to give court ERISA removal jurisdiction over well-pleaded state law complaint).

84. 115 S. Ct. 1671 (1995).

85. *Id.* at 1677.

86. *Id.* (quoting H. James, Roderick Hudson xli (New York ed., WORLD’S CLASSICS (1980)).

must have expected would survive the enactment of ERISA.⁸⁷ Specifically, the Court held that in light of the long held understanding that preemption analysis begins with "the starting assumption that Congress does not intend to supplant state law,"⁸⁸ indirect economic impact from legislation on ERISA plans is not reason enough to believe that Congress meant to nullify such laws.

The Supreme Court's disenchantment with application of a literal "relates to" test as a guide in preemption analysis became further evident in its February 1997 decision in *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A.*⁸⁹ The case involved a California prevailing wage law that required contractors on public works projects to pay workers the prevailing wage in the workers' locale, except that a lower wage could be paid to workers in an approved apprenticeship program. The Court held that ERISA did not preempt the law to the extent that it forbade payment of apprentice wages to apprentices in unapproved programs. After concluding that the California law did not "make reference to ERISA plans,"⁹⁰ the Court noted that the wage regulation was a traditional area of state concern as to which ERISA had little to say.⁹¹ Since the prevailing wage statute altered the incentives affecting ERISA plans but did not dictate their choices, it was "no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate."⁹²

Justice Scalia, joined by Justice Ginsburg, would have gone even further, proposing in his concurring opinion that the Court acknowledge that the "'relates to' project was doomed to failure," since it provided no real measure of Congressional intent or framework for discerning analysis, and that the criteria that evolved around that standard "have been abandoned."⁹³ Justice Scalia would undertake ERISA preemption analysis within the framework of "ordinary field preemption" and "ordinary conflict preemption" as applied to other questions of the supremacy of federal law. "Nothing more mysterious than that; and except as establishing that," Scalia wrote, "'relates to' is irrelevant."⁹⁴

87. *Id.*

88. *Id.* at 1676.

89. 117 S. Ct. 832 (1997).

90. *Id.* at 838.

91. *Id.* at 840.

92. *Id.* at 842 (quoting *New York Blues*, 115 S. Ct. at 1673).

93. 117 S. Ct. at 843 (Scalia, J., concurring).

94. *Id.* (Scalia, J., concurring) (citing *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984) (explaining that preemption can occur when Congress has either (1) evidenced an intent to occupy an entire field, or (2) entirely displaced state regulation over the matter in question to the extent it actually conflicts with federal law.)).

D. The Multi-Factor Test: Specific Impact

This we know of Congressional intent: section 514 was meant to prevent states from imposing varying obligations on ERISA plans in ways that might discourage or limit adoption of such plans, to the detriment of employees. Thus, the Eighth Circuit's multi-factor test—with its focus on impact on the plan, its entities, and its administration—seems appropriately directed toward discarding the confusion of “relates to” analysis in favor of an examination in each case of the core of Congressional concern.

“[T]he six factors are not themselves a magic formula.”⁹⁵ They serve instead to focus a reviewing court's attention on

the totality of the state [law's] impact on the plan: (1) whether the state law negates a plan provision; (2) the effect on primary ERISA entities; (3) the impact on plan administration; (4) the economic impact on the plan; (5) whether ERISA is consistent with other provisions of ERISA; and (6) whether the state law at issue is an exercise of traditional state power.”⁹⁶

It seems as well that impact, like relationships, can be relative. While one should resist the tendency to distill analyses to ever more terse formulas expressed in shorthand terms, it is useful to understand that common law that imposes duties, rather than mere cost choices among legally acceptable alternatives, is most at risk of preemption. An impact of this kind will almost always lead to a finding of preemption.

This is so even though the claim may not constitute the sort of direct request for plan benefits that lies at the pole of plain preemption. The fiduciary's unfavorable decision sometimes marks the beginning, rather than the denouement, of a beneficiary's otherwise legally cognizable injury. Accordingly, courts have been called upon to address actions for wrongful death, emotional distress, indirect financial loss, and exacerbation of physical injury claimed to have been legally caused by administrative choices within the framework of a benefit plan. Plaintiffs generally have not been successful in seeking to avoid preemption of actions against plans for their roles in utilization review or benefit-denial decisions even when the plans seem to have caused or contributed to injury. The Eighth Circuit's decision in *Kuhl v. Lincoln National Health Plan*⁹⁷ is illustrative. After Buddy Kuhl suffered a

95. *Bannister*, 103 F.3d at 636.

96. *Id.* (quoting *Arkansas Blue Cross & Blue Shield*, 947 F.2d at 1345). In some formulations, the Court has inserted as the third of seven factors consideration of whether the state law impacts the structure of ERISA plans.

97. 999 F.2d 293 (8th Cir. 1993). For a thorough discussion of the interplay between healthcare delivery systems and various liability theories, see generally, Brian P. Battaglia, *The Shift Toward Managed Care and Emerging Utilization Management and Financial Incentive*

heart attack, his physicians recommended prompt open heart surgery to alleviate a "high risk of sudden death."⁹⁸ Doctors at the Kansas City hospital where Kuhl was being treated determined that they did not have the equipment for the procedures Kuhl needed, and recommended that the operation be performed at Barnes Hospital in St. Louis.⁹⁹ The procedure was scheduled for July 6, 1989, at Barnes Hospital. On June 23, 1989, Lincoln National refused to precertify payment for the surgery because Barnes was out of its service area. The July surgery was canceled, and by the time Lincoln National determined in July that it would pay for the treatment, the surgery team at Barnes had become unavailable until September. Early in September, Kuhl's doctors discovered that his heart had deteriorated to such an extent that the surgery no longer was a viable option. Kuhl was placed on a heart transplant waiting list, but died in December 1989.

Addressing the district court's dismissal of the ensuing suit by the Kuhl family, the Eighth Circuit acknowledged that the Supreme Court's decisions did not "provide a clear-cut method for determining whether a state law which merely has some unintended effects on ERISA-governed plans will be preempted."¹⁰⁰ Nevertheless, the court presaged its coming focus on duty-based specific impact in the common law context when it noted no difference between Lincoln National's admitted cancellation¹⁰¹ of the surgery and its "decision not to precertify payment [which] relates directly to Lincoln National's administration of benefits."¹⁰²

Claims based on delay in approving treatment,¹⁰³ withholding of recommended equipment,¹⁰⁴ hospitalization or services,¹⁰⁵ termination of

Arrangements Between Healthcare Providers and Payers, 19 U. ARK. LITTLE ROCK L.J. 155 (1997).

98. 999 F.2d at 300.

99. *Id.*

100. *Id.* at 302.

101. The defendant admitted, apparently in an inadvertent response or lack of response to the filing by plaintiffs of a set of facts claimed not to be in dispute, that it had "canceled" the surgery. *Id.*

102. *Id.* at 303. Notably, the Court did not believe that the fact that the alleged wrong involves precertification necessarily would result in preemption in every case. The court mused that a state law claim might have survived if the facts had shown that the cancellation of the surgery or the delay in treatment had caused Kuhl to miss an opportunity for surgery for which he was prepared to pay. *Id.*

103. See, e.g., *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993) (claim preempted where treating doctor believed autologous bone marrow treatment for testicular cancer was necessary, but window of opportunity for such procedure passed while plan reconsidered its refusal to pay), *cert. denied*, 114 S. Ct. 1612 (1994).

104. *E.g.*, *Elsesser v. Philadelphia College of Osteopathic Medicine*, 802 F.2d 1286 (3d Cir. 1992) (HMO decision not to pay for heart monitor).

105. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.) (suit against utilization review provider following refusal to precertify expectant mother's hospitalization for high-risk

coverage,¹⁰⁶ refusal to refer to a specialist,¹⁰⁷ refusal to authorize psychiatric treatment,¹⁰⁸ or selection of facilities,¹⁰⁹ have been held preempted. Similarly, lower courts often have declined to allow state law actions based on the asserted negligence of managed care organizations in choosing or supervising health care providers.¹¹⁰

The Eighth Circuit's recent opinion in *Shea v. Esensten*¹¹¹ provides another guidepost. Although clearly disturbed at the defendant's alleged conduct of failing to reveal to a participant the serious financial incentives affecting his primary care physician's decision not to refer him to a cardiologist,¹¹² the court noted that "claims of misconduct against the administrator of an employer's health plan fall comfortably within ERISA's broad preemption provision."¹¹³ Applying the multi-factor test, the court concluded that the "outcome of [the plaintiff's] lawsuit would clearly affect how [the employer's] ERISA-regulated benefit plan is administered, and if similar cases are brought across the country, ERISA plan administrators will inevitably be forced to tailor their plan disclosures to meet each state's unique requirements."¹¹⁴ Such a result, the court reasoned, would plainly interfere with the uniform administration of plans.¹¹⁵

The result in *Shea* signals that the future of preemption analysis may be shaped as well by emerging notions of the remedies available under ERISA. The court's inquiry did not end with a finding of preemption; the plaintiff had charged the HMO with a breach of its fiduciary duty to the participant, and the

pregnancy) *cert. denied*, 113 S.Ct. 812 (1992).

106. *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505 (10th Cir. 1991) (allegation that depression over retroactive termination of life insurance brought about heart attack was preempted by ERISA).

107. *Rodriguez v. Pacificare of Texas, Inc.*, 980 F.2d 1014 (5th Cir. 1993).

108. *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995).

109. *Dearmas v. A.V. Med, Inc.*, 814 F. Supp. 1103 (S.D. Fla. 1995).

110. *See, e.g., Pomeroy v. Johns Hopkins Medical Serv., Inc.*, 868 F. Supp. 110 (D. Md. 1994); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994).

111. 107 F.3d 625 (8th Cir. 1997).

112. After experiencing chest pains, Patrick Shea made several visits to his family doctor. "Despite all the warning signs," *id.* at 626, the physician stated that referral to a cardiologist was unnecessary for his forty-year-old patient. *Id.* When Shea offered to pay for the cardiologist himself, the doctor persuaded him that he was too young and did not have enough symptoms to justify the visit. *Id.* Months later, Shea died of heart failure. *Id.* According to his widow's complaint, Shea did not know that his HMO's contract with the physician rewarded doctors for not making covered referrals, and that primary care doctors were docked a portion of their fees if they made too many such referrals. *Id.* at 627. The plaintiff alleged that if her husband had known this, he would have disregarded his physician's advice and would have seen a cardiologist at his own expense. *Id.*

113. *Id.* at 627 (citing *Kuhl*, 999 F.2d 298, 301-04).

114. *Shea*, 107 F.3d at 627.

115. *Id.*

court agreed that the plaintiff had stated a claim for breach of the duty to deal fairly and honestly with plan members by disclosing material information.¹¹⁶ The court declined to address issues about what remedies, if any, might be available to the plaintiff, since those matters were not addressed by the district court.¹¹⁷

The importance of the shift away from a focus on the existence of relationships toward an evaluation of the specific types of impact on plan administration or plan entities is well illustrated by the different outcomes of two lawsuits arising from the same denial of medical benefits under a group policy purchased by Candace Wilson's employer. Wilson first sued in state court in Missouri. After removing the case to federal court, defendant Prudential Insurance Company obtained summary judgment based on the terms of the exclusion in its policy applicable to expenses that were, or could have been, covered by workers' compensation. The Eighth Circuit affirmed.¹¹⁸ In a subsequent action, however, the appellate court reversed a summary judgment in favor of the Prudential agent who sold the policy to Wilson's employer, holding that Wilson could proceed with her state law claim of negligent misrepresentation against the agent.¹¹⁹ Since the state law had no implied or express reference to ERISA plans, the court applied the multi-factor test for the totality of the circumstances constituting any "connection" between the law and the plan. Although Wilson's suit against the agent seemingly did "relate to" her employer's welfare benefit plan, the Eighth Circuit noted that the action did not seek benefits under the employer's plan, and it did not affect relations between ERISA entities, impact plan structure, or affect plan administration.¹²⁰ In a significant aspect of the latter determination, the court characterized the agent's alleged misrepresentation as "pre-plan tortious conduct" of a type that would not impose new duties on plan administrators. Had the alleged tort occurred during the course of plan administration, it seems the preemption calculus would be altered, even for a claim solely against the insurance company agent.¹²¹

116. *Id.* at 628.

117. The plaintiff's victory might have been an empty one, if only traditional equitable relief, and not damages, are available for breach of fiduciary duty. *See supra* note 78.

118. *Wilson v. Prudential Ins. Co.*, 97 F.3d 1010 (8th Cir. 1996). Four circuit judges voted to grant Wilson's petition for rehearing with suggestion of rehearing in banc.

119. *Wilson v. Zoellner*, 114 F.3d 713 (8th Cir. 1997).

120. *Id.* at 718-719.

121. The court was untroubled by the possibility that Prudential might be obliged to indemnify Zoellner, and thus could be liable in its capacity as the employer of a tortfeasor, since "Prudential will not be liable in any way for its administration of an ERISA plan, but rather for the coincidental and unrelated conduct of its agent." *Id.* at 718.

The Eighth Circuit's decision in *In Home Health, Inc. v. The Prudential Insurance Co.*¹²² represents an important application of the multi-factor preemption test to claims arising from representations regarding the limits of plan benefits. It seems likely that under an expansive "relates to" analysis, such claims would be preempted, since the validity of the claim could not be determined without reference to the plan. Applying the multifactor test, however, the Eighth Circuit held that this connection was not controlling, because the health care provider's claim that an insurer had negligently represented that a benefit limit had not been reached was not based on the provider's assignment of rights by the participant.¹²³ Thus, allowance of the claim would not negate a plan provision by allowing greater benefits than the plan provided.¹²⁴ The court also found that allowing the claim would not impose additional administrative requirements on the insurer, an ERISA entity, because it would be free in the future to decline to respond to inquiries about benefit limits.¹²⁵ Even if it chose to respond, it would only be required to perform a bookkeeping function, not change its procedures for administering claims.¹²⁶ This distinguished the case from *Arkansas Blue Cross & Blue Shield*, in which the assignment statute at issue would have forced the administrator to alter the way in which it processed claims and "would have imposed significant administrative burdens on the administrator in determining whether a beneficiary had assigned his or her benefits to a health care provider."¹²⁷

122. 101 F.3d 600 (8th Cir. 1996).

123. *Id.* Courts regularly view the claims of providers who have been misled about the benefits available as distinct from the claims asserted by participants who have been similarly misled. Recovery for the former species of claims does not, in a sense, result in greater benefits being provided under the plan, since the duty to make good for the representation derives from the plan terms or administration, despite its connection to those matters. *See, e.g.,* *The Meadows v. Employers Health Ins.*, 47 F.3d 1006, 1011 (9th Cir. 1995); *Lordmann Enterprises, Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533 (11th Cir. 1994), *cert. denied*, 116 S. Ct. 335 (1995); *Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc.*, 944 F.2d 752, 756 (10th Cir. 1991); and *Memorial Hosp. System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 250 (5th Cir. 1990). *Contra*, *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (6th Cir. 1991), *cert. dismissed*, 113 S. Ct. 2 (1992).

124. *In Home Health*, 101 F.3d 600. ERISA generally preempts claims seeking greater or different benefits based on misrepresentations or fraud concerning plan provisions. *See, e.g.,* *Pohl v. National Benefit Consultants, Inc.*, 959 F.2d 126 (7th Cir. 1992); *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6 (2d Cir. 1992); *Lister v. Stark*, 890 F.2d 941 (7th Cir. 1989), *cert. denied*, 498 U.S. 1011 (1990); *Degan v. Ford Motor Co.*, 869 F.2d 889 (5th Cir. 1989).

125. *In Home Health*, 101 F.3d at 606.

126. *Id.*

127. *Id.* at 606. Although the claim against an ERISA entity arising from actions it took in the course of plan duties was not preempted, it is unclear whether the Eighth Circuit would align with those courts holding that claims arising from common law related to corporate duties may not be preempted, if the impact on plan entities is not strong. *Cf. Williams v. Cypert*, 708

IV. CONCLUSION

Between the poles of claims for benefits on one hand and state legislation that has only indirect economic impact on ERISA plans on the other hand lie a species of claims that in some sense "relate to" employee benefit claims; they may require a reference to the plan for resolution or calculation of damages, or they may be connected with the plan in some other manner. If analyzing these cases in light of any relationship or connection to plans is, as Justice Scalia suggests, a doomed exercise, then multifactor tests can help courts make decisions based on the specific types of impact visited on plan terms and administration by the common law at issue and thus may dominate ongoing preemption analysis as to these claims.

F. Supp. 229, 231 (W.D. Ark. 1989) (no preemption of state claims connected to ERISA plan when allegation is that defendants have breached a state law duty arising from their separate capacities as officers and directors of a corporation) (citing *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters., Inc.*, 793 F.2d 1456, 1468 (5th Cir. 1986)). *See also* *Richmond v. American Sys. Corp.*, 792 F. Supp. 449, 458 (E.D. Va. 1992) (law governing corporations is quintessentially the province of traditional state authority and should not be displaced when dispute only incidentally implicates ERISA plan). Even if such suits alleging breach of corporate law duties are preempted, it is unlikely that the complete preemption exists to justify removal in the face of the well-pleaded complaint rule. *See* *Constantine v. Minis*, 910 F. Supp. 657 (S.D. Ga. 1995).